A G E N D A
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, November 17, 2011 at 7:00 p.m.
399 Ridout Street North
Side Entrance, (Recessed Door)
Board of Health Boardroom

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

SCHEDULE OF APPOINTMENTS

7:10 - 7:20 p.m.	Mr. Ken Hall, Advisor, Community Relations, Enbridge Pipelines Inc., re Item #8
7:20 - 7:35 p.m.	Ms. Christine Heffer, Lyme Disease Awareness Advocate, re Item #1
7:35 - 7:50 p.m.	Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease & Sexual Health Services, re Item #1
7:50 - 8:00 p.m.	Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team, and Dr. Graham Pollett, Medical Officer of Health re Item #2
8:00 - 8:10 p.m.	Ms. Heather Thomas, Public Health Dietitian, re Item #3

ACTION REQUIRED

1) Report No. 102-11 re Lyme Disease Surveillance and Promotional Activities in Middlesex-London
2) Report No. 103-11 re Smoke-Free Public Outdoor Spaces - Technical Report and Recommended Policy Option
3) Report No. 104-11 re Nutritious Food Basket Costing Results for 2011 and the Opportunities for Action
4) Report No. 105-11 re Chief Nursing Officer Funding
5) Report No. 106-11 re Accessibility for Ontarians with Disabilities Act (AODA)
6) Report No. 107-11 re Energy Drinks: Health, Safety and Regulation

FOR INFORMATION

7) Report No. 108-11 re Medical Officer of Health Activity Report – November
8) Report No. 109-11 re Emergency Preparedness - 2011
9) Report No. 110-11 re Strategic Plan –Ten Year Vision and Three Year Strategic Directions - Update
10) Report No. 111-11 re Child and Youth Network: Ending Poverty Demonstration Project
11) Report No. 112-11 re Addressing Food Insecurity in Two Priority Populations
12) Report No. 113-11 re Food Security, Literacy and Skills Programs in Middlesex-London
13) Report No. 114 -11 re Mother Reach Postpartum Support Services
14) Report No. 115-11 re Update on Parenting Support
15) Report No. 116-11 re Revisions to the Healthy Workplace Program Resources
16) Report No. 117-11 re The Last Smear Campaign Aims to Raise Awareness about the Importance of PAP Tests
17) Report No. 118-11 re 2011 Budget – Third Quarter Review
18) Report No. 119-11 re HVAC Upgrades – Tender Results
19) Report No. 120-11 re Board of Health Performance Assessment – Third Review

CONFIDENTIAL

20) Report No. 121-11 - The Board of Health will move in camera for the purpose of considering a matter concerning labour relations or employee negotiations.

OTHER BUSINESS

Next scheduled Board of Health Meeting – **Thursday, December 8, 2011 at 6:00 p.m.**

CORRESPONDENCE RECEIVED

a) Dated 2011 September 22 (received 2011 October 14) A copy of correspondence from Dr. Penny Sutcliffe, Medical Officer of Health/Chief Executive Officer to The Honourable Leona Aglukkaq, Minister of Health, advising that at its September 15, 2011, meeting, the Sudbury & District Board of Health carried the following resolution:

WHEREAS the Sudbury & District Board of Health passed motion #55-06 encouraging the Federal Minister of Health to act on the recommendations from the Trans Fat Task Force report: TRANSforming the Food Supply, June 2006; and

WHEREAS the Federal Minister of Health introduced a voluntary approach to reducing artificial trans fat in the food supply rather than the regulatory approach recommended by the Trans Fat Task Force; and

WHEREAS the results of the Trans Fat Monitoring Program, implemented by the Federal Minister of Health between 2006 and 2009, indicate that some progress has been made to reduce artificial trans fat in the Canadian food supply, a considerable number of products continue to contain unacceptable levels including many foods often consumed by children; and

WHEREAS, in 2009, the World Health Organization published its scientific update on the health consequences of artificial trans fat, confirming that artificial trans fats adversely affect cardiovascular risk factors and increase the risk of coronary heart disease events, and recommended that artificial trans fat be significantly reduced or virtually eliminated in the food supply; and

WHEREAS products labelled 'trans fat free' are often more expensive than comparable products creating disparities in exposure to artificial trans fat thus disproportionately affecting people living on low income; and

WHEREAS the Toronto Board of Health passed the report Reducing Artificial Trans Fat in Toronto: Need for Action, July 2011, that calls for the Federal Minister of Health to regulate the amount of artificial trans fat in the Canadian food supply, as recommended by the Trans Fat Task Force, June 2006, and requests that Health Canada ensure monitoring of trans fat in the Canadian food supply;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support the Toronto Board of Health and continue to urge the Federal Minister of Health to implement the recommendations of the Trans Fat Task Force report: TRANSforming the Food Supply, June 2006, and introduce national regulation of trans fat in the Canadian food supply as well introduce a comprehensive, timely monitoring of trans fat with regular reports to the public; and

FURTHER THAT copies of this motion be forwarded to the Federal Ministers of Health, Agriculture and Agri-Food, the Chief Public Health Officer of the Public Health Agency of Canada, Members of Parliament for Sudbury and districts, Members of Provincial Parliament for Sudbury and districts, the premier of Ontario, the provincial Ministers of Health and Long-Term Care, Health Promotion and Sport and Agriculture, Ontario's Chief Medical Officer of Health, as well as the Ontario Public Health Association (OPHA), and the Association of Local Public Health Agencies (alPHa) for distribution to all Ontario Boards of Health and constituent municipalities.

b) Dated 2011 October 5 (received 2011 October 17) Correspondence from Ms. C. Saunders, City Clerk, City of London, to the Chair and Members of the Board of Health of the Middlesex-London Health Unit, advising that City of London Council resolved:

That Councillor S. Orser BE APPOINTED to the Middlesex-London Health Unit for the term ending November 2014.

c) Dated 2011 October 24 (received 2011 October 25) A copy of correspondence from Dr. Penny Sutcliffe, Medical Officer of Health/Chief Executive Officer, Sudbury and District Health Unit, to the Mayor/Reeves of the Constituent Municipalities, advising that at its October 19, 2011, meeting, the Sudbury & District Board of Health moved the following resolution:

WHEREAS the United Nations Secretary General Ban Ki-Moon has described noncommunicable diseases (NCDs) such as cancer, cardiovascular disease, chronic respiratory disease and diabetes a public health emergency in slow motion; and

WHEREAS the September 2011 United Nations high level meeting on the prevention and control of NCDs ratified a political declaration calling for governments to adopt approaches that go beyond the health sector; and

WHEREAS healthy public policies can increase the availability of and accessibility to healthy living conditions for community members, leading to a better quality of life for all; and

WHEREAS the Ontario Public Health Standards (2008) require that boards of health work with municipalities to support healthy public policies; and

WHEREAS the recent scan of the 19 SDHU area municipalities indicate that municipalities are engaged in policy making that is supportive of health and chronic disease and injury prevention; and

WHEREAS in 2010, the Partners for Community Wellness (Healthy Communities Fund Partnership) includes municipal partners and is established to promote coordinated planning, advocacy and action to support the development of healthy policies in the Sudbury and Manitoulin Districts;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health direct staff to continue their policy work with local municipalities and encourage all municipalities to develop long-term comprehensive plans for policies that support health and prevent chronic disease and injury; and

FURTHER THAT copies of this motion be forwarded to all Ontario boards of health, provincial government partners and local members of provincial parliament, the Ontario Public Health Association, the Association of Local Public Health Agencies, the Association of Municipalities of Ontario and the Federation of Northern Ontario Municipalities.

d) Dated 2011 October 19 (received 2011 October 25) Copies of correspondence from Mr. Barry Ward, Chair, Simcoe Muskoka District Board of Health, to that health unit's obligated municipalities supporting the letter from the Ontario Public Health Association, Centre for Addiction & Mental Health and Mothers Against Drunk Driving urging municipalities to pass a resolution to oppose any plans to sell beer and wine in convenience stores.

e) Dated 2011 November 2 (received 2011 November 9) A copy of correspondence from Mr. Andy Sharpe, Chair, Board of Health, Peterborough County-City Health Unit, to The Honourable Bob Chiarelli, Ontario Minister of Transportation, supporting a Provincial Policy Framework for Cycling Infrastruture.

Copies of all correspondence are available for perusal from the Secretary-Treasurer.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 102-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Lyme Disease Surveillance and Promotional Activities in Middlesex-London

Recommendation

It is recommended that the Board of Health endorse the ongoing Lyme Disease surveillance and promotional activities in Middlesex-London as outlined in Report No. 102-11.

Clinical information

Lyme disease is caused by a bacteria called *Borrelia burgdorferi*. It is transmitted to humans from the bite of an infected tick. The tick which carries this infection in Central and Eastern North America is called *Ixodes scapularis* (also called the blacklegged or deer tick). To spread infection, the tick must remain attached to the person for at least 24 hours. The symptoms of the infection generally start within 3 to 30 days of a tick bite and consist of a distinctive "bull's-eye" rash in the area of the bite. The bull's-eye rash, also called erythema migrans, expands to more than 5 cm in diameter. The rash is present in 70 to 80% of Lyme disease infections and is accompanied by non-specific symptoms such as tiredness, fever, headache, and joint and muscle pain. If untreated, the second stage of the disease can develop which includes symptoms affecting the nervous symptoms, joints and heart and can cause skin rashes, fatigue and weakness. If the second stage is left untreated, it can progress to the third stage which involves joint and neurologic problems.

Lyme disease is treated with antibiotics and is rarely fatal. In the early stages, the antibiotics are given by mouth for 14 days; later stages of the infection may require longer courses of treatment or treatment given by the intravenous route. A condition called "Post-Treatment Lyme Disease Syndrome" occurs in approximately 10-20% of patients who have been successfully treated for Lyme disease; symptoms can include muscle and joint pains, cognitive complaints such as difficulty with memory or concentration, sleep disturbance, or fatigue that can last for months. These symptoms generally gradually resolve and do not require further treatment. "Chronic Lyme Disease" is an inappropriate term used to describe non-specific symptoms, often in people who have not been confirmed to have a Lyme disease infection.

Endemic Areas for Lyme disease

The *Ixodes scapularis* tick, which transmits the Lyme disease bacteria, can routinely be found in specific geographic locations in North America. In Canada, Lyme disease from these ticks is a particular risk in southeastern Quebec, southern and eastern Ontario, southeastern Manitoba and parts of New Brunswick and Nova Scotia. In Ontario, there are seven locations which are known to be endemic for Lyme disease (meaning the *Ixodes scapularis* tick is established in these areas and the ticks have been found to be infected with the *Borrelia burgdorferi* bacteria). These areas are: Long Point Provincial Park, Turkey Point Provincial Park, Rondeau Provincial Park, Point Pelee National Park, Prince Edward Point National Wildlife Area, Wainfleet Bog Conservation Area, and the St. Lawrence Island National Park.

Passive and active surveillance are used to determine if an area is endemic for Lyme disease. Passive surveillance involves testing ticks that are found on and submitted by residents. Ticks are tested to determine if they are *Ixodes scapularis*, and if found to be this tick, they are then tested at the National Microbiology Laboratory to determine if they carry the *Borrelia burgdorferi* bacteria. In geographic areas that are the source of multiple tick submissions or human cases of Lyme disease, active tick surveillance may be conducted. This consists of dragging the area to find and identify ticks and/or testing small mammals for the presence of ticks.

Lyme disease occurs most commonly in endemic areas. Occasionally, infected ticks can be spread by migratory birds on which the ticks feed, so it is possible, but rare, to acquire Lyme disease while in non-endemic areas.

Testing for Lyme Disease in Humans

Testing for Lyme disease in humans must be done by an accredited laboratory. In Ontario, this testing is performed by the Public Health Ontario Laboratories using well established guidelines. In 2010, over 13,000 specimens were submitted to the Public Health Ontario Laboratories for Lyme disease testing, which is a significant increase from the approximately 4,000 tests submitted in 2003.

The testing method used by the Public Health Ontario Laboratories is referred to as a “two-tiered” algorithm. Using this method, a first test is done (called an enzyme-linked immunosorbent assay or ELISA). If this test is found to be positive, a second more specific test (called a Western Blot) is done to confirm the diagnosis. Using this methodology, 95 people in Ontario were diagnosed with Lyme disease in 2010 for a rate of 0.72 per 100,000 residents. This has increased from 2001 when 24 people were diagnosed with Lyme disease. This increase may be attributed to increased Lyme disease activity in the province, as well as enhanced awareness of the condition leading to more testing and diagnosis. Rates of Lyme disease are considerably higher in the United States with approximately 30,000 confirmed and probable cases diagnosed in 2010 for a rate of 7.3 confirmed cases per 100,000 people. Twelve states (mainly the northeast / mid-Atlantic and upper mid-western states) account for approximately 94% of the cases.

There are several limitations to Lyme disease testing which include the following:

- The first test may not be positive early in the course of infection;
- The first test may never become positive if the infection is treated early;
- The first and second test may be erroneously positive in people with other infections or conditions.

To overcome these limitations in testing, it is essential to consider the clinical symptoms and history of exposure to ticks when making the diagnosis. In some instances, repeat testing may be indicated several weeks later. Testing for Lyme disease should be done only when there are symptoms suggestive of the infection and/or a known tick exposure; testing should not be done for non-specific symptoms.

Lyme Disease in Middlesex-London

Middlesex-London is not a Lyme disease endemic area. Tick surveillance is conducted for Lyme disease using passive surveillance. In 2009, 17 ticks were submitted for testing; in 2010, 46 ticks were submitted and as of November 7, 2011, 73 ticks were submitted. Ticks are first tested at the Health Unit’s Strathroy Laboratory and then submitted to the Provincial Public Health Laboratory. In total, four ticks were determined to be *Ixodes scapularis*, all of which were acquired outside of Middlesex-London. Two of the four ticks tested positive for the *Borrelia burgdorferi* bacteria. In 2011, six tick drags have also been conducted in Middlesex-London; no *Ixodes scapularis* ticks have been identified using this active surveillance method. With respect to human cases of Lyme disease, five cases have been diagnosed among residents of Middlesex-London since 2002 (1 in 2009, 3 in 2010 and 1 in 2011). All five cases were acquired during travel outside of Middlesex-London.

Prevention of Lyme disease

Although the risk of Lyme disease in Middlesex-London is very low, the Health Unit provides education to the public regarding Lyme disease prevention such as how to avoid tick bites, how to check for ticks after outdoor exposure, how to remove ticks that are found on a person and how to submit them to the Health Unit for testing. The education is often done in conjunction with education regarding West Nile Virus prevention. Appendix A is an educational brochure used by Health Unit staff to disseminate Lyme disease information to Middlesex-London residents. Other promotional activities include a Lyme disease television commercial that ran on Rogers TV, an advertisement in the City of London's 2010 and 2011 garbage collection calendar, and bus shelter advertisements throughout the City of London. Information on Lyme disease has also been provided to health care providers in Middlesex-London. Appendix B is an Ontario Ministry of Health and Long-Term Care information sheet that was distributed to health care providers in Middlesex-London.

Plans for 2012 include continued passive surveillance for ticks as well as active tick surveillance if indicated, continued education of the public with regard to Lyme disease prevention, particularly when traveling to Lyme disease endemic areas, and updates for health care providers with regard to Lyme disease diagnosis and treatment.

This report was prepared by Dr. Bryna Warshawsky, Associate Medical Officer of Health; Mr. Jeremy Hogeveen, Vector Borne Disease Coordinator; Ms. Amy Pavletic, Public Health Inspector; Ms. Cathie Walker, Manager, Infectious Disease Control Team; Mr. Iqbal Kalsi, Manager, Environmental Health and Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention.

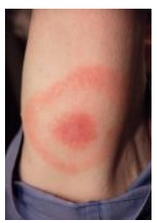
Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Infectious Disease Prevention and Control

What is Lyme Disease?

Lyme disease (LD) is an infection caused by the bacterium, *Borrelia burgdorferi*. This bacterium can be transmitted to humans through the bite of an infected tick.

Symptoms of LD usually occur within one to two weeks, but can occur as soon as three days or as long as a month, after a tick bite. Early symptoms of LD may include:



- A “bull’s eye” rash which spreads out from the tick bite
- General symptoms of fever, headache, muscle and joint pain

If diagnosed early, most cases of LD can be treated successfully with antibiotics. If left untreated, LD can affect the joints, the heart and the nervous system resulting in long-term health effects.

If you are concerned about LD, you should speak to your health care professional. It is important to inform them when and where you were bitten by a tick.

What is a tick?

Ticks are similar to mites, about the size of a sesame seed, which feed on blood. They move about the ground slowly or they settle on tall grass and bushes until they attach themselves to a person or animal passing by. There are many different types of ticks but only a few are capable of carrying the bacteria which causes LD. In Ontario the tick that is known to transmit LD is *Ixodes scapularis*, also known as the black-legged tick or the deer tick.

What is being done in the Province of Ontario to monitor and control Lyme Disease?

The Ontario Ministry of Health and Long-Term Care gathers information about Lyme disease to try to determine where individuals may have come in contact with infected ticks. Encouraging the public to submit ticks that are found attached to themselves or to family members to their local health units is another form of tick surveillance.

MIDDLESEX-LONDON HEALTH UNIT

For tick submission, protection, and general information contact the Vector-Borne Disease Team at 519-663-5317, ext. 2300

For questions regarding human health and Lyme Disease information, contact the Infectious Disease Control Team at 519-663-5317, ext. 2330

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Lyme Disease

www.healthunit.com

What is the Middlesex-London Health Unit doing to monitor and control Lyme Disease?

Lyme disease is a reportable disease and the Middlesex-London Health Unit (MLHU) receives notification if anyone living in the area has, or is suspected of having, LD. Health unit staff contacts these individuals to determine where and when they were exposed to the infection. Based on recent tick submissions to the Middlesex-London Health Unit, it appears that the area does not have an established population of the ticks that are capable of transmitting LD. Members of the public are encouraged to continue to submit any ticks that are found attached to themselves or to family members for identification. It is important to inform Health Unit Staff where and when you were exposed to the tick.

Is there a concern with Lyme Disease when traveling?

In Ontario, Lyme disease-carrying ticks are more commonly found along the north shore of Lake Erie, particularly in Long Point, Turkey Point, and Rondeau Provincial Park. Most recently, they have been found in the areas of Point Pelee National Park, Wainfleet Bog Conservation Area, Prince Edward Point Wildlife Area, and St. Lawrence Islands National Park. About half of the LD cases that are reported each year in Ontario acquired the infection outside of the province. Within Canada, parts of British Columbia and Manitoba have areas where Lyme disease-carrying ticks are found. Ticks carrying LD are commonly found in the United States along the Atlantic seaboard from Maine to Virginia and in Minnesota and Wisconsin. Europe also has areas were LD carrying ticks are present. Be sure to be aware of the risk when doing outdoor activities in these areas

What can I do to protect myself against Lyme Disease?

A few simple steps can help to reduce the risk of getting bit by a tick.

- Wear light coloured clothes to make it easier to spot ticks.
- Wear long pants, a long sleeved shirt and closed footwear with socks when walking in grassy or wooded areas. Tuck your pants inside your socks.
- Apply insect repellent containing DEET. Follow the directions on the container.
- Check yourself and family members including pets after leaving an area where ticks may live including long grass, wooded areas
- Keep the grass cut short in areas around your house and cottage where people and pets may walk.

Tips to remember...

- Wear light coloured clothing and DEET
- Check yourself and family members
- Submit ticks to the health unit for identification

How do I remove a tick?

It is important to remove a tick promptly in prevent infection. Transmission of *Borrelia burgdorferi* is unlikely to occur when the tick was attached for less than a day. For safe removal follow these instructions:

- Try to wear gloves when handling an engorged (blood filled) tick.
- Use tweezers and grab the tick as close to the head as possible. Do not use your fingers.
- Pull the tick upward and away from the body with steady pressure.

- Once the tick has been removed, clean the area with soap and water. Seek medical attention if concerned about possible skin infection.
- Wash your hands
- If possible, save the tick so it can be submitted to the health unit for identification. Put the tick in a container with a tight fitting lid
- Label the container with the name and birth date of the person bitten.
- Submit the tick to one of the following MLHU locations: Kenwick Mall, 51 Front St. E., Strathroy, or 50 King St., London.

Lyme disease is on the increase

Message from the Chief Medical Officer of Health

Ontario is seeing an increase in human cases of Lyme disease and an increase in numbers and range of black-legged ticks, especially in southern Ontario.

Reporting of all cases is critical.

Lyme disease is a preventable disease caused by a *Borrelia burgdorferi* bacterial infection and transmitted through the bite of an infected tick.

In Ontario, the black-legged tick (or deer tick) Ixodes scapularis is the sole vector of *B. burgdorferi.* People who spend time outdoors may encounter other tick species, but only the black-legged tick can transmit the Lyme disease bacteria. These ticks are small (3-5 mm) and people often do not realize they have a black-legged tick on them.

Risk Areas

The greatest risk of acquiring Lyme disease is found in areas where black-legged ticks carrying the bacteria are endemic (well-established).

The endemic areas in Ontario include:

- Long Point Provincial Park (northwest shore of Lake Erie near Port Rowan)
- Point Pelee National Park (near Leamington)
- Prince Edward Point National Wildlife Area (located at the southeastern tip of Prince Edward County)
- St. Lawrence Islands National Park (near Brockville)
- Rondeau Provincial Park (southeast of Chatham)
- Turkey Point Provincial Park (near Port Rowan)
- Wainfleet Bog Conservation Area (in Port Colborne)

The black-legged tick also feeds on birds and can be transported to almost anywhere in the province; therefore, Lyme disease can be acquired almost anywhere in the province.

When a person is showing signs and symptoms of Lyme disease, health care professionals should consider this diagnosis even if the person is not from, or has not visited, an endemic area.

Persons can come into contact with ticks is from early spring to the end of fall. The ticks can also be active in the winter in areas with no snow and mild temperatures (>4°C).

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Highlights:

- Since 2005, there has been an increasing trend in the number of Lyme disease cases acquired in Ontario.

REPORT:

- Lyme disease is a reportable disease as per O. Reg. 559. Clinically diagnosed Lyme disease, even in the absence of laboratory confirmation, should be **reported** to your local public health unit.

TEST:

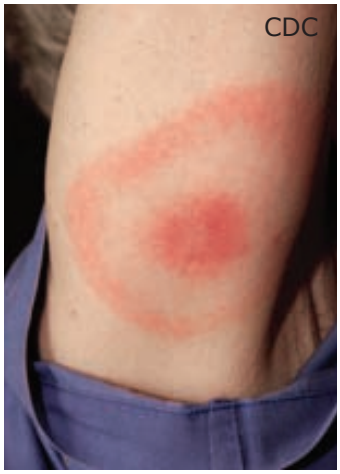
- While the probability is low, it is possible to acquire Lyme disease almost anywhere in Ontario. If you suspect Lyme disease, have the patient **tested**.

TREAT:

- Early **treatment** with appropriate antibiotics is important.

Information for Clinicians

Clinical Presentation



The incubation period for *B. burgdorferi* is usually one to four weeks after a bite from an infected tick. Early infection is characterized in 70 to 80 per cent of cases by erythema migrans, a skin lesion commonly known as a "bull's eye rash" (see picture, right).

Other early symptoms include fever, headache, muscle and joint pains, fatigue and stiff neck. Clinical diagnosis can sometimes be difficult as the symptoms can mimic many other diseases.

If left untreated, Lyme disease can progress to an early-disseminated disease with migraines, weakness, multiple skin rashes, painful or stiff joints, cardiac abnormalities and extreme fatigue. If the disease continues, arthritis, along with neurological symptoms such as headaches, dizziness, numbness and paralysis can occur.

(see over)

Ontario

Lyme Disease is on the increase

Treatment

If treated early with appropriate antibiotics, patients can expect to make a full recovery[1]. People should seek medical attention if symptoms develop within 30 days of suspected tick exposure. If the patient still has the tick, or a health care professional removes it, submit the tick to the local public health unit where it will be sent for identification and Lyme bacteria testing (black-legged ticks only species tested). If the initial infection is not treated, then infection can become difficult to treat and patients may experience joint, heart and neurological symptoms.

Testing

Laboratory testing is used to support the diagnosis of Lyme disease and should be used in conjunction with clinical signs and symptoms[2]. It is up to the attending physician to make the diagnosis and determine treatment. Patients tested during early infection may not have developed antibodies (negative serology) to the bacteria, making detection difficult; therefore, testing patients again in four weeks is recommended. Health Canada-approved blood tests are performed at the Ontario Public Health Laboratory and follow the recommendations of the Canadian Public Health Laboratory Network.

Testing patients for Lyme disease can be requested by writing "Lyme Serology" on the requisition form and providing clinical background.

The Centers for Disease Control and Prevention in the United States and the Public Health Agency of Canada caution health care professionals and the public regarding the use of private laboratories offering Lyme disease testing in the USA. These "for-profit" laboratories may not follow the same testing protocols as most provincial, state and federal laboratories in Canada and the USA.

Removing a Tick

- Using fine-tipped tweezers, carefully grasp the tick as close to the skin as possible. Pull it straight out, gently but firmly.
- Do not squeeze the tick. Squeezing can accidentally introduce Lyme bacteria into the body.
- Do not put anything on the tick, or try to burn the tick off.
- After tick removal, place it in a screw-top bottle (pill vial or film canister) and submit it to your local health unit for identification and testing. Establishing the type of tick will help assess the risk of acquiring Lyme disease.
- It is important to remember where the person most likely acquired the tick. It will help public health workers to identify areas of higher risk.
- Thoroughly cleanse the bite site with rubbing alcohol and/or soap and water.

If the tick is removed soon after its attachment, it will help to prevent infection as not all black-legged ticks are infected. An infected black-legged tick has to be feeding for at least 24 hours before it can transmit the bacteria to the human host.

For Further Information:

1. Canadian Family Physician: Lyme Disease, a zoonotic disease of increasing importance to Canadians. http://www.cfp.ca/cgi/reprint/54/10/1381.pdf
2. The laboratory diagnosis of Lyme borreliosis: Guidelines from the Canadian Public Health Laboratory Network. http://www.pulsus.com/journals/abstract.jsp?HCtype=Physician&sCurrPg=abstract&jnlKy=3&atlKy=7231&isuKy=711&isArt=t&fromfold=&
3. Erythema Migrans Lesions of Lyme Disease Photos. http://www.cdc.gov/ncidod/dvbid/lyme/ld_LymeDiseaseRashPhotos.htm
4. Ontario Lyme Disease Fact Sheet http://www.health.gov.on.ca/en/public/publications/disease/lyme.aspx
5. Health Canada, It's Your Health: Lyme Disease http://www.hc-sc.gc.ca/hl-vs/alt_formats/pacrb-dgapcr/pdf/iyh-vsv/diseases-maladies/lyme-eng.pdf
6. Public Health Agency of Canada: Ticks and Lyme Disease. http://www.phac-aspc.gc.ca/id-mi/tickinfo-eng.php

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Ontario

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 103-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Smoke-Free Public Outdoor Spaces – Technical Report and Recommended Policy Option

Recommendations

It is recommended:

1. That the Board of Health support the establishment of smoke-free public outdoor spaces by endorsing Option 3 of the document entitled, Building the Case for Smoke-Free Public Outdoor Spaces: Technical Report, attached as Appendix A to Report No. 103-11; and further
2. That London City Council and Middlesex County Council be petitioned to establish smoke-free public outdoor spaces by amending their smoking bylaws to include the provisions of Option 3 as highlighted in Board of Health Report No. 103-11.

Background

Ontario has a history of progressive legislation providing protection from second-hand smoke. Numerous municipalities, including the City of London and the County of Middlesex in 2003, have enacted bylaws to ensure that all enclosed public places and workplaces are smoke-free. The *Smoke-Free Ontario Act* (*SFOA*), which came into effect May 31, 2006, helped create a more level playing field for proprietors across Ontario and a standard level of protection from second-hand smoke exposure. However, emerging evidence and results from local public opinion surveys have demonstrated that the current provincial standard of second-hand smoke protection is not high enough for Middlesex-London residents, and that bylaws that extend protection beyond that covered by the *SFOA* are required.

At the September 15, 2011, Board of Health meeting, Board members endorsed the Smoke-Free Outdoor Public Spaces Position Statement and directed staff to prepare a report summarizing existing municipal bylaw amendment options for establishing smoke-free outdoor public spaces. Attached as Appendix A is a report entitled, Building the Case for Smoke-Free Public Outdoor Spaces Technical Report, which highlights existing municipal bylaws that address smoke-free public outdoor spaces. This report also presents a number of options for consideration to expand existing City of London and Middlesex County bylaws.

Scan of Ontario's Bylaws

Approximately 60 Ontario municipalities have enacted bylaws regulating smoking in public outdoor spaces. In addition to these, many municipalities including the City of Ottawa, City of Kingston, Grey-Bruce County and Region of Waterloo are in the development/consultation phase of smoke-free public outdoor spaces bylaws.

These bylaws and the restrictions they entail generally fall into 6 categories:

1. Smoke-free parks, playgrounds and recreational fields (27)
2. 100% smoke-free patios (8)
3. Hospitals or LTC grounds (4)
4. 100% smoke-free hotels (1)
5. Smoke-free beaches (6)
6. Buffer zones around doorways, air intakes, transit shelters (32)

Some smoke-free public outdoor spaces bylaws also prohibit smoking on city/municipally-owned property and community/special events which may or may not fall into one of the 6 categories mentioned above.

Appendix A provides a comprehensive overview of outdoor smoking restrictions in public spaces. A complete listing of all municipal bylaws which currently exceed provincial or federal regulations is available online at http://www.nsra-adnf.ca/cms/file/Compendium_Winter_2011.pdf.

Proposed Policy Approach for Moving Forward

Jurisdictions across Canada and most notably in Ontario have successfully regulated outdoor smoking. Table 1 of Appendix A highlights the provision of a number of Ontario municipal bylaws. Also included in Appendix A, are four options for Board members consideration to address smoke free pubic outdoor spaces in the City of London and Middlesex County. Staff recommends the adoption of Option 3 which calls for:

A complete smoking ban in the following:

- All outdoor areas used for public enjoyment and children recreation areas (including parks, playgrounds, playing fields, swimming pools, splash pads, petting zoos, trails, public gardens, festivals and public beaches)
- Municipally-owned and/or operated recreational properties*
- All outdoor seating areas - bar and restaurant patios
- No smoking within 9 m of all public places and workplaces entrances/doorways (public places and workplaces, as defined in existing legislation).
- Application process required for Designated Smoking Areas (DSAs) at public outdoor events and festivals used for public enjoyment and recreation where the audience is adult.
- Application process enabled for hospital campuses, university/college campuses to be named within a schedule of the bylaw for designated smoking areas (DSAs) or for 100% smoke-free campuses.

*Exemptions permitted for long-term care homes and campgrounds - only current legislation would apply.

Conclusion
Tobacco-free environments provide the greatest level of protection from second-hand smoke, help to prevent young people from starting to use tobacco products and assist smokers to quit. It is recommended that the Board of Health support the establishment of smoke-free public outdoor spaces by adopting Option 3 of Appendix A and that the Board of Health petition London City Council and Middlesex County Council to implement the provisions of Option 3 by amending their existing municipal smoking bylaw.

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Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Comprehensive Tobacco Control; **1, 6, 7, 11**

Building the Case for Smoke-Free Public Outdoor Spaces

Technical Report



MIDDLESEX-LONDON HEALTH UNIT

November, 2011

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Acknowledgements

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Public Health Ontario's Smoke-Free Ontario Scientific Advisory Committee's report "Evidence to Guide Action: Comprehensive Tobacco Control in Ontario".

Physicians for a Smoke-Free Canada is a national health organization, founded in 1985 as a registered charity. It is a unique organization of Canadian physicians who share one goal: the reduction of tobacco-caused illness through reduced smoking and reduced exposure to second-hand smoke.

Smoking and Health Action Foundation is a national, non-profit health organization formed in 1974 to conduct public policy research and education designed to reduce tobacco-related disease and death. SHAF is the sister organization of the Non-Smokers' Rights Association, and acts as a policy think-tank for governments and NGOs in Canada and abroad.

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Introduction

In September 2011, the Board of Health for Middlesex-London passed the following motion:

1. **That the Board of Health endorse the Smoke-Free Public Outdoor Spaces Position Statement attached as Appendix A to Report No. 081-11; and further**
2. **That the Board of Health direct staff to prepare a report summarizing existing municipal bylaw amendment options for establishing smoke-free public outdoor spaces.**

This report has been prepared to address the Board of Health direction.

Background

Smoking and other forms of tobacco use remain the leading cause of preventable death and disease in Ontario. Currently, tobacco use costs the Ontario economy an estimated $7.73 billion annually. For 2009, the use of tobacco products cost Ontario $1.93 billion in direct health care costs. These costs include specialized inpatient and outpatient treatment, ambulatory care, and prescribed drugs. When you factor in lost productivity from illness, hospitalization and death, these costs become much higher. In 2002, tobacco use cost the Ontario economy $4.4 billion in lost productivity, and accounted for 2.2 million acute care hospitalization days.[i]

Despite the significant achievements that have been made in tobacco control, the public health community still faces many challenges, including

- Elimination of the remaining exposure to tobacco smoke
- Absence of an ongoing media campaign to denormalize the tobacco industry and promote protection, prevention and cessation
- Persistent inequities with regard to reaching sub-populations
- Low prices of tobacco products and low tobacco taxes
- Widespread availability of contraband tobacco products
- Innovative marketing and other activities of the tobacco industry
- The lack of a federal tobacco control strategy to address some of the broader, national tobacco issues that burden our communities.

Public Health Ontario's Evidence to Guide Action Report, prepared by leading tobacco researchers, calls for policy changes to provide further protection from second-hand smoke. The evidence indicates that as part of the next phase of tobacco control across Ontario, policy changes that would eliminate exposure to outdoor tobacco smoke and limit youth's exposure to tobacco use are required.

Ontario has a history of progressive legislation providing protection from second-hand smoke. Numerous municipalities, including the City of London and the County of Middlesex in 2003, have enacted bylaws to ensure that all enclosed public places and workplaces are smoke-free. The *Smoke-Free Ontario Act* (*SFOA*) came into effect May 31, 2006, prohibiting smoking in enclosed workplaces and public places. The law includes a ban on smoking within nine metres of entrances and exits to healthcare facilities. In addition, the law prohibits smoking in common areas of multi-unit dwellings and partially enclosed restaurant and bar patios. Effective January 21, 2009, an amendment to the *SFOA* prohibits smoking in motor vehicles when children under the age of 16 years are present. The provincial legislation helped create a more level playing field for proprietors across Ontario, and a standard level of protection from second-hand smoke exposure. Emerging evidence and results from public opinion surveys has demonstrated that the current provincial standard of second-hand smoke protection is not high enough, and that bylaws that extend protection beyond that covered by the *SFOA* are required.

A provision of the *SFOA* permits municipalities to pass smoking bylaws which exceed the requirements of the *Act* and where such bylaws are in place, "the provision that is more restrictive of smoking prevails." Under Section 115 of the Municipal Act, municipalities have the authority to enact bylaws to prohibit or regulate the smoking of tobacco in public places and workplaces. Under this section, a bylaw shall not apply to a highway but may apply to public transportation vehicles and taxicabs on a highway. This legislative authority and public health's experience in the tobacco control policy domain positions the Health Unit, the City of London and the County of Middlesex nicely to work together to respond to the community's demand for greater prohibitions on smoking and social exposure to tobacco use.

Tobacco Smoke and Social Exposure to Tobacco Use

Second-hand smoke (also referred to as environmental tobacco smoke or passive smoking) is a mix of smoke that is exhaled and smoke that is emitted when a tobacco product is burned such as in cigarettes, cigars, cigarillos, or water pipes. Second-hand smoke contains over 4000 chemicals of which more that 50 are known carcinogens. Some of the chemicals that can be found in cigarettes are: carbon monoxide (found in car exhaust), ammonia (found in window cleaners), cadmium (found in batteries), arsenic (rat poison), benzene, acetone and formaldehyde[ii]. According to the World Health Organization there is no safe level of second-hand smoke and all exposure to tobacco smoke should be eliminated.

Table 1. Adverse Long-Term Health Effects of Second-Hand Smoke Exposure

SHS Exposure and Adults	SHS Exposure and Children	SHS Exposure and Pregnant Women
▪ Acute respiratory illness ▪ Heart disease ▪ Cancer (including breast) ▪ Premature death ▪ COPD ▪ Stroke	▪ Exacerbations of asthma ▪ Decreased lung function ▪ Lower respiratory illness ▪ Middle ear infections ▪ Sudden Infant Death (SIDS) ▪ Low birth weight ▪ Adverse impact on cognition and behaviour	▪ Spontaneous abortion/miscarriage ▪ Premature birth ▪ Congenital anomalies and smaller head circumference

In addition to the above health concerns, second-hand smoke can have immediate affects such as asthma attacks, headaches, nausea, vomiting and irritation of the nasal passage way[iii].

Some of the adverse health effects are more severe for infants and young children because their bodies, lungs and brains are still in development and they have higher respiratory rates than adults. Children and youth are especially vulnerable to the poisons in secondhand smoke and when compounded with the fact that exposure to second-hand smoke in childhood can persist into adulthood (longer duration of exposure), only emphasizes the severity of exposure to second-hand smoke[iv]. It is estimated that for every eight smokers who die from smoking, one non-smoker will die from second-hand smoke.

Second-hand smoke can be found wherever a tobacco product is burned such as in the entrance to doorways of buildings and workplaces, at local transit stops, at sports events, and basically in any public outdoor space where there is a smoker. When looking at outdoor places there is a common belief that it is safe to smoke outdoors because the smoke will drift away, or individuals can move out of the way of the second-hand smoke. However, children are less likely to leave a smoke filled place or even complain about the level of smoke, given the difference in power between an adult and a child. In addition, there are places that are nearly impossible to avoid exposure to second-hand smoke, including entrance-ways or restaurant patios, and there is often repeated exposure if that place is visited frequently, like the door way to a workplace.

In 2009, it was estimated that 54% of individuals were exposed to second-hand smoke at an entrance in the last month[v]. Recent research indicates that outdoor levels of tobacco smoke within one to two metres of a lit cigarette can be as high as indoors[vi]. If there is no wind, tobacco smoke will rise and fall and will saturate the local area with second-hand smoke; if there is a breeze, tobacco smoke will spread in various directions, and will expose non-smokers down-wind[vii]. Depending upon weather conditions and air flow, tobacco smoke can be detected at distances between 25-30 feet away[viii]. The closer an individual is to tobacco smoke, and the greater the number of lit cigarettes, the greater the amount of tobacco smoke, and consequently, the greater the harm. For example, if the number of lit cigarettes increases, the concentration of tobacco smoke can increase 2.5-3 times and be detected 9m away[ix].

In addition to emerging evidence on outdoor exposure to second-hand smoke, it has been identified that the application of Social Norms Theory is invaluable to explain tobacco initiation in young people. Tobacco use is increasingly influenced by social norms and what is seen as acceptable or normal behaviour [x]. Therefore, in order for young people to see smoking as less common, tobacco use needs to be removed from our cultural landscape and made less visible. It is important for youth to receive the same tobacco-free messages in their wider community as they experience at school.

In addition, a person's behaviour is influenced by the perception of how others behave in society, meaning that an individual is more likely to engage in harmful behaviour if that behaviour is seen as typical behaviour[xi]. The large crowd of smokers standing at the entrance way to the local library normalizes tobacco use; tobacco use is an addiction and policies which restrict where people can smoke will send a strong, consistent message to young people that a healthy life is one that is free from tobacco use.

Worldwide over 4.5 trillion cigarettes are littered each year and cigarettes have been considered the most littered item in the world. Cigarette butts are non-biodegradable and can take up to 12 years to break down into smaller particles. This is mostly due to the cellulose acetate, a form of plastic, which is found in the cigarette butt filter[xii]. Discarded cigarette butts leach chemicals and toxins into the soil and into water systems. In parks and playgrounds, discarded cigarette butts are picked up and eaten by children and pets. It only takes two to three cigarette butts to harm or kill a small animal[xiii].

Furthermore, there is the concern of discarded cigarette butts and our homeless population. It has been found that due to the strength of the addiction, many homeless individuals will resort to borrowing,

sharing, selling cigarettes and even "sniping", the smoking of discarded cigarette butts or rerolling of discarded cigarette butts. The latter not only makes these individuals more susceptible to tobacco related disparities but also potentially exposes them to infectious diseases[xiv]. Cessation supports, along with greater restrictions on where tobacco is smoked will provide greater protection for our most vulnerable populations.

Stronger restrictions on smoking in outdoor public places can have a protective effect on smoking uptake among youth and young adults, supports those who are currently addicted to tobacco trying to quit, and improves the health of our environment.

Strong Public Support for Smoke-Free Public Outdoor Spaces

Public support is an important factor to consider when implementing smoking restrictions, such as those commonly found in smoke-free outdoor public places bylaws. Often there is concern that increased smoking restrictions will negatively impact business or the public's use of facilities where smoking restrictions have been put into place. However, when reviewing the many municipal smoke-free outdoor public places bylaws that have been enacted since 2000 and their impact, this has not been the case. In many jurisdictions where public support for the smoking restrictions had been high, once the bylaw came into effect, support for the smoking restrictions increased even more, in both non-smokers and smokers[xv]. Generally support was highest in places where children play and congregate such as parks and recreational fields.

The City of Woodstock's Smoke-Free Outdoor Public Places Bylaw has been in effect since September 2009 and their evaluation showed that there has been no negative impact on the use of facilities such as parks or recreational fields, and 84% of smokers in Woodstock stated that their outdoor smoke-free bylaw was good for their children's health. In Ottawa, there was an Ipsos Reid telephone survey conducted of 400 Ottawa residents and it showed that 73% were in favour of smoking bans on patios, 77% for parks and playgrounds and 68% for beaches. The highest support that they found was for entrances to doorways to public places (84%). In Sarnia-Lambton, which is currently looking going through a similar process, support has ranged from 68% - 89%, with doorways to public places (89.1%) and doorways to workplaces (87.8%) having the highest support followed by public playgrounds (79.1%) and sports fields (76.1%).

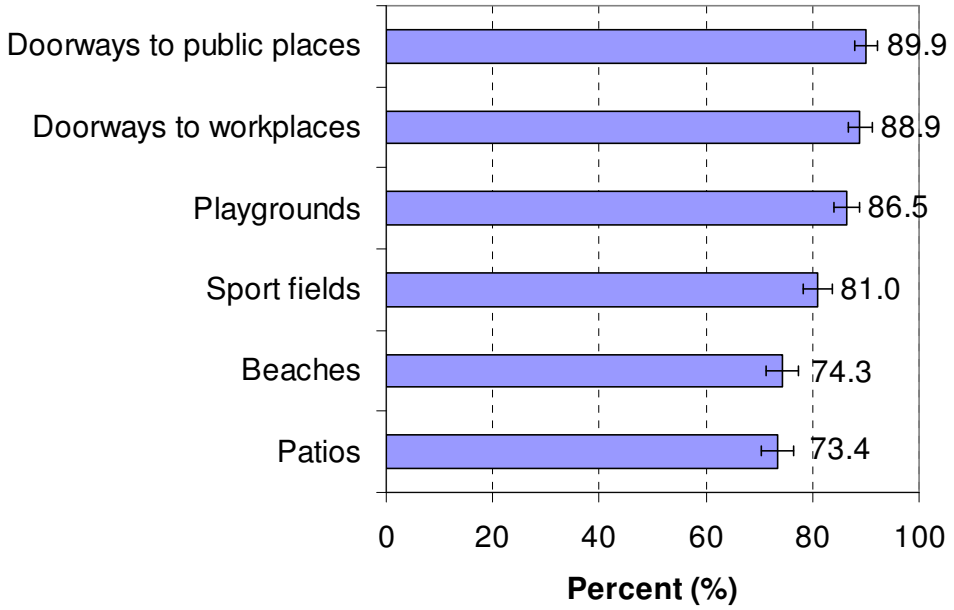
Internationally, in Upper Hutt Council, New Zealand, 83% of park users thought that it was a good idea. Minnesota has been an international leader, and when their park directors were interviewed, ninety percent (90%) of park directors in parks with tobacco-free policies would recommend a tobacco free-park to other communities, and 83% said it was not difficult at all to establish such parks[xvi].

Strong Public Support for Middlesex-London

When looking locally at the Middlesex-London area, the support continues both in the City of London and Middlesex County. Between May and December of 2009 data were collected from the Rapid Risk Factor Surveillance System (RRFSS) which are summarized in Figure 1, next page.

Figure 1. Support for local by-laws for smoke-free public places.

Adults (18+) in Middlesex-London May – Dec 2009.



Source: RRFSS May – Dec 2009.

* It is important to note that only 5.3% (± 1.6%) of the respondents did not support any suggested by-laws.

The highest level of support was observed for doorways to public places (89.9% ± 2.1%), doorways to workplaces (88.9% ± 2.2%), and playgrounds (86.5% ± 2.4%). Support for smoke-free sport fields was found among 81.0% (± 2.7%) of adults, and among three-quarters for smoke-free beaches and patios (74.3% ± 3.1% and 73.4% ± 3.1%, respectively).

In addition, the Health Unit's Tobacco Control Program staff members receive a number of inquiries and complaints from concerned citizens about smoking in outdoor spaces, including doorways to public places and workplaces. When looking at the above data and drawing upon the experiences of other municipalities who have enacted outdoor smoking restrictions, it can be anticipated that public support will continue to increase once the residents of the City of London and Middlesex County see the benefits that can come from such bylaws.

Relationship to Public Health Mandate

The mandate of the Middlesex-London Health Unit, as defined by the Ontario Ministry of Health and Long-Term Care, Ontario Public Health Standards (2008) is to promote and protect the health of Middlesex-London residents by providing public health programs and services that contribute to residents' physical, mental and emotional health and well-being. Under the Chronic Disease and Injuries Program Standards, the Health Unit's goal is to reduce the burden of preventable chronic diseases of public health importance, which include cardiovascular disease, cancer, respiratory diseases and type II diabetes. The reduction or elimination of exposure to tobacco smoke and the adoption of tobacco-free living through bylaw amendments are grounded in scientific evidence and will significantly reduce the burden of disease and death from tobacco use.

Scan of Ontario Municipal Bylaws

Almost 60 Ontario municipalities have enacted bylaws regulating smoking in outdoor public spaces[xvii]. In addition, dozens of other municipalities including the City of Ottawa, City of Kingston, Grey-Bruce County and Region of Waterloo are in the development/consultation phase of smoke-free public outdoor spaces bylaws.

These bylaws and the restrictions they entail generally fall into six (6) categories. Some policies regarding smoke-free public outdoor spaces also prohibit smoking on city / municipally-owned property and community/special events which may or may not fall into one of the six (6) categories mentioned below.

These six (6) categories are as follows:

1. Smoke-free parks, playgrounds and recreational fields (27)
2. 100% smoke-free patios (8)
3. Hospitals or LTC grounds (4)
4. 100% smoke-free hotels (1)
5. Smoke-free beaches (6)
6. Buffer zones around doorways, air intakes, transit shelters (32)[xviii]

Table 2, on the following page, provides an overview of outdoor smoking restrictions in public places. A complete listing of all municipal bylaws which currently exceed provincial or federal regulations is available online at http://www.nsra-adnf.ca/cms/file/Compendium_Winter_2011.pdf.

Table 2. Overview of Outdoor Smoking Restrictions in Ontario Municipalities

Municipality	Year Implemented	Restrictions / Policy
Barrie	2010	Prohibits smoking in any public place within the city whether or not a No Smoking sign is posted
Clearview	July 2009	Smoking prohibited in public places defined as: municipal building, playground area, playing field and municipal property. With a 9 meter rule for the entrance to any municipal building, playground area, and playing fields. Municipal property means any outdoor area owned or operated by the city
Collingwood	2000 Amended June 2005	Smoking was prohibited within 25 metres of any playground equipment defined as: swings, slides, climbing apparatus, facilities expressly designed for rollerblades, and municipally-owned swimming pools. The definition does not include facilities for hockey, baseball or walking and biking trails. As of June 2005 the bylaw was amended to include 25 metres from playing fields
Hamilton	May 2011 (in effect May 2012)	A complete smoking ban on any city-owned recreational property (excludes golf courses).
Orillia	Feb 2010	No person shall smoke in any place, including but not limited to, those designated under section 9253.2.1 which includes within 10 metres from a playground area, 10 metres from a beach area, 10 metres of a sport activity area, 10 meters from an entrance to a municipally owned or managed building
Sault Ste. Marie	2003 amended 2005, 2007, 2009 and 2011	No person shall smoke any public place within the City or in a City building whether or not a sign is posted; no person shall smoke at any City entranceway; 15 metres of a playground area and recreational field; no person shall smoke on the Sault Area Hospital site; no person shall smoke on the Algoma Public Health site.
Thunder Bay	2004 amended in 2010	10 metres radius of the entrance to a recreational Facility; 10 metres of any playground equipment that it located on land owned by the corporation, 10 metres from the edge of the beach (water's edge), 3 metres from the entrance to a workplace. Smoking is also prohibited on a patio.
Woodstock	September 2008	No one shall smoke or hold lighted tobacco in any downtown sidewalk café, within 30 meters of any playground equipment or 15 metres from any baseball diamond, soccer pitch or tennis court, within 4 metres of any bus stop, and within 9 metres of the entrance to any municipal owned building.
Niagara Falls	May 2010 (in effect May 2011)	Complete smoking ban on any city owned park (included playgrounds, sport & recreation fields, skate parks, sport and recreation seating and community events)
City of Peterborough	December 2007 (last revision May 2011)	Parks (9 m) Playgrounds, skate parks, splash pads (9 m) Beaches (9 m) Sport & recreation playing fields includes seating (9 m) Municipal entrances (9 m)
Ottawa	August 2004 (currently undergoing community consultation to go 100% smoke-free.	Municipal parks (9 m) Playgrounds (9 m) Beaches (9 m) Sport & recreation playing fields (9 m) Municipal entrances (9 m)

Smoke-Free Public Outdoor Spaces Policy Options

The list below reflects four available options presented in order from least restrictive to most restrictive of smoking in public outdoor spaces.

Table 3. Options for the Regulation of Outdoor Smoking

OPTION 1	PROS	CONS
No smoking within nine (9) metres of: a) All public playgrounds and arenas, including but not limited to swimming pools, splash pads, sports and recreation playing fields, outdoor areas used for public enjoyment and recreation areas for children such as petting zoos, trails, and public gardens. b) All public places and workplaces entrances/doorways (public places and workplaces, as defined in existing legislation.	• Moves exposure to ETS out of danger zone for the listed settings. • Most people believe existing law requires a buffer of 9 m from all entrances.	• Several public settings not included. • A defined distance (9 m) creates confusion with a setting since the property boundary may be unclear. • Creates confusion re: "How far is 9 metres?" • Places increased demands on enforcement staff. • Does not address role modelling or social norms concerns. Children still view the smokers. • Not reflective of trends for outdoor bylaw development in other communities. Bad image for our communities. • Safety concerns - adults attempting to smoke 9 m from child/setting can no longer actively supervise.

OPTION 2	PROS	CONS
A complete smoking ban in: a) All outdoor areas used for public enjoyment and recreation areas for children, including but not limited to parks, playgrounds, playing fields, swimming pools, splash pads, petting zoos, trails, public gardens, festivals, etc.) b) All municipally-owned and/or operated recreational properties* ❑ No smoking within 9 m of all public places and workplaces entrances/doorways (public places and workplaces, as defined in existing legislation). ❑ Application process required for Designated Smoking Areas at public outdoor events and festivals used for public enjoyment and recreation where the audience is adult. * Exemptions for long-term care homes, campgrounds, beaches, and golf courses - current legislation to apply.	• Increased protection from ETS. • Complete ban is easier to understand and obey; easier to enforce. • Festival option for designated smoking area addresses concerns of organizers of events whose audience is adult. Requires consultation with Enforcement Officers which provides an opportunity to explain the Smoke-Free Ontario Act and ensure increased compliance. • Less litter. • Attempts to address role modelling and social norms related to child focused settings. • Reflects recent trend for outdoor bylaw development.	• Does not include beaches, or golf courses. • While exemptions may increase perception of co-operation with festival and event organizers, residents and workers/volunteers would potentially be exposed to environmental tobacco smoke. • Festival organizers required to apply for a designated smoking area.

OPTION 3	PROS	CONS
A complete smoking ban in: a. All outdoor areas used for public enjoyment and recreation areas (including parks, playgrounds, playing fields, swimming pools, splash pads, petting zoos, trails, public gardens, festivals and public beaches) b. Municipally-owned and/or operated recreational properties* c. All outdoor seating areas - bar and restaurant patios ❑ No smoking within 9 m of all public places and workplaces entrances/doorways (public places and workplaces, as defined in existing legislation). ❑ Application process required for Designated Smoking Areas (DSAs) at public outdoor events and festivals used for public enjoyment and recreation where the audience is adult. ❑ Application process enabled for hospital campuses, university campuses and college campuses to be named within a schedule of the bylaw for designated smoking areas (DSAs) or for 100% smoke-free campuses. * Exemptions for long-term care homes and campgrounds - current legislation to apply.	• As above and: • Enforcement simplified with a clearer message on restrictions. • Protects staff and patrons who work/dine outdoors on patios equally with those who work/dine indoors. • Protects children who frequent outdoor patios. • Simplifies compliance requirements for restaurant and bar proprietors. Equitable for all restaurants and bar operators – level playing field for all proprietors • Includes beaches and golf courses – consistent message that tobacco, sports and recreation don't mix.	• Does not fully respond to social norms and role modelling issues. • Increased cost in reviewing and processing applications for DSAs.

OPTION 4	PROS	CONS
4) A complete smoking ban in: a. All areas used for public enjoyment and recreation (including parks, playgrounds, playing fields, swimming pools, splash pads, petting zoos, trails, beaches, public gardens, golf courses, etc.). b. Municipally-owned and operated recreational properties c. All outdoor areas and venues d. Outdoor seating areas - restaurant and bar patios e. Outdoor public events and community festivals f. All areas of hospital campuses g. All areas of university and college campuses h. All hotels, motels and bed and breakfasts	• As in Option 2 and 3 and: • Best for the health of Middlesex-London; protecting everyone from ETS. • Fully addresses role modelling and social norms issues. • Includes full property of all golf courses. • Potential for an increase in attendance and visitor satisfaction at festivals similar to the experience of restaurants and bars.	• Imposes on private living spaces at campgrounds, hotels, motels and bed and breakfasts. • Imposes on those who are patients, visiting or working in hospitals – could put patients in risky situations if not supported with withdrawal management treatment in hospital. • Large university campus – difficult for addicted staff on campus. • The expectation is that you smoke only outside at home, which could be unrealistic, creating enforcement challenges which exceed capacity.

Definitions*:

Outdoor areas:

Includes but not limited to - parks, playgrounds, wading or swimming pools, splash pads, sports fields, (e.g. but not limited to, soccer fields, football fields, baseball/softball diamonds, basketball courts, skateboard parks, tennis courts, lawn bowling greens, golf courses, horseshoe pits, ice surfaces, toboggan hills).

Outdoor venues:

Includes but not limited to - stadiums, grandstands, public areas adjacent to water, beaches, horticultural display areas or ornamental gardens, walking/hiking trails, campgrounds, bike paths.

Outdoor seating areas:

Includes but not limited to - restaurant and bar patios, buffer zone of a specific number of meters around the perimeter of the patio, entranceways and air intakes; buffer zone makes patios truly smoke-free.

Outdoor public events:

- Includes but not limited to - festivals, fairs and spectator events – including tents that may be erected on the grounds – such as concerts, sporting events and parades.
- Specific streets, e.g., in a main shopping area or within a school zone, including the sidewalk, street, lane, thoroughfare, curb, retaining wall, boulevard, etc.

***These definitions are for reference only and to help illustrate the four options available. Specific language and definitions would need to be reviewed by legal counsel before adoption into bylaws or corresponding regulations.**

Recommended Option

Staff recommends the adoption of Option 3, that is:

A complete smoking ban in:

a) All outdoor areas used for public enjoyment and children recreation areas (including parks, playgrounds, playing fields, swimming pools, splash pads, petting zoos, trails, public gardens, festivals and public beaches)
b) Municipally-owned and/or operated recreational properties*
c) All outdoor seating areas - bar and restaurant patios

- No smoking within 9 m of all public places and workplaces entrances/doorways (public places and workplaces, as defined in existing legislation).

- Application process required for Designated Smoking Areas (DSAs) at public outdoor events and festivals used for public enjoyment and recreation where the audience is adult.

- Application process enabled for hospital campuses, university campuses and college campuses to be named within a schedule of the bylaw for designated smoking areas (DSAs) or for 100% smoke-free campuses.

* Exemptions permitted for long-term care homes and campgrounds – only current legislation would apply.

Why This Option?

- This policy option aligns the closest with the RRFSS results and matches current levels of public support for smoke-free playgrounds, recreational playing fields, entrances and patios.
- This policy option achieves the goal of protecting children from exposure to second-hand smoke, enhances role modelling of tobacco-free choices, and addresses the need to role model tobacco-free living, while acknowledging the addiction at adult-focused events.
- Enables hospital, university and college partners who have been increasing smoking restrictions on campus with the opportunity to be named within the bylaw and receive additional enforcement support than what can currently be offered.
- Increased compliance with the bylaw given that the restrictions match closest to public readiness.
- Enforcement less complex and increased public comprehension with a complete ban than with bylaws with set-backs from play structures and splash pads.
- Reflects current bylaws in development or recently enacted (Hamilton, Niagara).

Enforcement

The Health Unit currently employs five (a total of 3.6 FTE) Tobacco Enforcement Officers (TEOs) who are trained, experienced and are responsible for enforcement of the City of London and County of Middlesex 2003 Smoke-free Public Places and Workplaces bylaws and the 2006 *Smoke-Free Ontario Act*. No additional funding is required for enforcement; TEOs are 100% provincially funded through the Smoke-Free Ontario Strategy. The Tobacco Enforcement Team would be responsible to assist with the smooth introduction and implementation of the proposed bylaw. Police Services would also be empowered to enforce the proposed bylaw. If University, College and Hospital Campuses applied to be named within a schedule of the Bylaw, Campus and Hospital Security would also be empowered to assist with enforcement of the proposed bylaw.

Proposed Approach for Moving Forward

Jurisdictions across Canada and most notably in Ontario, including some of our neighbouring communities, have successfully regulated outdoor smoking. While not all bylaws have been formally evaluated, studies of some existing bylaws demonstrate that enforcement has not been difficult and compliance is not a significant issue[xix, xx, xxi]. Municipalities reported either no increase in complaints, or minimal complaints/inquiries that required a response. Municipalities also reported no impact on the use of city recreational facilities[xxii]. The Health Unit's Tobacco Control Team anticipates a similar situation for this community.

With the Board of Health's support and approval, Middlesex-London Health Unit Tobacco Control staff will prepare a community engagement plan, based on Policy Option 3 to enable the Health Unit to approach key community stakeholders and representatives from the City of London and the County of Middlesex in early 2012 to begin working together on this important policy initiative. With involvement and input from community leaders and the development of a community consultation, communication and education plan, these steps will help to ensure that proposed amendments to local bylaws are met with strong public and political support.

A bylaw is only effective if it has a high compliance rate, is easily understood by the public and is enforceable. Policy Option 3 provides strong direction on how the City of London and the County of Middlesex can provide greater protection from second-hand smoke and begin to role model a culture free from tobacco use to our children and youth.

Conclusion and Recommendation

Tobacco-free environments provide the greatest level of protection from second-hand smoke, help to prevent young people from starting to use tobacco products and assist smokers to quit smoking.

Public Health Ontario recommends that tobacco use be eliminated in selected outdoor public spaces, and local data suggest that City of London and Middlesex County residents are prepared and ready for greater restrictions on smoking in outdoor public spaces. It is recommended that the Middlesex-London Board of Health support Policy Option 3 and direct staff to approach City Council and Middlesex County Council to seek approval for amendments to each municipality's existing bylaws consistent with the requirements of Option 3.

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[xvi] Physicians f*or a* Smoke-Free Canada, 2010.

[xvii] Lynch, Megan, McDonald, Kevin. Smoking and Second-hand Smoke in Outdoor Municipal Recreational Areas in Hamilton. Submitted by Elizabeth Richardson, MD, MHSc, FRCPC, Medical Officer of Health, Public Health Services Department. City of Hamilton, Public Health Services Division, February 28, 2011

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[xxi] Thinkwell Research. (2010) "Smoke free Nova Scotia Bridgewater smoke free spaces survey". Accessed at www.smokefreens.ca/current-initiatives/outdoor-spaces-resources

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MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 104-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Nutritious Food Basket Costing Survey Results for 2011 and the Opportunities for Action

Recommendations

It is recommended:

1. That the Board of Health petition the Premier of Ontario, the Right Honourable Dalton McGuinty, to develop a comprehensive Ontario Food and Nutrition Strategy ; and further
2. That Report No. 104-11 re Nutritious Food Basket Costing Survey Results for 2011 and the Opportunities for Action be forwarded to appropriate community agencies.

Background

The Nutritious Food Basket (NFB) survey is conducted annually in May as per the Ontario Public Health Standards. The survey provides a measure of the cost of basic healthy eating that represents current nutrition recommendations and average food purchasing patterns of Canadians.

Cost information based on the NFB can be used to:

- determine what the basic cost might be for an individual or household to eat healthy;
- compare the basic cost of healthy eating with income and other basic living expenses;
- plan programs that promote access to nutritious, safe and personally acceptable foods;
- inform policy decisions.

The Public Health Dietitians on the Chronic Disease Prevention and Tobacco Control Team conduct the NFB Survey to provide a measure for the cost of food available to residents in Middlesex-London. In 2011, 12 grocery stores in Middlesex-London were surveyed, including areas of variable economic status.

Survey Results

Appendix A provides the 2011 weekly cost of the NFB in London and Middlesex County.

Table 1 below highlights some real life situations for people living in this area utilizing the NFB costing survey data. It can be seen, for those on government assistance or earning minimum wage, there is little if any money left after costs for shelter, food and utilities.

In previous years, the then Ministry of Health Promotion and Sport provided cumulative provincial survey results; however, this year, comparison information was not provided to public health units. Consequently, it is not possible to compare Middlesex London results with similar sized communities.

Table 1 – Monthly Income and Cost of Living Scenarios

	Single Man on Ontario Works (OW)	Single Man on ODSP	Single Woman over 70 (Old Age Security/ Guaranteed Income Security)	Single Mother Family of 3 on OW	Family of 4 Minimum Wage Earner	Family of 4 Medium Income After tax
Monthly Income Including Benefits & Credits	$635	$1103	$1245	$1836	$2619	$5767
Estimated Shelter Cost	$554	$705	$705	$921	$921	$1052
Cost of a Nutritious Diet	$197.97	$197.97	$151.15	$462.29	$736.70	$736.70
WHAT'S LEFT?	-$116.97	$200.03	$388.85	$452.71	$960.30	$3977.30
% Income	87%	64%	57%	50%	35%	18%

Required for Shelter						
% Income Required for Nutritious Diet	31%	18%	12%	25%	28%	13%
Remember: People still need to pay for utilities, phone, transportation, cleaning supplies, personal care items, clothing, gift, entertainment, internet, school essentials, medical and dental costs and other purchases.						

Notes: Rental estimates from CMHC Rental Market Report – Annual Survey (October 2011). Note that utility costs are assumed to be included in the figures that go into calculating the averages. Utility costs vary considerably based on age and condition of housing, type of heating, range of appliances, air conditioning or cooling, and household size.

Opportunities for Action

The relationship between poverty and poor health is clear. Poor nutrition can lead to increased risk for chronic and infectious diseases, pregnancy outcomes with greater risk for low birth weight and negative impacts on the growth and development of children. It costs more to treat and manage these conditions than to prevent them by ensuring people can afford an adequate, healthy diet. Provincially and locally, advocacy efforts to improve access to healthy foods for people with lower incomes have been ongoing. A number of advocacy efforts have been suggested and supported in many jurisdictions across the province. These are highlighted in Appendix B.

Conclusion

The NFB annual surveys have repeatedly shown that people with low incomes do not have an adequate baseline to afford healthy eating after meeting other essential needs for basic living such as housing and utility costs. One immediate strategy to improve food security is to implement a monthly $100 Healthy Food Supplement for social assistance recipients. Long-term strategies include policies for social programs combined with community planning involving the agri-food system, community/business leaders and the social service sectors to yield sustainable change which will mitigate the underlying problems of poverty and food insecurity. A comprehensive *Ontario Food and Nutrition Strategy* is urgently needed.

This report was written by Ms. Heather Thomas, Public Health Dietitian, and Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards (2008): Foundational Standard 3, 4, 5, 8, 9, 10; Chronic Disease Prevention 2, 7, 8, 11, 12

Appendix A

Nutrition Facts

The Weekly Cost of the Nutritious Food Basket London and Middlesex County 2011

This information represents the approximate cost to eat well in Middlesex County and London. Weekly costs are based on a May 2011 survey of 67 food items (the *Nutritious Food Basket*) from 12 main chain and independent grocery stores in Middlesex County and London. The foods surveyed are determined by food purchasing patterns of average Canadians and data provided by Statistics Canada. The *Nutritious Food Basket* is calculated to meet the nutrient needs of most people in each age and sex group.

	Age	Approximate Cost Per Week ($)
Boy	2-3	22.48
	4-8	29.04
	9-13	38.53
	14-18	54.31
Girl	2-3	22.07
	4-8	28.21
	9-13	32.98
	14-18	39.43

	Age	Approximate Cost Per Week ($)
Man	19-30	52.43
	31-50	47.35
	51-70	45.69
	70+	45.24
Woman	19-30	40.60
	31-50	40.15
	51-70	35.61
	70+	34.88
Pregnant Woman	Younger than 18 years	43.90
Pregnant Woman	19-30	44.34
Pregnant Woman	31-50	43.24
Breastfeeding Woman	Younger than 18 years	45.79
Breastfeeding Woman	19-30	46.99
Breastfeeding Woman	31-50	45.88

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(519) 663 - 5317 fax: (519) 663 - 9581
www.healthunit.com

MIDDLESEX-LONDON HEALTH UNIT
An Accredited Teaching Health Unit

Strathroy Office - Kenwick Mall
51 Front St. E., Strathroy, ON N7G 1Y5
(519) 245 - 3230 fax: (519) 245 - 4772
health@mlhu.on.ca

To estimate the cost of a nutritious diet for your household, follow these steps.

Step 1
Write down the gender and age for each person you are feeding.

Step 2
Using the chart on the other side of this fact sheet, write down the weekly food cost for each person.

Step 3
Add the weekly food costs together.

Step 4
If you feel it costs you more per person to feed a small group and less per person to feed a large group, you may choose to adjust the total cost in Step 3. The Toronto Social Planning Council suggests using the following adjustments for family size:

If you are feeding:

1 person	**Multiply by 1.20**
2 people	**Multiply by 1.10**
3 people	**Multiply by 1.05**
4 people	**Make no change**
5-6 people	**Multiply by 0.95**
7 or more people	**Multiply by 0.90**

Note: The *Nutritious Food Basket* represents **food costs only**. You may have other non-food items on your grocery list that will make your grocery bill more expensive.

Example		
Sex	Age	Approximate Cost per Week
Man	42	47.35
Woman	39	40.15
Girl	8	28.21
Boy	14	54.31
Boy	3	22.48
Subtotal =		192.50
X (0.95) Adjustment factor		**$182.88 Total per week**
Total per month		**$182.88 x 4.33 = $791.87**

Your Household		
Sex	Age	Approximate Cost per Week
Subtotal =		
X Adjustment factor		**Total per week**
Total per month		

Understanding the Nutritious Food Basket

Generally, highly processed foods and foods with little nutrition (e.g. soft drinks, potato chips) are not included in the costing survey. The food basket does not include any foods that may be required for special diets (e.g. gluten-free products, sugar-free products). **Personal and household care items** (e.g. toothpaste, laundry detergent, soap, feminine products, cleaning and supplies) are **not** included.

Putting the Nutritious Food Basket into Action

The Nutritious Food Basket design assumes that most people have **the necessary time, food skills, and equipment** to be able to prepare most meals from scratch. It also assumes that most people are able to shop at a quality grocery store. **Food literacy and cooking skills are necessary** for people to select, prepare, and store foods to ensure healthy eating for individuals and families. If someone is unable to prepare meals from scratch, the cost of groceries will be greater.

Does Food Cost Too Much?

The cost of food is not the issue for most people. The main problem for many people is that their income is too low. For people living on low incomes, there is not enough money left to buy healthy food after paying rent and utility bills.

Estimated weekly food costs for local households	
2011 "Family of Four" – reference group (Man 31-50 years, Woman 31-50 years, Male 14-18 years, Female 4-8 years)	**$170.02**
Estimated monthly food costs for local households	
2011 "Family of Four" – reference group (Man 31-50 years, Woman 31-50 years, Male 14-18 years, Female 4-8 years)	**$736.70**
% of income of a family supported by a minimum wage earner	**28%**
% of income supported by an average income wage earner	**13%**

When money is tight, people are forced to make ends meet by cutting into their food budget. The food budget is not fixed as are rent and utilities. It is easier to dip into the food budget to help pay those bills each month.

- Sometimes people are forced to skip meals or fill up on cheap foods that can often be less nutritious.
- Many people on fixed incomes do not eat sufficient fruit, vegetables, and milk products because they are unable to afford them.
- Parents who are low income earners will often feed their children first and go with less food themselves. As a result, the parents' nutrition and health will suffer.
- Often as a very last resort, people are forced to use food banks or other emergency food programs.
- Foods provided in food bank hampers tend to provide only about three days' supply of food per month and often do not provide a good balance of all food groups required to stay healthy.

Poverty and Health: Impact on Families

Poverty is linked with health. Food security is necessary for good health. When an individual has adequate income for food and other necessities, he has a lower risk of disease.

- Poor nutrition leads to an increased risk of chronic diseases such as diabetes, cardiovascular disease and cancer, as well as conditions such as low birth weight.
- People living on low incomes have more health problems and die younger than people with higher incomes.
- Children living in low income households are more likely to get sick and are less able to do well in school.

- In 2009, 38% of the clients helped by the London Food Bank were children and youth.
- In 2010, over 3000 families visited the London Food Bank each month.
- In 2008, approximately 8,000 London children under the age of 18 lived in families receiving social assistance from Ontario Works or the Ontario Disability Support Program.

How much money is available after shelter, utility, and food costs?

A summary of some real life situations for people living in London appears below. These scenarios illustrate that after paying for shelter, utilities, and food, minimum wage earners and households on fixed incomes and assistance have little, if any money left over to cover other basic monthly expenses.

	Single Man on Ontario Works	Single Man on ODSP	Single Woman over 70 years (Old Age Security/Guaranteed Income Security)	Single Mother Family of 3 on Ontario Works	Family of 4 Minimum Wage Earner	Family of 4 Medium Income after tax
Monthly Income, Including Benefits & Credits	$635	$1103	$1245	$1836	$2619	$5767
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Cost of a Nutritious Diet	$197.97	$197.97	$151.15	$462.29	$736.70	$736.70
WHAT'S LEFT?	-$116.97	$200.03	$388.85	$452.71	$960.30	$3977.30
% Income Required for Shelter	87%	64%	57%	50%	35%	18%
% Income Required for Nutritious Diet	31%	18%	12%	25%	28%	13%
REMEMBER: People still need to pay for utilities, phone, transportation, cleaning supplies, personal care items, clothing, gift, entertainment, internet, school essentials, medical and dental costs, and other purchases.						

Notes: Rental estimates from CMHC Rental Market Report – Annual Survey (October 2011). Note that utility costs are assumed to be included in the figures that go into calculating the averages. Utility costs vary considerably based on age and condition of housing, type of heating, range of appliances, air conditioning or cooling, and household size.

Learn More about Poverty and Hunger

www.povertyfree.ca
www.children.gov.on.ca/htdocs/English/breakingthecycle/strategy/strategy.aspx
www.foodbankscanada.ca/main2.cfm?id=107185CB-B6A7-8AA0-6FE6B5477106193A
www.dothemath.thestop.org
www.therealissue.ca
www.oafb.ca

Recommended Strategies to Improve Access to Healthy Food for People with Lower Incomes

- The Ministry of Community and Social Services should implement a Healthy Food Supplement of $100 per month for social assistance recipients. This benefit would ensure that individuals can pay for their household expenses without needing to access funds set aside for food.
- Social assistance rates need to reflect the real cost of living and be indexed annually to inflation. Social assistance rates were cut drastically in 1995 and have yet to recover. The gap between assistance and actual cost of living continues to grow (Appendix B).
- The Ministry of Municipal Affairs and Housing should create an Ontario housing benefit to assist low income tenants to pay their rent thus preventing them from falling short of meeting their housing costs and requiring access to local emergency food charities or going hungry instead.
- The Ministry of Municipal Affairs and Housing should ensure municipalities throughout Ontario implement significant strategies to ensure affordable housing initiatives are actively in place to assist low income earners in accessing affordable, safe, and appropriate housing.
- The Ministry of Health Promotion and Sport should implement a comprehensive ***Ontario Food and Nutrition Strategy*** that addresses both the sustainability of a healthy food supply and the needs of Ontarians, particularly those with low socioeconomic status.

Public Health Ontario should ensure funding in 2012 for the Locally Driven Collaborative Partnerships project to support the investigation of food skills among priority populations in the context of enhancing food security among these populations. Food skills connect with food security. A collaboration of several heath units has already been created to focus on the development of a research question and objectives related to food skills research. The Middlesex-London Health Unit is well-positioned to be a supporting agency in this collaboration given staff expertise, leadership, and capacity in the area of food skills research.

Strategies that promote food security are positioned along a continuum:

- short-term relief strategies: food charities such as food banks, soup kitchens, and community meal programs; capacity-building strategies including the NFB, advocacy networks, food charters, food skill and literacy development, community gardens, buying clubs, and food councils.
- long-term system and policy changes: development, implementation, and coordination of a comprehensive Ontario Food and Nutrition Strategy; policy changes to social assistance and housing benefits.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 105-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Chief Nursing Officer Funding

Recommendations

It is recommended that the Board of Health approve the following actions to access the $116,699 100% ministry funding and to ensure compliance to Requirement 6.16 of the Organizational Standards:

a) Designate the Chief Nursing Officer role to the Director, Family Health Services,
b) Implement 1.0 FTE public health nursing hours as described in Report No. 105-11 re Chief Nursing Officer funding; and further
c) Authorize the signing of the amendments to the Public Health Accountability Agreement as appended to Report No. 105-11.

On August 23, 2011, the Board of Health received notification of new annualized base funding in the amount of $116,699 to support the implementation of the Chief Nursing Officer (CNO) initiative. This funding was offered to all 36 health units across Ontario. The CNO initiative is expected to enhance public health nursing practice, professional development, and quality assurance for public health programs and services delivered by public health nurses.

Further, on October 11, 2011, the Health Unit received additional information, attached as Appendix A, which outlined administrative details of the CNO initiative.

Ontario Public Health Organizational Standards - Requirement 6.16

In February 2011, the province issued the Ontario Public Health Organization Standards, and as part of these standards, Requirement 6.16 states that the Board of Health is required to designate a CNO by January 2013. This funding is intended to facilitate and support Boards of Health to meet this requirement.

The administrative letter further details the roles and requirements of the CNO position and describes the process that each Board of Health needs to follow in order to access the funding for the CNO initiative. If a Board of Health already fulfills the CNO requirements, as is the case for Middlesex London Health Unit, the Board of Health must designate a qualified CNO, and establish additional hours of nursing (minimum of 1.0 Full Time Equivalent - FTE).

Each Board of Health must sign an amendment to the Public Health Accountability Agreement (Appendix B) and provide proof of designation and establishment of a CNO prior to receiving the new base funding.

CNO Designation

For a number of years the Health Unit has fulfilled the CNO requirements through the leadership of Ms. Diane Bewick, Director, Family Health Services and Senior Nurse Leader, with support from the Community Health Nurse Specialist position. It is recommended that this practice continue and to satisfy the requirements for the new funding, that the Director, Family Health Services, be designated the Chief Nursing Officer.

Additional Hours of Nursing Services

The intent of the funding was to create new resources for health units and wasn't intended to offset current cost-shared positions. Therefore, to satisfy the requirements and receive the funding, the health unit must hire a minimum of 1.0 FTE of new nursing hours.

In September, as part of the development of the 2012 Board of Health budget, the Senior Management Team considered this new funding; however, at the time, the administrative details had not been released. It is recommended that 0.5 FTE public health nursing hours be created on the Chronic Disease Prevention Team and 0.5 FTE public health nursing hours be created on the Vaccine Preventable Disease Team. The remaining funds will be used to enhance the support for the CNO role respecting quality assurance and nursing practice leadership.

Conclusion

New provincial funding is available to support the implementation of a CNO position. For many years, the Health Unit has had a Senior Nurse Leader role which has been provided administrative support by the Community Health Nurse Specialist position. To comply with the requirements for accessing the provincial CNO initiative, it is recommended that the Director, Family Health Services, be designated as the CNO for the Health Unit. As well, it is recommended that two 0.5 FTE positions be created: one on the Vaccine Preventable Disease Team, and another on the Chronic Disease Prevention Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Requirement 6.16 states that the Board of Health is required to designate a CNO by January 2013.

Ministry of Health and Long-Term Care

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Ontario

OCT 11 2011

Dr. Graham Pollett
Medical Officer of Health
Middlesex-London Health Unit
50 King Street
London ON N6A 5L7

Dear Dr. Pollett:

Re: Ministry of Health and Long-Term Care and Ministry of Health Promotion and Sport Public Health Accountability Agreement with the Board of Health for the Middlesex-London Health Unit dated January 1, 2011 (the "Accountability Agreement")

This letter is further to the recent letter from the Honourable Deb Matthews, Minister of Health and Long-Term Care, in which she informed you that the Ministry of Health and Long-Term Care ("the ministry") will provide the Middlesex-London Health Unit up to $116,699 (at 100%) in annualized base funding beginning in 2011 to support implementation of the Chief Nursing Officer (CNO) Initiative.

As you know, the ministry issued the Ontario Public Health Organizational Standards (Organizational Standards) in February 2011. Requirement 6.16 of the Organizational Standards states that the Board of Health is required to designate a CNO by January 2013. The CNO Initiative is intended to facilitate and support this requirement.

Contingent upon the Board of Health meeting the terms and conditions for funding, up to $29,175 in salary and benefits for 1.0 nursing Full-Time Equivalent (FTE) is available for the period October 1 to December 31, 2011. This new base funding will be annualized to $116,699 in the 2012 funding year.

.../2

Dr. Graham Pollett

The ministry and the Board of Health for the Middlesex-London Health Unit will be entering into an Accountability Agreement effective January 1, 2011. I am pleased to provide you with 2 copies of an Amending Agreement that would, if executed, amend that Accountability Agreement, and which contain the terms and conditions governing the funding referred to in the Minister's letter. Once the Accountability Agreement has been executed and you have signed the Amending Agreement and met the funding conditions described in the following paragraph and provided a completed copy of the proof of designation and establishment form attached as Appendix 2 to the ministry, the ministry intends to execute the Amending Agreement.

The requirements for receipt of funding under the CNO initiative include: designation of a qualified CNO and implementation of CNO roles at a management level within the health unit, reporting to the Medical Officer of Health or Chief Executive Officer; establishment of additional hours of nursing services (minimum 1.0 FTE) which may include responsibilities that support the designated CNO's roles respecting nursing quality assurance and nursing practice leadership; and submission of a report to the ministry confirming the designation of a qualified CNO and the recruitment of a new 1.0 FTE nurse. The roles and requirements for the CNO position and the proof of designation and establishment form are attached to this letter as **Appendix 1** and **Appendix 2**, respectively.

As you are aware, Ontario has felt the effects of the global recession and is running a deficit in order to create jobs and protect public services. While the contributions of those who deliver public services are valued and appreciated, the public also expects those who are paid by tax dollars to do their part to help sustain public services.

The government has passed the *Public Sector Compensation Restraint to Protect Public Services Act, 2010* (the "Act"), which freezes compensation plans for all non-bargaining employees in the broader public sector, including the Ontario Public Service, for two years. For employees who bargain collectively, the government will respect all current collective agreements. When these agreements expire and new contracts are negotiated, the government will work with transfer payment partners and bargaining agents to seek agreements of at least two years' duration that do not include net compensation increases. The fiscal plan provides no funding for compensation increases for future collective agreements.

Funding provided by the province to transfer payment partners and agencies is for the purpose of providing and protecting public services and is not to be diverted to fund increases in employee compensation.

.../3

Dr. Graham Pollett

The provision of funding does not relieve your organization from responsibility for complying with the Act and does not permit it to give increases that are not authorized by the Act.

Please review the Amending Agreement carefully and sign both copies enclosed and return both copies, as well as the completed proof of designation form to:

Brent Feeney
A/Manager, Funding and Accountability
Public Health Standards, Practice and Accountability Branch
Public Health Division, Ministry of Health and Long-Term Care
393 University Avenue, Suite 2100
Toronto ON M7A 2S1

Once the Accountability Agreement between the Province and the Middlesex-London Health Unit has been executed, you have provided a completed copy of the proof of designation form to the ministry, and once the enclosed Amending Agreement has been executed by both parties, the ministry will return one copy of the executed Amending Agreement to you and will begin to flow the funds.

If you have any questions, please contact Mr. Feeney at 416-212-6397 or by email at brent.feeney@ontario.ca.

Sincerely,

Roselle Martino
Executive Director (A)

Attachments

c: John Millson, Manager, Finance & Operations, Middlesex-London Health Unit
Dr. Arlene King, Chief Medical Officer of Health, Public Health Division
Debra Bournes, Provincial Chief Nursing Officer, Nursing Secretariat
Pier Falotico, Director, Financial Management Branch, MOHLTC
Michael Parzei, Director, Fiscal Oversight & Performance Branch, MOHLTC
Sylvia Shedden, Director, Public Health Standards, Practice and Accountability Branch, MOHLTC
Brent Feeney, A/Manger Funding and Accountability, Public Health Standards, Practice and Accountability Branch, MOHLTC

Ontario

Appendix 1

Chief Nursing Officer Roles

In February 2011, the Ministries of Health and Long-Term Care and Health Promotion and Sport issued the Ontario Public Health Organizational Standards (Organizational Standards). Requirement 6.16 of the Organizational Standards states that the Board of Health is required to designate a Chief Nursing Officer (CNO) by January 2013. Formal recognition and implementation of CNO roles at a management level will assist in implementation of requirements of the Organizational Standards that relate to management operations, such as:

- Contributing to health human resource strategies;
- Planning and implementing staff development initiatives; and
- Providing support on issues and activities related to professional practice.

The presence of a CNO in each health unit will enhance the health outcomes of the community at individual, group and population levels: through contributions to organizational strategic planning and decision making; by facilitating recruitment and retention of qualified, competent public health nursing staff; and enabling quality public health nursing practice. Furthermore, the CNO articulates, models and leads the way towards a vision of excellence in public health nursing practice, which facilitates evidence-based services and quality health outcomes in the public health context.

It is expected that the CNO role will be implemented at a management level within the health unit reporting to the Medical Officer of Health (MOH) or Chief Executive Officer (CEO) and, in that context, contributes to organizational effectiveness.

Providing Nursing Practice Quality Assurance and Continuous Quality Improvement:

The Chief Nursing Officer:

1. Acts as the principal lead and resource for nursing practice and professional issues; oversees and has the authority to manage quality assurance and improvement activities related to nursing practice. Such activities include:
   - Leading or contributing to the resolution of issues respecting the quality of nursing practice for nurses employed by the organization and ensuring nursing practice requirements are met;
   - Leading and overseeing policy and procedure development for public health nursing practice;
   - Promoting and consulting on on-going evaluation of public health nursing practices, services and programs;
   - Fostering a culture of enquiry and innovation in public health nursing practices;
   - Providing leadership to the Nursing Practice Council;
   - Liaising with, and participating as an active member in nursing and public health organizations;
   - Facilitating the application of standards, best practice guidelines, legislation, regulations, competencies and trends of public health nursing practice (e.g., Ontario Public Health Standards, College of Nurses of Ontario and Canadian Community Health Nursing Standards of Practice, Public Health and Public Health Nursing Core Competencies,) towards quality public health practice; and,
   - Engaging and collaborating with the inter-professional teams on public health practice issues representing the nursing perspective and promoting inter-disciplinary public health practice.

2. Promotes nursing professional development and continuous learning of public health and related nursing knowledge by:
   - Facilitating planning for professional development, including securing and managing resources for training and education, and professional development resources and tools; and,
   - Leading and overseeing knowledge exchange/translation, research, staff orientation, mentoring.

Providing Nursing Leadership:

3. The Chief Nursing Officer represents public health nursing at the community, provincial and national level by:
   - Contributing the perspective of public health nursing to multi-sectoral planning groups, organizations and governmental committees within and beyond the public health sector;
   - Communicating nursing's contributions to and influencing the functions of public health (i.e., health protection, health surveillance, population health assessment, health promotion, illness and injury prevention, and emergency preparedness and response); and,
   - Communicating nursing's contributions to the health of individuals, communities and populations by addressing the social determinants of health.

4. Additionally, the CNO liaises with academic bodies and community partners to:
   - Coordinate and support quality student placements, orientation and learning in public and community health nursing practice;
   - Consult in the development of curriculum;
   - Develop inter-disciplinary and multi-disciplinary learning opportunities; and,
   - Identify public health nursing research questions and foster academic/practice research partnerships.

Supporting Organizational Effectiveness:

5. The Chief Nursing Officer:
   - Advances a nursing perspective in support of, and to further, organizational effectiveness to meet the Ontario Public Health Standards and Organizational Standards through contributions to organizational strategic planning;
   - Promotes the full utilization of nursing scope of practice and competencies within a healthy work environment, which contributes to nursing job satisfaction; and,
   - Promotes professionalism by implementing and supporting evidence-informed leadership and professional practice standards.

Minimum CNO Requirements:

1. Registered Nurse with the College of Nurses of Ontario;
2. Baccalaureate degree in nursing;
3. Graduate degree with a focus on public health or nursing, or a relevant academic equivalent[1], or be committed to obtaining such qualifications within 3 years of designation;
4. Minimum of 10 years nursing experience with progressive leadership responsibilities, including a significant level of experience in public health; and,
5. Member of appropriate professional organizations (e.g., RNAO, ANDSOOHA-PH Nursing Management; OPHA; etc.).

Recruitment:

In recruiting a qualified CNO, Boards of Health are encouraged to designate or accept applicants that have:

- Knowledge and experience in public health nursing that reflects an understanding of professional practice and development issues.
- The knowledge and skills required to contribute to workforce capacity building in public health nursing, recruitment and retention of public health nurses and support improvements in nursing practice that contribute to the health and well-being of individuals, communities and populations.

[1] For example, community health, health promotion, and health administration, etc.

Ontario

Appendix 2

CHIEF NURSING OFFICER INITIATIVE TEMPLATE FORM – PROOF OF DESIGNATION AND ESTABLISHMENT OF NEW 1.0 NURSING FTE

TO BE COMPLETED BY BOARDS OF HEALTH TO: (A) CONFIRM DESIGNATION OF A CHIEF NURSING OFFICER, AND (B) UPON SUCCESSFUL RECRUITMENT OF A NEW PUBLIC HEALTH NURSE FTE, AND PROVIDED TO THE MINISTRY FOR REVIEW AND TRANSFER OF FUNDING

Health Unit Name:	
DESIGNATION OF A CHIEF NURSING OFFICER (CNO)	Date CNO Designated (YYY/MM):
	Designation Method (check ✓as appropriate): ☐ Board of Health Resolution (Reference):_____ ☐ Staff Announcement (please attach) ☐ Other (please specify)_____
	Full Title of CNO Designee:
FTE Allocation (Minimum Total is 1.0 FTE) **What proportion of the new FTE is allocated to the CNO and/or a new nursing FTE?**	Designated CNO: _____ FTE
	Other **New** Nursing FTE (if applicable): _____ FTE Position Title for New FTE: _____
Proportional Distribution of allocation <u>provided through CNO Initiative</u>.	**CNO** Salary Amount = $_____ Benefits as a Percentage (%) of Salary = _____%
	Salary amount to **New** Nursing FTE (if applicable) = $ _____ Benefits as a Percentage (%) of Salary= _____%
Start Date of New Nursing FTE (if appropriate):	New Position: _____ (day/month/year)
Additional comments, if any:	
Authorized signing-officer	Print Name Signature Date

Please send the form to the attention of:

Brent Feeney
Manager, Funding and Accountability
Public Health Standards, Practice and Accountability Branch
Public Health Division, Ministry of Health and Long-Term Care
393 University Avenue, Suite 2100
Toronto ON M7A 2S1

Should you have any questions regarding this form, please contact Mr. Feeney via e-mail or telephone at Brent.Feeney@ontario.ca or 416-212-6397.

Amending Agreement No. 1

Between:

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO
as represented by the Minister of Health and Long-Term Care and the Minister of Health Promotion and Sport

(the "**Province**")

- and -

Middlesex-London Board of Health

(the "**Board of Health**")

WHEREAS the Province and the Board of Health entered into a Public Health Accountability Agreement effective as of the first day of January 2011 (the **"Accountability Agreement"**); and

AND WHEREAS the Parties wish to amend the Accountability Agreement;

NOW THEREFORE IN CONSIDERATION of the mutual covenants and agreements contained in this Amending Agreement No.1, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

1. This amending agreement ("Amending Agreement No. 1") shall be effective as the date it is signed by the Province.

2. Except for the amendments provided for in this Amending Agreement No. 1, all provisions in the Accountability Agreement shall remain in full force and effect.

3. Capitalized terms used but not defined in this Amending Agreement No. 1 have the meanings ascribed to them in the Accountability Agreement.

4. The Accountability Agreement is amended by:

   [a] Deleting Schedule A (Program-Based Grants) and substituting Schedule A-1 (Program-Based Grants), attached to this Amending Agreement No. 1.

   [b] Deleting Schedule B (Related Program Policies and Guidelines) and substituting Schedule B-1 (Related Program Policies and Guidelines), attached to this Amending Agreement No. 1.

   [c] Deleting Schedule C (Reporting Requirements) and substituting Schedule C-1 (Reporting Requirements), attached to this Amending Agreement No. 1.

The Parties have executed the Amending Agreement No. 1 as of the date last written below.

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO
as represented by the Minister of **Health and Long-Term Care**

_____ _____
Name: Date
Title:

Middlesex-London Board of Health

I/We have authority to bind the Board of Health.

_____ _____
Name: Date
Position:

_____ _____
Name: Date
Position:

SCHEDULE A-1

PROGRAM-BASED GRANTS

Middlesex-London Board of Health			
Base Funding			**2011 Approved Allocation**
Mandatory Programs (75%)			$14,803,135
Children In Need Of Treatment (CINOT) Expansion Program (75%)			$57,468
Chief Nursing Officer Initiative (100%) **(1)**	# of FTEs	1.00	$29,175
Enhanced Food Safety – Haines Initiative (100%) **(2)**			$60,000
Enhanced Safe Water Initiative (100%) **(2)**			$26,720
Healthy Smiles Ontario Program (100%)			$871,027
Infection Prevention and Control Nurses Initiative (100%)	# of FTEs	1.00	$84,872
Infectious Diseases Control Initiative (100%)	# of FTEs	10.50	$1,166,722
Needle Exchange Program Initiative (100%) **(2)**			$176,243
Public Health Awareness Initiatives: Infection Prevention and Control Week (100%)			$8,000
Public Health Nurses Initiative (100%) **(3)**	# of FTEs	2.00	$170,040
Small Drinking Water Systems Program (100%)			$52,700
Unorganized Territories (100%)			-
Vector-Borne Diseases Program (75%)			$461,967
Sub-Total			**$17,968,069**

One-Time Funding	**2011 Approved Allocation**
Bed Bugs (100%) **(4)**	$180,103
Healthy Smiles Ontario – Capital (100%) **(5)**	$510,000
Small Drinking Water Systems (100%)	$54,400
Sub-Total	**$744,503**

Total	**$18,712,572**

(1) Base Funding is pro-rated for the 3 month period of October 1, 2011 to December 31, 2011.

(2) Base Funding is pro-rated for the 9 month period of April 1, 2011 to December 31, 2011.

(3) To receive funding for the Public Health Nurses Initiative, boards of health are required to provide proof of offer of employment, which should not include any personal or identifiable information related to the nurse recruit.

(4) One-time funding is approved for the 12 month period of April 1, 2011 to March 31, 2012.

(5) One-time funding is approved for the 9 month period of April 1, 2011 to December 31, 2011.

SCHEDULE B-1

RELATED PROGRAM POLICIES AND GUIDELINES

BASE FUNDING:

B1. CINOT Expansion Program (MHPS)

The CINOT Expansion Program provides coverage for basic dental care for children 14 through 17 years in addition to general anaesthetic coverage for children 5 through 13 years. Boards of health must be in compliance with the Ontario Public Health Standards and the CINOT Protocol.

Boards of health must use the Oral Health Information Support System (OHISS) application to process all CINOT Expansion claims. Financial report data should align with expenditures as recorded in OHISS and reflected in Age Profile and Procedure Code Profile Reports for the period January 1st through December 31st.

Boards of health will not be permitted to transfer any projected CINOT Expansion Program surplus to their CINOT 0-13 year old budget.

B2. Chief Nursing Officer Initiative (MOHLTC)

In February 2011, the Ministries of Health and Long-Term Care and Health Promotion and Sport issued the Ontario Public Health Organizational Standards (Organizational Standards). Requirement 6.16 of the Organizational Standards states that the Board of Health is required to designate a Chief Nursing Officer (CNO) by January 2013.

The presence of a CNO in each health unit will enhance the health outcomes of the community at individual, group and population levels: through contributions to organizational strategic planning and decision making; by facilitating recruitment and retention of qualified, competent public health nursing staff; and enabling quality public health nursing practice. Furthermore, the CNO articulates, models and leads the way towards a vision of excellence in public health nursing practice, which facilitates evidence-based services and quality health outcomes in the public health context.

It is expected that the CNO role will be implemented at a management level within the health unit reporting to the Medical Officer of Health (MOH) or Chief Executive Officer (CEO) and, in that context, contributes to organizational effectiveness.

The Board of Health shall:

1. Designate a qualified manager to be accountable for and implement the CNO roles. The designated manager/CNO shall report and be accountable to the MOH or the CEO of the health unit.

   The following qualifications are required for designation as a CNO: Registered Nurse in good standing with the College of Nurses of Ontario; a Baccalaureate degree in nursing; a graduate degree in nursing, community health, public heath, health promotion, health administration or other relevant equivalent OR be committed to obtaining such qualification within three (3) years of designation (this

will be reviewed in 2014); and, a minimum of 10 years nursing experience with progressive leadership responsibilities, including a significant level of experience in public health.

2. Create additional hours of nursing service (minimum is 1.0 FTE). Such FTE may be used to support implementation of the CNO role through inclusion of functions relating to nursing quality assurance and leadership. Funding is for nursing salaries/benefits only and cannot be used to support operating or education costs.

3. Confirm to the Ministry that a qualified CNO has been designated and that a new FTE has been established[1]. In addition, the Board shall submit an annual year-end program report to the Ministry confirming the maintenance of the funded 1.0 FTE and a year-end program report highlighting CNO activities for the previous funding period.

B3. <u>Enhanced Food Safety – Haines Initiative (MOHLTC)</u>

The Enhanced Food Safety – Haines Initiative was established to augment a board of health's capacity to deliver the Food Safety Program as a result of the Provincial Government's response to Justice Haines' recommendations in his report "Farm to Fork: A Strategy for Meat Safety in Ontario".

Base funding for this initiative must be used for the sole purpose of implementing the Food Safety Program Standard. Eligible expenses include such activities as: hiring staff, delivering additional food-handler training courses, providing public education materials, and program evaluation. Funded projects/activities must be over and above the level of activities underway or planned based on existing mandatory programs base funding.

B4. <u>Enhanced Safe Water Initiative (MOHLTC)</u>

Base funding for this initiative must be used for the sole purpose of increasing the Board of Health's capacity to meet the requirements of the Safe Water Program Standard. Funded projects/activities must be over and above the level of activities underway or planned based on existing mandatory programs base funding.

B5. <u>Healthy Smiles Ontario Program (MOHLTC)</u>

Base funding for the Healthy Smiles Ontario (HSO) Program may only be used for costs associated with the HSO Program in accordance with the following conditions:

1. Base funds may only be used for ongoing day-to-day expenses associated with delivering services under the HSO Program in accordance with the HSO Capital and Operational Funding Policy Guideline, unless otherwise approved by the MOHLTC.
2. Boards of Health must use the Oral Health Information Support System (OHISS) to administer the HSO Program.
3. Boards of health must enter into Service Level Agreements with any organization they partner with for purposes of delivering the HSO Program. The Service Level

[1] Report template provided.

Agreement must set out clear performance expectations and ensure accountability for public funds. For greater certainty, this condition also applies where a board of health may be providing funding for capital improvements to partnering organizations.

4. Any significant changes to the MOHLTC-approved HSO business model, including changes to plans, partnerships, or processes, or otherwise as outlined in the board of health's MOHLTC-approved business case and supporting documents must be approved by the MOHLTC before being implemented.
5. Any contract or subcontract entered into by the board of health for the purposes of implementing the HSO Program must be conducted according to relevant municipal procurement guidelines.

B6. Infection Prevention and Control Nurses Initiative (MOHLTC)

The Infection Prevention and Control Nurses Initiative was established to support one additional FTE Infection Prevention and Control Nurse for every board of health in the province.

Base funding for the initiative must be used for the creation of additional hours of nursing service (FTE) and for nursing salaries/benefits and cannot be used to support operating or education costs. The applicant must have a nursing designation (Registered Nurse, Registered Practical Nurse, or Registered Nurse in the Extended Class), and must have or is committed to obtaining a Certification in Infection Control within three (3) years of beginning of employment.

The majority of the Infection Prevention and Control Nurses time must be spent on infection prevention and control activities. Boards of health are required to maintain this position as part of baseline nursing staffing levels.

B7. Infectious Diseases Control Initiative (180 FTEs) (MOHLTC)

Boards of health are required to remain within both the funding levels and the number of FTE positions approved by the Ministry.

Base funding for this initiative must be used solely for the purpose of hiring and supporting staff (e.g. recruitment, salaries/benefits, accommodations, program management, supplies and equipment, other directly related costs) to monitor and control infectious diseases, and enhance a board of health's ability to handle and coordinate increased activities related to outbreak management.

Staff funded through the Infectious Diseases Control Initiative is required to be available for redeployment, when requested by the Ministry, to assist other boards of health with managing outbreaks and to increase the system's surge capacity.

B8. Needle Exchange Program Initiative (MOHLTC)

Base funding for this initiative must be used for the purchase of needles and syringes, and their associated disposal costs, for the Boards of Health's Needle Exchange Program.

B9. Public Health Awareness Initiatives (MOHLTC)

Infection Prevention and Control Week

Infection Prevention and Control Week occurs annually during the third week of October.

Base funding for this initiative must be used for development, purchasing, and distribution of materials, and/or educational sessions to promote educational awareness during Infection Prevention and Control Week.

Expected outcomes include: increased public awareness of infection prevention and control principles; increased knowledge of infection prevention and control practices for service providers; and improved health of Ontarians. Appropriate use of funds include, but are not limited to: conducting public education sessions; honorarium for a speaker; creation and development of teaching aids and promotional items (e.g. fact sheets, pamphlets, etc.); distributing educational resources; media releases/articles, and poster displays to raise awareness in different settings.

Funds are not to be used for staff salaries and benefits, staff education (e.g. attendance at a conference) and for payment of staff professional fees/dues.

B10. Public Health Nurses Initiative (MOHLTC)

The Public Health Nurses Initiative was established to support two new FTE public health nursing positions for each board of health as part of the 9,000 Nurses Commitment.

Public health nurses with specific knowledge and expertise will provide enhanced supports to address the program and service needs of priority populations impacted most negatively by the social determinants of health in the Board of Health area.

Boards of health are required to adhere to the following: base funding for this program must be used for the creation of additional hours of nursing service (FTEs); boards of health must commit to maintaining baseline nurse staffing levels and creating two new public health nursing FTEs above this baseline; base funding is for public health nursing salaries and benefits only and cannot be used to support operating or education costs; and, boards of health must commit to maintenance of, and gains towards, the 70% full-employment target for nurses. The applicant must be a registered nurse and must have or be committed to obtaining the qualifications of a public health nurse as specified under the Act.

To receive base funding for these positions, boards of health are required to sign back agreeing to the terms and conditions of the funding and provide proof of offer of employment including starting salary level and benefits for each FTE (per the March 10, 2011 administrative letter).

B11. Small Drinking Water Systems Program (MOHLTC)

Base funding for this program must be used for eligible start-up costs, including: salaries, wages and benefits to support the public health inspector resources to conduct initial and ongoing site-specific risk assessments of all small drinking waters systems;

ongoing office accommodation costs; transportation and communication costs; and supplies and equipment.

Please note that the ongoing Small Drinking Water Systems Program funding allocation (cost-shared on a 75% provincial / 25% municipal basis) will be determined once the initial risk assessments have been completed by December 31, 2011.

B12. Unorganized Territories (MOHLTC)

Base funding must be used for the delivery of mandatory programs in Unorganized Territories (areas without municipal organization).

B13. Vector-Borne Diseases Program (MOHLTC)

The Vector-Borne Diseases Program focuses on all reportable and communicable vector-borne diseases and outbreaks of vector-borne diseases, which include, but are not limited to, West Nile virus and Lyme Disease.

ONE-TIME FUNDING:

B14. Bed Bugs Initiative (MOHLTC)

One-time funding for the Bed Bugs Initiative was established to support local efforts aimed at preventing and controlling bed bug infestations.

One-time funding for this initiative must align with the activities and services detailed in the board of health's application for funding. One-time funding is intended to support activities in one or both of the following streams; (a) education and outreach to the public and stakeholders to enhance awareness and knowledge in the identification, prevention and control of bed bug infestations, and/or (b) supports to vulnerable populations (e.g. individuals with physical, mental health, or addiction issues; people living in poverty; the under-housed or homeless, or frail elderly) impacted most negatively by bed bug infestations. The board of health is also expected to collect data on the degree of infestations, and the populations and settings most impacted by bed bug infestations in their area. Reporting of this data to the province will allow for assessment of the scope of the bed bug issue in the province and the effectiveness of implemented interventions.

Ineligible activities/items as part of this one-time funding include: translation costs for communication resources and materials; costs associated with the creation of communication resources and materials already available for use and customization by health units at www.bedbugsinfo.ca; office supplies and IT equipment such as laptops; any funding identified only as "miscellaneous" or as "other items"; and costs associated with the replacement, depreciation or repair of bed bug related equipment (e.g. monitoring equipment such as the Night Watch).

For further details regarding conditions of this one-time funding, please refer to the funding letter dated April 28, 2011 which outlines the accountability and administrative details for the bed bugs initiative.

B15. Healthy Smiles Ontario - Capital (MOHLTC)

One-time capital funds may only be used for the purchase of program dental equipment, necessary leasehold improvements and/or mobile dental clinics for development or expansion of community dental infrastructure. Funds may only be used in accordance with the HSO Capital and Operational Funding Policy Guideline, unless otherwise approved by the MOHLTC. Any changes to the MOHLTC-approved business case must be approved by the MOHLTC before being implemented.

Boards of health must enter into Service Level Agreements with any organization they partner with for purposes of delivering the HSO program. The Service Level Agreement must set out clear performance expectations and ensure accountability for public funds. For greater certainty, this condition also applies where a board of health may be providing funding for capital improvements to partnering organizations.

Any contract or subcontract entered into by the board of health for the purposes of implementing the HSO Program must be conducted according to relevant municipal procurement guidelines.

B16. Small Drinking Water Systems Program (MOHLTC)

One-time funding for this program must be used for eligible start-up costs, including: salaries, wages and benefits to support the public health inspector resources to conduct initial and ongoing site-specific risk assessments of all small drinking waters systems; ongoing office accommodation costs; transportation and communication costs; and supplies and equipment.

OTHER:

B17. Vaccine Programs (MOHLTC)

Funding on a per dose basis will be provided to boards of health for the administration of the following vaccines:

Influenza

The MOHLTC will continue to pay $5.00/dose for the administration of the influenza vaccine. In order to claim the Universal Influenza Immunization Program administration fee, boards of health are required to submit, as part of quarterly reports, the number of doses administered. Reimbursement by the MOHLTC will be made on a quarterly basis based on the information.

Meningococcal

The MOHLTC will continue to pay $8.50/dose for the administration of the meningococcal vaccine. In order to claim the meningococcal vaccine administration fee, boards of health are required to submit, as part of quarterly reports, the number of doses administered. Reimbursement by the MOHLTC will be made on a quarterly basis based on the information.

Human Papilloma Virus (HPV)

The MOHLTC will continue to pay $8.50/dose for the administration of the HPV vaccine. In order to claim the HPV vaccine administration fee, boards of health are required to submit, as part of quarterly reports, the number of doses administered. Reimbursement by the MOHLTC will be made on a quarterly basis based on the information.

SCHEDULE C

REPORTING REQUIREMENTS

The Board of Health is required to provide the following reports/information in accordance with the direction provided in writing by the Province:

ONGOING REPORTING REQUIREMENTS			
Due Date	**Description of Item**	**From**	**To**
January 31	4th Quarter Financial Report (to December 31)	BOH	MOHLTC
January 31	Project Report for Public Health Nurses Initiative[1]	BOH	MOHLTC
January 31	Project Report for Chief Nursing Officer Initiative	BOH	MOHLTC
February 28	CINOT Expansion Budget Request	BOH	MHPS
April 01	Program-Based Grants Budget Request	BOH	MOHLTC
April 01	Valid Certificate of Insurance	BOH	MOHTLC
April 01	Implementation Plan for the Enhanced Food Safety – Haines Initiative	BOH	MOHLTC
April 01	Implementation Plan for the Enhanced Safe Water Initiative	BOH	MOHLTC
April 30	1st Quarter Financial Report (to March 31)	BOH	MOHLTC
June 30 (or earlier if possible)	Annual Settlement Report (consisting of Audited Financial Statements, Auditor's Questionnaire with Auditor's Report, and a Certificate of Settlement) [2, 3]	BOH	MOHLTC
July 31	2nd Quarter Financial Report (to June 30)	BOH	MOHLTC
October 31	3rd Quarter Financial Report (to September 30)	BOH	MOHLTC

ONGOING REPORTING REQUIREMENTS			
Due Date	**Description of Item**	**From**	**To**
As Requested	Needle Exchange Program Activity Reports	BOH	MOHLTC
As Requested	Infection Prevention and Control Week Report Back	BOH	MOHLTC
As Requested	Baby Friendly Initiative Designation Status Report	BOH	MHPS

ONE-TIME REPORTING REQUIREMENTS			
Due Date	**Description of Item**	**From**	**To**
July 31, 2011	Bed Bugs – Initial Project Report for 2011	BOH	MOHLTC
October 31, 2011	Bed Bugs – Initial Surveillance and Evaluation Report for 2011	BOH	MOHLTC
April 30, 2012	Bed Bugs - Final Surveillance and Evaluation Report for 2011	BOH	MOHLTC
April 30, 2012	Beg Bugs – Final Project Report for 2011	BOH	MOHLTC
As Requested	One-Time Funding Project Report Backs	BOH	MOHLTC & MHPS

Notes:

1 – Specific reporting requirements are outlined in the March 10, 2011 administrative letter.

2 – Annual Settlement Reports: As of 2008, the Ministries limited the re-evaluation of settlements to one year after the settlement results have been provided to the Board of Health.

3 – The Audited Financial Statements must separately identify funding provided by MOHLTC and MHPS and include a separate account of the revenues and expenditures of mandatory programs, as a whole, and each related program. This may be presented in separate schedules by program category or by separate disclosure in the notes to the Audited Financial Statements.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 106-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Accessibility for Ontarians with Disabilities Act (AODA)

Recommendation

It is recommended that the Board of Health members complete the MLHU two-part self-study training program in compliance with the training requirements under the Accessibility for Ontarians with Disabilities Act and its regulations.

Background

The Accessibility for Ontarians with Disabilities Act (AODA) became law in June 2005. Its goal is to achieve equal access for all persons with disabilities by the year 2025. The AODA applies to every person and every organization in Ontario. It sets out the process for developing, implementing and enforcing standards for accessibility, in the areas of Customer Service, Transportation, Built Environment, Information and Communication, and Employment.

To date, only two regulations have received final approval from the government through the passing of regulations: the Customer Service Standard, which was passed in January of 2009, and the Integrated Standard, which was passed in June of 2011. The Integrated Standard is a combination of the Employment Standard, the Information and Communication Standard, and the (Public) Transportation Standard. The Transportation Standard does not apply to the Health Unit. Training is required under both standards, with the first deadline for Customer Service training being January 1, 2012. Ongoing training is also required as organizations develop and implement accessibility plans to meet future deadlines under these standards.

Customer Service Training

Several Board of Health members will have received Customer Service training through the municipalities they represent, as municipalities were obligated to complete this training by January 1, 2010. Municipalities are "designated public sector organizations" for the purposes of the AODA, while the Health Unit is an "obligated organization" or a "large organization" for the purposes of the AODA and the Standards. Policies and procedures at different organizations will be very similar as the legislation and standards are extremely prescriptive concerning the content of policies, the type of training, the availability of documents, and the requirement to make certain documents available in accessible format upon request. However, in order to comply with the legislation, the Board of Health members need to complete the Health Unit training and be familiar with the policy which is attached as Appendix A.

One of the advantages of postponing the Customer Service training at MLHU until late in 2011 has been that the training requirements under the Integrated Standard can now be met at the same time that the training on the Customer Service standard is conducted. This portion of the training will be new to those persons who have completed AODA Customer Service training with other organizations.

The training materials are available in three parts:

(i) a PowerPoint presentation (Appendix B);

(ii) an on-line presentation called "Serve-Ability" available to the public on the web in both HTML and Flash format; and,

(iii) a training guide (hard copy) that includes the information in the first two parts as well as other helpful information. This guide can be kept and used as a reference for all staff as the Health Unit develops accessibility plans over the next three years. A copy of the training guide will be given to the Board of Health members at the November 17 meeting.

Each member of the Board of Health, all staff and volunteers, and any other persons providing services to the public on behalf of the Health Unit must complete the first two parts of the training, and return a signed Training Confirmation Form to Human Resources, as outlined on the form. The PowerPoint presentation and the on-line training meet the minimum legislated requirements, including:

- An overview of the AODA and standards including the goals of the legislation
- An overview of the Ontario Human Rights Code as it applies to persons with disabilities

- An awareness of the range of disabilities and suggested best practices related to providing services to persons with disabilities in a way that takes the disability into account
- Awareness of assistive devices and how to use those that are available when services are provided
- How to welcome and assist persons with service dogs or support persons

This training program has been developed in a way to provide the flexibility to complete the training individually as a self-study, or as part of a team meeting, at work stations, in public libraries, or at home (casual staff and volunteers). If needed, Human Resources may be contacted to arrange access to a computer or to sign up for a group presentation in a meeting room.

Training is the first step to increased awareness of the challenges that persons with disabilities face in their daily lives. The recommended practices are consistent with good customer service. However, the information will provoke thinking beyond simply making adjustments, modifying rules, or reducing barriers, to thinking about how our society should be structured and designed for inclusiveness. Inclusive design and integration in all that we do will ensure equal participation of persons with varying levels of abilities in the future.

This report was prepared by Ms. Louise Tyler, Director, Human Resources & Labour Relations, and Ms. Diana Barr, HR Project Coordinator.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses Administrative Policy 5-110 Human Rights Recognition, and the Accessibility for Ontarians with Disabilities Act and Regulations

SUBJECT: **ACCESSIBILITY FOR ONTARIANS WITH DISABILITIES** **POLICY NUMBER: 5 - 112**

SECTION: Human Resources

IMPLEMENTATION DATE: October 27, 2011

APPROVED BY: Directors Committee

REVISION DATE:

SIGNATURE:

PURPOSE

To fulfil the mission of the Middlesex-London Health Unit (MLHU) in a way that is consistent with the accessibility principles of dignity, independence, integration and equality of opportunity for all persons with disabilities.

To establish a framework for meeting present and future legal obligations regarding customer service, employment, information and communication and the built environment, as set out in the Accessibility for Ontarians with Disabilities Act, 2005 (AODA) and its regulations, as amended from time to time.

POLICY

The Middlesex-London Health Unit (MLHU) is committed to meet the accessibility needs of persons with disabilities in a timely manner in accordance with the AODA and its Standards. MLHU will develop accessibility plans to fully implement its responsibilities under the AODA and AODA Standards in support of the goal of making the province fully accessible by 2025. The plans will identify and address barriers to accessibility: physical, attitudinal, technological, organizational (systemic), and informational.

MLHU will strive to meet the AODA standards regarding Customer Service, Employment, and Information and Communication, within the timelines for implementation for large organizations summarized in Appendix A. The regulation for the AODA Standard concerning the Built Environment Standard is expected to become law by 2012.

This policy applies to all members of the Board of Health, employees, volunteers, and students, and, in addition, the Customer Service Standard applies to all other persons providing services on behalf of MLHU.

The Customer Service Standard applies to all persons providing goods and services to members of the public. The Customer Service Standard requires that goods and services be provided in a way that respects the dignity and independence of people with disabilities. The goal is to give persons with disabilities the same opportunity to access our services and programs and to benefit from those services in the same place and in a similar way as other members of the public.

The Employment Standard requires that there be equal opportunity throughout the employment lifecycle by January 1, 2020. It addresses all aspects of employment: recruitment, assessment, selection, information sharing, accessible formats, communication supports and workplace emergency response information, accommodation plans, return to work process, performance management, career development and advancement and redeployment.

The Information and Communication Standard requires, no later than 2021:

- that emergency procedures, plans and public safety information be available in an accessible format;
- that certain notices and information be available upon request in accessible formats or with communication supports in accordance with the published timelines; and
- that websites and web content be compliant with web accessibility guidelines.

For ease of reference, Appendix B sets out the MLHU policy statements regarding different aspects of the requirements of the AODA and the Standards currently in force, regarding:

- training
- ways to communicate with persons with disabilities
- service animals
- support persons
- assistive devices
- emergency procedures for employees with disabilities
- the availability of documents provided to the public regarding emergency procedures in accessible formats
- required notices to the public, and
- feedback processes.

The Director of Human Resources & Labour Relations will have the following responsibilities:

- serve as the AODA Compliance Officer
- oversee training regarding this policy
- ensure that this policy and any other policy having an impact on persons with disabilities is regularly reviewed, recommend new policies or revisions to policies to achieve the purpose of this policy,
- coordinate the development of accessibility plans and annual reports on the implementation of those plans, and
- answer any questions about this policy and accessibility or accommodation at MLHU

PROCEDURES

1.0 Training for Staff, volunteers, members of the Board of Health and other persons who provide services to the public on behalf of MLHU:

1.1 Training will include the following:

- an overview of the Ontario Human Rights Code as it applies to persons with disabilities.
- the purposes of the Accessibility for Ontarians with Disabilities Act, 2005
- the requirements of the AODA Standards set by regulations
- how to interact and communicate with people with various types of disabilities
- how to interact with people with disabilities who use an assistive device or require the assistance of a service animal or a support person
- how to use assistive devices available that may help with the provision of goods or services to people with disabilities
- what to do if a person with a disability is having difficulty in accessing programs and services
- MLHU's policies, practices and procedures relating to the AODA, to the customer service standard, and to the parts of the Integrated Standard that take effect in 2012 and 2013.

1.2 All persons covered by this policy will receive a written guide to assist them individually and as team members and leaders to identify and remove barriers to accessibility by persons with disabilities.

1.3 Training will be conducted in a variety of ways on an ongoing basis to facilitate the implementation of procedures and practices that promote accessibility.

2.0 Notice of temporary disruption

2.1 Whenever there is a temporary or planned disruption of facilities or services that persons with disabilities would usually use, Finance & Operations will consult with Communications and Human Resources as soon as practicable, so that staff are notified, and notices to the public can be posted in appropriate locations.

2.2 A notice of temporary disruption will include information about the reason for the disruption, its anticipated duration, and a description of alternative facilities or services, if available. (See example in Appendix C.)

2.3 The notice will be placed at all public entrances and service counters on MLHU premises, and on the website if practicable.

2.4 A document setting out the steps to be taken in connection with a temporary disruption shall be available to any person.

3.0 Feedback process

3.1 Feedback regarding the way MLHU provides goods and services to people with disabilities can be given by voicemail, email, verbally in person, or by completing a feedback form. All feedback will be reported to the Director of Human Resources and Labour Relations and to the Director of the Service Area to which the complaint relates. (See feedback form in Appendix D.)

3.2 Complaints will be addressed in a timely manner. If a complaint is not addressed or resolved informally, the complaint will be referred to the Medical Officer of Health.

4.0 Notice of Availability of Documents

4.1 Notices will be posted on the premises, or on the website, or by other reasonable method, to provide a list of the documents required under the AODA regulations to be available in accessible format upon request.

Other related policies:

1. Human Rights 5-110
2. Return to Work and Accommodation Policy 5-265
3. Complaints 5-155

Timelines for Compliance with AODA Standards Applicable to the Middlesex-London Health Unit[i]

	Customer Service	Integrated Standard		
		General	Employment	Information & Communication
January 1, 2012	Customer service policy, procedures, s. 3 and training[ii] s. 6 Notices of availability of documents under the standard, s. 8 Notice of temporary disruption, s. 5 Notice re feedback, s. 7		Workplace emergency information[iii] individualized to employees with disabilities, s. 27	Emergency and public safety information[iv], s. 13
January 1, 2014		Accessibility Policies[v] s. 3 Accessibility Plans[vi], s. 4 Integrated Standards training[vii], S.7		All ***new*** internet websites[viii] and web content on those sites to conform to WCAG 2.0 level A, s. 14;
January 1, 2015				Accessible Feedback processes[ix], s. 11
January 1, 2016				Accessible formats and communication supports[x], s. 12
January 1, 2020			Recruitment[xi], s. 22-24 Employee accommodation[xii], s. 25, 26, 28 Performance management, career development and redeployment[xiii], s. 30-32	
January 1, 2021				All internet website and web content conforms with WCAG 2.0 level AA (excluding live captioning and audio description, s. 14

[i] MLHU is considered to be a large organization under the definitions for both standards; health units that are part of municipalities are required to meet the earlier deadlines for designated public sector organizations

[ii] Documents summarizing policies, etc. to be available to be given to anyone upon request, in a format that takes into account the person's disability

[iii] For employees, volunteers, etc. with disabilities – individualized

[iv] Organizations that prepare emergency procedures, plans or public safety information that is available to the public must also make such information available in an accessible format or with appropriate communication supports, as soon as practicable and upon request.

[v] Shall include a statement of commitment to meet the accessibility needs of persons with disabilities in a timely manner; must prepare document(s) describing policies and make available publicly

[vi] Establish, implement, maintain and document a multi-year accessibility plan to reduce barriers and achieve timelines in the regulation; post it on the MLHU website, and review and update it at least once every five years

[vii] Preferable to do Customer Service Training and integrated standard training at the same time, but training is required again whenever the policy changes

[viii] Also includes any major revision of website; gradually increasing requirements over the years to 2021

[ix] Notice of availability of accessible formats for feedback, upon request

[x] Accessible formats to be provided in a timely manner, taking into account the needs of the persons with disabilities, after consultation with the person making the request

[xi] Notification to employees and public concerning availability of accommodation for applicants with disabilities in the recruitment process; offers of employment include notification of policies for accommodating employees with disabilities

[xii] Inform employees of policies that support persons with disabilities, e.g. job accommodation that takes into account accessibility needs

[xiii] Employer to take into account the accessibility needs of employees with disabilities

MLHU Policy Statements regarding the Accessibility for Ontarians with Disabilities Act, the Customer Service Standard, and the Integrated Standard

A. TRAINING:

- MLHU will provide training on policies, practices and procedures that affect the provision of services to, or employment of, people with disabilities.
- This training will be provided to all members of the Board of Health, all employees, all volunteers, all students, and any other persons providing services on behalf of MLHU, as well as any persons who may be involved in the development and approvals of such policies and procedures.
- Training will include information about the Human Rights Code as it applies to persons with disabilities.
- Training will also be provided when changes are made to these policies, practices and procedures.

B. CUSTOMER SERVICE STANDARD:

- MLHU will communicate with people with disabilities in ways that take into account their disability.
- MLHU will serve people with disabilities who use assistive devices.
- MLHU will welcome people with disabilities who are accompanied by a service animal at workplace sites that are open to the public.
- MLHU will welcome people with disabilities who are accompanied by a support person, and will not prevent a support person from having the same access to a workplace site as the person being supported.
- MLHU will provide a notice of temporary disruption in the event of a planned or unexpected disruption in the facilities or services usually used by people with disabilities.
- MLHU will welcome feedback from customers with disabilities regarding how well the Health Unit is meeting customer expectations. MLHU will respond to any complaints about service in a timely way.
- MLHU will identify and regularly review the Administration and Service Area policies that may have an impact on persons with disabilities, and will consider the impact of policy revisions for persons with disabilities

C. EMPLOYMENT STANDARD:

- MLHU will provide employees with disabilities with emergency response information that is tailored to the employee's needs, if the disability requires it.

D. INFORMATION AND COMMUNICATION STANDARD:

- Emergency procedures, plans or public safety information provided by MLHU to the public shall also be provided in an accessible format or with appropriate communication supports, as soon as practicable, upon request.
- MLHU will develop processes for obtaining feedback regarding information and communication, and the processes will be accessible to persons with disabilities. MLHU will notify the public of the availability of information, upon request, in accessible formats or with communication supports.

Sample Document for Notifying the Public about Disruptions in Service

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Notice to the Public and MLHU Staff:

Our accessible washroom on the first floor is out of service due to a broken pipe. A repair person will be on the premises tomorrow to fix it. In the interim, please use the elevator to go to the lower level to use the accessible washroom on that floor. We apologize for any inconvenience.

Thank you.

Management

Date:

Examples of Disruptions of Facilities or Services that persons with disabilities would usually use when accessing services at MLHU:

- Elevator out of service
- Accessible washroom not available due to repairs
- Automatic door openers not working
- Reduced clinic hours of service due to water main breakage, hydro outage, etc.
- Reduced access or space for traffic in hallways, etc. due to painting, cleaning, delivery of equipment/furniture, etc.
- Increased noise due to renovation work

MIDDLESEX-LONDON HEALTH UNIT

Customer Feedback Form

The Middlesex-London Health Unit recognizes that receiving feedback provides a valuable opportunity to learn and improve. We strive to provide excellent customer service. We are also committed to addressing the accessibility needs of persons with disabilities.

Every person has the right to make a complaint, offer a suggestion or compliment us on the way we provide goods or services to people with disabilities. If you wish assistance to provide feedback, please ask a staff member to complete a "Record of Customer Feedback" form on your behalf (on reverse side of this form). Thank you for sharing your experience.

Date and Time of your visit: _____

Location: _____

Description of complaint, suggestion or compliment: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Staff will use the other side to record follow-up after you provide this information.

**Optional information – complete only if you wish to be contacted*

*Name: _____

*Preferred contact method (telephone number, email address): _____

_____

Notice: Personal information contained on this form is collected pursuant to Ontario Regulation 429/07, the Accessibility Standards for Customer Service and will be used for the purpose of responding to your request for feedback. Questions should be directed to the Director of Human Resources & Labour Relations, MLHU, 50 King Street, London ON N6A 5L7, 519 663-5317 ext. 2396, louise.tyler@mlhu.on.ca

Record of Customer Feedback and Follow-up Form
(To be completed by a Staff Member)

Note to Staff Member: Please advise the person providing feedback that any personal information provided regarding feedback will be treated as confidential and shared internally only to the extent that it is necessary to respond to the feedback. Please give this form to the Manager overseeing the services for follow-up, or to the Director of HR & Labour Relations.

Date feedback received:

Name of customer **[optional]**:

Contact information (if appropriate)*:

Name of staff member completing this form:

Details (use other side for more space if required):

Note to the supervising Manager: Include below information regarding contact with the client, if any, to address the concern. As appropriate, discuss with your Director, or with the Director of HR&LR. Distribute copies as indicated below.

Follow-up:

Resulting Action:

Date the matter was resolved or addressed: _____

Manager (print name below signature): _____

Original record filed in: [ ] Human Resources & Labour Relations re AODA compliance
[ ] Office of the Medical Officer of Health

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Accessibility for Ontarians with Disabilities Act (AODA)

Training Program

Middlesex London Health Unit

November 4, 2011

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MIDDLESEX-LONDON HEALTH UNIT

Did You Know?

- One out of every seven Canadians is living with a disability. In twenty years this will rise to one in five, due in part to the aging population.
- There are more than 1.3 million people in Ontario living with a disability?

Ministry of Community and Social Services Ontario 2003

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Did You Know?

Service dogs are trained not only to assist persons with visual impairment, but also for those with other disabilities such as:

- Hearing impairment
- Seizures
- Autism
- Post traumatic stress disorder

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Did You Know?

- There is a 26% unemployment rate for persons with disabilities.
- This is five times higher than the unemployment rate for people without disabilities.

Labour Report Statistics Canada 2006

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Did you Know?

- Assistive/adaptive devices are increasing in variety and application.
- Some examples are: computer programs converting text to speech, electronic notetakers, vibrating pillows, liquid indicators, colour identifiers, and talking clocks.

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The Training Objectives

To become familiar with and understand:

- the Accessibility for Ontarians with Disabilities Act, including regulations applying to MLHU
- how the Human Rights Code provides the basis for the AODA
- best practices for providing customer service to persons with disabilities
- MLHU's policies related to accessibility and accommodation

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5 MLHU Training Steps

1. View this Power Point presentation (15 minutes).
2. Watch the on-line AODA Accessible Customer Service presentation ("Serve-Ability", 45 minutes, web link provided later in the presentation, and in the guide).
3. Refer to and review the MLHU Training Guide during or after on-line presentation (as desired) – teams will work with the guide in 2012 to develop best practices for improved accessibility.

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5 Training Steps, p. 2

4. Review the MLHU policy and appendices (15 minutes). Note that the policy very closely follows the requirements of the Customer Service and Integrated Standards.

5. Complete and submit the "Confirmation of AODA Training" form provided with the MLHU Training Guide. All training is to be completed a.s.a.p., but no later than December 24. Training can be completed individually or in teams or groups, as coordinated by HR and your Director/Manager.

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Why is this Training Mandatory for all MLHU?

- MLHU is a "large organization" within the group of "obligated organizations" who are required by law to have accessible Customer Service policies and practices in place, and to conduct Customer Service training by January 1, 2012.

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AODA and the Human Rights Code (OHRC)

- The legal rights basis for the AODA is the Ontario Human Rights Code, which became legislation 50 years ago.
- The Code provides for equal rights and opportunity, and freedom from discrimination on several grounds (e.g. race, sex, family status, and disability) in the areas of services, employment, and memberships in associations

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AODA and the Human Rights Code – p. 2

- The Human Rights Code recognizes the dignity and worth of every person in Ontario.
- Customers or clients with disabilities also have the right to equal treatment and equal access to services.
- In the workplace, employees with disabilities are entitled to the same opportunities and benefits as people without disabilities.

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Disabilities

- The OHRC and AODA use the same definition of disability, which includes:
- any degree of physical disability, infirmity, malformation or disfigurement
  - a hearing impediment, muteness or speech impediment
  - a condition of mental impairment or a developmental disability
  - a learning disability

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The Origins of the AODA

- The Ontarians with Disabilities Act, 2001 required provincial and municipal governments, public transportation organizations, and educational institutions to develop accessibility plans that would promote the identification, removal and prevention of barriers to their full participation in the life of the province. It was soon realized that equal opportunity could not be realized without a more comprehensive approach involving the private as well as the broader public sector.

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Origins of the AODA, p. 2

- In 2005, the passing of the AODA initiated the process to set standards for all organizations in the areas of Customer Service, Public Transportation, Information and Communication, Employment, and the Built Environment. Consultation with all stakeholders took place over several years.
- The goal of the Act is to make Ontario accessible for all individuals with disabilities by 2025, by implementing the AODA Standards in stages over many years.

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The Customer Service Standard

- This is the first of five standards to be set out in a regulation that applies to all obligated organizations.
- The Transportation Standard applies to those providing public transportation, not to MLHU.
- The Built Environment Standard has not yet been passed as a regulation.

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Goal of the The Customer Service Standard

- To provide persons with disabilities with the same opportunity to access and benefit from our services as other members of the public in a similar way and same location.
- The best practice for all Standards is a proactive approach involving inclusive design and integration, rather than modification of rules or barrier removal, but both approaches can support/promote equal participation of persons with varying abilities.

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Requirements of the Customer Service Standard

The on-line presentation “Serve-Ability” will provide you with more information about the AODA and the requirements of the Customer Service Standard.

The next few slides introduce the Integrated Standard which was passed as a regulation in June of 2011.

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MLHU Policies and the Integrated Standard

- The new MLHU policy on the AODA sets out the requirements under the Act and the Standards that apply to MLHU. Please review the policy after you have viewed the on-line presentation.
- The Integrated Standard sets out deadlines between 2012 and 2021 to address accessibility with regard to:
  - Employment
  - Information and Communication
  - Public Transportation (not applicable to MLHU)

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Integrated Standard – General Requirements

- Develop/revise policies and procedures to meet the new standards
- Develop a multi-year accessibility plan
- Post or file reports on implementation of accessibility plans
- Continue training re accessibility and OHRC
- Provide required documents and information in an accessible format upon request

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Integrated Standard - Information and Communication

- By January 1, 2012, be prepared to provide "emergency information provided to the public" in an accessible format, upon request.
- The accessible format will take into consideration the nature of the customer's disability. Eventually all information given to the public will need to be available in an accessible format upon request. Websites will also need to meet international accessibility standards.

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Integrated Standard - Employment

- By January 1, 2012, develop individualized workplace emergency response information for employees with disabilities, where such information is necessary and the employer is aware of the need for accommodation due to the employee's disability.
- See MLHU Training Guide for more information.

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Integrated Standard – Employment, p. 2

- Give notices to all employees and all applicants for employment that MLHU accommodates persons with disability.
- Review all HR policies and practices regarding all stages of employment, to ensure that they take into account the accessibility needs of employees with disabilities.

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Steps to Accessibility at MLHU

How can you contribute to the AODA goals?

- Complete the training and consider how the way you work affects persons with disabilities.
- Use the Training Guide to make notes, record questions or make suggestions, for future discussion.
- Implement accessible customer service practices in your daily routine – be customer service ready!
- Assist clients to provide feedback re accessibility.
- Stay tuned for more information in 2012 on how you and your team can contribute to MLHU accessibility plans at all levels of the organization.

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Training Confirmation Forms

Once you have viewed the Powerpoint and on-line presentations, locate the Training Confirmation Form provided with your guide. Complete it, sign it, and send/give it to:

- Your manager, if you are assigned to a team, or are a provider of services retained by the manager; or
- Human Resources, if you are a casual or temporary employee working for more than one team, a volunteer, a member of the Board of Health, a Director, and all others not already listed. Managers will collect the forms for their team and send them to Human Resources when all team training is completed, no later than Dec. 24/11.

Prizes will be given to the first 5 teams to complete training.

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Remember, Accessibility Benefits Everyone!

Copy and paste this url into your browser to go to Serve-Ability:

http://www.mcss.gov.on.ca/mcss/serve-ability/FLASH_Eng/index.html

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MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 107-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Energy Drinks: Health, Safety and Regulation

Recommendation

It is recommended that the Board of Health endorse the recommendations of the Public Health Energy Drink workgroup position paper attached as Appendix B to Report No. 107-11.

Background

Energy drinks are beverages that typically contain caffeine, taurine (an amino acid), vitamins, herbal ingredients, and sugar or artificial sweeteners. Most energy drinks contain 70 to 80 mg caffeine per 8 oz (237 ml) serving, approximately 3 times the amount in cola drinks. They are marketed to improve energy and concentration, for weight loss, increased stamina, and improved athletic performance.

The production of energy drinks is a rapidly growing industry. In 2006, the Canadian energy drink market was valued at $287.2 million and is expected to reach $375.2 million by 2011. Energy drinks are particularly popular with children (<12 years old), youth (12-18 years) and young adults (19-25 years). Thirty to 50% of children, youth and young adults claim to regularly consume energy drinks.

The following are some health and safety concerns regarding energy drinks;

- potential to displace healthier beverages (e.g., milk, 100% juice, and water),
- consumption of sugar-sweetened beverages is associated with increased risk of heart disease, diabetes, and weight gain,
- known and unknown pharmacological effects and interactions of various ingredients, combined with reports of toxicity,
- caffeine intake can be a cause for concern in children; youth; preconception, pregnant and breastfeeding women; or people with certain health conditions (e.g., cardiovascular, renal, or liver disease, seizures, diabetes, mood and behaviour disorders, or hyperthyroidism),
- potential higher risk for adverse reactions when combined with prescription medication,
- side effects in children and youth from high caffeine intake,
- heavy caffeine consumption (e.g., drinking multiple energy drinks) is associated with seizures, mania, stroke, and death,
- multi-serving containers may lead to consumption of large amounts,
- perception of 'safe' beverage because currently regulated in Canada as a Natural Health Product and proposed regulation as a food,
- promotion as improving athletic performance leads to consumption during exercise which may cause stomach upset and dehydration, and
- consumption of alcohol and caffeinated beverages reduces the feeling of alcohol intoxication, without reducing actual alcohol-related impairment resulting in an increase in risk behaviour and injury (e.g., may not realize inability to perform tasks that require alertness, such as driving a vehicle).

Next Steps

In the summer of 2011, a Public Health "call to action" was initiated by the Chatham-Kent Public Health Unit asking for collaboration around advocacy work and information sharing on energy drinks. A small workgroup of public health staff in both the nutrition and substance misuse fields was created and began work on a joint energy drink position paper. Currently, the workgroup is comprised of 32 health unit staff representing 19 Ontario health units. Members from this Health Unit's Chronic Disease Prevention & Tobacco Control and Healthy Communities & Injury Prevention Teams co-chair the workgroup.

In October of 2011, Health Canada announced a proposed approach to managing caffeinated energy drinks (Appendix A). Key topic areas included: 1) Setting Formulation and Labeling Requirements on Energy Drinks Made Available as Beverages, 2) Consumer Education, 3) Research and Monitoring of Long-term Health Effects, and 4) Leverage Tools Developed by Stakeholders. Comments on Health Canada's approach were invited to be received by November 15, 2011. Concerned about aspects of Health Canada's proposed approach, the Public Health workgroup prepared a coordinated response made available to all Ontario health units (Appendix B).

Key recommendations from this workgroup include;

- lowering the maximum suggested caffeine levels for adults,
- making the maximum and minimum caffeine levels clear and understandable to the public,
- adding warning labels (e.g., concerning suitability for children and teenagers, use during/after exercise, interactions with natural health products and medications, and maximum daily intake levels) and warning label prominence on beverage packaging,
- removing caffeinated-alcoholic beverages from provincial outlets,
- setting strict limits consistently across the country for the amount of caffeine from all sources that is allowed to be added to alcoholic products, if such products are not removed,
- banning of energy drinks at venues where alcohol is also sold,
- mandatory training for anyone selling and/or serving alcohol regarding the dangers of combining alcohol and energy drinks,
- marketing considerations to children and teenagers, and
- reviewing new and upcoming energy shots and other related products (e.g., caffeine gum).

Conclusion

The workgroup now awaits Health Canada's official approach to managing caffeinated energy drinks to help direct and inform future advocacy work. The workgroup will continue development of a position paper in the hope that it will be endorsed by all health units in Ontario and will aid in consistent messaging. Regardless of Health Canada's direction, public health needs to ensure that there is increased local and provincial consumer education to enhance the public's knowledge about energy drinks so they can make informed and safe choices thereby reducing overall harm.

This report was prepared by Ms. Melissa Rennison, Public Health Nurse, Healthy Communities and Injury Prevention Team, and Ms. Kim Leacy, Public Health Dietitian, Chronic Disease Prevention and Tobacco Control Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Chronic Disease Prevention and Prevention of Injury and Substance Misuse.

Health Canada Santé Canada

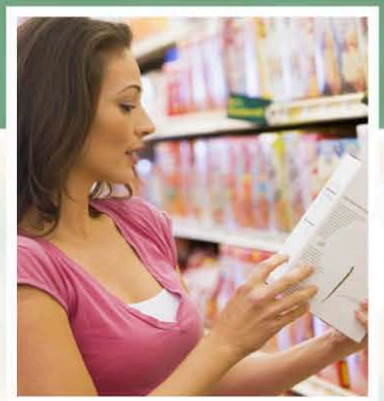
Your health and safety… our priority. *Votre santé et votre sécurité… notre priorité.*

Health Canada's Proposed Approach to Managing Caffeinated Energy Drinks

October 2011

Food Directorate

Health Products and Food Branch



Canada

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Background

In recent years, an increasing number of caffeinated beverages have been introduced into the Canadian marketplace. Some of these products are known as "Energy Drinks", which usually contain a range of unique ingredients and may feature health claims related to their capacity to restore energy and alertness. A common substance found in most Energy Drinks is caffeine at levels ranging from those found in a weak cup of coffee to much higher levels. These products also generally contain other ingredients such as vitamins and minerals, and may contain various herbals.

Health Canada has determined, based on consumption patterns, history of use, representation to consumers, and in accordance with its guidance document on "Classification of Products at the Food-Natural Health Product Interface: Products in Food Formats", that products known as Energy Drinks fit the regulatory definition of a food and as such intends to classify these products as foods. As a result, the Department intends to assess, manage the potential risks associated with these products, and regulate their availability in the Canadian marketplace in the context of their use as a beverage.

This is consistent with the policy intent of the NHPR, as outlined in the regulatory impact analysis statement of these regulations published in 2004, as well as the outcomes of the NHPR regulatory review conducted in 2007, which reiterated that foods are excluded from the scope of the NHPR. This is also consistent with the approach followed by Canada's major trading partners, where Energy Drinks are consumed and regulated as foods.

Assessment of the Potential Health Risks

There are indications that the overall dietary intake and consumption patterns of caffeine by Canadians, particularly by adolescents and young adults, is increasing. This is supported by the fact that Energy Drinks with high levels of caffeine are marketed to this subset of the population and are readily available in several locations such as convenience stores, gas stations and grocery stores. These caffeinated beverages are having an increasing impact on the dietary habits of Canadians.

Due to the high levels of caffeine found in most of these beverages, concerns were raised over the potential to exceed the maximum caffeine intake levels recommended by Health Canada for various groups, particularly for susceptible subgroups such as children and adolescents (< 18 years old).

Therefore, Health Canada conducted a scientific assessment of the potential hazards and exposure associated with the common ingredients found in these caffeinated beverages (including caffeine, vitamins, minerals, taurine etc.). The common amounts consumed of similar beverages, such as caffeinated soft drinks, were considered to help assess the risks to different populations based on different formulations. Children and adolescents were found to be the most at risk of exceeding Health Canada's Recommended Maximum Daily Intakes (RMDI) for caffeine because of the volumes potentially consumed and the lower RMDI established for these

populations, in comparison to adults. This assessment also identified that if children and adolescents who normally consume caffeinated carbonated soft drinks as their primary source of caffeine replaced them with Energy Drinks, a greater percentage of these individuals would exceed Health Canada's RMDI for their age group. Health Canada's assessment has concluded that a number of information gaps need to be addressed to support the Department in its efforts to regulate these products and enable their safe consumption. Similar concerns regarding overexposure of children and adolescents to caffeine were expressed by the Independent Expert Advisory Panel on Caffeinated Energy Drinks (the Panel) convened by Health Canada. The Panel also highlighted the need for additional data. Health Canada's scientific assessment will be peer reviewed prior to its publication in the international scientific literature.

Health Canada's Proposed Approach to Manage Caffeinated Energy Drinks

Based on the outcomes of Health Canada's scientific assessment, and additional information such as the findings of the Panel on caffeinated Energy Drinks, the Department has identified a number of measures to mitigate the potential risks associated with the overconsumption of these beverages.

A multifaceted policy approach is being proposed and will include the following elements:

1. Setting Formulation and Labelling Requirements on Energy Drinks Made Available as Beverages

As a result of the classification decision that caffeinated beverages known as Energy Drinks are foods, Health Canada is setting additional safety requirements to account for the way these products are perceived and consumed by Canadians. Health Canada will also collect additional information through data submitted by industry in order to assess the effectiveness of some of the management options. The proposed new requirements are:

1.1 Composition Requirements

Specific requirements will be established to better control the types and levels of ingredients added to Energy Drinks. These requirements include, for example, setting minimum and maximum limits for caffeine from all sources (natural and synthetic sources), vitamins and minerals as well as other ingredients e.g. herbal extracts.

Specific to caffeine, Health Canada's scientific assessment supports the establishment of an initial maximum limit for total caffeine of **400 mg per litre** with a maximum amount of caffeine **not to exceed 180 mg per container presented as a single-serve container**. Health Canada has determined that any Energy Drink container that cannot be resealed will be treated as a single-serve container. Health Canada has determined that re-sealable containers equal to or less than 591 mL will be treated as single-serve containers.

1.2 Labelling Requirements

Caffeinated Energy Drinks will be subject to all food labelling provisions such as ingredient labelling, nutrition facts panel, allergen labelling etc. Health Canada proposes the following additional labelling information requirements:

- The amount of caffeine from all sources in mg per container or serving size.
- A statement on the label identifying the product as a "high source of caffeine" given that a Energy Drink will be required to contain a minimum amount of caffeine that is deemed to be sufficiently high.
- A statement indicating that the product is "Not recommended for children, pregnant or breastfeeding women, and individuals sensitive to caffeine"
- The statement "Do not mix with alcohol"

Depending on the formulation of the product, additional labelling requirements may be required.

1.3 Prohibition of Premixed Alcoholic Beverages with Caffeinated Energy Drinks

Health Canada would prohibit the use of caffeinated Energy Drink beverages as an ingredient in pre-mixed alcoholic beverages.

1.4 Consumption Incident Reporting

Health Canada would require that industry collect data on any consumption incident associated with their products that they receive through consumer complaints. These data would be reported to Health Canada every six months.

Products that meet these requirements will be issued a Temporary Marketing Authorization (TMA) and will be subjected to data collection related to the product consumption, market share and consumer complaints (incident reporting etc).

2. Consumer Education

Health Canada proposes to work with its partners in the Provinces and Territories, health professional groups and other stakeholders to develop education tools and materials regarding the risks associated with caffeinated products, in particular Energy Drink beverages. In conjunction with labelling information, consumers will be better equipped to make informed decisions about the caffeinated products they choose.

3. Research and Monitoring of Long-term Health Effects

Research and monitoring for long term health effects has been identified as an information gap in Health Canada's scientific assessment and by the Panel. Health Canada would collaborate with

Provincial, Territorial and international partners, in government and academia, to gather further data related to the long-term potential health effects associated with the consumption of caffeinated beverages such as Energy Drinks. Health Canada's initial focus will be on collecting up to date information on Canadians' consumption patterns for caffeinated beverages in order to better estimate exposure to caffeine and other ingredients, and the associated risks to support appropriate regulatory oversight.

4. Leverage Tools Developed by Stakeholders

Health Canada would work closely with all interested stakeholders to develop and implement other appropriate risk management approaches such as marketing and advertising Codes of Practice.

Conclusion

The approach outlined above is intended to manage the availability of Energy Drinks in the Canadian market while collecting the proposed additional information necessary for the development of the final regulatory requirements for these products. Health Canada will continuously monitor and review the effectiveness of these measures. Should new information be made available on emerging health risks associated with the consumption of caffeinated Energy Drinks, Health Canada would take the appropriate action required to protect the health and safety of Canadians – actions ranging from updated information to Canadian consumers to the cancellation of the Temporary Marketing Authorizations for the targeted products.

Comments

Comments on this propose approach may be submitted in writing, either electronically or by regular mail. If you are submitting your comments electronically, please use the term "Energy Drinks" in the subject box of your e-mail. **Comments must be received by 12:00 a.m. EDT, November 15, 2011.**

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Ottawa, Ontario
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November 14, 2011 **Appendix B**

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Re: Health Canada's Proposed Approach to Managing Caffeinated Energy Drinks

To Whom it May Concern:

We applaud Health Canada for proposing a comprehensive approach to managing caffeinated energy drinks. We support the inclusion of additional information to help guide the consumer in making an educated choice (e.g., listing total caffeine from all sources and including a Nutrition Facts Table).

Energy drinks are unique beverages with unique concerns. Although some energy drinks have caffeine levels similar to coffee, there is evidence to suggest that the pure caffeine often added to energy drinks, as compared to the caffeine naturally occurring in coffee beans, may have different and more potent effects on blood pressure and glucose tolerance (Dietitians of Canada, 2009). Consumers may also find it easier to consume energy drinks more rapidly and in greater quantities compared to hot beverages like coffee and tea (Dietitians of Canada, 2009). In addition, energy drinks contain other herbal ingredients (e.g., gingko biloba, ginseng, taurine, and glucuronolactone) that risk interacting with certain medications and are lacking long-term safety and health impact data (Dietitians of Canada, 2009).

Although not recommended for children and teenagers (Health Canada, 2011a; Health Canada, 2011c), 40% or more of children and adolescents consume energy drinks (Dietitians of Canada, 2009). Additionally, energy drinks are not recommended to be mixed with alcohol (Health Canada, 2005); however, approximately 25% of college-aged energy drink users regularly mix them with alcohol (Dietitians of Canada, 2009). Energy drink companies may claim they do not directly market to children and youth; however, their marketing strategies include youth appealing promotion strategies, including eye appealing packaging and product names, advertising via sporting events, athlete sponsorships, alcohol-alternative promotions, and product placement in video games (Seifert et al., 2011).

We believe that Health Canada's proposed approach can be further strengthened. A summary of the changes recommended to Health Canada's proposed approach are detailed below. Further information and rational with respect to these recommendations are detailed in the body of this report.

Summary of Recommendations:

- **A lower caffeine maximum per single-serve container and per litre.**
- **Consultation with Registered Dietitians to determine safe and appropriate regulations for the addition of vitamins and minerals.**
- **The inclusion of the following additional warning labels:**
    - **Energy drinks are not suitable for consumption by children <u>and teenager.</u>**
    - **Energy drinks are not recommended for use during exercise or to rehydrate following exercise.**
    - **Ingredients contained in energy drinks may interact with certain natural health products and medications and consumers should consult their health care practitioner before use.**
    - **The maximum daily caffeine intake from all sources for adults is 400 mg and 300 mg for pregnant and breastfeeding adults.**
- **Warning labels cover at least 25% of the package.**
- **Prohibit the sale of caffeinated-alcoholic beverages from Provincial Liquor outlets.**
- **If the prohibited sale of caffeinated-alcoholic beverages is not supported the following are recommended:**
    - **Strict limits, consistently across the country, restricting the amount of caffeine from all sources that is allowed to be added to pre-mixed alcoholic beverages. A maximum caffeine level from all sources of 30 mg per 500 ml or 60 mg per litre is recommended.**
    - **A warning label added to caffeinated-alcoholic beverages that states: "This product contains alcohol and caffeine. Consuming alcohol and caffeine together may increase your risk of injury." This warning label should be displayed prominently on the container and packaging for visibility and readability.**
    - **A more discernible difference in the packaging of caffeinated-alcoholic beverages from that of their energy drink counterparts (e.g., RockStar™ + Vodka versus RockStar™ Energy Drink) to help avoid consumer confusion.**
- **Prohibit the sale of energy drinks at all locations where alcohol is sold and served. At a minimum, mandatory training be instituted to anyone selling and/or serving alcohol around the dangers of combining alcohol and energy drinks.**
- **Prohibit marketing and advertising of energy drinks to children and teenagers. This prohibition should include all forms of marketing and advertising to children and teenagers (e.g., free samples, sponsorship of children and/or teenage targeted events, online advertising through social media platforms, and online games).**
- **Prohibit the sale of energy drinks to children and teenagers utilizing the infrastructure currently in place for restricting the purchase of tobacco products.**
- **Review the current regulations for other high caffeine products (e.g., energy shots) and propose stricter caffeine limits and additional warning labels similar to energy drinks. A review of the marketing and advertising of the high caffeine products, particularly to children and teenagers.**

Re. 1.1 Composition Requirements

Caffeine Content

While the proposed 180 mg caffeine limit for single-serve containers is less than half the recommended amount for adults, it is twice the 85 mg Recommended Maximum Daily Intake (RMDI) for children 10 to 12 years of age, almost three times greater than the 62.5 mg RMDI for children 7 to 9, and four times greater than the 45 mg RMDI for children 4 to 6 (Health Canada, 2010a; Nawrot et al., 2003). Based on a suggested caffeine limit of 2.5 mg per kg body weight per day (Health Canada, 2010a; Nawrot et al., 2003), 180 mg caffeine would be equal to or exceed the maximum daily caffeine for all adolescents 72 kg (158 lbs) and under. As there are no restrictions related to who can purchase energy drinks, children and adolescents may purchase and drink them, easily consuming unsafe caffeine levels (Reissig et al., 2009).

There are a substantial proportion of Canadian adults who do not consume caffeine within safe limits. As of 2004, more than 20% of men and 15% of women aged 31 to 70 exceeded the recommended maximum of 400 mg of caffeine per day (Health Canada, 2004a). With the increasing popularity of energy drinks, these beverages likely contribute further to excessive intakes and thereby have detrimental effects. **Given that the maximum suggested caffeine level for adults is 400 mg and that energy drinks probably are not the sole source of caffeine in the diet, a lower caffeine maximum per single-serve container and per litre is strongly recommended.**

Energy drinks and related legislation are an international concern. The Australia New Zealand Food Authority limits caffeinated beverages to 320 mg per litre (Australia New Zealand Food Authority, 2001). Using the same ratio as 180 mg per single-serve container to 400 mg per litre, this would equate to a maximum of 145 mg caffeine per single-serve container.

A proposed limit of 400 mg per litre, but only 180 mg per single-serve container, would allow multi-serve containers to contain a higher concentration of caffeine than a 591 ml single-serve container. Using the same caffeine concentration proposed in a 591 ml single-serve container, the maximum caffeine limit should be 305 mg per litre.

The maximum caffeine levels for cola-type beverages and carbonated non-cola beverages are 200 ppm and 150 ppm, or approximately 200 mg per litre and 150 mg per litre, respectively (Health Canada, 2010a). The expert panel recommended a maximum amount of 80 mg caffeine per single serving (Macdonald, Hamilton, Malloy, Moride & Shearer, 2010). These caffeine levels are likely closer to more reasonable and safe limits.

Health Canada's proposed approach refers to a minimum amount of caffeine a beverage must contain in order to be classified as an energy drink. This minimum amount was not included in Health Canada's proposed approach, but should be public knowledge to aid consumers in making informed choices.

Health Canada's proposed approach also refers to requirements to control the types and levels of ingredients added to energy drinks. Typically vitamins and/or minerals are added to energy drinks; however, their regulation was not specified in Health Canada's proposed approach.

It is recommended that consultation occurs with Registered Dietitians to determine safe and appropriate regulations for the addition of vitamins and minerals to energy drinks.

Re 1.2 Labelling Requirements

Health Canada's approach should define the caffeine threshold for a beverage to be considered a 'high source of caffeine'. The Union of European Beverages Association (2010) defines high caffeine content as greater than 150 mg caffeine per litre. The Australia New Zealand Food Authority defines high caffeine as greater than 145 mg caffeine per litre and requires advisory statements on these products similar to current Canadian legislation (Australia New Zealand Food Authority, 2001).

Warning labels that are more comprehensive in content are shown to be more effective in communicating health risks (Hammond et al., 2006). **In addition to the statements proposed by Health Canada, the following additional warning labels to facilitate consumer education and awareness of the health concerns related to energy drinks are recommended.**

- **A statement indicating energy drinks are not suitable for consumption by children and teenagers.** This warning label is important for safety, consumer education, and consistency in messaging. Health Canada recently posted a video stating that energy drinks were not recommended for children and teens (Health Canada, 2011a) and has stated its continued commitment to advising consumers and parents not to seek these products for children and adolescents (Health Canada, 2011c). Based on a suggested caffeine limit of 2.5 mg per kg body weight per day (Health Canada, 2010a; Nawrot et al., 2003), the proposed maximum 180 mg caffeine in one single-serve container would be equal to or exceed the maximum daily caffeine for all adolescents 71.8 kg (158 lbs) and under. Therefore, it would be prudent to include a statement to indicate these products are not appropriate for consumption by 'teenagers', an easier term for consumers to understand than 'adolescents'.

- **A statement indicating energy drinks are not recommended for use during exercise or to rehydrate following exercise.** It is well documented that energy drinks are not recommended for use during exercise and interfere with proper hydration (Dietitians of Canada, 2009; Health Canada, 2005). Sweden requires warning labels stating the dangers of consuming high amounts of caffeine after exercise (Seifert, Schaechter, Hershorin, Lipshultz et al., 2011). This is particularly important as consumer confusion exists about the difference between sports drinks and energy drinks. Adolescents in particular have been shown to use energy drinks as ergogenic aids (O'Dea, 2003).

- **A statement indicating that ingredients contained in energy drinks may interact with certain natural health products and medications and that consumers should consult their health care practitioner before use.** By regulating energy drinks as food, consumer perception may be that energy drinks are now safe to consume. It is vital that consumers are

aware of possible risky interactions. For example, ginseng and gingko biloba may adversely interact with warfarin and affect blood clotting (Health Canada, 2004b).

- **A statement indicating that the maximum daily caffeine intake from all sources for adults is 400 mg and 300 mg for pregnant and breastfeeding adults.** Previous guidelines suggested that consumers restrict their intake of energy drinks to no more than 500 ml per day (Health Canada, 2005); however, this statement is not included in the proposed approach. Consumers require knowledge of a maximum daily caffeine amount to help safely monitor their own consumption.

As with other food labels (e.g., Nutrition Facts Table), Health Canada should consider specifying the formatting and prominence of the energy drink warning labels on the packaging to ensure visibility and readability. Larger warning labels are shown to be more effective in communicating health risks (Hammond et al., 2006). Health Canada currently requires warning labels on tobacco products to cover at least 75% of the package, an increase over the previous requirement of at least 50% (Department of Justice, 2011). **Given the additional information required on energy drinks (e.g., Nutrition Facts Table), it is recommended that warning labels on energy drinks cover at least 25% of the package.**

Re 1.3 Prohibition of Premixed Alcoholic Beverages with Caffeinated Energy Drinks

Although Health Canada currently prohibits energy drinks as an ingredient in pre-mixed alcoholic beverages, this does not address alcoholic beverages currently being sold in Provincial Liquor outlets containing natural sources of caffeine and not defined as energy drinks. These products, such as RockStar™ + Vodka, have high levels of alcohol (6.9%), added caffeine from natural sources (e.g., guarana), and elevated levels of sugar.

Caffeinated-alcoholic beverages are a public health concern due to their association with injury and high risk-behaviour and increased alcohol consumption (e.g., binge drinking). Research has demonstrated that when individuals consume caffeinated-alcoholic beverages, as compared to alcohol alone, they experience a greater likelihood of being injured, requiring medical treatment, driving intoxicated or riding with an intoxicated driver, having alcohol poisoning, and being a victim or perpetrator of aggressive physical or sexual behaviour (Atlantic Collaborative on Preventative Injury, 2011; Donkin & Birks, 2007; Ferreira et al., 2006; O'Brien, 2008). These outcomes are a result of the countering effects of the stimulant (i.e., caffeine) with the sedative effects of alcohol. Even though the person is impaired by alcohol, the stimulating effects of the caffeine give the subjective feeling of being more awake and having increased motor control and visual reactions. This increases the likelihood of poor decision making and risky behaviours.

It is recommended that Health Canada prohibit the sale of caffeinated-alcoholic beverages from Provincial Liquor outlets.

If the prohibited sale of caffeinated-alcoholic beverages is not supported by Health Canada, it is recommended that Health Canada set strict limits, consistently across the country, restricting the amount of caffeine from all sources that is allowed to be added to pre-mixed

alcoholic beverages. A maximum caffeine level from all sources of 30 mg per 500 ml or 60 mg per litre is recommended.

In addition, if the prohibited sale of caffeinated-alcoholic beverages is not supported by Health Canada, it is recommended that a warning label be added to caffeinated-alcoholic beverages that states: "This product contains alcohol and caffeine. Consuming alcohol and caffeine together may increase your risk of injury." It is recommended that this warning label be displayed prominently on the container and packaging for visibility and readability.

In addition, if the prohibited sale of caffeinated-alcoholic beverages is not supported by Health Canada, it is recommended there be a more discernible difference in the packaging of caffeinated-alcoholic beverages from that of their energy drink counterparts (e.g., RockStar™ + Vodka versus RockStar™ Energy Drink) to avoid consumer confusion.

An additional concern with alcohol and energy drinks occurs at bar and restaurant points of sale. Currently, energy drinks are allowed to be sold at bars and restaurants alongside, and sometimes mixed with alcohol. As stated previously, mixing energy drinks and alcohol increases patrons' risk for injury and risk-taking behaviours (Atlantic Collaborative on Preventative Injury, 2011; Donkin & Birks, 2007; Ferreira et al., 2006) and is not considered safe by Health Canada (Health Canada, 2005).

It is recommended that Health Canada prohibit the sale of energy drinks at all locations where alcohol is sold and served. At a minimum, it is recommended that mandatory training be instituted to anyone selling and/or serving alcohol around the dangers of combining alcohol and energy drinks.

Re 4. Leverage Tools Developed by Stakeholders

There is a well documented ability of advertisements aimed at children to influence food preference, food choice, and purchasing behaviour (Dietitians of Canada, 2010). Canada's Health Ministers support the reduction of marketing of foods high in sugar to children as part of the Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights (Public Health Agency of Canada, 2010). Since energy drinks are sugar sweetened beverages, addressing energy drink marketing supports this key policy priority area from the framework.

Despite warning labels that energy drinks are not for children, marketing and availability targets young people. Energy drink companies may claim they do not directly market to children and youth; however, their marketing strategies include youth appealing promotion strategies, including advertising via sporting events, athlete sponsorships, alcohol-alternative promotions, and product placement in video games (Seifert et al., 2011). We are concerned with the limited impact industry-regulated marketing and advertising Code of Practices would have on current practice. We recommend Health Canada take a stronger stance about marketing to both children and teenagers, as Health Canada does not recommend energy drinks for either age group (Health Canada, 2011a; Health Canada, 2011c).

Internationally, recognizing the impact and prevalence of energy drink marketing to young people, the British Soft Drinks Association has legislated that high caffeine drinks (i.e., > 150 mg/L) may not be promoted or marketed to children less than 16 years of age (British Soft Drinks Association, 2010).

In 2010, the Union of European Beverages Associations released its Code for the Labelling and Marketing of Energy Drinks (Union of European Beverages Association, 2010). The principles for sales and marketing of energy drinks included:

- No marketing communications concerning energy drinks will be placed in any media with a majority audience of under 12 years of age.
- No claims will be made on alcohol together with energy drinks.
- Energy drinks will not be marketed as sports beverages which deliver a rehydration benefit.
- Samplings will not be conducted in the close proximity of primary and secondary schools or other institutions taking care of this age group.

Given that energy drinks are not recommended for children and teenagers (Health Canada, 2011a; Health Canada, 2011c), it is recommended that Health Canada prohibit marketing and advertising of energy drinks to children and teenagers. This prohibition should include all forms of marketing and advertising to children and teenagers (e.g., free samples, sponsorship of children and/or teenage targeted events, online advertising through social media platforms, and online games).

Additional Recommendations

Given that energy drinks are not recommended for children and teenagers (Health Canada, 2011a; Health Canada, 2011c) and there are limits to the effectiveness of consumer education, it is recommended that Health Canada prohibit the sale of energy drinks to children and teenagers utilizing the infrastructure currently in place for restricting the purchase of tobacco products.

In addition to energy drinks, other high caffeine products (e.g., energy shots) are widely available for sale in Canada. The product variety of these concentrated caffeine sources is rapidly expanding. **It is strongly recommended that Health Canada review the current regulations for other high caffeine products and propose stricter caffeine limits and additional warning labels similar to energy drinks. A review of the marketing and advertising of the high caffeine products, particularly to children and teenagers is also recommended.**

We appreciate the opportunity to comment and provide feedback on Health Canada's Proposed Approach to Managing Caffeinated Energy Drinks. As Public Health professionals we are dedicated to the health and well-being of the whole population through the promotion and protection of health and the prevention of illness and injury. Strengthening the approach proposed by Health Canada to managing caffeinated energy drinks by incorporating the recommendations detailed in this report will help to ensure greater safety related to energy drink formulation, greater consumer protection through additional warnings, label information, and contraindications to use, and the marketing and the sale of these products to the intended market segment only. Thank you

for this opportunity to provide feedback and we look forward to a favourable result with respect to our recommendations.

Sincerely,

Comment [a1]: Insert own health unit/organization

cc. Dr. Samuel Godefroy
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MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 108-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Medical Officer of Health Activity Report – November

Recommendation

It is recommended that Report No. 108-11 re Medical Officer of Health Activity Report – November be received for information.

The following report highlights activities of the Medical Officer of Health since the last Board of Health meeting.

Collective bargaining activities continued with a successful conciliation meeting being held with Local 101 of the Canadian Union of Public Employees (CUPE). The outcome of this meeting is the subject of Confidential Board of Health Report No. 121-11, this agenda. Conciliation will continue with the Ontario Nurses Association Local 136 on November 21st.

An environmental issue involving a multi-use building in London required significant attention on the part of the Medical Officer of Health, Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services, and Mr. Iqbal Kalsi, Manager, Environmental Health. This situation required close collaboration with Ministry of the Environment staff, London Regional office. An update will be provided at the November 17th Board of Health meeting.

Mr. John Millson, Director, Finance and Operations, and the Medical Officer of Health attended a City of London meeting with the Service Review Committee at City Hall. As part of the 2012 City Budget Preparation process, this City Council subcommittee is reviewing business plans for city departments and external boards and agencies who receive city funding. A verbal update will be provided at the November 17th Board of Health meeting.

The Medical Officer of Health participated in the local media awareness campaign for the Rotary International initiative to eradicate polio worldwide. The campaign entitled 'Pinkie Painted for Polio' highlighted how when children in developing countries receive a polio vaccination, one of their fingers is painted to indicate their vaccination status. Board member, Ms. Denise Brown, also participated at this event.

The Senior Management Team completed work on the development of 3 year outcomes for the Board of Health approved Ten Year Vision and Three Year Strategic Directions document. This is the subject of Board of Health Report 110-11, this agenda.

The Medical Officer of Health provided welcoming remarks to the 'Getting it Right –The Early Years Matter!' conference at the Child and Parent Resource Institute (CPRI) in London. Health Unit coordinators for this important initiative were Ms. Ruby Brewer, Manager, Family Health Services, and Ms. Joanne Simpson, Public Health Nurse. It brought together family physicians and representatives from community agencies in an innovative, interactive manner for the physicians to learn about community resources available for children with developmental delays and/or behavioural issues.

Other activities involving the Medical Officer of Health since the last Board meeting included:
Chairing a Board of Directors meeting for Healthline.ca; attendance at and introduction of a keynote speaker for the Violence in the Media Conference held at Althouse College, University of Western Ontario; attendance and remarks at the reception for Ms. Joan Carrothers, Manager, Oral Health, who retired after 30 years with the Health Unit; participation in a Corporate Services Strategic Planning meeting; and participation in the Board of Health special education session about the Ontario Public Health Organizational Standards.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 109-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC. Medical Officer of Health
DATE: 2011 November 17

Emergency Preparedness - 2011

Recommendation

It is recommended that Report No. 109-11 re Emergency Preparedness - 2011 be received for information.

Background

Emergency preparedness is one of the requirements of Board of Health under the Ontario Public Health Standards. The operational plans in the Emergency Preparedness Program for this Health Unit are prepared annually to create awareness and educate, ensure co-ordination with external partners, assess hazards and risks, build a supportive volunteer base, and test plans. This report highlights Emergency Preparedness Program activities for 2011.

Response to Emergency Events

The year 2011 started with an unprecedented snow emergency in Middlesex and London which tested the Health Unit's Adverse Winter Weather Protocol, the communication infrastructure and all aspects of the Emergency Response Plan. The Health Unit also provided guidance and public education to the County and City for their residents. No one thought at that time that this region would also see tornadoes, severe storms, power outages, and even an earthquake in the coming months.

Municipalities are mandated to conduct emergency exercises. The Health Unit also conducts such drills, recognizing the value of hands-on-learning for unexpected occurrences that may arise. In June, an exercise with a Power Outage theme tested the use of the Provincial Incident Management System.

In August, several municipalities agreed to host evacuees from the Northern Ontario communities affected by forest fires. Although the forest fire situation improved and the use of the Middlesex-London sites was not needed, Health Unit staff members were well prepared to service the designated evacuation centres and coordinated well with the Community Emergency Management Coordinators.

Emergency Preparedness Activities

The Emergency Preparedness Program ran fun and innovative awareness campaigns for Health Unit staff at Valentine's (A Low Calorie Valentine Treat – Appendix A), and at Halloween (Zombie Uprising at the MLHU! – Appendix B), and participated in the annual Emergency Preparedness Day in Strathroy in May. The Health Unit sponsored workshops in Critical Incident Stress Management (Level 1 and 2) in the spring. In November, a workshop (Faithful Readiness: Preparing Your Congregation for Disaster – Appendix C) is being offered to clergy and their congregants.

New guidelines for the Canadian Standards Association and the Ministry of Labour direct that staff members need to be fit tested for the N95 respirator bi-annually. This extensive project is underway and will continue until all staff and volunteers are in compliance (It's Fit-Testing Time Again – Appendix D).

The Manager, Emergency Preparedness, attended the World Conference on Disaster Management in Toronto (June), the Provincial Emergency Management Conference in Kingston (November), and received the Certified Municipal Manager designation from the Ontario Municipal Management Institute (March).

All of the Health Unit's emergency themed brochures have been translated into large print and Braille, the first steps of compliance to meet the standards of the Accessibility for all Ontarians Act (AODA). The same brochures were also translated to Spanish, as part of a program of joint projects with the Canadian American Latin Association.

Mr. Ken Hall, Advisor, Community Relations, Enbridge Pipelines Inc., will be in attendance at the November 17th Board of Health meeting to present a donation to the Community Emergency Response Volunteer Program (CERV).

This report was prepared by Ms. Patricia Simone, Manager, Emergency Preparedness.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Mandatory Health Programs and Services Guidelines:
Emergency Preparedness Program Standard requirements #1 through #8.

MIDDLESEX-LONDON HEALTH UNIT

A Low Calorie Valentine Treat with an Emergency Preparedness Twist!

How do you plan to find your loved ones when a disaster strikes?

Hand held signs?

Post it Notes?

Message boards?

A better way is to:

1. Gather important information like names, phone numbers, emails, and addresses.

2. Create a plan that is secure, easy to access, easy to retrieve and easy to back-up.

3. Send it to a designated contact. This is CRITICAL! Send a copy to an outside area contact, like a family member.

4. Update your plan regularly. Keep the plan alive, and current. Be aware!

5. Use the attached forms as a guide and talk about this with your Valentine(s) now!

www.healthunit.com

ZOMBIE UPRISING AT THE MLHU!

DON'T BE A ZOMBIE: BE PREPARED!

This is a Halloween reminder to be prepared for any type of emergency or disaster (including attacks by Killer Zombies!)

The point is to get prepared - Take an all-hazards approach to preparing for things like tornadoes, floods, fire, and severe winter weather.

If you are prepared for Zombies, you'll be prepared for anything!
To start: check & replace batteries in smoke detectors and CO alarms.

BE SPOOKTACULAR!

MIDDLESEX-LONDON HEALTH UNIT
Emergency Preparedness

Got a creative emergency preparedness idea?
Send it to emergency@mlhu.on.ca to win a prize.

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com
Emergency Preparedness

EMERGENCY DISASTER SERVICES
THE SALVATION ARMY

Faithful Readiness:
Preparing Your Congregation for Disaster

Wednesday, November 30, 2011
9:00 am – 4:00 pm
Middlesex County Building
399 Ridout Street North at Dundas Street

Participants will:

- learn about the role that places of worship and their congregations have in emergencies
- be introduced to hazards that can lead to disaster
- analyze hazards in their own communities
- learn about emergency preparedness measures
- be given tools that can aid in disaster planning and organization
- learn the role government agencies and other community organizations play in response
- learn the importance of collaboration when emergencies occur
- learn about community disaster services that may already exist or could be established

$20.00/person
(Includes manual and refreshments; lunch on your own!)

For more information, please contact
Patricia Simone (519-663-5317 x 2371) or pat.simone@mlhu.on.ca

Parking: There are several parking lots within blocks of the County Building; some parking lots accept only cash and some are credit card payment only. The average cost for parking for the day is $5.00 - $8.00. All metered street parking in the area is for a maximum of 2 hours.

Parking Lot Locations:
NW corner of Horton St. and Ridout St. or NE corner of York St. and Ridout St.
Covent Garden Market parking – NE corner of Talbot St. and King St.

Facilitator: Perron Goodyear, The Salvation Army, Divisional Director of Emergency Disaster Services

Featuring: Cheryl Tung, Middlesex-London Health Unit, Public Health Inspector & survivor of "Snowmaggedon" 2011, Hwy #402 evacuation!

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
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Emergency Preparedness

EMERGENCY DISASTER SERVICES
THE SALVATION ARMY

Faithful Readiness:
Preparing Your Congregation for Disaster

REGISTRATION

Name: _____

Congregation: _____

Address: _____

City: _____

Province: _____Postal Code:_____

Phone: _____

Email: _____

PAYMENT IS DUE BY THE START OF THE COURSE

Please return completed form and cheque for $20.00 to:

Middlesex-London Health Unit
Attn: Patricia Simone, Manager of Emergency Preparedness
50 King Street, London, Ontario N5A 5L7

It's Fit-Testing Time Again

The MLHU has committed to fit-test our staff every two years on the N95 respirator.

Please register for a session which will take a maximum of 30 minutes of your time.

When: Monday, Oct 31 (1 PM – 4 PM) or
Friday, Dec 2 (9 AM – 12 PM) or
Thursday, Jan. 5 (9 AM – 12 PM)

Where: Middlesex Room in the County Building

IMPORTANT:
No eating, drinking or gum chewing during test!

Sign Up Today – K drive

Fit Testing File, Fit Testing signup sheet (2).doc

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 110-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Strategic Plan – Ten Year Vision and Three Year Strategic Directions - Update

Recommendation

It is recommended that Report 110-11 re Strategic Plan – Ten Year Vision and Three Year Strategic Directions - Update be received for information.

Background

At the June 16, 2011, Board of Health meeting, Board members reviewed and approved the Strategic Plan – Ten Year Vision and Three Year Strategic Directions (Appendix A). This document was the result of a comprehensive strategic planning process involving extensive consultation with clients, staff and members of the Board over an eighteen month period.

Since the June 16, Board of Health meeting, members of the Senior Management Team have been meeting to advance the Ten Year Vision and Three Year Strategic Directions document by identifying outcomes to be achieved over the next 36 months. Attached as Appendix B is a document summarizing the results of these meetings. It can be seen that each of the Three Year Strategic Directions subheadings (Improved Health Outcomes, Organizational Health and Vitality, and Infrastructure) and their respective objectives have been matched with three year outcomes, including identification of the group that will take the lead in addressing the outcomes.

Next Step

The next step in the process is for the leads within the Health Unit to form working groups who will in turn develop an annual operational plan focused on strategies or activities to achieve the assigned outcomes. Board members will recall that one of the requirements of the Provincial Organizational Standards is that the Board of Health have in place a 3 to 5 year strategic plan and that this plan be reviewed on an annual basis. To assist the Board in fulfilling this obligation, staff will provide annual updates on the status of achieving the Three Year Strategic Directions.

In many areas, activities are well underway to address the three strategic direction outcomes. For example, a number of the reports on this agenda (Report No. 104-11 re Nutritious Food Basket Costing Results for 2011 and the Opportunities for Action; Report No. 111-11 re Child and Youth Network: Ending Poverty Demonstration Project; Report No. 112-11 re Addressing Food Insecurity in Two Priority Populations; and Report No. 113-11 re Food Security, Literacy and Skills Programs in Middlesex-London) demonstrate the work that is currently being undertaken to address Strategic Direction A2 - Improve Health Outcomes by enhancing service delivery through collaborative, comprehensive, integrated strategies in Middlesex-London in the areas of reducing health inequities.

The three year outcomes for Strategic Direction A2 that apply to these reports are as follows:

- MLHU staff will actively engage with community partners to address systemic issues related to the SDOH. In particular staff will seek to mitigate the impact of poverty and work towards decreasing the incidence of poverty in Middlesex-London.
- MLHU staff will successfully build collaborative partnerships internally and across the community which ensure inequities in health services which stem from poverty are minimized.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON
HEALTH
UNIT

Middlesex London Health Unit
Strategic Planning
Ten Year Vision & Three Year Strategic Directions

Ten Year Vision

We are Public Health - we focus on preventing illness and injury, promoting and protecting health and improving quality of life.

We serve our diverse and ever changing community, ensuring accessibility to all. We reach out to our Middlesex-London community both physically and virtually. We provide our services where people live, learn, work and play.

Together with our partners, we are a vital part of the community, trusted to provide credible and reliable public health information, programs and services.

We are an integrated public health team committed to providing service excellence through client-centred, & evidence-informed practice; innovation; and collaboration.

Our workplace culture is marked by effective leadership, mutual trust, respect, transparency, professionalism and personal well being.

We have ample human, physical, technological and financial resources; and are accountable for effective use of these resources.

We share a common vision, each of us contributing our expertise toward enabling the people of Middlesex-London to reach optimal health!

Middlesex-London Board of Health Approved – June 16, 2011

Three Year Strategic Directions

A. Improved Health Outcomes:

The Public Health Standards will continue to be met and monitored within the context of the accountability framework. In addition to this work, special emphasis will be placed on the following:

- Improve health outcomes by enhancing service delivery through collaborative comprehensive, integrated strategies in Middlesex-London in the areas of:
  - Healthy eating, and physical activity for all
  - Reducing health inequities

[Strategies must: be integrated, expand what we do, have a virtual component, serve Middlesex-London, provide excellent health information to staff and partners, contain an outcomes and evaluation plan,

B. Organizational Health and Vitality

- Continually enhance internal collaboration
- Foster effective internal communication and decision-making processes and practices
- Enhance Health Unit leadership at all levels

C. Infrastructure

To support the work of better health outcomes:

- Enhance the capacity of the Health Unit to inform and respond to its communities through the application of communications strategies (enhanced online presence, marketing)
- Enable the delivery of the Health Unit's services through the use of current and emerging technologies
- Develop a Facilities Plan to address the needs of the HU and the growing, ever changing community it serves

MIDDLESEX-LONDON
HEALTH
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Middlesex London Health Unit
Strategic Planning
Ten Year Vision & Three Year Strategic Directions

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MIDDLESEX-LONDON HEALTH UNIT

Strategic Planning – 3 Year Directions & Outcomes

Draft

	Strategic Directions	Lead	3 Year Outcomes By December 2014 we will have….
A	**Improved Health Outcomes**		
A1	Improve health outcomes by enhancing service delivery through collaborative comprehensive, integrated strategies in Middlesex-London in the areas of: Healthy eating, and physical activity for all	Co-led by Family Health Services and Environmental Health & Chronic Disease Prevention Services	• In order to increase the physical activity of children, youth and adults, MLHU staff will advocate for and support the implementation of municipal policies that facilitate physical activity in the community. • In order to increase healthy eating, staff will focus on increasing the number of families that have access to fruits & vegetables and increase the skills of families in healthy food preparation.
A2	Improve health outcomes by enhancing service delivery through collaborative comprehensive, integrated strategies in Middlesex-London in the areas of: Reducing health inequities	Co-led by Family Health Services, and Oral Health, Communicable Disease and Sexual Health Services	• In order to increase awareness of the Social Determinants of Health (SDOH) and the significant impact they have on the effectiveness of MLHU programs and services, professional development opportunities will be provided to all staff based on an agency learning needs assessment. • All programs and services provided by MLHU staff will be reviewed to determine how they can be adapted and/or realigned to better address health inequities, with a focus on inequities which are as result of poverty. • MLHU staff will actively engage with community partners to address systemic issues related to the SDOH. In particular staff will seek to mitigate the impact of poverty and work towards decreasing the incidence of poverty in Middlesex-London. • MLHU staff will successfully build collaborative partnerships internally and across the community which ensure inequities in health services which stem from poverty are minimized.

Strategic Planning – 3 Year Directions & Outcomes
Draft

	Strategic Directions	Lead	3 Year Outcomes By December 2014 we will have….
B	**Organizational Health and Vitality**		
B1 B2 B3	Continually enhance internal collaboration Foster effective internal communication and decision-making processes and practices Enhance Health Unit leadership at all levels	Senior Management Team	MLHU staff will further explore issues, develop options and implement a plan to strengthen: • Internal communication / Collaboration • Decision making / Leadership
C	**Infrastructure**		
C1	To support the work of improved health outcomes: • Enhance the capacity of the Health Unit to inform and respond to its communities through the application of communications strategies (enhanced online presence, marketing).	Communications Office	MLHU staff will increase community awareness of programs and services and enhance service delivery through optimal use of: • Media • Marketing • Social media, including the website
C2	To support the work of improved health outcomes: • Enable the delivery of the Health Unit's services through the use of current and emerging technologies.	Information Technology Services	MLHU staff will function more efficiently and effectively through the optimal use of: • Technology that is current and accessible • An electronic record strategy • Technology applications that enhance communication and collaboration
C3	To support the work of improved health outcomes: • Develop a Facilities Plan to address the needs of the Health Unit and the growing, ever changing community it serves.	Finance and Operations Services	MLHU staff will develop and begin to implement a functional facilities plan that includes facilities to support: • Ever-changing program and service delivery needs • Collaboration and communication • Business continuity

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 111-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Child and Youth Network: Ending Poverty Demonstration Project

Recommendation

It is recommended that Report No. 111-11 re Child and Youth Network: Ending Poverty Demonstration Project be received for information.

Background

The City of London Child and Youth Network (CYN) aims to improve the well-being of children and youth by looking at the issues of poverty, literacy, and healthy eating/ physical activity. As a result, the members of the CYN have been divided into working groups and have created strategies to address these issues.

The aim of the Poverty Working Group is to reduce the proportion of London families who are living in poverty by 25% in five years and 50% in 10 years. Many strategies were identified and as a result, the Poverty Working Group was divided into different subgroups with one of the groups focusing on Education, Literacy & Employment. This Subgroup consists of members from the community who are interested in the link between education and employment, including the Health Unit, City of London, Thames Valley District School Board (TVDSB), London Catholic District School Board, Junior Achievement (JA), London Urban Services Organization, Children's Aid, and an independent Health Promotion Consultant.

This report describes an initiative of the Education, Literacy & Employment Subgroup.

Project Description

This project was launched in the Glen Cairn neighbourhood in October of 2011, as a means of supporting youth and families "at risk" of generational poverty. A Community Development Coordinator was hired through funding by the CYN. The Health Unit is the lead agency for this project, and the Coordinator is located here. The aim is to help youth achieve positive educational outcomes, ultimately resulting in long-term career engagement. The project focuses on building positive relationships and community collaborations while creating linkages for students and their families and enhancing resources available. A steering committee guides this project, with representation from CYN, the Health Unit, the City of London, the Glen Cairn Community Resource Centre, Glen Cairn Public School and the TVDSB.

The anticipated outcomes for this project are as follows:

1. Enhanced protective factors for students to assist in breaking the cycle of poverty
2. Engaged students with opportunities for social, emotional, physical, mental and spiritual growth
3. Positive relationships between students and mentors
4. Positive transition from elementary to secondary school and
5. Increased alignment between school, home and community supports.

Project Update

In the first year of the project enhanced protective factors were put in place to assist students in breaking the cycle of poverty. The Community Development Coordinator referred students, parents and teachers to support services provided by 11 community partners. Students, parents and teachers also had the opportunity to connect with many of these partners at a Community Dinner and Resource Fair held at Glen Cairn Public School – an event attended by 120 students and family members.

Over the course of the school year, students have been engaged with over 30 opportunities for social, emotional, physical, mental and spiritual growth. Seventy-three (73) Grade 7 students (100% of the first year cohort) participated in a leadership conference facilitated by the Community Development Coordinator, as well as financial literacy training provided by JA. Sixty (60) Grade 7 students (82%) have participated in voluntary extracurricular activities coordinated by the Community Development Coordinator. These activities centered on youth engagement and the development of skills related to leadership, health and employability. Eighty-four (84) students from the broader school community have

also directly benefited from the project through extracurricular participation such as volunteer placements, leadership activities, recreational opportunities and summer camps.

Year two of the project has started, involving approximately 75 more students, for a total of 150 students participating. Emphasis is being placed on parent engagement, mentorship and the transition to secondary school. Community partnerships are being expanded in scope, thus providing rich opportunities for youth and family engagement at Glen Cairn Public School, in the Glen Cairn Neighbourhood and throughout the City of London.

Summary
Building linkages to community partners and drawing on existing resources is an important factor in the success of this project. The Community Development Coordinator will continue to work in the school, assisting youth in making a smooth transition from elementary to secondary school, a factor that can impact the rest of their lives.

This report was prepared by Ms. Jennifer Martino, Community Development Coordinator, and Ms. Christine Preece, Manager, Young Adult Team, Family Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Chronic Disease Prevention Standard 3, 4 and 11. Child Health Standard 4 and 8.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 112-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Addressing Food Insecurity in Two Priority Populations

Recommendation

It is recommended that Report No. 112-11 re Addressing Food Insecurity in Two Priority Populations be received for information.

Background

Food security is the ability of individuals to obtain safe, healthy, personally and culturally acceptable food. Food security contributes to good health, lowers risk of disease, and reduces health care costs. Food insecurity exists when the factors listed above do not exist for individuals and families. Research indicates that food insecurity often results from a lack of resources such as income and housing. In Canada, nearly 60% of social assistance recipients report food insecurity. Studies show that as household income drops, the consumption of energy-dense but nutrient-poor food increases, further exacerbating poor health status and increasing the risk of chronic illnesses such as obesity, cancer and cardiovascular disease.

Strategies that address food security can be categorized into three types: short term, intermediate and long-term. Examples of short-term strategies (sometimes referred to as food charity) are food banks, soup kitchens and community meal programs. While these strategies do little to mitigate the problem and do not ensure people will achieve food security, they do address the immediate reality that many people in the community are hungry and have limited access to food. Intermediate (capacity-building strategies) include food costing surveys, nutrition education, cooking sessions, and community gardening. These strategies build the capacity of individuals and families participating in programs but are unlikely to address underlying issues such as income insufficiency. Long-term system and policy changes, such as changes to the social assistance program, would provide people with opportunities to achieve food security but will not be addressed in this report.

Developing Food Skills in Priority Populations

Food skill development can be a strategy to improve food access for marginalized populations. Skill development is a necessary precursor for behaviour change and can contribute to change by increasing confidence. Food skills programs may address the following: food selection (menu planning, budgeting and shopping), healthy food preparation (chopping, cooking, food safety) and food storage (refrigeration, freezing, canning). When teaching food skills to priority populations, it is vital to be aware of the population's ability to access healthy foods. Given the trend toward consuming more foods outside the home and rising food costs, teaching priority populations basic food skills can help lower spending on food and facilitate simple meal preparation at home. To demonstrate how the Health Unit addresses the problem of food security, two food skills development efforts offered by Family Health Services staff are described: Smart Start for Babies and Local Foods Gardening Program.

Smart Start for Babies

At Smart Start for Babies, a prenatal education program for vulnerable pregnant women, staff members have made food skill development a priority. These clients and their young families are particularly vulnerable to health inequities due to poor nutrition intake and lack of food preparation skills, for example. The Public Health Dietitian and Nutrition Assistant have taught meal planning, basic food preparation, healthy eating on a budget and food safety. Very simple, nutritious and low cost meals and snacks are prepared with clients. Staff members have offered extensive hands-on learning opportunities, preparing simple foods with a slow cooker and blenders (Magic Bullets). Funding from the Public Health Agency of Canada allowed the program to distribute some food ingredients and cooking utensils for the participants to take home and further practice the skills they had acquired at the program.

Local Foods Gardening Program

Within the Local Foods Gardening Program, Spanish-speaking newcomers to Canada were given the opportunity and the tools needed to plant and harvest a community gardening plot. In the fall, Health Unit staff offered a series of three food preservation sessions. A Spanish-speaking interpreter attended all three sessions. One session was a participatory canning session held in a food laboratory at Brescia University College. Participants learned how to prepare and can salsa and peach jam safely assisted by a Registered Dietitian and lay people who have many years' experience with canning. During two other

sessions, attendees learned how to preserve the harvest by blanching and freezing and how to prepare simple, healthy and economical recipes containing local in-season produce that they are unfamiliar with being new to Canada. Evaluation results show that the intake of vegetables of the participants' families increased as a result of participating in the program.

Conclusion

The needs of these two priority populations were assessed considering social determinants of health and health inequities. It was determined that capacity-building strategies could be effective at improving food skills in an effort to address food insecurity in the two vulnerable populations. Long-term system and policy changes are vitally needed to address the environments and circumstances that increase access to safe, healthy, affordable and accessible food.

This report was prepared by Ms. Ginette Blake, Public Health Dietitian, and Mr. Jim Madden, Manager, Family Health Promotion Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Foundational Standards Requirements 3 and 4, Chronic Disease Prevention Standard 8, Reproductive Health Standards 5 and 6 and Child Health Standards 7 and 8.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 113-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Food Security, Literacy and Skills Programs in Middlesex-London

Recommendation

It is recommended that Report No. 113-11 re Food Security, Literacy and Skills Programs in Middlesex-London be received for information.

Background

Public Health Dietitians on the Chronic Disease Prevention and Tobacco Control (CDPTC) Team are engaged in many community-focused activities (e.g. Ending Poverty Workgroup of the Child and Youth Network, London Food Bank Board of Directors, London Community Resource Centre Board of Directors and Food Charter Workgroup) aimed at directly and indirectly enhancing food security for vulnerable populations in the community. This report highlights a number of these initiatives.

Food Literacy / Cooking Skills Programs

Food literacy can be defined as a complex, interrelated, person-centered set of skills that are necessary to provide and prepare safe, nutritious, and culturally-acceptable meals for all members of one's household. From August 2009 to December 2010, the *Cook It Up!* Program, a community-based cooking program targeting at-risk youth aged 13-18 years, provided opportunities for cooking skills development facilitated by local chefs and field trips to local farms and farmers' markets to introduce this vulnerable population to the local agri-food industry. The London Community Resource Centre was the lead agency for the program and worked in partnership with the Health Unit and other community agencies. The London Community Resource Centre created a "how-to" manual which provides other program providers with the tools required to facilitate a similar program in their communities (Appendix A). The manual can also be found on the Internet at http://lcrc.on.ca/ESW/Files/Cook_It_Up!_How_To_Manual.pdf .

Though *Cook It Up!* is no longer operating, it became the impetus for the planning, implementation and evaluation of other local food literacy and cooking skills interventions. A number of offshoot programs focusing on food literacy and cooking skill development are being offered locally. A selection of these initiatives is highlighted in Appendix B.

Second Harvest and Community Harvest Programs

Currently, the Public Health Dietitian is working with the Ending Poverty Workgroup of the Child and Youth Network and London Food Banks to investigate the feasibility of starting a Second Harvest program in Middlesex-London. Second Harvest is a program that facilitates partnerships between London Food Banks and local grocers to distribute fresh foods near their expiry dates (e.g. meats, dairy, produce and grains) through food banks. Toronto has enjoyed success in this type of program for the past 25 years. Additionally, the Public Health Dietitian will be working with London Food Bank and distribution centres to expand the Community Harvest program, a program that partners with regional farmers to provide fresh, local produce to food bank clientele.

London Food Charter

The vision of the London Food Charter is for London to be a food secure community. The charter outlines commitments and action steps to achieve this vision. The five commitments include: assessing existing food-related policies, programs and services and developing new ones as required; developing strategies to eliminate food deserts in London; supporting an ecological and economically viable food system; developing education and awareness strategies to encourage healthy food consumption; and bringing people together through food in celebration of culture and diversity. In December 2010 and April 2011, the London Food Charter was endorsed by the Child and Youth Network and the City of London, respectively. A Public Health Dietitian from the CDPTC Team is an active member of the Child and Youth Network Food Charter Steering Committee. The Steering Committee is currently developing a three-year work and marketing plan to support the Food Charter commitments and action steps.

Monthly Meal Calendar Distribution

Each month, the Public Health Dietitians facilitate the collection of data and distribution of information related to community meal programs, collective kitchens, food banks and distribution centres, and other food security-related programs and services offered to residents in London. The monthly meal calendar is

distributed to over 250 social service agencies electronically, by fax, and by mail. It is not known how widely how many individuals the calendar reaches but it has been distributed for over ten years by the Health Unit.

Conclusion

These capacity-building strategies provide opportunities to build food skills and literacy through cooking, gardening, increasing access to healthy foods, and the development of guidance documents linking sustainable food security policies to community action. Additionally, they engage low income earners and vulnerable populations to participate in activities that enhance their food security. Longer-term solutions are still needed; however, the strategies outlined above provide ongoing support to the most vulnerable populations within the community.

This report was written by Ms. Heather Thomas and Ms. Kim Leacy, Public Health Dietitians, and Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards (2008): Foundational Standard 3, 4, 5, 8, 9, 10; Chronic Disease Prevention 2, 7, 8, 11, 12

Cook It Up! How-to Manual
Planning, Implementing, & Evaluating a Community-based Cooking Program

London Community Resource Centre

London, ON

London Community Resource Centre
together we grow, together we thrive

November 1, 2010

For information, please contact:

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London Community Resource Centre
652 Elizabeth Street.
London, Ontario
N5Y 6L3
phone: 519-432-1801

e-mail:linda@lcrc.on.ca

London Community Resource Centre
652 Elizabeth Street
London, Ontario
N5Y 6L3

Cite reference as: London Community Resource Centre (2010).
Cook It Up! How-to Manual: Planning, Implementing & Evaluating a Community-based Cooking Program.
London, Ontario: Author.

Authors:
Linda Davies
Heather Thomas

Table of Contents

Acknowledgements

The London Community Resource Centre would like to thank the Steering Committee for their direction throughout the entire *Cook It Up!* project. We have had some superb volunteers who have assisted, instructed, and supported the participants in cooking sessions and field trips. These volunteers demonstrated passion and commitment and we are very appreciative of their involvement. The chefs who volunteered their time and skills along with a dash of patience and kindness need to be acknowledged. These food professionals are so busy in their own businesses, restaurants, and personal lives but felt the need to give back to our program and did so very generously. Thank you! Local farmers, folks running farmers' markets and academic culinary programs, grocery stores, and other local agri-food industries must be recognized. The field trip component truly created the opportunity for our participants to finally understand all aspects of the food they eat, from farm to fork.

Acknowledgement, of course, to our funding agency, Ontario Agri-food Education Inc. The Healthy Eating Program provided us with the financial opportunity to promote nutrition and healthy eating of Ontario products by engaging with youth and non-traditional community partners in a unique, hands-on, and rewarding way. Thank you!

Also, a special thank you to our community partners who supported *Cook It Up!* financially and in-kind: Ontario Bean Producers Marketing Board; Ontario Pork; Healthy Living Partnership Middlesex-London; London Lawyers Feed the Hungry; Brescia University College (BUC); and the Middlesex-London Health Unit.

In addition, Brescia University College provided Cook It Up! with students who were eager to gain some valuable community volunteer experience, with research advice and expertise, and with direction for our Steering Committee. Reaching out to our community partners such as BUC ensures we are approaching our community work in a comprehensive and thoughtful way.

Over the past year, *Cook It Up!* was approached on two different occasions by two community agencies who were so impressed by the work of the participants in this initiative that they asked *Cook It Up!* to cater events they were hosting for their communities. The Boys and Girls Club of London and the Medway Community Centre deserve recognition for having the trust, faith, and insight to give the participants in *Cook It Up!* an opportunity to shine while representing their program. This empowerment is graciously acknowledged and appreciated by the Steering Committee and the participants in the program alike.

Our Program Coordinator was instrumental in building the bridges between us and the local chefs and farmers in our community. His dedication to *Cook It Up!* and enthusiasm for Ontario products essentially sold the program to everyone with whom he came in contact. Thanks Andrew Fleet, for your energy and commitment to *Cook It Up!* Finally, a special thank you to Heather Thomas, Public Health Dietitian at the Middlesex-London Health Unit and my community partner whose vision and passion ignited this project and ensured it was on track, well researched, and promoted at many conferences, in the media, and with our colleagues locally and across the province.

This initiative was very rewarding, challenging, and inspiring and could not have been achieved at this level of success without everyone's contribution and commitment. Thanks to each and every person involved in this program!

Introduction

The purpose of this how-to manual is to share with many communities the lessons we learned from our community-based cooking program for at-risk youth. The intention is to facilitate knowledge transfer to like-minded community agencies interested in enhancing food literacy. Our program met our community's needs and reflected what worked best for us. That is not to say that it won't work in your community; however, the premise is that this manual is a template for you to use what you feel is appropriate for your community and tailor other aspects to meet your community's needs. We see this program effectively being adapted for many groups, for example: single mothers, multicultural communities, older adults, people with disabilities, and any group requiring cooking skill development and food literacy awareness.

Please feel free to contact Linda Davies, Executive Director of the London Community Resource Centre (the lead agency of *Cook It Up!*) if you have any questions about our program and our approach. Also feel free to adapt the information in this manual as you see fit – this manual is just one way to create engaged, food literate communities.

Food Literacy is the ability to make healthy food choices by having the skills and knowledge necessary to buy, grow, and cook food.
- Food Literacy Project

Background: What is Cook It Up?

Cook It Up! was a community-based cooking program for at-risk youth focusing on education and skill building. *Cook It Up!* offered youth education and hands-on food experiences focusing on general nutrition, food safety, food preparation, food selection and cooking skills, and agriculture fieldtrip experiences to a variety of local farms and farmers' markets. Educational topics include: General Healthy Eating and Safe Food Handling, Ontario-grown Spring, Summer, Fall, and Winter food themes, and a Graduation Celebration. The sessions included specific recipes featuring Ontario-grown foods, participation by local chefs, and fieldtrip opportunities to local farms and farmers' markets involving a variety of local food commodities. The facilitators targeted, coordinated, and implemented the activities within each module relevant to the needs and desires of the youth group. The final Graduation Celebration provided an opportunity for the sharing of learning experiences, networking with sustainable new partnerships (e.g., local farmers, local food commodity marketing associations, local chefs, and local farmers' markets) and media coverage which served to promote the support from and philosophy of Ontario Agri-Food Education Inc. via local print, radio, and television media outlets.

Purpose and Need for *Cook It Up!*

Poor dietary habits during adolescence may impact on day-to-day wellbeing and performance, achievement and maintenance of healthy weights, growth and development, dental health, among other health indicators (1-5). Research suggests involvement in preparing food for meals is related to more nutrient-rich eating patterns including higher intake of fruits and vegetables, higher intake of key nutrients, and lower intake of fat (6-11). These studies all assume youth have access to food on a regular basis and involve youth living in a family environment. What is less evident in the literature is youth involvement in food-related tasks such as food shopping and preparation (12-14), especially when the target population is at-risk youth in transition from the family home or foster care to independent living. These urban youth are at-risk for homelessness and often experience social, physical, and psychological issues, inclusive of addiction, which may present barriers to healthy lifestyle behaviours (15). The provision of a hands-on, practical life skills program with the purpose of building self-efficacy, knowledge, self-confidence, and self-esteem is perceived as an effective and necessary intervention for at-risk youth in transition. According to Bandura (16), one's perceived ability to perform behaviours, that is, self-efficacy, is enhanced when one has the practical and necessary skills for completion of the task and/or behaviour. *Cook It Up!* provided participants with the skills and experience needed to promote their existing skills and enhance their self-efficacy.

The adolescent age group has been overlooked for effective, skills-based programming offered in the community setting. As youth are transitioning from home, group homes, or foster care to independent living, they have a need for food purchasing, preparation and cooking skills. For the purpose of *Cook It Up!*, the term "at-risk youth" is described as youth at increased risk for a variety of physical and psycho-social issues including poor nutrition which, in turn, can exacerbate physical and psycho-social issues. Addressing at-risk youth by implementing a program with emphasis on healthy eating may be

successful in addressing other social determinants of health with positive results regarding behaviour change. The target population in this pilot initiative was a vulnerable, urban group of youth. Many of these youth lacked an understanding of agriculture and food systems, and none of them had ever visited a rural setting. This project was essential to build an understanding of our local agricultural community through hands-on experiences that served to empower participants. The results from the formative evaluation of the program provided evidence-informed practice and knowledge that can be transferred to broader community agencies and groups, including public health units, local community resource centres, schools, the agricultural community, and other agencies demonstrating interest in the results.

The purpose of the *Cook It Up!* program was to:

- increase education and awareness of agriculture, healthy eating, and food preparation and purchasing skills among this unique target population
- introduce this target group to local agricultural and food systems
- crystallize the appreciation of local food systems, from farm to fork, among this target group
- increase the impact and awareness of the benefits of the Ontario agricultural industry with key stakeholders and participants in the program
- build new and essential life skills
- create sustainable investment through networking with new partnerships (e.g., local farmers, farmers' markets, local food commodity marketing associations, local chefs, community agencies)
- create supportive, positive learning environments
- provide evidence-informed practice, based on research outcomes
- create and distribute a "how-to" manual highlighting all details necessary for implementation of this project in other settings and with other target groups (e.g., post-secondary school students, young adults, Ontario Early Years Centres, parents, multicultural groups, older adults)
- offer knowledge transfer to other community groups (e.g., community resource centres, public health units, schools, workplaces, community agencies, agricultural groups, food commodity marketing associations)
- offer public messaging of the importance of local agricultural and food systems via local and extended media outlets (e.g., print, radio, television)

Getting Started

The *Cook It Up!* program was conceived because of the need in our community to provide food-related programming to at-risk youth given the absence of many opportunities for this population in this skill development area. While no formal needs assessment took place, conversations with community partners working specifically with youth agreed that food skills development was an important area of focus for this population.

One of the first steps in getting started on this initiative was to start defining the project in broad strokes to determine how best to approach food skills development. We had to determine in the literature the extent to which food and cooking skills were relevant to the youth population. A literature search confirmed limited evidence with adolescent age groups (ages 13-18) and demonstrated the opportunity to create a pilot project focusing on youth ages 13-18 years. Broad strokes outlining key components of cooking programs from the literature were drafted and discussions with agencies working with youth, focusing on health and social services, and with an education background were polled to determine interest in a community-based cooking program for youth and to glean ideas for program content. The program started taking shape with input from these key stakeholders and eventually the lead agency was able to identify clearly and concisely the program ideas, structure, and funding.

Specific Steps:

- Literature search
- Decide upon target population and age group
- Decide upon broad program components to include in the project
- Key stakeholder meeting
- Specific ideas for pilot program generated
- Review funding opportunities available

Funding Proposals

The local food movement currently is very popular and relevant in Ontario. The agri-food industry has been engaging in various promotional campaigns, including media (e.g., Real Food Movement [http://www.youtube.com/watch?v=dIsEG2SFOvM], health promotion strategies (e.g., National Nutrition Month 2010), food manufacturers (e.g., www.eatrealeatlocal.ca), and the explosion of food programming on The Food Network, to name but a few. Additionally, attention to local food and the agri-food industry have garnered support from various funding agencies with focus on healthy eating. The Ontario Agri-food Education (OAFE) Inc., an arm of the Ministry of Agriculture, Food, and Rural Affairs, was the primary funding agency for *Cook It Up!* The main programs and services offered by OAFE include:

- Distribution of agri-food educational resources.
- Development of curriculum-based resources that articulate a clear agri-food message.
- Providing professional development services for educators across the province.
- Support and training of local agri-food volunteers and committees to enhance their efforts.
- Providing consultative support to major agricultural events such as the International Plowing Match and the Royal Agricultural Winter Fair.

In addition to these programs, in 2008 OAFE provided funding through their Healthy Eating Program, in which community agencies worked in partnership to promote nutrition and healthy eating of Ontario products. The purpose of this Healthy Eating Program Request for Proposal (RFP) was to solicit submissions from organizations wishing to undertake innovative projects with non-traditional partners that focus on communicating the public health benefits of Ontario grown products including their vitamin content and nutritional value.

Cook It Up! seemed to be a perfect fit for this funding opportunity. As such, the London Community Resource Center (LCRC) investigated the RFP in depth.

Alternative funding agencies were also approached. Below is a list of potential funders for consideration when developing a community-based cooking program:

- Local health unit;
- Food commodity marketing associations;
- Heart and Stroke Foundation – SPARK Together for Healthy Kids Advocacy grant;
- Local chefs' association;
- Academic institutions (e.g., colleges and universities);
- Ontario Trillium Foundation;
- Healthy Communities Fund (Ministry of Health Promotion and Sport); and
- Local Service clubs.

Once the best funding agency is selected for the project, the funding proposal can be drafted. This process enables the lead agency to determine how best to plan, implement, and evaluate the program. Careful consideration needs to go into the various stages of proposal development so as to not leave any considerations ignored.

In most proposals, there are clear guidelines regarding how to structure the RFP. These guidelines assist in organizing the project and identifying all aspects for consideration, from plans through to budget. Establishing a timeline with planning phases built in at the beginning and evaluation built in at the end ensures the project will be thorough and comprehensive. We allotted three months to finalize all aspects of our program planning prior to its official commencement. In addition, three months were allowed at the program's conclusion to complete all evaluation tasks and provide a final written report to the funding agency. Allowing time at the beginning and end of the program also provides flexibility in the program delivery and ensures program implementation is well considered prior to launching. Additional time at the beginning also offers opportunities to recruit Steering Committee members, the program coordinator, the participants, and provides the ability to promote the program effectively. Promoting the program helps generate interest in all active participants as well, from Steering Committee members, to community partners, to participants themselves.

Steering Committee Recruitment

Having the "correct" people around the table to assist in the program development is key to its success. We considered the RFP and requirements therein, specifically, the need to engage in new or non-traditional community partners with interest in promoting the local agri-food industry and the public health benefits of Ontario grown products. With this requirement in the forefront of our planning, we considered which key stakeholders would be important to include around the table. The following experts were considered for *Cook It Up!* Depending on how other community groups choose to approach their program development, different key stakeholders from these communities may be considered:

- Local chefs (for cooking skills education);
- Local farmers (for field trip opportunities and connection to local agri-food industry);
- Education specialists (active or retired, for enlightenment regarding how best to handle youth, especially at-risk youth);
- Social service agency representatives focusing on the youth population (to assist in participant recruitment and engagement);
- Public health representatives (to assist in proposal writing, research, evaluation, and nutritional aspects of the initiative);
- Food service industry representatives (to provide opportunities for field trips in this area);
- Academic representatives (to assist with research and evaluation);
- Community members with interest and skills in this project and/or target group (to ground the Steering Committee and ensure best interests of the participants and program goals are always being met); and

- Food specialty store owner (to provide business representation and possible program resources).

These unique groups from come from very different backgrounds and share different perspectives on working with the target populations. However, the Steering Committee, at the same time, shares a similar interest and passion for the local agri-food industry. For these reasons, the lead agency felt it was very important to include this diverse yet comprehensive and collaborative group of experts to construct the Steering Committee for *Cook It Up!* The Terms of Reference for the Steering Committee are outlined in Appendix A.

Program Coordinator Selection and Recruitment

Equally important as the Steering Committee recruitment, is the Program Coordinator selection and recruitment. We had the fortuitous opportunity to meet an individual who worked in the food service industry in our community who shared a passion for local food, education of youth, and cooking. His greatest strength was his connections to local chefs, farms, and farmers' markets. Working in a local restaurant (whose chef/owner was very engaged in local food such that he developed a daily menu based on the products he could source locally), our program coordinator proved invaluable in creating instant connections to chefs in our community. His passion for the program was evident and he easily "sold" the idea of engaging local chefs in teaching cooking skills to youth.

The opportunity to create new relationships with non-traditional partners was an important one for the lead agency. Recognizing the need to enhance existing food-related programming, LCRC was eager to find a way to build rapport with local chefs, farmers, and farmers' markets. It is, therefore, important to stress to your program coordinator to stretch beyond his/her comfort level and engage chefs, farms, markets, and other field trip opportunities that one may not immediately know on a personal level so as to ensure broad and diverse opportunities for cooking and field trip development are sought. A job description of the program coordinator and relevant job activities is found in Appendix B.

We were fortunate to have a prior connection with the individual we hired to be our program coordinator for Cook It Up! Alternatively, we would have first connected with our community partners to see if any of them would have an individual in mind to recruit for this position. Given limited funding to do an extensive recruitment in newspapers and other typical methods of position recruitment, we would have considered placing a notice on a local volunteer association website (Charity Village www.charityvillage.com) which also offers a job posting recruitment function.

Chef and Volunteer Recruitment

Our program coordinator had existing connections to local chefs. However, we did approach a community contact who was involved in the local chefs' association as well to promote the need for chef recruitment. Equipped with information about the program, this contact not only assisted in recruiting a chef for the Steering Committee, but he also provided the chefs in this association with an overview of the initiative and engaged them in becoming involved in some capacity, whether through providing a cooking demonstration and skill session with the youth or getting the Steering Committee in touch with potential field trip opportunities.

In addition to this method of chef recruitment and selection, the Program Coordinator also reviewed the proposed "menu" of cooking skills and seasonal availability of local produce and paired local chefs with particular interest and/or skill in certain cooking methods and recipes. The Steering Committee insisted that any skills being taught be continuously built upon from session to session in order to enhance the participants' cooking skills ability from start to finish. This was relayed to chefs recruited to participate in the cooking skills development such that skills explained and demonstrated by the chefs were replicated by the youth on several different occasions throughout the duration of the program so as to build their confidence and ability to apply the skills in a variety of different settings and in different recipes. The literature demonstrated the effectiveness of providing hands-on learning opportunities for participants with the option of building skills throughout the program as a successful implementation technique.

We were fortunate to have a strong connection to the University of Western Ontario and one of its affiliated colleges, Brescia University College (BUC). The Food and Nutritional Sciences program (undergraduate and Masters level) is offered at BUC. One of our Steering Committee members is also a professor at BUC and offered to promote the opportunity to

volunteer in the *Cook It Up!* program with her students. Additionally, she taught a community nutrition course in which there is a community placement component. She recruited four students from that course to volunteer with *Cook It Up!*, not only to provide them with a community nutrition placement but also to ensure there was a good group of dedicated nutrition undergraduate students available to assist with volunteer duties.

In addition to the undergraduate students, we were also able to involve graduate nutrition students who were also completing their dietetic internship to assist in the program. The Public Health Dietitian from the Middlesex-London Health Unit supervised three dietetic interns who participated as volunteers at the cooking and field trip sessions and also contributed to proposal writing, research, and program content development. Details about program content development will be presented in another section of this how-to manual.

Because our program targeted at-risk youth, the Steering Committee thought it would be important to have some volunteers available to assist who had specific background working with this population. We were fortunate to recruit a Steering Committee member who also was a retired teacher who specialized in working with special needs children. Her background, patience, problem-solving strategies, and general demeanor with the participants in *Cook It Up!* was the perfect combination when working with youth that were easily distracted, demonstrated behavioural issues, and generally were at times difficult to connect with. In addition to this retired teacher, we also had an active teacher with expertise in family studies and food and nutrition curriculum at the high school level who volunteered her time to assist with the cooking and field trips as well.

We placed two participants with one volunteer for each session. The volunteers' roles and responsibilities were:

- To help keep the participants on track in terms of completing tasks generated by the chefs;
- To help participants navigate through the field trip components when independently completing assigned tasks (e.g., collecting produce from the field, apple picking, grocery shopping);
- To review with the participants and record the components necessary for their "journals," specifically what they liked and did not like about the cooking or field trip session; what they learned about the session; what they prepared; whether or not they would independently prepare this dish at home; and what they learned from being involved in the program.;
- To monitor safety issues in the kitchen and remind participants of the need to be safe, clean, and organized.;
- To ensure cooking and field trip sessions run smoothly.; and
- To assist the Program Coordinator or chefs in any way required.

The volunteers recruited were very positive about the program; however, some of them had never worked with at-risk youth in the past. For this reason, it was necessary to implement some sensitivity training. We worked closely with one of our community partners, Youth Opportunities Unlimited (YOU), which specializes in facilitating education and awareness groups with at-risk youth.

Since 1982 Youth Opportunities Unlimited has helped lead youth in London and Middlesex County toward success. This agency believes that investing in youth and strong communities are connected. Many youth need guidance and support to reach their true potential and YOU works with business, community and government partners to address youths' most pressing needs. YOU provides youth with the training, skills development, support and referrals they need to develop their potential and lead positive lives. It is clear from YOU's mandate that the fit with *Cook It Up!* is a good one.

The sensitivity training was conducted by one of the youth outreach workers from YOU. She informed our volunteers of language issues, how to be mindful of treating at-risk youth with respect and kindness, and to remind them that the volunteers' involvement will eventually be ending when the program concludes. At-risk youth often have adults and others they look up to come in and out of their lives without warning and this may lead to the disruption of their routine, trust, and understanding of others within their social and family circles. Reminding the at-risk youth that the volunteers are not abandoning them but rather moving on to other opportunities is important so the at-risk youth do not feel deserted or discarded by yet

another adult or young adult they have connected with in their lives.

If a future community-based cooking program is developed, it may also be useful to include at-risk youth in the development of the initiative so as to continuously tailor the needs of the group from week to week. Youth engagement is an important approach that we implemented through the weekly journal entries and connections with the Program Coordinator and volunteers. Youth engagement served to ensure we were on the right path with the program.

Youth engagement is the meaningful participation and sustained involvement of a young person in an activity, with a focus outside of him or herself. The kind of activity in which the youth is engaged can be almost anything - sports, the arts, music, volunteer work, politics, social activism - and it can occur in almost any kind of setting.
- Centers of Excellence for Children's Well-Being, 2009

Research and Evaluation Considerations

Because Cook It Up! was a unique program in our community, the Steering Committee felt it would be important to conduct an evaluation of the initiative. With expertise in research and evaluation around our Steering Committee, the local Public Health unit, University of Western Ontario (UWO) and BUC worked together to develop an ethics proposal for consideration prior to starting any research project. Ethical approval for all research projects in *Cook It Up!* was approved by the Office of Research Ethics at the University of Western Ontario.

The research team decided to conduct two qualitative studies and one quantitative study from Cook It Up! First, a formative evaluation of the program was developed. This research focused on conducting in-depth interviews with all participants in the program: Steering Committee members, chefs, farmers, field trip operators, volunteers, and participants. The lead investigators were interested in determining what worked well in the program, what did not, and how the program could be adapted to other groups in different communities, and overall, how to improve *Cook It Up!* Secondly, a photovoice study was implemented to determine how the Cook It Up! program had served to enhance the participants' cooking skills. Along similar lines as the photovoice research, a pre- and post-test cooking skills assessment was conducted to determine any changes in cooking skills among the participants at the beginning of the program compared to at the completion of the program. At the time of the publication of this manual, a fourth qualitative study focusing on perspectives of parents/guardians was under review by the Office of Research Ethics at the University of Western Ontario and therefore is not included here.

Full data analysis of these research projects was underway at the printing of this how-to manual and can be shared with interested parties once interpreted and written up. Please contact Heather Thomas if you are interested in finding out the results from this research (hclarke4@uwo.ca).

Documents related to the research aspect of *Cook It Up!* are available in Appendices C through P (Letter of Information for community partners and Participants; Semi-structured interview guide for community partners and participants; Demographic Survey and Pre- and Post-test Questionnaires; Camera Orientation Session; Consent Form for Photovoice; Consent Form; Ethical Issues in Photovoice; Letter of Information for Photovoice; Rights and Responsibilities of Photovoice; Semi-structured Discussion Group Guide; SHOWED Document). Table 1 outlines research and evaluation plan and activities.

Policies and Procedures

The Steering Committee spent considerable time thinking about which policies and procedures needed to be implemented to keep the participants, volunteers, and all other community partners safe when participating in *Cook It Up!* When working with kitchen appliances and utensils, the opportunity for injuring oneself might present itself from time to time. The policies and procedures related to preventing and treating injuries were some of the first ones to be developed. In addition, cooking with certain ingredients also provided potential challenges due to food allergies or intolerances. We needed to establish proper health information records to identify potential food allergens and other relevant health history that would facilitate our understanding of how to treat certain circumstances. All staff and volunteers involved in the cooking and field trip sessions, especially the Program Coordinator, reviewed these documents thoroughly should an emergency arise. To gather the correct information for these forms, the Steering Committee consulted existing health forms and included relevant information and sections from those forms in the development of the ones for this program. The Middlesex-London Health unit was an important partner in the development of medical/health forms given the focus of this agency.

The other documents that generated much discussion from the Steering Committee were the forms related to Code of Conduct and managing behaviour. These forms were put into place given the at-risk population with whom we were engaging. These documents were adapted from similar ones utilized at a program facilitated by one of our Steering Committee members who also worked with at-risk youth in his agency. The Steering Committee discussed at length the purpose of *Cook It Up!* in reaching at-risk youth and how we wanted to give the participants sufficient "chances" before taking drastic measures with respect to their involvement in the program. That said, we also did not want the behaviour of one or two participants to impact on the learning and skill development of others. There were circumstances in which one of our participants acted out on occasion and was inappropriate. It was decided at the Steering Committee level that our volunteer who had experience working with special needs children would work one-on-one with this particular participant to assist in curbing her behaviour. The volunteer and participant pairing in this situation proved to be very positive and the participant who was problematic improved her behaviour significantly such that she did not need to be removed from the program. At all stages in the discussion about this particular participant, parental/guardian involvement was included and encouraged. The situation was resolved and this participant remained in the program for its duration.

Appendices Q through V highlight some of the key policies and documents we used in *Cook It Up!*

Participant Recruitment Strategy and Program Promotion

Because the program was targeting at-risk youth and also involved significant time and participation commitment, we wanted to ensure the participants involved in this pilot project were fully committed to the program, from start to finish. To this end, we had an online application form available for potential participants to complete and submit (Appendix W). Paper copies were also available to those without internet access. In addition to the application form, the potential participants met with a few members of the Steering Committee who conducted informal interviews with the youth to determine whether or not they were the right fit for the program and if they understood the time commitment as well. At this interview, youth were informed about the research projects and asked to consider if they might have interest in participating in those as well, at a later date. Even though participants were not obligated to become involved in the research component of *Cook It Up!* we felt it was only fair to inform them of this potential so that they could make a full decision about their possible involvement in the program, should they be selected.

The Steering Committee deliberated about the need to interview potential participants and decided that given the pilot nature of this initiative and the desire to share our findings broadly, we wanted to ensure some level of success in the process and as such, decided to interview participants to determine fit, interest, enthusiasm, and commitment to the program. This proved to be an effective way to retain participants as well. We had only one participant withdraw from the initiative due to unforeseen personal difficulties.

In terms of program promotion, we utilized our local media outlets to introduce the program to our local community. We were interviewed in local newspapers and on television. We promoted the initiative on websites (LCRC, Middlesex-London Health Unit, and www.healthylivinginfo.ca) and on Facebook and Youtube. In all media outlets, we directed interested parties to the LCRC website to complete the application form and learn more about the program. Two website articles to date were published on the Middlesex-London Health Unit, Healthy Living Partnership Middlesex-London, and London Community Resource Centre websites (Appendix X).

Promotion of *Cook It Up!* also occurred via word of mouth. With a strategically selected Steering Committee with working background in diverse sectors within our community, we were able to promote the program through our networking groups, community partners, colleagues, and professional associations. This informal sharing of the program served us well in that we were able to describe the program in good detail with others who were in contact with groups focusing on at-risk youth. Steering Committee members working in the social service industry were able to identify potential youth participants directly and those youth, once learning more about the initiative could apply should they choose to do so. We originally recruited nearly 30 youth but through self-selection out of the program (due to a variety of different reasons, e.g., time commitment, program components, conflicts with other activities) the final number of participants was nine. There was attrition of one participant due to personal issues. The remaining eight participants remained with the program from start to finish.

While it may seem that eight participants is a small number of youth, our Program Coordinator reassured

the Steering Committee on a regular basis that this number was a very comfortable one to work with. At-risk youth can be very easily distracted and having more than eight participants may have created a difficult learning environment and frustration among volunteers, chefs, and others in the program. It is necessary to keep in mind that for each session, there were eight participants, a minimum of four volunteers, the Program Coordinator, Steering Committee chef, and guest chef. A maximum of about 15 people is desirable. If larger numbers of participants are considered, cooking space becomes a very important consideration. Careful consideration of the target group selected and their unique needs will determine the number and expertise of volunteers at each session.

Program Development

The original development of the program commenced with the proposal writing. Using the proposal as a template, we focused on incorporating seasonal local foods into cooking sessions and field trips to farms and farmers' markets. The Program Coordinator also considered which specific professional chefs to recruit given the season, their expertise, and their availability. Table 2 outlines the module topics and brief description / themes for each cooking and field trip session. This information is based on opportunities to highlight local seasonal produce on field trips and to demonstrate how to use this produce in the cooking sessions.

The original program concepts were developed by dietetic interns supervised by the Public Health Dietitian on our Steering Committee. From this point, the Steering Committee put the Program Coordinator in charge of fine-tuning each session. Recipes selected for each cooking session were decided upon by the Program Coordinator and professional chef on our Steering Committee. Ingredient lists, equipment required, and other cooking considerations were also discussed by these two professionals prior to each cooking session. Additionally, potential field trip opportunities were considered and connections to the appropriate farmers were made accordingly.

The Program Coordinator contacted local chefs to see if they had interest in volunteering their time to instruct the participants on a variety of cooking techniques while showcasing local, seasonal produce. There was never any difficulty recruiting chefs to lend their skills, expertise, and enthusiasm to the program and its participants. In fact, some chefs enjoyed the experience and their involvement so much that they asked to return to the program on an ongoing basis. This commitment from some of the chefs demonstrated to the participants that *Cook It Up!* was an important initiative and one valued by the local chefs participating in the program. Even though there was great interest in the program by some returning chefs, it is very important to continue to recruit additional chefs to the initiative to avoid potential volunteer burnout and to diversify community capacity. Table 3 highlights key Program Coordinator activities.

Budget

The budget for Cook It Up! included details about the following components:

- Project management;
- Program Coordinator;
- Cooking Sessions;
- Fieldtrips;
- Transportation; and
- Graduation Ceremony.

Cash and in-kind contributions from community partners for all of the above components were also identified in the proposal. Additionally, time and in-kind allotments for many operational costs were considered. Some of these in-kind expenses included:

- estimated wages for Steering Committee members attending meetings;
- meeting space;
- office space, supplies, and equipment;
- financial management of all funding;
- human resource management and supervision;
- promotion of program;
- reporting responsibilities to funding agencies;

- kitchen space;
- transportation;
- community consultation and advisory roles; and
- orientation of volunteers, interns, Program Coordinator, Steering Committee members.

Depending on the capacity of your community to contribute in different ways to a community-based cooking program, you may or may not need to include all components that we did in our proposal. We would recommend reaching out to your community partners to determine how they can assist in the implementation phase of your initiative.

For specific budget information related to Cook It Up!, please contact Linda Davies, Executive Director at London Community Resource Centre (linda@lcrc.on.ca).

Sustainability Plan

The overarching principle of the sustainability plan originates with building community capacity and strong community partnerships. Having your community behind your effort facilitates the sustainability even during times of limited financial resources. Your community partners champion your program and serves to connect the correct partners at the beginning of the program. Having these enthusiastic key stakeholders around the table ensures that the initiative is fostered well and grows effectively. Greater community involvement creates less demand on one agency or group to pull the project together independently. Many funding opportunities now mandate collaborative community efforts as they recognize that many parts make a strong entity. It is very important to strategize which key stakeholders need to be approached to become involved in your project.

We have some positive examples that generated wonderful opportunities for the *Cook It Up!* program. For example, one of our Steering Committee members was a business owner of a specialty food shop. She was able to approach some of her suppliers for donations of kitchen utensils to supply our kitchen as well as provide gifts for the participants at the end of the program. On more than one occasion, the farms we visited on the field trips allowed us to have produce from their fields to use in the next cooking session. This helped to reduce our budget for food costs. Administratively, community partners and Steering Committee members provided access to administrative support, mail outs, office supplies, and meeting space. It is important to ask community partners and Steering Committee members how and what they can contribute to the program beyond attendance at meetings.

Unexpected Opportunities

On two separate occasions, the *Cook It Up!* program was approached to cater community events. The first event was the launch of a newly renovated community arena and meeting space. The group was asked to prepare a vegetarian chili and whole wheat rolls for a group of approximately 170. For this event, the chef on our Steering Committee worked with the youth to discuss how to develop a catering menu including shopping lists, equipment required, kitchen and service area layout, and other details relevant to the event. The day before the event, the participants travelled to the event location and completed the food preparation so they would be prepared to cook it the next day. The participants decided who would be "back of house," preparing the food and getting it ready for service and who would be "front of house," delivering the food and mixing with the people attending the event.

For this event, the Steering Committee members decided to purchase professional chefs' jackets for the participants, one of the many "perks" for their involvement in the program. The participants were not told about the special jackets until the day of the event. On the day of this catered event, the jackets were presented to the youth and as they put them on, they seemed to stand up taller and recognized the importance of the jacket – they were professionals and represented *Cook It Up!* in the community. The sense of pride and respect for each other was palpable. We were very pleased we invested some funding to purchase these special jackets.

At this event, The Honourable Chris Bentley, Attorney General for the Province of Ontario, was present and met with the participants to congratulate them for their involvement in the *Cook It Up!* program. It was a great opportunity for the participants to meet Mr. Bentley and for him to see community youth engagement in action.

The second catering event occurred during National Youth Week. It was fitting that the participants in *Cook It Up!* were asked to prepare and serve meals for 40 members at the local Boys and Girls Club. The

youth prepared homemade lasagna and Caesar salad. They performed all duties associated with the catering once again and performed these tasks with confidence and excitement.

In addition to these events directly involving the participants of *Cook It Up!*, Linda Davies and Heather Thomas had the opportunity to promote the program at a number of conferences and workshops across the province. They presented to delegates the purpose of the program; recruitment strategies for Steering Committee members, chef volunteers, and participants; key learnings to date; and some of the early results from the research program. Delegates were very interested in the program and eagerly awaited the release of this manual! Some of the workshops and conferences attended included:

- University of Western Ontario, Health and Rehabilitation Sciences Annual Research Day (London, February 2010);
- FoodNet Ontario conference "Bring Food Home" (Kitchener, March 2010);
- Ontario Society of Nutrition Professionals in Public Health Annual Nutrition Exchange (Niagara-on-the-Lake, May 2010);
- FoodNet Ontario "Making Connections" workshop (London, November 2010); and
- Provincial Consortium on Youth In Recreation "MBA 10 Symposium" (Barrie 2010).

Troubleshooting

Although the program was very well received and exciting to contribute to, there have been some challenges along the way. However, we viewed these difficulties as lessons learned and hope that other community groups can learn from our challenges to strengthen their proposed initiatives.

One of the greatest challenges we faced was the **cooking location**. We needed to be adaptable on a number of occasions until we found a suitable, health unit approved location that was centrally located and large enough to accommodate our group. We have created a link with a local faith-based organization who have opened their doors to our program. They were interested in engaging with youth and felt that *Cook It Up!* was an excellent program in which skill development of at-risk was being met.

Many faith-based organizations have superb kitchens that are not being utilized during the week nights. Careful consideration must be given when approaching these organizations because many of them have programming requiring the use of their kitchens throughout the week (e.g., for community dinners). As such, you may need to be flexible in terms of changing your day and/or time of conducting your program.

The Steering Committee was very dedicated to ensure the project **stayed on track** from start to finish. Given the popularity of *Cook It Up!*, there were a number of potential initiatives and opportunities the youth could have been involved in but these opportunities did not necessarily align with the original purpose and goals of the program. The Steering Committee ensured the Program Coordinator remained true to the original concept. That said, we were flexible to embrace opportunities that enhanced that concept, for example, in the two catering events that presented themselves to our group.

We found it important to ensure that we had the **expertise** to deal with situations that arise that are unique to the population with whom we were working. Our Steering Committee was the first point where this philosophy was applied. Ensuring diversity among Steering Committee members' backgrounds while meeting specific needs of our population ensured we were well prepared to handle any challenges encountered.

As with any project**, managing the budget** effectively is key to project success. We were very fortunate to have a very diligent Executive Director of the host agency for *Cook It Up!* to stay on top of our spending and to ensure that reports and other tasks associated with the administration of the program were also in line. If the Project Coordinator does not have these specialized skills, it is very important to find someone else involved in the project to ensure budget is adhered to strictly.

From time to time, front line staff and volunteers involved in the project are unable to attend due to illness or other family emergencies. In these cases, it is essential to have a **back up plan** so that the program still runs on time and on schedule. Unforeseen circumstances create the opportunity to teach program participants that life sometimes just "happens" and they need to be flexible and adaptable so that they can cope will with changes to their regular schedule. For the volunteers and Program

Coordinator, we established a **"buddy system"** so we could still facilitate the program with the same number of affiliated staff and/or volunteers.

While all these contingency plans are important, we also need to stress the importance of being flexible to deal with the unexpected events that may occur. Instead of cancelling the program from time to time due to absence of the Program Coordinator or volunteers, we ensured that "the show must go on" and put in place plans to continue running the program as smoothly as possible. We felt that this approach would demonstrate to the at-risk youth that we were as committed to *Cook It Up!* as they were. It was important for them to see that we would not let them down and that we valued their attendance.

Closing Thoughts

This how-to manual outlines how we approached the development of a community-based cooking program for at-risk youth. It provides a possible template for your consideration and for you to adapt or modify to meet your community's identified needs. As we approached the project right from the very beginning, we had the development of this how-to manual in the back of our minds. We took notes about what needed to be included in the manual, as well as what could be excluded. We wanted this resource to be comprehensive and instructive but never too arduous to use in your own community.

Communities need to advocate for food literacy programming. Delivering supportive learning environments where children, youth, adults, and seniors can engage in all aspects of food, from how it is grown and harvested to making it taste delicious on your plate ensures that all populations have the necessary food literacy skills for a healthy life. Developing a sound food literacy policy that provides these required elements for such a program is key to its success.

Table 1: Evaluation Plan and Success Indicators

The Evaluation Plan and Success Indicators provide some direction for program planning, implementation, and evaluation.

Measures of Success	Indicators
Planning and Implementation: Generation of interest from potential community partners • Local, high profile chefs • Sponsoring agencies • Pilot Site Agency • Project Coordinator • Steering Committee • Community volunteers • Local farmers • Local farmers' markets • Media awareness and attention	• Local chefs' involvement and ongoing commitment to the project • Successful youth recruitment and participation in Cook It Up! • Community partners provision of financial contributions to Cook It Up! • Corporate donations received to sponsor Cook It Up! • Regular review of the implementation process to ensure progress towards indicators of success and make adjustments as necessary to reach objectives • Generated interest within the local community (urban and rural) regarding the project • Repeated participation by youth in multiple modules • Repeated participation by farmers visited on fieldtrips (this indicator demonstrates that the fieldtrip experience was rewarding) • Feedback from youth to facilitator(s) after each session • Number of media interviews (paper, radio, television)
Formative Evaluation: • Completed "How-to" manual incorporating all suggestions for improvements • Qualitative research • Knowledge transfer of research results at provincial/national conferences and relevant professional meetings	• Rapport generated with youth participants encourages honest participation in formal and informal evaluations • Agencies request "how-to" manual for implementation of similar programs in their communities • Demand for the "How-to" manual generated by community groups • Successful recruitment for in-depth interviews with participants and stakeholders • Rich, contextual data generated from participants in formative evaluation • Acceptance of abstract from this project at provincial and national academic and professional conferences • Completion and presentation of evaluation results at Board of Directors' meetings; Board of Health meeting; annual public health conference; other relevant conferences • Sharing of experiences with peers and colleagues, personally and professionally

Table 2: Program Activities

Module Topics	**Brief Description / Themes**
(1) Spring • General Healthy Eating relevant to Ontario-grown Spring food products • Safe Food Handling • Recipes selection • Fieldtrip choices • Evaluation – feedback from group to coordinator/facilitator	Planning and planting crops; agriculture overview; "farm to fork" discussion; Promote the use of locally grown foods; 2 cooking sessions during each month of this season (i.e. 6 cooking sessions in total); 1 fieldtrip per module FOOD DEMONSTRATION: Choose seasonal recipes incorporating foods from each of the four food groups EARLY SPRING FIELDTRIP IDEA: Sugar Bush, asparagus farm, local farmer's market
(2) Summer • General Healthy Eating relevant to Ontario-grown Summer food products • Safe Food Handling • Recipes selection • Fieldtrip choices to local Ontario farms • Evaluation – feedback from group to coordinator/facilitator	Get Fresh…Eat Local farm map; what's in season; why buy local; indigenous knowledge; Promote the use of locally grown foods; 2 cooking sessions during each month of this season (i.e. 6 cooking sessions in total); 1 fieldtrip per module FOOD DEMONSTRATION: Entire Meal on the Barbecue incorporating foods from each of the four food groups SUMMER FIELDTRIP IDEA: Pick Your Own farm
(3) Fall • General Healthy Eating relevant to Ontario-grown Fall food products • Safe Food Handling • Recipes selection • Fieldtrip choices to local Ontario farms • Evaluation – feedback from group to coordinator/facilitator	Fall harvest; food preservation; Global food system; Promote the use of locally grown foods; 2 cooking sessions during each month of this season (i.e. 6 cooking sessions in total); 1 fieldtrip per module FOOD DEMONSTRATION: using root vegetables in soups and stews and incorporating foods from each of the four food groups FALL FIELDTRIP IDEA: Farmers Market
(4) Winter • General Healthy Eating relevant to Ontario-grown Winter food products • Safe Food Handling • Recipes selection • Fieldtrip choices to local Ontario farms • Evaluation – feedback from group to coordinator/facilitator	Promote the use of locally grown foods; 2 cooking sessions during each month of this season (i.e. 6 cooking sessions in total); 1 fieldtrip per module FOOD DEMONSTRATION: Using meat alternatives and other vegetarian dishes and incorporating foods from each of the four food groups TRIP IDEA: Local produce farm (choose from 1 of 30+ local farm map contacts)
(5) Graduation Celebration • Sit-down dinner celebration for participants and all community partners • Media release promoting success of OAFE sponsored program • Invitations to all local chefs who participated or could be potential future partners, local farmers visited, YOU Board of Directors, Steering Committee, etc. • Certificates of Achievement and Cookbooks provided to all participants	Media release to all local print, radio, television outlets to: • promote the success of the project • promote OAFE initiatives and support for this specific initiative • recognize the participation of youth • recognize the support of key stakeholders • promote preliminary research results

Table 3: Program Coordinator Activities

Program implementation through promotion of Onario agri-food industry and community stakeholders.

Activity	Brief Description
Media Launch of Project	Media release to all local print, radio, television outlets to: • promote the project • promote OAFE initiatives and support for this specific initiative • solicit the participation of youth • recognize the support of key stakeholders involved in the projects
Development and coordination of modules	See Table 2 for details.
Participant recruitment and selection	Work with Host Agency to identify other community agencies targeting similar population and recruit and select participants for program
Assist in the "how-to" manual development	Document activities of the program, summarize, and edit manual for implementation with other community groups and target populations
Assist in resource gathering	Identify and contact key stakeholders to accumulate recipes, fact sheets, farm maps, food commodities information etc. for use in the program
Coordinate fieldtrip/farmers' market visits	Coordination of transportation arrangements, site selection
Recruit local chefs for program involvement	Identify and contact local chefs for involvement
Participate in evaluation	Work with Research and Evaluation Committee to discuss program evaluation; overview of research component with Research and Evaluation Committee; Solicitation of feedback from participants and Pilot Site Agency after each module completion; Revising the subsequent modules as necessary and as identified by participants and Pilot Site Agency

Appendix A: Terms of Reference for Steering Committee

Cook It Up! Community-based cooking program for at-risk youth Steering Committee Terms of Reference

Date of Approval: April 30, 2009

Chair: Linda Davies, Executive Director, London Community Resource Centre (LCRC)

Recorder: Heather Thomas, Middlesex-London Health Unit (MLHU)

Purpose: The role of the Steering Committee is:

To oversee the management of the project grant funds for the development of the Cook It Up! project;

To provide advice and guidance on the design and implementation of the project;

To provide and guidance on the research and evaluation of the project; and,

To share information, tools, and resources with project staff and community partners.

Frequency of Meetings: Meetings will be held monthly in the first three months of the project (April, May, June, 2009) and the bi-monthly for the next 12 months. At the end of the end of the 12 month period (June 2010), the meetings will be held monthly again for the last three months of the project (July, August, September 2010). Meeting dates for the entire duration of the project will be decided upon in the first Steering Committee meeting. Meetings will be scheduled for 1.5 to 2 hours. Additional meetings outside the scheduled times allotted for meetings will be called by the Chair.

Location of Meetings: The meetings will be held primarily at the LCRC. It is centrally located and there is free parking available.

Agendas and Minutes: The agenda and minutes will be kept electronically by the Chair and the Recorder. A hard copy of the minutes will be kept in a binder at LCRC. The recorder takes minutes at each meeting and prepares the minutes for the Chair. The Chair reviews the minutes and circulates them to the Steering Committee by email for corrections. Any corrections will be discussed at the next meeting, the minutes amended to reflect the changes.

Areas of Responsibility: Chair

The Chair will set and circulate the agenda to the Steering Committee at least one week prior to the meeting.

On the day of the meeting, the Chair will bring copies of the most current agenda for each Steering Committee member.

The Chair facilitates the meetings and collects email votes if there is no quorum.

The Chair will be responsible for tabulating email votes.

The Chair stores the documents and distributes agendas and minutes via email.

The Chair assumes responsibility of adding agenda items to the agenda as deemed necessary.

Areas of Responsibility: Steering Committee

Maintain an overall view of the project's progress, direction and impact.

Make decisions relating to finance, policy and strategic directions, within the administrative requirements of OHCC and the funder.

Be a resource to the project in terms of helping to identify key issues, resource people and organizations to be contacted.

Provide guidelines to the project regarding priorities, timelines, data collection and capacity-building.

Provide feedback on the design and evaluation of the project.

Composition: The Steering Committee will be comprised of at least one representative of each of the collaborating organizations:

London Community Resource Centre

Middlesex-London Health Unit

Youth

Farmer

Restaurant Owner / Chef

Social Service personnel working with at-risk youth

Teacher (active or retired)

Police Officer (active or retired)

Decision Making Protocol: Decisions regarding policy and strategic directions will be made by the Committee using a consensus decision-making process. Consensus of the Committee will be sought for decisions regarding project activities, financial matters, human resources and evaluation procedures. Consensus decision-making requires that all Committee members participate in reaching decisions, and that all committee members are in support of the decisions made.

Ideas and recommendations are brought to the table by Steering Committee members and an open discussion occurs. Decision is made by a vote and majority rules. Every attempt will be made for consensus. When consensus cannot be reached, the following options may be pursued: 1) the person or persons with dissenting opinions may step aside, thereby voicing their opposition to the decision while allowing it to be made; 2) the decision can be postponed to allow time for cooling off or further study; or 3) the issue may be discussed further in various ways including "go-arounds".

Quorum must be present to confirm a decision. Quorum is 2/3 of membership. Email may be used for committee members unable to attend for an external vote to make quorum. The minutes will be attached to the email for context related to the vote. The Chair will be responsible for collecting the votes and tabulating the results. In the

event dissenting opinion remains after the vote, the position will be reflected in the minutes. Failing consensus, LCRC, as the lead organization, may call a vote or take other steps to ensure the project is implemented in a timely and effective manner and that it conforms to the terms of the funding agreement.

In instances where the Terms of Reference and the Collaborative Agreement from the funding agency do not agree, the Collaborative Agreement shall be used to guide decisions.

Appendix B: Program Coordinator Job Description

Project Manager – Cook It Up! Job Description

Revised June 5, 2009

Position Title: Project Manager – Cook It Up! program

Number of Positions: 1

Position Commences: May 4, 2009 (contract position)

Salary: $20.00/hour

Hours of Work Per Week: 20

Position Concludes: October, 2010

Driver's License Required: yes

Automobile Required: yes

Basic Education: post secondary education in areas of business administration and/or secretarial sciences or social sciences.

Skills and Experience Required: highly organized; experience and skills in foodservice and business; have the ability to be self-directed; work cooperatively with staff, volunteers, community groups, community partners, youth, and granters; excellent oral and written communication skills; ability to relate well with youth aged 13-18 years; excellent cooking skills; a minimum of 5 years experience in the foodservice industry, preferably as a chef or cook; ability to multi-task efficiently and effectively; be a productive and congenial team member

Working Conditions: office environment, kitchens, local farmers' markets and farms

Physical Demands: minimal (cooking, shopping, touring of local farms)

Responsible to: Executive Director, London Community Resource Centre; Steering Committee for Cook It Up!

Purpose of Position: The project manager will support the development of Cook It Up! a community-based cooking program for at-risk youth focusing on education and skill building. This initiative will include a pilot project implemented for groups of at-risk youth (aged 13-18) as well as the development of a "how-to" manual to be utilized by provincial organizations wishing to implement a similar project in their communities. Youth participants for the project will be selected from various local groups offering programs and services to this age group.

Details of Job Description:

1. Develop effective working relationships with staff, volunteers and community members, and youth.

2. Organize, facilitate and report back on community and volunteer committee meetings.

3. Participate as a member of the Steering Committee, taking part in all related meetings.

4. Meet with Executive Director or designate regularly to report progress.

5. Submit monthly activity reports to the Executive Director.

6. Report any problems or concerns promptly to the Executive Director.

7. Carry out additional tasks pertinent to Cook It Up! as required.

8. Participate in relevant youth training and identify additional learning goals specific to Cook It Up! program development.

9. Document all experiences, work plans, and training sessions.

10. Abide by the Personnel Policies and Guidelines of LCRC.

11. Create education sessions to youth participants including: general nutrition, food safety; food preparation; food selection; cooking skills; and agriculture fieldtrip experiences to a variety of local farms and farmers' markets.

12. Topics in modules to be developed and offered include: General Healthy Eating and Safe Food Handling; Ontario-grown Spring, Summer, Fall, and Winter food themes; and a Graduation Celebration. The modules will include specific recipes featuring Ontario-grown foods, participation by local chefs, and fieldtrip opportunities to local farms and farmers' markets involving a variety of local food commodities.

13. Plan and coordinate the final Graduation Celebration to showcase youths' learning experiences, networking with sustainable new partnerships (e.g., local farmers, local food commodity marketing associations, local chefs, and local farmers' markets) including provision of media coverage in conjunction with the promotion and administrative assistant at LCRC.

Appendix C: Letter of Information: Community Partners

Cook It Up! program for Youth

Investigators:
Heather Thomas, MSc, RD, PhD Candidate, Middlesex-London Health Unit
Dr. Jennifer Irwin, PhD, Faculty of Health Sciences, University of Western Ontario
Dr. Trish Tucker, PhD, Middlesex-London Health Unit & Faculty of Health Sciences, University of Western Ontario
Dr. Danielle Battram, PhD, Foods and Nutritional Sciences Division, Brescia University College, UWO

Background: Cook It Up! is a community-based, education and skill-building program for at-risk youth (13-18 years). It is a fun and practical program offering nutrition information, food safety, food preparation and selection and cooking skills, taught by some of London's best local chefs. Through agricultural field trip experiences to a variety of local farms and farmers' markets, participants will be able to explore future employment potential in a variety of agricultural and food service environments, as well as to gain an understanding of where our food comes from, and how it gets from farm to plate. Investigators at the Middlesex-London Health Unit and the University of Western Ontario are conducting research on the *Cook It Up*! program for youth in which you were involved. The purpose of this study is to assess Community Agencies' and Partners' experiences with the program in service of improving all aspects of the program. If you have participated in *Cook It Up*! in this capacity, the research team would like to hear your ideas.

What will happen in this study: If you agree, you will be invited to participate in an in-depth interview at a location convenient to you. This will be a one-on-one interview and it will last about 1 hour. We will be audio-recording the discussion so we don't miss anything. The audio-recording will be transcribed and a computer program called NVivo will be used to help find the themes from the information provided in the interviews. Also, we will be collecting information from you before the Cook It Up! program starts and after it ends to compare the information you provide us before and after the program. We will also be collecting information about you in a demographic survey which will give us a bit more information about who was interested in participating in the Cook It Up! program

Alternatives and your right to withdraw from the study: Your participation in this study is voluntary. You may refuse to participate, refuse to answer any questions, and ask to stop the recording at any time during the interview, or withdraw from the study at any time. Your decision will not influence your participation as a community partner in other projects now or in the future.

Possible benefits and risks to you for participating in the study: There are no known risks to you associated with your participation in this study. Possible benefits for you include having the opportunity to contribute to developing the "how-to" community resource manual that will be promoted and made available for local and provincial distribution. You do not waive any of the legal rights you would otherwise have as a participant in a research study.

Confidentiality: We will keep your identity and comments, as well as all audio-tapes and written records, confidential and secure. No names will appear on any transcripts generated during the course of this study. Representatives from the University of Western Ontario Health Sciences Research Ethics Board may contact you or required access to your study-related records to monitor the conduct of the research. We will keep your identity and comments, as well as all audio-tapes and written records, confidential and secure. No names will appear on any transcripts generated during the course of this study. We will keep all data in a secured placed for five years after the study results have

been published. Data will be destroyed at the end of this time period. All computer data will be erased and all written/paper data will be shredded.

Costs and compensation: There is no cost to you for participating in the study. To acknowledge your contribution to the study, you will receive a small token of appreciation.

Publication of the results: When the results of the study are published, your name will not be used. If you would like to receive a copy of the overall results of the study, please put your name and address on a blank piece of paper and give it to the researcher present at the in-depth interview.

Contact persons (should you have any further questions about the study):

Heather Thomas, MSc, RD	Dr. Jennifer D. Irwin, PhD	Dr. Trish Tucker, PhD	Dr. Danielle Battram, PhD
519-663-5317 ext. 2222	519-661-2111 ext. 88367	519-663-5317 ext. 2483	519-432-8353 ext. 28228
heather.thomas@mlhu.on.ca	jenirwin@uwo.ca	trish.tucker@mlhu.on.ca	dbattra@uwo.ca

* If you have any questions about your rights as a research participant or the conduct of the study you may contact the Office of Research Ethics at (519) 661-3036 or by email at ethics@uwo.ca.

This letter is for you to keep.
You will also be given a copy of the consent form once it has been signed.

Appendix D: Letter of Information: Participants

Cook It Up! program for Youth

Investigators:

Heather Thomas, MSc, RD, PhD Student, Middlesex-London Health Unit
Dr. Jennifer Irwin, PhD, Faculty of Health Sciences, University of Western Ontario
Dr. Trish Tucker, PhD, Middlesex-London Health Unit & Faculty of Health Sciences, University of Western Ontario
Dr. Danielle Battram, PhD, Foods and Nutritional Sciences Division, Brescia University College, UWO

Background:

Cook It Up! is a community-based, education and skill-building program for youth (13-18 years). It is a fun and practical program offering nutrition information, food safety, food preparation and selection and cooking skills, taught by some of London's best local chefs. Through agricultural field trip experiences to a variety of local farms and farmers' markets, participants will be able to explore future employment potential in a variety of agricultural and food service environments, as well as to gain an understanding of where our food comes from, and how it gets from farm to plate. Researchers at the Middlesex-London Health Unit and the University of Western Ontario are looking at the *Cook It Up*! program you recently participated in. We want to find out what you liked and didn't like about the program so we can improve it. Your help will give us lots of information improve this community-based cooking program. If you have participated in *Cook It Up*!, the research team would like to hear your ideas.

What will happen in this study:

If you agree, you will be invited to participate in an in-depth interview at a location convenient to you. This will be a one-on-one interview and it will last about 1 hour. We will be audio-recording the discussion so we don't miss anything. The audio-recording will be transcribed and a computer program called NVivo will be used to help find the themes from the information provided in the interviews. Also, we will be collecting information from you before the Cook It Up! program starts and after it ends to compare the information you provide us before and after the program. We will also be collecting information about you in a demographic survey which will give us a bit more information about who was interested in participating in the Cook It Up! program.

Alternatives and your right to withdraw from the study:

Your participation in this study is voluntary. You may refuse to participate, refuse to answer any questions, and ask to stop the recording at any time during the interview, or withdraw from the study at any time. Your decision will not influence your access to community programs or services you may be currently receiving, or may choose to partake in the future.

Possible benefits and risks to you for participating in the study:

There are no known risks to you associated with your participation in this study. Possible benefits for you include having the opportunity to contribute to developing the "how-to" community resource manual that will be promoted and made available for local and provincial distribution. You do not waive any of the legal rights you would otherwise have as a participant in a research study.

Confidentiality:

We will keep your identity and comments, as well as all audio-tapes and written records, confidential and secure. No names will appear on any transcripts generated during the course of this study. Representatives from the University of Western Ontario Health Sciences Research Ethics Board may contact you or required access to your study-related records to monitor the conduct of the research. We will keep your identity and comments, as well as all audio-tapes

and written records, confidential and secure. No names will appear on any transcripts generated during the course of this study. We will keep all data in a secured placed for five years after the study results have been published. Data will be destroyed at the end of this time period. All computer data will be erased and all written/paper data will be shredded.

Costs and compensation:
There is no cost to you for participating in the study. To acknowledge your contribution to the study, you will receive a small token of appreciation.

Publication of the results:
When the results of the study are published, your name will not be used. If you would like to receive a copy of the overall results of the study, please put your name and address on a blank piece of paper and give it to the researcher present at the interview.

Contact persons (should you have any further questions about the study):

Heather Thomas, MSc, RD	Dr. Jennifer D. Irwin, PhD	Dr. Trish Tucker, PhD	Dr. Danielle Battram, PhD
519-663-5317 ext. 2222	519-661-2111 ext. 88367	519-663-5317 ext. 2483	519-432-8353 ext. 28228
heather.thomas@mlhu.on.ca	jenirwin@uwo.ca	trish.tucker@mlhu.on.ca	dbattra@uwo.ca

* If you have any questions about your rights as a research participant or the conduct of the study you may contact the Office of Research Ethics at (519) 661-3036 or by email at ethics@uwo.ca.

This letter is for you to keep.
You will also be given a copy of the consent form once it has been signed.

Appendix E: Semi-Structured Interview Guide – Community Partners

Semi-Structured Interview Guide – Community Partners

The purpose of this interview is to gain an understanding of your experience with the *Cook It Up*! program so the program can be modified to ensure it is as useful as possible for all participants and community partners.

For Community Agencies and Community Partners participating in Cook It Up!: I'd like to ask you about the logistics of booking the fieldtrip:

1. How did the process of booking the fieldtrip work for you?

   Probes:
   - Deciding on the destination
   - Arranging and confirming transportation
   - Effectiveness of the fieldtrip re: introducing youth to local agricultural industry
   - Other issues related to booking the fieldtrip
   - What worked well with the Cook it Up! program?
   - What did not work well?

2. Why did you become involved in the *Cook It Up*! program?

3. What barriers or challenges, if any, restricted your involvement or may have limited your involvement in any way?

4. How did being involved in the program benefit your agency?

5. How effective was the Steering Committee in meeting its objectives for this project? Please say more?

6. How did you find the Steering Committee meetings? How would you have changed them?

7. What recommendations would you make to improve this program?

8. How could this program be adapted to other target groups in other communities?

9. If you could change anything about this program, what would it be?

10. Please tell me anything else about the cooking program that you'd like to share with me? Is there anything we missed?

Appendix F: Semi-Structured Interview Guide – Participants

Semi-Structured Interview Guide – Youth Participants

The purpose of this interview is to gain an understanding of your experience with the *Cook It Up*! program so the program can be modified to ensure it is as useful as possible for all participants and community partners.

For youth participants: We are asking you questions about Cook It Up! to try to make it better.

1. What did you like best or value most about the cooking program? Why?
   Prompts:
   - Cooking sessions with local chefs
   - Field trips to local farms
   - Field trips to farmers' markets
   - Planning what food we would be preparing
   - Shopping for food
   - Eating the food we prepared
   - Other aspects of the program
   - Making new friends
   - Learning about healthy eating
   - Learning about food preparation
   - Trying new foods
   - Improving cooking skills

2. What did you like least or value least about the cooking program? Why?

3. How was Cook It Up! beneficial to you? Why was it good to be a part of Cook it Up!
   - How did it impact your life?
   - How did it improve your cooking skills?
   - What did you get out of the program?

4. In what ways could the cooking program be improved? If you could change anything about the program, what would it be?

5. How did your group use the curriculum components (modules) developed for the program?
   - Lesson plans
   - Activities
   - Recipes
   - Fieldtrip information

6. What is different for you since being in the *Cook It Up*! program? What, if anything, is different about how you're eating? What, if anything, is different about where you're purchasing?

7. What did you get out of the program?

8. In what ways did being a part of this program impact on your feelings about yourself? Please say more?

9. What recommendations would you make to improve this program so it could be adapted to other target groups in other communities?

10. Is there anything else you'd like to tell us about your involvement in the Cook It Up! program?

Appendix G: Demographic Survey and Pre-test Cooking Skills Assessment (Participants) adapted from Region of Waterloo Public Health

1. Are you attending school? ☐Yes ☐No
   If yes, what is the name of your school? _____
   What grade are you in? _____

2. What is your family situation? (please check)
   ☐Single-parent
   ☐Double-parent
   ☐Guardian-led
   ☐I live by myself
   ☐I live with a roommate(s), but not with my parent(s)/guardian(s)
   ☐I live in a group home
   ☐Other (please specify): _____

3. To which ethnic or cultural group do you belong? (please check)

☐White
☐Arab
☐Chinese
☐Japanese
☐West Asian
☐South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
☐Aboriginal Canadian
☐Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc)
☐Korean
☐Black
☐Filipino
☐Latin American
☐Other (please specify): _____

4. What is your postal code? _____

5. Are you working? ☐Yes ☐No

6. If yes, do you work ☐ Part time ☐Full time

7. What kind of job do you have? _____

The next questions ask about food preparation and eating habits.

8. How many days in the last week did you eat fully ready-to-eat meals, prepared by the manufacturer, may need to be warmed up (examples – roasted chicken, cold deli salads, freshly-made cabbage rolls, granola bars, cookies, crackers, cake, pie, bread)

☐0 ☐ 4
☐1 ☐ 5
☐ 2 ☐ 6
☐ 3 ☐ 7 or more

9. How many times in the last week did you eat foods that require the addition of water or milk and/or some cooking time, but have been mostly prepared by the manufacturer (examples – canned soups, instant oatmeal, mixes for pancakes/cake/pudding, frozen lasagna, fish sticks, frozen pizza, cold cereal, garlic bread, macaroni dinner)

☐0	☐ 4
☐1	☐ 5
☐ 2	☐ 6
☐ 3	☐ 7 or more

10. How many times in the last week did you eat foods that are basic foods/ food ingredients, may be fresh, frozen or canned, but are minimally processed; often combined to make something "from scratch" or cooked and served plain (examples – raw, frozen or canned vegetables, fruit, meat or fish, dry or canned kidney beans, plain rice or pasta, flour, rolled oats, cheese, yogurt, milk, eggs)

☐0	☐ 4
☐1	☐ 5
☐ 2	☐ 6
☐ 3	☐ 7 or more

11. How many days in the last week did you eat breakfast?

☐0	☐ 4
☐1	☐ 5
☐ 2	☐ 6
☐ 3	☐ 7 or more

12. How many times in the last week did you eat fruits and vegetables?

Fruits:	Vegetables:
☐less than1	☐less than 1
☐1	☐1
☐ 2	☐ 2
☐ 3	☐ 3
☐ 4	☐ 4
☐ 5 or more	☐ 5 or more

13. How many times in the last week did you eat fast-foods (e.g., McDonalds, KFC, Pizza Hut)?

☐0	☐ 4
☐1	☐ 5
☐ 2	☐ 6
☐ 3	☐ 7 or more

14. How many times in the past week did you eat meals away from home?

☐0	☐ 4
☐1	☐ 5
☐ 2	☐ 6
☐ 3	☐ 7 or more

15. How many times in the past week did you buy food from a convenience store?

☐0 ☐ 4
☐1 ☐ 5
☐ 2 ☐ 6
☐ 3 ☐ 7 or more

16. How would you rate your skills in the following areas?

My food skill rating	Very good skill	Good skill	Basic level skill	Very limited or no skill
Using a kitchen knife safely				
Peeling, chopping or slicing vegetables or fruit				
Cooking a piece of raw or frozen meat/chicken/fish, (not processed or partially-prepared)				
Cooking a soup, stew or casserole using a pre-packaged mix (like macaroni dinner, rice mix)				
Cooking a soup, stew or casserole "from scratch"				
Choosing a spice or herb that goes well with the food I am cooking				
Adjusting a recipe to make it healthier (for example, decrease the amount of fat, sugar or salt)				
Baking muffins or cake using a pre-packaged mix				
Baking muffins or cake "from scratch" with a recipe				
Coordinating the preparation and cooking of a few food dishes at the same time so I can serve them all together for a meal				
Planning a quick, healthy meal using only foods already in my home a, and then preparing these foods so I can serve them all together within 1 hour or less				
Freezing vegetables or fruit, from raw to bagged in my home freezer				
Canning fruit or salsa etc, from raw ingredients to finished products in sealed glass jars				

17. On average, how long does it take to prepare the "main" meal eaten in your home? The "main" meal would take the most time to prepare of any meal in a given day. Choose the answer that best represents the average time range.

☐0-19 minutes ☐ 40-49 minutes
☐ 20-29 minutes ☐ 50-59 minutes
☐30-39 minutes ☐more than 60 minutes

18. Are you the person responsible for preparing the "main" meal? Choose the answer that best describes you.
☐Yes, I am always/ almost always solely responsible for preparing the main meal
☐Yes, I am responsible most of the time for preparing the main meal
☐Yes, I am responsible some of the time for preparing the main meal
☐Yes, but I often prepare the main meal together with someone else
☐No, I seldom or never prepare the main meal

19. How many times in the last week did you prepare or cook any meal at least partly "from scratch" – that is, using basic food items, with a recipe as needed?
☐0 times in the past week ☐5-9 times
☐1-2 times ☐10-14 times
☐3-4 times ☐15 or more times

20. How sure are you that you can prepare foods at home at least partly "from scratch" – that is, using basic food items, with a recipe as needed?
☐ I know I can
☐ I think I can
☐ I'm not sure I can
☐ I know I can't
☐ I don't know

21. How would you rate the food skills you had developed before being involved in *Cook It Up*? By food skills, we mean things like shopping for food, growing food, preparing & cooking food.
☐ very good skills
☐ good skills
☐ basic skills
☐ very limited skills
☐ no skills

22. Prior to the *Cook It Up!* program, have you or anyone in your household, grow and eat any food that you grew in your yard, on your balcony or in a community garden? By food, we mean vegetables, fruit, berries, nuts.
☐Yes ☐No ☐Unsure

23. How sure are you that you know what "local food" means?
☐ I know what it means
☐ I think I know what it means
☐ I'm not sure what it means
☐ I don't know what it means

Appendix H: Demographic Survey and Post-test Cooking Skills Assessment (Participants) adapted from Region of Waterloo Public Health

Demographic Survey and Post-Test (Youth Participants)

1. Are you attending school? ☐Yes ☐No
   If yes, what is the name of your school? _____
   What grade are you in? _____

2. What is your family situation? (please check)
   ☐Single-parent
   ☐Double-parent
   ☐Guardian-led
   ☐I live by myself
   ☐I live with a roommate(s), but not with my parent(s)/guardian(s)
   ☐ I live in a group home
   ☐Other (please specify): _____

3. To which ethnic or cultural group do you belong? (please check)

☐White
☐Arab
☐Chinese
☐Japanese
☐West Asian
☐South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
☐Aboriginal Canadian
☐Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc)
☐Korean
☐Black
☐Filipino
☐Latin American
☐Other (please specify): _____

4. What is your postal code? _____

5. Are you working? ☐Yes ☐No

6. If yes, do you work ☐ Part time ☐Full time

7. What kind of job do you have? _____

The next questions ask about food preparation and eating habits.

8. How many days in the last week did you eat fully ready-to-eat, prepared by the manufacturer, may need to be warmed up (examples – roasted chicken, cold deli salads, freshly-made cabbage rolls, granola bars, cookies, crackers, cake, pie, bread)

☐0 ☐ 4
☐1 ☐ 5
☐ 2 ☐ 6
☐ 3 ☐ 7 or more

9. How many times in the last week did you eat foods that require the addition of water or milk and/or some cooking time, but have been mostly prepared by the manufacturer (examples – canned soups, instant oatmeal, mixes for pancakes/cake/pudding, frozen lasagna, fish sticks, frozen pizza, cold cereal, garlic bread, macaroni dinner)

☐0 ☐ 4
☐1 ☐ 5
☐ 2 ☐ 6
☐ 3 ☐ 7 or more

10. How many times in the last week did you eat foods that are basic foods/ food ingredients, may be fresh, frozen or canned, but are minimally processed; often combined to make something "from scratch" or cooked and served plain (examples – raw, frozen or canned vegetables, fruit, meat or fish, dry or canned kidney beans, plain rice or pasta, flour, rolled oats, cheese, yogurt, milk, eggs)

☐0 ☐ 4
☐1 ☐ 5
☐ 2 ☐ 6
☐ 3 ☐ 7 or more

11. How many days in the last week did you eat breakfast?

☐0 ☐ 4
☐1 ☐ 5
☐ 2 ☐ 6
☐ 3 ☐ 7 or more

12. How many times in the last week did you eat fruits and vegetables?

Fruits:	Vegetables:
☐less than1	☐less than 1
☐1	☐1
☐ 2	☐ 2
☐ 3	☐ 3
☐ 4	☐ 4
☐ 5 or more	☐ 5 or more

13. How many times in the last week did you eat fast-foods (e.g., McDonalds, KFC, Pizza Hut)?

☐0 ☐ 4
☐1 ☐ 5
☐ 2 ☐ 6
☐ 3 ☐ 7 or more

14. How many times in the past week did you purchase food from a convenience store?

☐0 ☐ 4
☐1 ☐ 5
☐ 2 ☐ 6
☐ 3 ☐ 7 or more

15. How many times in the past week did you eat meals away from home?

☐0 ☐ 4
☐1 ☐ 5
☐ 2 ☐ 6
☐ 3 ☐ 7 or more

16. How would you rate your skills in the following areas?

My food skill rating →	Very good skill	Good skill	Basic level skill	Very limited or no skill
Using a kitchen knife safely				
Peeling, chopping or slicing vegetables or fruit				
Cooking a piece of raw or frozen meat/chicken/fish, (not processed or partially-prepared)				
Cooking a soup, stew or casserole using a pre-packaged mix (like macaroni dinner, rice mix)				
Cooking a soup, stew or casserole "from scratch"				
Choosing a spice or herb that goes well with the food I am cooking				
Adjusting a recipe to make it healthier (for example, decrease the amount of fat, sugar or salt)				
Baking muffins or cake using a pre-packaged mix				
Baking muffins or cake "from scratch" with a recipe				
Coordinating the preparation and cooking of a few food dishes at the same time so I can serve them all together for a meal				
Planning a quick, healthy meal using only foods already in my home a, and then preparing these foods so I can serve them all together within 1 hour or less				
Freezing vegetables or fruit, from raw to bagged in my home freezer				
Canning fruit or salsa etc, from raw ingredients to finished products in sealed glass jars				

17. Overall, how would you rate the food skills you had developed **after** being involved in *Cook It Up*? By food skills, we mean thinks like shopping for food, growing food, preparing & cooking food.

☐ very good skills
☐ good skills
☐ basic skills
☐ very limited skills
☐ no skills

18. On average, how long does it take to prepare the "main" meal eaten in your home? The "main" meal would take the most time to prepare of any meal in a given day. Choose the answer that best represents the average time range.
☐0-19 minutes ☐ 40-49 minutes
☐ 20-29 minutes ☐ 50-59 minutes
☐30-39 minutes ☐ more than 60 minutes

19. Are you the person responsible for preparing the "main" meal? Choose the answer that best describes you.
☐Yes, I am always/ almost always solely responsible for preparing the main meal
☐Yes, I am responsible most of the time for preparing the main meal
☐Yes, I am responsible some of the time for preparing the main meal
☐Yes, but I often prepare the main meal together with someone else
☐No, I seldom or never prepare the main meal

20. How sure are you that you can prepare foods at home at least partly "from scratch" – that is, using basic food items, with a recipe as needed?
☐ I know I can
☐ I think I can
☐ I'm not sure I can
☐ I know I can't
☐ I don't know

21. How many times in the last week did you prepare or cook any meal at least partly "from scratch" – that is, using basic food items, with a recipe as needed?
☐0 times in the past week ☐5-9 times
☐1-2 times ☐10-14 times
☐3-4 times ☐15 or more times

22. How likely are you to use any food skills you learned during *Cook It Up!* to make food "from scratch"– that is, using basic food items, with a recipe as needed, in your own home?
☐ Very likely
☐ Likely
☐ Unsure
☐ Not likely
☐ Definitely will not use any food skills

23. During the *Cook It Up!* program, did you or anyone in your household, grow and eat any food that was grown in your yard, on your balcony or in a community garden? By food, we mean vegetables, fruit, berries, nuts.
☐Yes ☐No ☐Unsure

24. After the *Cook It Up!* program, did you or anyone in your household, grow and eat any food that was grown in your yard, on your balcony or in a community garden? By food, we mean vegetables, fruit, berries, nuts.
☐Yes ☐No ☐Unsure

25. Since participating in *Cook It Up!*, how sure are you that you can purchase foods from a local farmers' market?
    - ☐ I know I can
    - ☐ I think I can
    - ☐ I'm not sure I can
    - ☐ I know I can't
    - ☐ I don't know

26. Since participating in *Cook It Up!,* how likely are you to purchase foods from a local farmers' market?
    - ☐ very likely
    - ☐ likely
    - ☐ unsure
    - ☐ not likely
    - ☐ definitely will not purchase foods from a local farmers' market

27. Since participating in the *Cook It Up!* program, how sure are you that you know what "local food" means?
    - ☐ I know what it means
    - ☐ I think I know what it means
    - ☐ I'm not sure what it means
    - ☐ I don't know what it means

Appendix I: Camera Orientation Session for Photovoice

Participants will be informed that consent must be obtained from individuals prior to photographing them, and that they must only take pictures to which these individuals agree. Pictures will not be taken of individuals who can be identified without their knowledge and consent. Participants will also be informed that the anonymity of individuals in pictures should be maintained, unless the individual provides consent that allows for identification (see consent form). Whether the person can or cannot be identified in the photographs, participants will be oriented to the respectful and responsible taking of photographic images. As the camera can be a source for invasion of privacy, participants will be oriented to the ethical use of the camera and their photography in such a way as to prevent intrusion into a person's private space, to avoid disclosure of embarrassing facts, to avoid twisting the trust, and to not publish any photographs as a way to make money (Moffitt & Vollman, 2004).

Topics that will be discussed at the Orientation Session are based on the recommendations of the creator of the photovoice method (Wang, 1999).

1. Introduction to the photovoice concept and method.
2. Discussion of the responsibility and authority conferred to the photographer wielding the camera.
3. Ways to minimize potential challenges.
4. Presentation of an ethic of giving photographs back to the community as a way to express appreciation, respect, and camaraderie.
5. Discussion questions will include the following:
    - How can a person take pictures of barriers to healthy cooking skills?
    - How can a person take pictures of facilitators of healthy cooking skills?
    - What is an acceptable way to approach someone to take his or her picture?
    - Should someone take pictures of another person without their knowledge?
    - To whom might you wish to give photographs, and what might be the implications?
    - When would you not want to have your picture taken?
6. Discussion of time lines and expectations.

Adapted from Photovoice Hamilton Ontario, 2007.

References:
Moffit P, Vollman AR. Photovoice: picturing the health of aboriginal women in a remote northern community. CJNR 2004;36(4):189-201.

Wang C. Photovoice: a participatory action research strategy applied to women's health. J Womens Health 1999;8(2):185-192.

Appendix J: Consent for Human Subject in Photovoice

You are invited to have your picture taken by one of the photographers involved with *Cook It Up!* Photovoice Research Project. *Cook It Up!* is funded by the Ontario Agri-Food Education Inc.

Photovoice has four goals:

1. It helps people record and think about their community's strengths and problems.

2. It identifies important issues through group discussion and photographs.

3. It gets the attention of politicians and other decision-makers in our community.

4. It works toward positive change in our community.

Pictures taken in Photovoice will be shown to others in order to create awareness about the things that make it easy as well as more difficult for the youth in *Cook It Up!* to develop healthy cooking skills outside of their involvement in the *Cook It Up!* program. The pictures taken may be shown in gallery displays, presentations to local decision-makers, and/or published on our website: www.lcrc.on.ca. Others viewing the pictures may recognize you, but there are no names or contact information included with the photos. Photographs will not be used to make money.

Please sign this form if you agree to have your photograph taken by a participant in the *Cook It Up!* Photovoice Research Project.

If you would like a copy of the photograph taken of you, please write your address below as well.

Subject Name

Name of Photographer

Signature of Subject

Date

Adapted from Photovoice Hamilton Ontario, 2007.

Appendix K: Consent Form for Participation in Photovoice Research

Cook It Up! program for Youth

I have had the nature of the *Cook It Up!* **Photovoice research project** explained to me and I agree to participate. All questions have been answered to my satisfaction.

Date	Participant's name (please print)	Participant's signature
Date	Parent/Guardian's Name (please print)	Parent/Guardian's signature
Date	Name of person responsible for obtaining informed consent (please print)	Signature

Appendix L: Ethical Issues in Photovoice

There are possible ethical issues that may arise when using Photovoice as a research method. The following recommendations are based on the work of Caroline Wang, the originator of Photovoice. The purpose of discussing ethical issues is to reduce the risks to the photographer as well as to their subjects.

Invasion of Privacy:

Taking someone's photograph without his/her permission is a violation of privacy. Even if the person does not mind that you took his/her picture, when you do not ask permission, you may cause that individual to become upset and you could be put into a difficult situation as a result.

If the photographer believes there may be a loss of naturalness or spontaneity if permission is asked, the photographer must learn to be patient. Many professional photographers spend most of their time behind a camera just waiting for the perfect shot. After obtaining permission from the human subject you wish to photograph, wait until he/she has forgotten you are there, until they slip back into what they were doing. You will be able to get the photograph you want, but you need to first get permission to take that picture and then you must wait for it the perfect moment to snap the photograph.

Asking for someone's permission to photograph him/her is a way to build his/her trust. It will also give you, as the photographer, the opportunity to discuss what you are doing and explain the *Cook It Up!* Photovoice research project with your human subject again.

As a general rule, the photographer is not required to receive a signature when taking a picture of a group of people where individual faces are not recognizable or if the photographer is taking a photo of something and a person just happens to walk into the shot at the last moment.

Some people may not want their photograph taken, and will have their own reasons for this. People sometimes feel protective of their communities and as such, may not want their photograph taken in their community.

Representing communities and their members:

Taking a photo of someone doing something risky or incriminating would go against the values and goals of Photovoice.

Photographers will also be asked to write a story to display along with each photo. You can use the "SHOWED" form to help you write down the reasons why you decided to take different pictures. You will be provided with several copies of the "SHOWED" form before you start taking pictures.

It is important that photographers ask themselves if the subject would agree with the photo taken and with the text written to accompany the photo. You are making a photographic suggestion as the photographer. Any human subject in your photos must agree with this suggestion. Remember that the subjects are vulnerable to the image, even if they give permission to be photographed.

Using a camera gives the photographer a lot of power to create a message that is visually loaded with meaning. Within the image is the photographer's values and message as well as the values and messages the viewers of the

photographs will take away with them. Therefore, it is important to represent the image and the subjects within the image in an accurate and respectful way.

Photovoice is an exciting way to share with others how ***you*** feel about what makes it easier or more difficult to develop cooking skills. You have the opportunity to get really creative, but in a respectful and ethical way.

Appendix M: Letter of Information for Photovoice

Cook It Up! program for Youth

Investigators:

Heather Thomas, MSc, RD, PhD Candidate
Dr. Jennifer Irwin, PhD, Faculty of Health Sciences, University of Western Ontario
Dr. Trish Tucker, PhD, Faculty of Health Sciences; Middlesex-London Health Unit

Background:

Cook It Up! is a community-based, education and skill-building program for at-risk youth (13-18 years). It is a fun and practical program offering nutrition information, food safety, food preparation and selection and cooking skills, taught by some of London's best local chefs. Through agricultural field trip experiences to a variety of local farms and farmers' markets, participants will be able to explore future employment potential in a variety of agricultural and food service environments, as well as to gain an understanding of where our food comes from, and how it gets from farm to plate. Researchers at the University of Western Ontario are looking at the *Cook It Up!* program you recently participated in and want to know what you feel are the things that make it easier and more difficult to have healthy cooking skills, outside of your involvement in the *Cook It Up!* program. Through a research method called "Photovoice," you will take photos of pictures that you think explain the things that make it easier or more difficult to have healthy cooking skills. Your help will give us lots of information to learn about how to help youth like you improve their cooking skills. This information may lead to program and policy development that would acknowledge and help to address these barriers and facilitators. If you have participated in *Cook It Up!*, the research team would like to hear your ideas.

What will happen in this study:

If you agree to participate in this study, you will be contacted by one of the researchers with dates, times, and locations for a camera orientation session, which will take about ½ -1 hour, as well as a discussion group which will take 1-1.5 hours. A comprehensive 'training' session will be held where you will get the camera and learn how to take pictures using this camera for participation in the study. The camera orientation session and discussion group will both be located within your community. Prior to participating in this study, you will be asked to sign a consent form for your participation. You will also be asked if you are willing to have your pictures used within the focus group setting, and within any publication about the results of the study. This is completely voluntary, and not required.

At the camera orientation session, you will be oriented to the purpose of the study and be loaned a camera, as well as a logbook. You will be asked to take pictures of barriers and facilitators to developing healthy cooking skills outside of your involvement in the *Cook It Up!* program and keep a log of the thoughts that you have about the photos you take. You will be provided with the logbook that you will need for this. Prior to taking photos of people, you will need to provide written information to those people, and ask for their signed consent to allow for their pictures to be taken. If you are thinking about taking a photograph of a child or someone who is unable to consent for him/herself, it is VERY important that you receive permission from the child's or individual's parent or guardian BEFORE taking the photograph. This is very important so you don't offend or upset the child's or person's parent or guardian. If the child's or person's parent or guardian is not available to give you permission and signed consent to take the child's picture, you may NOT take that photograph. You will be provided with the information and consent forms that you will need for this. If you are unable to write down your thoughts in the log book, an audio recorder will be loaned to you for this purpose.

At the end of each session of *Cook It Up!*, you will return your camera, and attend a discussion group within your community where you will discuss 2-4 of your pictures with the others in the group. Ideally, each group will consist of

6-7 people. The discussion group sessions will be audio tape recorded and transcribed to ensure that all your comments are captured. We will be audio-recording the discussion so we don't miss anything. The audio-recording will be transcribed and a computer program called NVivo will be used to help find the themes from the information provided in the interviews. You will not be identified by your full name in the transcribing, in order to keep your identity confidential. We will also be collecting information about you in a demographic survey which will give us a bit more information about who participated in the Photovoice research of the *Cook It Up!* program. The questionnaire will take about 5-10 minutes to complete. If you agree to participate, your commitment to coming to both sessions is very important. We will be contacting you to arrange the discussion group date, time and location.

Alternatives and your right to withdraw from the study:
Your participation in this study is voluntary. You may refuse to participate, refuse to answer any questions, and ask to stop the recording at any time during the discussion group, or withdraw from the study at any time. Your decision will not influence your access to community programs or services you may be currently receiving, or may choose to register in at some time in the future.

Possible benefits and risks to you for participating in the study:
There are no known risks to you associated with your participation in this study. Possible benefits for you include feeling empowered, having the feeling of being involved with your community by being given a voice to speak about your healthy cooking skills development, connecting with others in their community, and advocating for change in service of improving other youths' development of healthy cooking skills through community-based programs. Additionally, you will learn basic marketable skills including photographic technique, working with digital images, and the process of creating an art show or product. You do not waive any of the legal rights you would otherwise have as a participant in a research study.

Confidentiality:
We will keep your identity and comments, as well as all audio-tapes and written records, confidential and secure. No names will appear on any transcripts generated during the course of this study. Representatives from the University of Western Ontario Health Sciences Research Ethics Board may contact you or required access to your study-related records to monitor the conduct of the research. We will keep all data in a secured placed for five years after the study results have been published. Data will be destroyed at the end of this time period. All computer data will be erased and all written/paper data will be shredded.

Costs and compensation:
There is no cost to you for participating in the study. To acknowledge your contribution to the study, you will receive a small token of appreciation.

Publication of the results:
When the results of the study are published, your name will not be used. If you would like to receive a copy of the overall results of the study, please put your name and address on a blank piece of paper and give it to the researcher present at the discussion group.

Contact persons (should you have any further questions about the study):

Heather Thomas, MSc, RD	Dr. Jennifer D. Irwin, PhD	Dr. Trish Tucker, PhD
519-663-5317 ext. 2222	519-661-2111 ext. 88367	519-663-5317 ext. 2483
heather.thomas@mlhu.on.ca	jenirwin@uwo.ca	trish.tucker@mlhu.on.ca

* If you have any questions about your rights as a research participant or the conduct of the study you may contact the Office of Research Ethics at (519) 661-3036 or by email at ethics@uwo.ca.

This letter is for you to keep. You will also be given a copy of the consent form once it has been signed

Appendix N: Rights and Responsibilities in Photovoice

As a participant in the *Cook It Up!* Photovoice Research Project, you have the following rights and responsibilities:

Rights:

- You have the right to express your views and experiences during the discussion group sessions.
- You have the right to be supported by the Photovoice group members and facilitators of the discussion group sessions.
- You have the right to choose the photographs you would like to display in public.
- You have the right to change your mind about displaying any of your photographs.

Responsibilities:

- We will do our best to start the sessions on time, so we can finish on time. Please do your best to arrive on time.
- Please contact the discussion group facilitator (Heather Thomas) or assistant moderator if you cannot make it to a session.
- Be positive to your peers. Please avoid putdowns or criticism.
- Since everyone has something important to say, only one person speaks at a time.
- You have the responsibility to ask human subjects if they will consent to be in a photograph before taking the photo.
- You have the responsibility to ask the owner of personal property (e.g., someone's house) permission before taking a photo of someone's personal property.
- You have the responsibility to be respectful when working with human subjects.
- You have the responsibility to use a buddy system, especially when taking photos in places you are not familiar with.
- You have the responsibility to NOT do something you usually would not do.
- You have the responsibility to NOT go somewhere you usually would not go.
- You have the responsibility to be aware of your surroundings.

Adapted from Photovoice Hamilton Ontario, 2007.

Appendix O: Semi-Structured Discussion Group Guide for Photovoice

Study Title: Using Photovoice to Explore Barriers and Facilitators to Healthy Cooking Skills Development

Introduction: Thank you for coming today to share with us your perceptions about the barriers and facilitators to developing healthy cooking skills outside of your involvement in the *Cook It Up!* program. In this interview, we will ask you for your opinions about using the camera and taking photographs, the meaning of the pictures that you have chosen, and your thoughts about being in this session. Each person will have a chance to talk. Your input is very valuable in helping us better understand the appropriateness of this type of research method, as well as to answer the research question: What are the barriers and facilitators to the development of healthy cooking skills for youth outside of their involvement in the *Cook It Up!* community-based cooking program? Please help yourself to refreshments at any time. Does anyone have any questions before we get started?

A. Icebreaker introductions

B. We would like to know your opinions about using the camera and taking photographs and how this was helpful or not helpful for you in expressing your opinions and thoughts about the barriers and facilitators that you face in the process of developing cooking skills.

a. How did taking the photos help/not help you illustrate your opinions about the barriers you face to developing healthy cooking skills?
b. How did taking the photos help/not help you to illustrate your opinions about the facilitators that help you healthy develop cooking skills?

Please tell us how you found using the camera and taking pictures in terms of the following:

a. How did you find the process of taking the photos? (e.g., time consuming, or did it fit in with your activities of daily living?)
b. How did you feel about the effort required to take the photos? (e.g., were you tired or energized by this process?)
c. How did you find using the camera and taking pictures?
d. How did this affect your interest about the development of healthy cooking skills for youth, and what affected these habits?
e. How did this process affect your ability to identify and/or discuss barriers and facilitators to your development of healthy cooking skills?
f. What other comments do you have about the process of taking pictures or the use of the camera?
g. What recommendations do you have for the researchers about how to enhance the use of cameras and picture taking in future research?

C. Now please select from your pictures the picture YOU think *best* represents a barrier to developing healthy cooking skills and a facilitator to developing healthy cooking skills. We will complete this section with additional photos if time permits, or if more pictures are needed to encourage conversation.

(We will ask the following of each participant)
a. Please tell us about the two pictures (one barrier and one facilitator) that you have chosen for this session.

b. What message do you want your pictures to convey about the barriers that you face, or facilitators that you encounter, in the development of healthy cooking skills outside your involvement with *Cook It Up*?
c. What made you select these two pictures over the other pictures?
d. To the group: Can anybody else relate to this picture or what (person's name) is describing?
e. Was there anything else that you would have liked to have taken a picture of, but could not? What prevented you from taking the picture and/or what would have helped you to be able to take the picture?

From the discussion, do you have other thoughts that you wish to share about the barriers that you face or facilitators that you encounter for developing healthy cooking skills?

Do you have any final comments about the barriers that youth face or facilitators that they encounter in the development of healthy cooking skills?

D. We would also like your opinions or thoughts on your experience in being part of this group interview.

a. How did participating in this discussion group help you to communicate your opinions or thoughts about the barriers that youth face when developing cooking skills?
b. How did participating in this discussion group help you to communicate your opinions about the facilitators that youth encounter when developing cooking skills?
c. How easy or difficult was it to voice your opinion or thoughts in front of the group?
d. What other comments do you have about the process of participating in this group interview?
e. What recommendations do you have for the researchers about the group interview for future research?

To Member check:
The Co-Investigator will provide an oral summary of the interview themes and then ask: Is this an adequate summary of what we discussed today? Once participants have given their feedback on this, move to closing.

Closing:
Thank you so much for your participation today. Before you leave, we have a brief demographic questionnaire that we would like you to complete. Also, as a token of our appreciation for your time and participation in the study, we have a $10 gift card for your local grocery store. We will also give you copies of your photographs to take home with you.

Appendix P: SHOWED Document for Photovoice

Photographers can use this form to help them complete their thoughts about the specific photo they have just taken.

Name of Photographer: _____
Title of Picture: _____
Date Picture Taken: _____

S	What is Seen here? (Describe what the eye sees)
H	What is really Happening? (The unseen "story" behind the image)
O	How does this relate to Our lives? (or MY life personally)
W	Why are things this way?
E	How could this image Educate people?
D	What can I Do about it? (What WILL I or WE do about it?)

Adapted from Photovoice Hamilton Ontario, 2007.

Appendix Q: Code of Conduct

The Cook It Up! program is supported by the London Community Resource Centre and a number of community agencies and associations (see attached). All supporters of the Cook It Up! program promote positive learning experiences for everyone. To that end, the following code of conduct applies to everyone (participants, chefs, fieldtrip operators, community agency representatives, Steering Committee members):

Appropriate Actions

- I will act as a responsible person
- I will acknowledge and appreciate efforts made by all participants
- I will be respectful of chefs, volunteers, farmers, participants, and others involved in the Cook It Up! program
- I will respect the rules
- I will encourage others to enjoy the program
- I will respect the facility

Inappropriate Actions

- I will not make any verbal comments or physical gestures about or toward anyone that could be considered offensive, derogatory, or abusive
- I will not engage in any action that might be considered to be verbally or physically abusive

Consequences

- For first time inappropriate actions, offenders will be ejected from the program
- Repeat offenders will be banned from the program and will not be able to participate in any aspect of the program (cooking AND fieldtrips) for the remainder of the program

Enforcement

- Chefs, volunteers, and Steering Committee members are responsible for enforcing the Code of Conduct
- The London Community Resource Centre will support chefs, volunteers, and Steering Committee members in upholding this Code of Conduct

MANAGING BEHAVIOUR AND CODE OF CONDUCT

Problem Solving:

When working to guide participant behaviour, staff will first employ problem solving techniques to help participants' understand the consequences of their behaviour. If problem solving shows insufficient results for maintaining a safe, constructive environment for all, staff will implement the following procedures.

Infraction	Behaviour	Discipline	
		Minor Infraction	**Moderate Infraction**
Minor	□ Continued disobedience of a program rule □ Continued disobedience of a verbal instruction from staff □ Other: _____ _____	Initial Offence: The participant will be required to sit out for a period of five minutes. Second Offence: The participant will sit out again and parents/legal guardian will be notified that a third infraction will result in a suspension Third Offence: The participant will be suspended from the program.	Initial Offence: The participant will be removed from the program for a period of time and parents/legal guardians will be notified immediately that a second infraction will result in removal from the program.
Moderate	□ Reckless disregard for safety of other participants, staff or self □ Fighting □ Swearing □ Defiance of staff authority □ Vandalism □ Bullying □ Other: _____ _____		
Disciplinary actions are progressive irrespective of the infraction with the exception of Zero Tolerance incidents.			
Zero Tolerance	□ Possession of or use of any weapons □ Physical abuse of other participants of staff □ Uttering physical threats □ Smoking or use of illegal drugs □ Theft	**Parents/legal guardian notified of the infraction and the participant is suspended for the duration of the season**. Police are notified if appropriate.	

The effectiveness of this procedure is dependent on the co-operation and communication between staff, parents/guardians and child.

Today, _____ was involved in _____
_____

We ask that you have a talk with your child explaining that this behaviour is not appropriate. This is the _____1st, the _____2nd, the _____ 3rd warning (discipline is progressive). After the requisite number of warnings as outlined above, we will have to ask that _____ leave our program. Should your child be suspended, staff will make every effort to contact you prior to your arrival. We hope that this issue is resolved and will not re-occur. Your co-operation is greatly appreciated.

Sincerely,

_____ _____

Signature Project Coordinator Date

_____ _____

Parent/Guardian Signature (please sign and return this letter with your child.) Date

Comments:

_____

_____

_____

_____

_____

Appendix R: Injury Report Form

Staff or volunteer with the Cook It Up! program MUST complete this document if a participant is injured during the cooking session and/or fieldtrip. Once completed by all parties, please give to Linda Davies, Executive Director at London Community Resource Centre for final signature and copies.

Injury Report

Name of participant:
Birth date of participant:
Date of injury:
Description of injury:
Treatment:
Parent/guardian notified (date, time):
Was there a piece of equipment involved in the incident?
What alterations have been made to improve the teaching opportunity regarding this equipment to avoid future injury?
Name of Cook It Up! staff/volunteer involved:
Signature of Cook It Up! staff/volunteer involved:
Signature of Executive Director, London Community Resource Centre:
Parent/guardian response:

Appendix S: Procedure for Injury or Emergency

- In the event of serious injury, or allergic reaction:
- Call 911 immediately. Stay with participant until medical help arrives.
- Call participant's emergency contact. Inform them about the situation and arrange for them to meet participant at hospital.
- Have volunteer accompany participant to hospital and stay with them until emergency contact arrives.
- Fill out Cook It Up! Injury Report Form and submit to Cook It Up! staff.

- In the event of minor injury (e.g. minor cuts or burns):
- Treat wound with program first aid kit.
- Call participant's emergency contact. Inform them about the situation and arrange for them to pick up participant or meet participant at hospital.
- Inform project coordinator or staff member in attendance of details and complete "injury report" form. Submit form to Cook It Up! staff.
- If participant's emergency contact is to meet participant at hospital, have volunteer accompany participant to hospital and stay with them until emergency contact arrives.
- Cook It Up! has set up an account with Aboutown (519-432-2222) to be used for transportation to and from hospital or participant's home in the event of injury.

Appendix T: Participant Information and Health History Form

Participant Information and Health History Form

Instructions: Complete this form **BEFORE PARTICIPANT ARRIVES AT PROGRAM**. (A physician's signature is **NOT** required on this form; however, we strongly encourage the participant to have a yearly physical check-up by your family doctor. One annual physical check-up is covered by OHIP). This information will be used for the Cook It Up! program planning and evaluation and will be kept confidential. For more information, contact The London Community Resource Centre at 519-432-1801.

Participant Information:	**PLEASE PRINT WHEN COMPLETING THIS FORM**	
Surname:	First Name:	Sex: ☐ M ☐ F
Date of Birth:___/___/___ (Day/Month/Year)		Age:
Address:		Home Phone:
Apt. # Street # Street Name		City:
Postal Code:		
Health Card Number:		Version Code:
Other Health Insurance:		
Parent/Guardian Surname:		First Name:
Address: (if different from above)		
Apt. # Street # Street Name		
City:	Postal Code:	
Home Phone:	Work Phone:	Cell Phone:
Emergency Contact: This individual will be contacted if the parent/guardian cannot be reached in an emergency.		
Contact Name:		Relationship:
Address:		
Apt. # Street # Street Name		Postal Code:
Home Phone:	Work Phone:	Cell Phone:
Family Physician:		Phone #:
I give permission for the participant to be photographed for promotional purposes (e.g. London Community Resource Centre website and written communications)		☐ Yes ☐ No

Health History

Allergies:	
Drugs:	
Food:	
Insect Stings or Bites:	
Seasonal Allergies (e.g., hay fever)	
Other:	
Reactions:	
Recent Illness, Operations, or Injuries:	
Is participant under any form of treatment/medication for any illness, condition, or injury? ☐ Yes ☐ No	
If yes, please explain:	
Will this condition limit or affect his/her participation in activities? ☐ Yes ☐ No	
If yes, please explain:	
Immunization: Please indicate if Immunizations/Boosters are up to date	
TdP (tetanus, diphtheria, polio)	☐ Yes ☐ No
MMR (measles, mumps, rubella)	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No
Hepatitis B	☐ Yes ☐ No
HIB	☐ Yes ☐ No
Meningitis	☐ Yes ☐ No
Past History of Communicable Diseases and Approximate Dates:	
Chicken Pox ___/___/___(day/month/year)	Hepatitis ___/___/___(day/month/year)
Whooping Cough ___/___/___(day/month/year)	Other:
Other Health Issues: Please check any applicable health issues	
☐ Asthma	☐ Eating Disorders
☐ Behavioural Concerns	☐ Emotional Limitations
☐ Clotting Disorders	☐ Physical Limitations
☐ Seizure Disorders	☐ Headaches

☐ Diabetes	☐ Hearing Aids
☐ Hearing Difficulties	☐ Skin Conditions
☐ Heart Disease/Defect	☐ Hypertension (high blood pressure)
☐ Urinary Tract Infections	☐ Use of prosthetics/aids

Medications beings sent and to be taken by Participant. If you require more space, please continue at the bottom of this form.

Medication Name	Dosage	Administration Time	Reason for Taking
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

To the best of my knowledge, this participant does not have a communicable disease, has not been in contact with anyone who has a communicable disease within 3 weeks of the program start date, and is physically able to participate in all program activities except as indicated in this form. All medical problems, or conditions requiring ongoing medical supervision or care, have been fully noted. I give permission for this health information to be shared with the appropriate staff and outside medical personnel as necessary. If the parent/guardian cannot be reached, permission is, hereby, given to the staff to take whatever steps deemed necessary to ensure the safety and health of the participant. This also allows permission for the staff to contact the participant's family physician/specialist. I will inform our family physician/specialist that I have given this authorization.

I, hereby, certify that all information completed in this form is accurate and up to date. I will contact the staff, in writing, if any changes occur in the participant's health status between now and arrival at the program as well as during the program.

_____

Parent/Guardian Name (please print) Parent/Guardian Signature

_____

Date

Appendix U: Permission Form for Field Trips

Parent/Guardian Permission Form for *Cook It Up!* Fieldtrips to local Farmers' Markets, Markets, and Farms

On-going field trips are defined as community activities which are part of the *Cook It Up!* program and will occur frequently (up to 20 fieldtrips over the course of one year) as part of the program. Monthly, participants will be involved in activities such as cooking, trips to local farms, farmers' markets, or grocery stores. For all on-going fieldtrips, the Program Manager will send home with the *Cook It Up!* program participant a complete itinerary/schedule showing the times, locations, dates, transportation and other arrangements.

Cook It Up! is a community-based, education and skill-building program for at-risk youth (13-18 years). It is a fun and practical program offering nutrition information, food safety, food preparation and selection and cooking skills, taught by some of London's best local chefs. Through agricultural field trip experiences to a variety of local farms and farmers' markets, participants will be able to explore future employment potential in a variety of agricultural and food service environments, as well as to gain an understanding of where our food comes from, and how it gets from farm to plate.

Cook It Up! provides an opportunity to be part of the creation of a program that will become a model for community groups, schools and focus groups across the province and country, helping youth to better understand their local food systems and to shop and cook for themselves in a practical, cost effective way. Participants will be given the tools to apply this knowledge in their daily lives. Through *Cook It Up!*, participants will experience being a part of a program that will help to bring together youth and our local food industry professionals to work towards making our community stronger.

Project Manager in charge: _____

Locations and Dates: _____

Note: Elements of Risk: The risk of injury exists in every field trip activity. However, due to the very nature of some activities, the risk of injury may increase. Injuries may range from minor sprains and strains to more serious injuries. The safety and well being of students is a prime concern and attempts are made to manage as effectively as possible, the foreseeable risks inherent in field trip activity.

_____ has my permission to participate in the ongoing Cook It Up! fieldtrips as described by the Project Manager for the duration of the program.

(PARTICIPATING YOUTH'S NAME)

_____

(PARENT/GUARDIAN SIGNATURE)

_____

(PRINTED NAME OF PARENT/GUARDIAN) (DATE)

Appendix V: Volunteer Responsibilities

Cook It Up!

As a volunteer or placement student of the Cook It Up Program, I agree that I will immediately advise the Cook It Up Program Coordinator if:

- I become physically, mentally or emotionally unable to fulfill my duties as a volunteer or placement,
- I become subject of any criminal investigation (conviction) that will negatively impact the organization or my ability to perform my responsibilities.

Please check the appropriate box below:

As of Orientation date on _____(date):

- ❑ As of my attendance at the volunteer orientation. I am unaware of any incidents or events that would inhibit a successful background check with police.

After police check received on _____(date):

- ❑ There are no occurrences, as described above, since my police check was submitted.
- ❑ All reportable matters as described in the attached information were discussed with my supervisor at the time of the occurrence.

I hereby attest that my response to the proceeding statement is true, complete and accurate to the best of my knowledge and belief.

_____ _____
Signature of Volunteer/Placement Student Date

_____ _____
Signature of Volunteer Coordinator/Full time staff Date

Note: This form will be reviewed and signed by all volunteers/ placement students of the London Community Resource Centre within three months of initial start date and on an annual basis (see below).

Date	Volunteer Signature	Date	Volunteer Signature

Appendix W: Participant Website Application Form

1. Tell us about your interest in food and cooking.

2. Why do you think cooking from scratch (using basic ingredients to make meals and snacks) is an important skill that youth should be learning?

3. Describe what you are hoping to learn from the Cook It Up! program.

4. Are you interested in working in the culinary industry in the future? If so, what area?

5. Describe your thoughts on the opportunity to work with local professional chefs and local farmers?

6. Where did you hear about the Cook It Up! program?

7. Other information:

Name:
Address:
Age:
City / Town:
Province:
Postal Code:
Email address:
Phone Number:

Today's Date:

Appendix X: Sample Website Articles

Youth get a chance to Cook-It Up!

The London Community Resource Centre is excited to launch a collaborative, new community-based program for youth ages 13 to 18.

Cook It Up! provides education and skill building for the youth participants facilitated by local chefs. The participants will learn about food safety, food selection and preparation skills, cooking skills, and will offer agricultural fieldtrips to a variety of local farms and farmers' markets.

Applications for Cook It Up! are currently being accepted. Interested youth can apply by visiting www.lcrc.on.ca and completing the application form. Cook It Up! will start in August 2009 and will be offered for one year, focusing on the four seasons in which we enjoy Ontario-grown food. Participants in Cook It Up! will be introduced to local agriculture and food systems with the idea of promoting a rural experience to the urban youth we hope to recruit to the program.

At the conclusion of the program the youth will be able to participate in a graduation celebration, giving them a sense of accomplishment and allowing them to share their learning experiences while networking with local farmers, food commodity marketing associations, local chefs and local farmers' markets.

Throughout the entire Cook It Up! program, the program leaders will be evaluating the process to learn how best to improve the program. A "how-to" manual will be created and distributed, highlighting details for implementing this project in settings for similar or different target groups (post-secondary students, young adults, Ontario Early Years Centres, parents, multicultural groups and older adults).

Cook It Up! is made possible with the generous funding of the Ontario Agri-Food Education Inc. Healthy Eating Fund, the Healthy Living Partnership Middlesex-London, the Middlesex-London Health Unit, Ontario Pork, and the White Bean Producers Marketing Board.

Things are heating up in the **Cook It Up!** kitchen

The **London Community Resource Centre's new, collaborative, community-based program** held its first session August 17, 2009, and under the tutelage of one of **London's premier chefs Paul Harding, of the Only on King**, the first class was an undeniable and resounding success.

The program, which is geared to **youth ages 13 to 18**, is gearing up for its next cooking session, sure to tantalize the taste buds and culinary curiosity of youth with an outdoor barbecue under the guidance of **chef Chris Meloche, owner of Flavour in Time Catering**, August 31, 2009.

In addition, the program's first fieldtrip is set for September 14, 2009, to **Dolway Organic Gardens**, where youth will get an up-close and detailed look at the operations of a seasonal producer of fresh, local produce.

For any youth still interested in applying for the program, do not despair. **There is still limited space available for additional participants:** Applications for Cook It Up!

Cook It Up! provides education and skill building for the youth participants facilitated by local chefs. The participants will learn about food safety, food selection and preparation skills, cooking skills, and will offer agricultural fieldtrips to a variety of local farms and farmers' markets.

The program will be **offered for one year**, focusing on the four seasons in which we enjoy Ontario-grown food. Participants in **Cook It Up!** will be introduced to local agriculture and food systems with the idea of promoting a rural experience to the urban youth.

At the **conclusion** of the program the **youth** will be **able to participate in a graduation celebration**, allowing them to share their learning experiences while networking with local farmers, food commodity marketing associations, and local chefs.

There will be **ongoing evaluation** throughout the **Cook It Up!** Program. This information will then be used to **create a** "how-to" manual which will be distributed, highlighting details for implementing this project in settings for similar or different target groups **(post-secondary students, young adults, Ontario Early Years Centres, parents, multicultural groups and older adults).**

Cook It Up! has been made possible through the **generous funding** of:

- Ontario Agri-Food Education Inc. Healthy Eating Fund
- Healthy Living Partnership Middlesex-London
- Middlesex-London Health Unit
- Ontario Pork
- Ontario White Bean Producers

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Appendix B

Initiatives Aimed to improve Food Security, Literacy and Skills

***Children's Aid Society (CAS) Youth in Transition Cooking Club**:* A Public Health Dietitian provides a monthly cooking program to youth 16-17 years of age who are currently living in foster care or group home settings within the CAS system. The Social Worker facilitating the *Youth in Transition* group recognized the value of cooking skills and food literacy for this vulnerable population of youth who are preparing to live independently at 18 years of age. The group of youth meets monthly at Dundas Street Centre United Church where they collectively work on preparing a variety of recipes decided upon by the group. At the end of the cooking period, the youth sit together with the facilitators of the program (Social Worker, church staff, and Public Health Dietitian) and enjoy a meal together. Over the course of the two hour cooking session, there are many opportunities to demonstrate and share cooking skills, nutrition education and to build confidence among the participants. This year, the group plan to prepare a turkey dinner together to share with participating staff from the church as well as other youth who may not have families with whom they can enjoy Christmas dinner.

***Youth Opportunities Unlimited (YOU) – Youth Employment Strategies Program**:* Youth Opportunities Unlimited is a local social service agency providing training, skills development, supports and referrals youth need to develop their potential and to lead positive lives. The Public Health Dietitian contributes to the Youth Employment Strategies Program through the facilitation of a cooking program offered bi-weekly at the community kitchen in the YOU program offices. Informal feedback from the addition of this programming to the Youth Employment Strategies Program has been very positive from youth participants and program facilitators alike. Youth are given the opportunity to prepare simple recipes and enjoy them as a group. Leftovers from the meal are provided to the participants along with a recipe book of meals prepared and tips about safe food handling.

***Grow Cook Learn – A Food Literacy Program**:* In partnership with the London Community Resource Centre and East London Anglican Ministries, the Public Health Dietitian helped coordinate and facilitate a community gardening demonstration plot and food literacy program. This pilot program invites community gardening experts to share their knowledge about the gardening process from start to finish. A variety of vegetables, fruits and herbs were grown in the community garden demonstration plot, harvested by program participants and brought into the church kitchen where a volunteer home economist or the Public Health Dietitian facilitated the cooking skills component of the program. The program has been promoted with the Family Home Visitor team, the East London Anglican Ministries' congregation and community programming targeting youth (i.e. Brownies and Girl Guides). The pilot program has been well documented and lessons learned will serve to strengthen future community garden locations in other quadrants of the city. The goal of the partnership is to facilitate four demonstration gardens and cooking skills programs in the city.

Colour It Up: Colour It Up is a food skills and health promotion program planned for January 2012. This fruit and vegetable promotion program is in partnership with the London Community Resource Centre, Goodwill Ontario Great Lakes, and the Middlesex-London Health Unit. *Colour It Up* will provide a six-week community-based, behaviour-change program designed to promote increased vegetable and fruit consumption to women between the ages of 19-50 and their families. The Nutrition Resource Centre created the intervention and it has been proven to be effective at increasing fruit and vegetable consumption among this age and sex group. Recruitment for participants is currently underway in collaboration with Family Home Visitors and other vulnerable populations in London. Resources have been dedicated to purchase program incentives, assist with childcare, and provide transportation (bus tickets) in an effort to facilitate recruitment, participation, and retention in the program.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 114-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Mother Reach Postpartum Support Services

Recommendation

It is recommended that Report No. 114-11 re Mother Reach Postpartum Support Services be received for information.

Background

Postpartum mood disorders, particularly depression and anxiety, affect up to one in five women and families within the Middlesex-London community. Because of the high prevalence of these disorders, Health Unit staff members have devoted a great deal of time and energy to finding ways to improve the mental health support that is available to postpartum families. This is important because untreated postpartum mood disorders often lead to insecure maternal attachment, growth and developmental delays, and behavioural and social difficulties for the child.

One key initiative has been the formation of the Mother Reach London & Middlesex Coalition which has been facilitated through the leadership of Family Health Services (FHS) since 2002. The goal of the Coalition is to promote a caring community to educate, treat and support women and their families who are at risk for or coping with postpartum mood and anxiety disorders. The Coalition has provided public and professional education and awareness, a weekly drop-in program for women, couples support sessions, the HOPEline (telephone support), and the www.helpformom.ca website. There has been great commitment from over 20 community members (agencies, businesses, and volunteers) on the Coalition to carry on this valuable work.

Postpartum Programs and Services

A weekly 2-hour drop-in program with peer and professional support is offered to women at risk for or experiencing symptoms of postpartum depression or anxiety. Child minding, interpretation and transportation are provided. Chalmers Presbyterian Church in London has hosted the drop-in program for the past three years. Mother Reach couples support sessions have also been offered over the past few years. Research has demonstrated that treatment for postpartum mood and anxiety disorders requires an approach that cares for both parents. Furthermore, 10% of men experience postpartum depression. The sessions are co-facilitated by both peer and professional staff, with child minding provided. Childreach has been the host of the couples' sessions.

In July 2010, the Mother Reach Coalition was successful in securing a one-year Ontario Trillium Foundation grant for $45,000. The Trillium grant supported not only the weekly drop-in program for women and the couples support sessions, it also allowed the coalition to offer outreach education and support sessions. The grant enabled the time for a peer support person to network and develop relationships throughout the community, targeting different demographic, language, cultural, and newcomer groups. Session topics covered the following: postpartum depression and anxiety, available resources, self-care strategies and support for the transition to parenting. Over 710 clients and professionals participated in the outreach sessions, as well as 40 women who accessed the drop-in, 50 men and women who participated in the couples sessions, and a wide number of people were reached through marketing and awareness raising activities over the course of the grant period.

Sustainability of the Programs

Program sustainability has been an ongoing goal for the Coalition, and a number of approaches have been taken to date. Utilizing key Coalition partners for in-kind support, grant applications, small and large scale fundraising activities, and acquiring some small-scale corporate donations have all been successful in supporting Mother Reach's programs over the past nine years. With the recent Ontario Trillium Foundation grant coming to an end, the Coalition was challenged to find ways to continue to offer its programs. In July 2011, Merrymount Family Support and Crisis Centre stepped forward to permanently take over the funding, staffing, and administration of the drop-in with the Coalition remaining in an advisory role. With this key program stabilized, the Coalition is able to refocus on leveraging other relationships within the community in order to continue to maximize its reach and support.

Future Directions

FHS has continued to provide leadership to the coalition through the provision of program staff for chairperson and member roles. The demand on the Public Health Nurse as Coalition chairperson has been significant over the past few years and has ensured stable programming during a period of temporary funding and changes to program administration. With sustainability of the drop-in now ensured, this demand is expected to lessen.

The Coalition will continue to meet regularly, oversee the drop-in, support the HOPEline and website, and provide education and support to clients and professionals about postpartum mood and anxiety disorders. Commitment remains high on the Coalition, and significant in-kind contributions are secured. This valuable linkage between the Health Unit and Mother Reach will continue to facilitate networking and partnerships, sharing of information and resources and increasing education and support for families experiencing postpartum depression and anxiety.

This report was prepared by Ms. Laura Dueck, Public Health Nurse, Family Health Promotion Team, Family Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Child Health, Requirements 4, 5, 6, 7.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 115-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Update on Parenting Support

Recommendation

It is recommended that Report No. 115-11 re Update on Parenting Support be received for information.

Background

The purpose of this report is to update the Board of Health about the planning and implementation of a comprehensive health promotion approach to parenting support for Middlesex-London. Report No. 150-10 re Triple P – Positive Parenting Program (December 2010) reviewed recent work to assess and improve the effectiveness of parenting support offered by the Health Unit. That report cited a recent synthesis of research literature which concluded that quality of parenting is the strongest potentially modifiable risk factor that contributes to a range of health outcomes for children. Also noted was the Ontario Public Health Standards OPHS requirement that health units undertake various activities such as communication campaigns and parenting groups to promote positive parenting and preparation for parenting. After a situational assessment and review of the Health Unit's parenting programs, staff in Family Health Services (FHS) began to develop a more integrated and comprehensive strategy in collaboration with staff in Chronic Disease, Injury Prevention and Sexual Health Promotion. This meant stronger connections among Health Unit teams and community partners and addressing multiple levels of intervention, ranging from individual to group, community and system levels.

Triple P – Positive Parenting Program

A key element of the emerging strategy was the adoption of the Triple P – Positive Parenting Program. Research has shown Triple P to be the best evaluated, most comprehensive program available. It has already been adopted by 12 Ontario health units and several local agencies. With parenting support designated a core service at each of the Neighbourhood Child and Family Centres that make up London's Child and Youth Network, Triple P offers strong potential to be the basis for a co-ordinated, community-wide approach to parenting support. Triple P takes advantage of existing community infrastructure by offering the opportunity for various community partners to take on elements of the program that are most consistent with their mandates.

Triple P was developed out of the University of Queensland, Australia, and has been subject to ongoing evaluation and refinement for over 25 years. The program's success is due to the high level of attention given to program implementation. In order to become eligible to deliver the program, staff must undergo a rigorous training and accreditation process. The Health Unit hosted three training sessions conducted by Triple P trainers in July and September. Fifty-four (54) health unit staff and nine staff from seven different community agencies participated in two-to-three full days of training per session. Participants were trained in the fundamental principles of the program as well as how to deliver the program effectively in one-to-one, small group and larger group settings. Trainees were also provided with a full array of tools and program materials. Health Unit staff members have already begun to offer the program in the Healthy Babies Healthy Children program and in schools and other community settings to parents of both young children and teens.

The Health Unit's Parenting Support Integration Workgroup is now finalizing operational plans to implement three of the five levels of Triple P: 1) a universal communication campaign designed to promote positive parenting and normalize the seeking of parenting support, 2) positive parenting seminars addressing specific child behaviour concerns in various community settings including schools and Neighbourhood Child and Family Centres, and 3) intensive one-to-one training of parents in parenting skills.

A strength of the Triple P Program is an integrated community system whereby parents can easily access information and be referred to specialized services that address their particular concerns (e.g., children's mental health). Health Unit staff will continue to offer other parenting supports such as the Let's Grow parenting information package (which is in the process of being reinvented at great cost savings as an on-line resource). Another evidence-based, rigorously evaluated program which is about to be adopted by FHS is the Nurse-Family Partnership. Details of this program will be presented in a future Board report.

Conclusion
Evidence regarding the potential impact of positive parenting on health outcomes continues to grow. For example, an article appearing in the Journal of the American Medical Association stated that "*programs or policies that increase children's exposure to safe, stable, and nurturing relationships and environments can improve health over their lifetime. Moreover, these programs can be more efficient than treating health problems as they arise later in life….The high-quality scientific evidence supporting these propositions justifies investments in prevention research and programs to support parents and communities in raising safe and healthy children*." The authors of this article also stated that "*the time has come to act on scientific knowledge about preventing early exposure to adversity and promoting child development.*" They cite two specific programs which meet this standard; they urge communities to adopt Triple P and the Nurse-Family Partnership.

This report was prepared by Mr. Jim Madden, Manager, Family Health Promotion Team, Family Health Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Child Health Standard, Requirements 4, 5, 6, 7.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 116-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Revisions to the Healthy Workplace Program Resources

Recommendation

It is recommended that Report No. 116-11 re Revisions to the Healthy Workplace Program Resources be received for information.

Background

In the Fall of 2001, in order to meet mandatory program requirements to address the health of employees, the Health Unit initiated the Healthy Workplace Program. A comprehensive self-help package entitled, Building a Healthy Workplace: Blueprint for Success, was developed in December 2004 for distribution to workplaces. The guide served two purposes: i) to provide an overview of comprehensive workplace health and ii) to provide easy-to-follow steps and examples that a workplace can use to implement a comprehensive workplace health program. Health Units in Ontario continue to be required under the new Ontario Public Health Standards as follows:

> *To use a comprehensive health promotion approach to increase the capacity of workplaces to develop and implement health policies and programs, and to create or enhance supportive environments to address the following topics, healthy eating, healthy weights, tobacco use, physical activity, alcohol use, physical activity, worker stress and exposure to ultraviolet radiation.*

Health at Work 4 All!

In the spring of 2010, it was determined that much of the information in the original guide, Building a Healthy Workplace: Blueprint for Success, was outdated and needed to be revised. The Blueprint had proven to be an integral part of the consultation process between Health Unit workplace staff and the wellness coordinators and committees from the workplaces. Using the manual supports independence on the part of the agencies wellness coordinators and their committees charged with creating wellness plans and initiatives. The project to revise and expand the information in the manual and update the overall look and feel of the healthy workplace program began in mid 2010.

In partnership with the healthy workplace program coordinator from the Elgin St Thomas Public Health Unit (ESTPH), revisions to the first section of the manual were initiated. Recent publications from the World Health Organization (WHO) expanded the original concept of comprehensive workplace health (promoted by the national Quality Institute) from having three (3) elements; the physical environment of a workplace, personal health practices of employees and the organizational culture of the workplace; to now include “enterprise community involvement”. Permission was granted by WHO for MLHU and ESTPH to be the first health units in North America to use the WHO Healthy Workplace Framework and Model, components and steps, to create the Health at Work 4 All! manual. All MLHU service areas and teams that offer programs, services or resources to workplaces were asked to provide updated information about their program area for the second section of the manual. The third section of the manual contains an overview of policy development (as promoted through The Health Communication Unit, University of Toronto), and provides real, practical examples of policies that workplaces may consider customizing to meet their unique needs.

Discussions were held with members of the internal Health Unit Healthy Workplace Working Group, Communications Manager and the ESTHU Coordinator to create a new name, look and feel for the redesigned program and manual. “Health at Work 4 All!” was chosen for the title of the new manual. An analogy linking a healthy workplace to a musical performance was created and the vision was brought to life by a graphic artist along with the tag line, “creating harmony in the workplace…through improved performance.” Creating music depends on many different elements coming together to produce a harmonious sound. Creating a healthy workplace also depends on many elements coming together in the workplace. Improved performance occurs in music, and can occur in the workplace, when the elements come together in harmony!

The manual Health at Work 4 All! is available for download at www.healthunit.com and www.healthlivinginfo.ca. ESTPH will be adapting the resources for use in their healthy workplace program and their web-site as well. This Health Unit provides the manual in hard copy as well as on a

USB stick. In September 2011, an article in Business London Magazine (see Appendix A) featured the Health Unit program along with the revised program materials and the upcoming workplace workshop. On Thursday October 27th, 2011, at a workshop hosted by the two health units, the revised Health at Work 4 All! program resources were presented and made available. The workshop featured two dynamic speakers - Mary Ann Baynton of The Great West Centre spoke on Mental Health in the Workplace, and Ellen Curitti of Region of Waterloo Public Health spoke on Nutrition. They presented timely, relevant information to participants about the importance of changing workplaces into psychologically safe places for employees.

Conclusion

The new Health at Work 4 All! manual is being offered to workplaces as a self-help resource and will be augmented with personal support from the Health Unit Healthy Workplace Program Coordinator. Through the Health at Work 4 All! resources, an increased number of employers will realize the moral, legal, ethical and fiscal advantages that a healthy workplace offers to both employees and ultimately, the company's financial bottom line.

This report was prepared by Ms. Sandy Richardson, Public Health Nurse, Healthy Communities and Injury Prevention Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
aChronic Diseases and Injury Prevention: Health Promotion and Policy Development, Requirement # 4
Area of Focus: Facilitate the effective and efficient implementation of the Ontario Public Health Standards (OPHS) at the Middlesex-London Health Unit.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 117-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

'The Last Smear Campaign' Aims To Raise Awareness About The Importance of Pap Tests

Recommendation

It is recommended that Report No. 117-11 'The Last Smear Campaign' Aims to Raise Awareness About the Importance of Pap Tests be received for information.

Background

Each year in Canada, 400,000 women receive an abnormal Pap test result, 1,300 to 1,500 women are diagnosed with cervical cancer and almost 400 women die of this disease. In Ontario, approximately 500 Ontario women will be diagnosed with cervical cancer, and 140 women will die. Cervical cancer incidence and deaths have been decreasing, mainly due to the widespread, regular use of Pap test screening. In the future, the availability of human papillomavirus vaccinations will also result in decreased incidence of cervical cancer. Nonetheless, it remains concerning that a largely preventable cancer continues to occur. According to the Public Health Agency of Canada, 15% of women have never had a Pap test and 30% have not had a Pap test in the last three years.

The main reason for abnormal Pap test results are infections caused by human papillomavirus (HPV), the most common sexually transmitted infection (STI) in Canada. There are many types of HPV infections, and it is estimated that approximately 75% of people will have an HPV infection at least once in their lifetime. All cervical cancers are the result of HPV infections. The types of HPV that cause cancer are referred to as high-risk types, and there are approximately 15 different high-risk types of HPV. Types 16 and 18 are the high-risk types against which the HPV vaccines provide protection, and these types cause approximately 70% of cervical cancers. Therefore, HPV vaccinations will significantly reduce the risk of cervical cancer in the future, but will not eliminate the risk, and so Pap smear screening will continued to be needed.

Many HPV infections that cause abnormal Pap smear results go away without any treatment and without causing any problems. However, in some cases, the HPV infection persists and if the abnormalities they cause are not detected by Pap smear screening and subsequently appropriately treated, the infection can eventually lead to cervical cancer. Currently, the Middlesex-London Health Unit's Family Planning Clinic and Sexually Transmitted Infections Clinic perform approximately 100 Pap tests each week. This number does not include the number of Pap smears done by the Health Unit's Nurse Practitioner at clinics in the community.

Cervical Cancer Awareness Week Campaign and Community Partnership

Cervical Cancer Awareness Week was October 23 to 29. The Health Unit supported this year's national Pap Test Campaign, organized by the Federation of Medical Women of Canada and the Society of Obstetricians and Gynaecologists of Canada. In an effort to raise awareness of the importance of Pap tests, the Health Unit's Sexual Health Promotion Team and Chronic Disease Prevention & Tobacco Control Team, in partnership with the South West Regional Cancer Program, the London Public Library and Medpoint Health Care Centre launched the "Last Smear Campaign" on Tuesday October 11th at 7:00 p.m. at the Central Library's Wolf Performance Hall. The promotional poster is attached as Appendix A. This event called on women of all ages to learn how they can prevent cervical cancer. Hosted by emcee Louise Karch, the event featured a presentation from cancer expert Dr. Monique Bertrand, from the Department of Gynecologic Oncology at London Health Sciences Centre. Fifty-two women attended the Last Smear Campaign event and were able to have their questions answered by Public Health Nurses (PHN) from the Middlesex-London Health Unit. Pap tests could be arranged at The Clinic at the Middlesex-London Health Unit, the Medpoint Health Care Centre (this clinic is located in the Galleria Mall very near the library, and so provided Pap smear screening that evening) or at other local clinics that opened their doors to offer Pap tests during Cervical Cancer Awareness Week.

Pap Smear Videos

As part of the "Last Smear Campaign" and Cervical Cancer Awareness Week, four videos were created. They feature Ms. Louise Karsh and "Dr. Feel Good," a Health Unit celebrity. The videos can be viewed at the following sites:

http://www.youtube.com/watch?v=gjytjRb2JH0
http://www.youtube.com/watch?v=nEg796EzWpI
http://www.youtube.com/watch?v=8HvHqp_hQic
http://www.youtube.com/watch?v=Y-Iz2Z3-WSk

Conclusion
This year, an estimated 500 Ontario women will be diagnosed with cervical cancer and 140 women will die of the disease. Cervical cancer is largely preventable with regular Pap test screening and HPV vaccination. In order to reach the Ontario Cancer 2020 targets of 95% of eligible women participating in organized cervical screening, and 95% of young women vaccinated against HPV before sexual activity begins, the Health Unit continues to work in collaboration with community partners. The importance of regular Pap tests and the HPV vaccine are promoted through events such as described in this Board of Health report and throughout the entire year. Plans are already in place with community partners to host similar awareness raising events in April and October 2012.

This report was written by Ms. Kaylene McKinnon, Public Health Nurse, Chronic Disease Prevention and Tobacco Control Team, and Ms. Erica Zarins, Public Health Nurse, Sexual Health Promotion Team.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Chronic Disease Prevention: The board of health shall collaborate with community partners to promote provincially approved screening programs related to the early detection of cancer.
Sexual Health Promotion: The board of health shall collaborate with community partners to create supportive environments to promote healthy sexuality and access to sexual health services.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 118-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

2011 Budget – Third Quarter Review

Recommendation

It is recommended that Report No. 118-11 re 2011 Budget – Third Quarter Review be received for information.

Background

The attached Budget Summary (Appendix A) shows actual and budgeted expenditures net of offset revenues for the nine-month period January 1 to September 30, 2011. For the programs with a March 31st year-end, this report shows the actual and budgeted expenditures net of offset revenues for the six-month period April 1 to September 30, 2011.

Mandatory and Related Programs

For the nine months ending September 30, 2011, Mandatory and Related Programs are reporting a favourable variance of $988,538. The majority of this variance is explained by timing differences in salary payments (increases in salary grids and the fact that salary costs are not equally distributed every month), other payments, staff vacancies and natural turnover. Timing difference may generate a modest surplus for 2011; however, there are a number of large expenditures expected in the fourth quarter such as the upgrades to the HVAC system at 50 King Street and annual purchasing for computer equipment.

At this point, it is believed that the Mandatory and Related Programs will complete the operating year in a break-even position.

Other Programs

For the December 31st programs, the third quarter shows a favourable variance of $844,845. Approximately 50% this variance is explained in timing differences in other operating expenditures (non-salary related). For example, in the Smoke Free Ontario and the Healthy Babies Healthy Children Programs, many of the health promotion projects are still outstanding and have not been purchased (e.g., advertising). The remainder may be explained by a lower than anticipated “up-take” for the new Healthy Smiles Ontario (HSO) program. The province has approved reallocating $75,000 in the last quarter of 2011 to be used to enhance promotional efforts. The HSO program will generate a significant favourable variance for 2011.

For the March 31st programs, there currently is a favourable variance of $210,609. At this time, it is not expected that these programs will generate significant favourable variances by year end.

Summary

It is projected the Health Unit will complete the operating year in a break-even position for the Cost-Shared Programs. For other 100% programs, it is expected that Healthy Smiles Ontario will generate approximately $350,000 favourable variance. It is also anticipated that the March 31st programs will end that fiscal year in a break-even position.

Mr. John Millson, Director, Finance and Operations, will be in attendance at the November 17th Board meeting to address any questions regarding this report.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses - Policy No. 4-20 Expenditure Reports as outlined in the MLHU Administration Policy Manual.

Middlesex-London Health Unit
BUDGET SUMMARY
As at September 30, 2011

	2011 YTD ACTUAL	2011 YTD BUDGET	VARIANCE (OVER) / UNDER	% VARIANCE	2011 ANNUAL BUDGET
COST-SHARED PROGRAMS					
Oral Health, Communicable Disease & Sexual Health Services					
Office of the Associate Medical Officer of Health	$ 216,759	$ 212,607	$ (4,152)	-2.0%	$ 283,476
Vaccine Preventable Diseases	821,725	772,185	(49,540)	-6.4%	1,029,580
The Clinic	965,681	959,943	(5,738)	-0.6%	1,279,924
Sexual Health Promotion	249,580	251,802	2,222	0.9%	335,736
Infectious Disease Control	390,538	426,619	36,081	8.5%	568,825
Dental Prevention	505,294	516,685	11,391	2.2%	688,913
Children In Need of Treatment (CINOT)	371,910	390,885	18,975	4.9%	521,180
Total Oral Health, Comm. Disease & Sexual Health Services	***$ 3,521,487***	***$ 3,530,726***	***$ 9,239***	***0.3%***	***$ 4,707,634***
Environmental Health & Chronic Disease & Injury Prevention					
Office of the Director	$ 323,396	$ 282,586	$ (40,810)	-14.4%	$ 376,781
Environmental Health	1,596,592	1,707,161	110,569	6.5%	2,276,215
Chronic Disease Prevention	404,399	433,479	29,080	6.7%	577,972
Injury Prevention	648,235	649,647	1,412	0.2%	866,196
Vector Borne Disease Program	464,040	461,967	(2,073)	-0.4%	615,956
Total Environmental Health & Chronic Disease & Injury Prev	***$ 3,436,662***	***$ 3,534,840***	***$ 98,178***	***2.8%***	***$ 4,713,120***
Family Health Services					
Office of the Director	$ 228,080	$ 387,252	$ 159,172	41.1%	$ 516,336
Program Evaluation	157,726	$ 176,510	$ 18,784	10.6%	$ 235,346
Young Families Team	933,147	976,455	43,308	4.4%	1,301,940
Family Health Promotion Team	784,211	854,232	70,021	8.2%	1,138,976
Infant & Family Development Team	506,675	531,416	24,741	4.7%	708,554
Young Adult Team	646,977	687,908	40,931	6.0%	917,210
Child Health Team	953,564	997,721	44,157	4.4%	1,330,294
Infant Line Program	44,736	51,018	6,282	12.3%	68,024
Let's Grow Program	26,579	35,930	9,351	26.0%	47,906
Total Family Health Services	***$ 4,281,695***	***$ 4,698,442***	***$ 416,747***	***8.9%***	***$ 6,264,586***

	2011 YTD ACTUAL	2011 YTD BUDGET	VARIANCE (OVER) / UNDER	% VARIANCE	2011 ANNUAL BUDGET
Office of the Medical Officer of Health					
Office of the Medical Officer of Health	$ 333,967	$ 307,574	$ (26,393)	-8.6%	$ 410,099
Communications	172,266	235,695	63,429	26.9%	314,260
Special Projects	126,821	112,382	(14,439)	-12.8%	149,843
Travel Clinic	52,030	53,162	1,132	2.1%	70,883
Emergency Planning	24,089	23,477	(612)	-2.6%	31,302
Records / CQI Management	111,282	81,264	(30,018)	-36.9%	108,352
Total Office of the Medical Officer of Health	***$ 820,455***	***$ 813,554***	***$ (6,901)***	***-0.8%***	***1,084,739***
Finance & Operations	***430,305***	***445,770***	***15,465***	***3.5%***	***594,360***
Human Resources & Labour Relations	***490,622***	***487,829***	***(2,793)***	***-0.6%***	***650,439***
Information Technology Services	***613,800***	***698,478***	***84,678***	***12.1%***	***931,304***
General Expenses & Revenues (Benefits and Operations)	***2,528,568***	***2,902,493***	***373,925***	***12.9%***	***3,869,990***
TOTAL COST-SHARED PROGRAMS	**$ 16,123,594**	**$ 17,112,132**	**$ 988,538**	**5.8%**	**$ 22,816,172**

	2011 YTD ACTUAL	2011 YTD BUDGET	VARIANCE (OVER) / UNDER	% VARIANCE	2011 ANNUAL BUDGET
OTHER PROGRAMS					
December 31 Year-End Programs:					
Infectious Disease Control (MOHLTC)	$ 865,489	$ 875,042	$ 9,553	1.1%	$ 1,166,722
Small Drinking Water Systems (MOHLTC)	61,980	80,325	18,345	22.8%	107,100
Infection Control & Prevention Nurse (MOHLTC)	63,524	63,654	130	0.2%	84,872
Smoke Free Ontario (MHP)	582,491	809,211	226,720	28.0%	1,078,948
Dental Treatment (User Fees)	(1,235)	-	1,235	-	-
Healthy Babies/Healthy Children (MCYS)	1,881,041	2,082,267	201,226	9.7%	2,776,356
Healthy Smiles Ontario (MHLTC)	265,635	653,271	387,636	59.3%	871,028
Total December 31 Year End Programs	***$ 3,718,925***	***$ 4,563,770***	***$ 844,845***	***18.5%***	***$ 6,085,026***
March 31 Year-End Programs (1):					
Smart Start for Babies (Federal)	$ 59,701	$ 76,215	$ 16,514	21.7%	$ 152,430
Tyke Talk - Preschool Speech & Language (MCYS)	670,357	741,158	70,801	9.6%	1,482,315
Blind-Low Vision Program (MCYS)	83,461	79,351	(4,110)	-5.2%	158,702
Infant Hearing Screening Program (MCYS)	302,077	429,481	127,404	29.7%	858,961
Total March 31 Year End Programs	***$ 1,115,596***	***$ 1,326,205***	***$ 210,609***	***15.9%***	***$ 2,652,408***
TOTAL OTHER PROGRAMS	**$ 4,834,521**	**$ 5,889,975**	**$ 1,055,454**	**17.9%**	**$ 8,737,434**
TOTAL MIDDLESEX-LONDON HEALTH UNIT	**$ 20,958,115**	**$ 23,002,107**	**$ 2,043,992**	**8.9%**	**$ 31,553,606**

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 119-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

HVAC Upgrades – Tender Results

Recommendation
It is recommended that Report No. 119-11 re HVAC Upgrades – Tender Results be received for information.

The purpose of this report is to provide Board members with the final result of the tendering process for the installation of HVAC equipment to address air quality issues at the 50 King Street office. The tender was initially opened on October 7, 2011, with two (2) submissions being received. On October 31st, after post tender negotiations, the bid from Curney Mechanical was accepted in the amount of $195,660 before taxes. Table 1 below details the outcome of the tendering process.

Table 1 – HVAC Tender Outcome

Company name	Tender Amount (before HST)
Curney Mechanical, 414 Neptune Crescent, London ON N6M 1A1	$ 195,660
Soan Mechanical, 11 Bayview Court, London ON N5W 5W4	215,750

This report was prepared by Mr. John Millson, Director of Finance & Operations. Mr. Millson will be in attendance at the November 17th Board meeting to address any questions regarding this report.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 120-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Board of Health Performance Assessment - Third Review

Recommendation

It is recommended that Report No. 120-11 re Board of Health Performance Assessment be received for information.

Background

On November 18, 2010, the Board of Health approved the use of the Board of Health Performance Assessment Tool. The tool is to be used three times per year, i.e., March, June and November.

Attached as Appendix A is the survey document for the third review. This document is also available online at http://app.fluidsurveys.com/s/BoardSelfAssessmentNovember/. The online option will be available until November 25, 2011. Completed hard copies can either be left with the Executive Assistant to the Board of Health, Ms. Sherri Sanders, or mailed directly to her attention at 50 King St., London, N6A 5L7.

The purpose of the assessment is to:

A. Focus on the performance of the Board of Health as a whole, not the performance of individual Board members;
B. Identify areas of Board strength; and
C. Identify areas that could be enhanced.

Please Note: the scale for both the online version and the paper version of the survey is as follows:
1= “Strongly Disagree” to 7 = “Strongly Agree.”

A summary of the results will be provided at the January 2012 Board of Health meeting.

This report was prepared by Ms. Sherri Sanders, Executive Assistant to the Board of Health.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses Board of Health direction given to Board Working Group # 3 and the draft Ontario Public Health Organizational Standards.

MIDDLESEX-LONDON HEALTH UNIT

Board of Health Performance Assessment Tool

This survey is expected to take approximately 10-15 minutes.

Please complete by Friday March 25, 2011.

As part of the Board's commitment to good governance and continuous quality improvement, all Board members are invited to complete the Board of Health Performance Assessment Tool. The tool is intended to 1) focus on the Board as a whole, 2) identify areas of strength, and 3) areas that could be enhanced.

Please note however, that your participation is voluntary and you may choose not to participate or not to respond to all questions.

"*Performance of Individual Board Members*" should not be submitted. It is provided to support self-reflection on your role as a Board member.

The results will be summarized and shared with the Board. All responses will be handled in confidence and individual responses will not be identifiable from the summary.

Once the summary has been shared with the Board, the questionnaires will be destroyed.

Please return your questionnaire in a sealed envelope to Sherri Sanders, Executive Assistant to the Board of Health. If you have any questions about the survey, please contact Sherri Sanders, 519-663-5317, Ext. 3011 or at sherri.sanders@mlhu.on.ca

Thank you

The electronic copy has the same content, yet will look different to accommodate the formatting required for the on-line survey.

A. How Well Has the Board Done Its Job?

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

Please indicate the extent to which you agree with the following statements?

The Board:

	Strongly Disagree 1	2	3	Neither Disagree Or Agree 4	5	6	Strongly Agree 7	Don't Know
1. Has a common understanding of the Board's mandate, scope and authority.	❑	❑	❑	❑	❑	❑	❑	❑
2. Keeps abreast of relevant trends, events and emerging issues.	❑	❑	❑	❑	❑	❑	❑	❑
3. Understands the Health Unit's mission.	❑	❑	❑	❑	❑	❑	❑	❑
4. Has a working knowledge of Board bylaws.	❑	❑	❑	❑	❑	❑	❑	❑
5. Ensures that the Health Unit has a long-term strategic plan.	❑	❑	❑	❑	❑	❑	❑	❑
6. Ensures that the Health Unit is responsive to needs of local communities.	❑	❑	❑	❑	❑	❑	❑	❑
7. Ensures processes are in place to identify, assess and manage any risks to the Health Unit	❑	❑	❑	❑	❑	❑	❑	❑
8. Focuses on long-term results and substantial policy issues rather than operational detail.	❑	❑	❑	❑	❑	❑	❑	❑
9. Is able to interpret, analyze and assess financial information, reports and proposals.	❑	❑	❑	❑	❑	❑	❑	❑

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree Or Agree 4	5	6	Strongly Agree 7	Don't Know
10. Has adequate information to monitor organizational performance. e.g. financial management; delivery of Ontario Public Health Standards ; work force issues, etc.	❑	❑	❑	❑	❑	❑	❑	❑
11. Ensures that decisions are based on accurate, timely and the best available information.	❑	❑	❑	❑	❑	❑	❑	❑
12. Has a process for handing urgent matters between meetings.	❑	❑	❑	❑	❑	❑	❑	❑
13. Is knowledgeable of the programs and services offered by the Health Unit.	❑	❑	❑	❑	❑	❑	❑	❑
14. Regularly assesses the performance of the MOH/CEO in a systematic way.	❑	❑	❑	❑	❑	❑	❑	❑

15. Additional observations, comments or suggestions about how well the Board has done its job:

B. How Well Has the Board Conducted Itself?

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

Please indicate the extent to which you agree with the following statements?

	Strongly Disagree 1	2	3	Neither Agree or Disagree 4	5	6	Strongly Agree 7	Don't Know
1. Board members are aware of what is expected of them.	❑	❑	❑	❑	❑	❑	❑	❑
2. The roles and responsibilities of the board are clearly defined and separate from those of staff.	❑	❑	❑	❑	❑	❑	❑	❑
3. <u>Complete ONLY If a New Board member</u> New Board members receive an effective orientation to their responsibilities as a Board member.	❑	❑	❑	❑	❑	❑	❑	❑
4. The Board is satisfied with the ongoing education it receives in order to fulfill its responsibilities.	❑	❑	❑	❑	❑	❑	❑	❑
5. Board information packages provide the right information and are received in a timely manner.	❑	❑	❑	❑	❑	❑	❑	❑
6. Board meeting agendas are well planned so that all necessary board business is addressed.	❑	❑	❑	❑	❑	❑	❑	❑
7. Agendas are appropriate e.g. topics are relevant to the mission and goals of the Health Unit; items are clearly identified as for information, discussion or decision.	❑	❑	❑	❑	❑	❑	❑	❑
8. Board members come prepared to participate in the discussion and decision–making.	❑	❑	❑	❑	❑	❑	❑	❑

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree Or Agree 4	5	6	Strongly Agree 7	Don't Know
9. The Board uses its meeting time effectively and efficiently i.e. discussion is focused, clear, concise and on topic.	❑	❑	❑	❑	❑	❑	❑	❑
10. All board members participate in important board discussions.	❑	❑	❑	❑	❑	❑	❑	❑
11. Board members do a good job of encouraging and dealing with different points of view.	❑	❑	❑	❑	❑	❑	❑	❑
12. Board members respect the rules of confidentiality	❑	❑	❑	❑	❑	❑	❑	❑
13. Decisions are supported once made.	❑	❑	❑	❑	❑	❑	❑	❑
14. Board decisions and processes are available to staff and community partners.	❑	❑	❑	❑	❑	❑	❑	❑
15. The Board Chair runs the meetings effectively.	❑	❑	❑	❑	❑	❑	❑	❑

16. Additional observations, comments or suggestions about how well the Board has conducted itself:

C. Open-Ended Questions

1. **What I like most about our meetings:**

2. **What I like least about our meetings:**

3. **Please indicate what training opportunities you would like as a board member.**

4. **What is the most important thing the Board could do to improve its performance as a Board?**

5. **Do you have additional comments that will help the Board increase its effectiveness?**

Thank you!

MIDDLESEX-LONDON HEALTH UNIT

Performance of Individual Board Members
(Not to be Submitted)

Are you satisfied with your performance as a board member in the following areas?

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree or Agree 4	5	6	Strongly Agree 7	Don't Know
1. I am aware of what is expected of me as a board member.	❑	❑	❑	❑	❑	❑	❑	❑
2. I have a good record of meeting attendance.	❑	❑	❑	❑	❑	❑	❑	❑
3. I read the minutes, reports and other materials in advance of the board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
4. I frequently encourage other board members to express their opinions at board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
5. I am encouraged to express my opinions at board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
6. I feel comfortable to ask questions if I do not understand something.	❑	❑	❑	❑	❑	❑	❑	❑
7. I am a good listener at board meetings.	❑	❑	❑	❑	❑	❑	❑	❑
8. I follow through on things I have said I would do.	❑	❑	❑	❑	❑	❑	❑	❑
9. I maintain the confidentiality of all board decisions.	❑	❑	❑	❑	❑	❑	❑	❑
10. When I have a different opinion than the majority, I raise it.	❑	❑	❑	❑	❑	❑	❑	❑

Please Note: the scale is from 1= "Strongly Disagree" to 7 = "Strongly Agree"

	Strongly Disagree 1	2	3	Neither Disagree or Agree 4	5	6	Strongly Agree 7	Don't Know
11. I support board decisions once they are made even if I do not agree with them.	❑	❑	❑	❑	❑	❑	❑	❑
12. I stay informed about issues relevant to the Health Unit mission and bring information to the attention of the board.	❑	❑	❑	❑	❑	❑	❑	❑
13. I understand my legal responsibilities.	❑	❑	❑	❑	❑	❑	❑	❑

14. Additional observations, comments or suggestions about my own performance as a Board Member:

THIS QUESTIONNAIRE IS FOR INDIVIDUAL USE ONLY AND IS NOT TO BE SUBMITTED.

MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 122-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Groundwater Contamination – 189 Adelaide Street, London

Recommendation

It is recommended that Report No. 122-11 re Groundwater Contamination – 189 Adelaide Street South, London, be received for information.

Background

On October 14, 2011, staff of the Ministry of Environment (MOE) notified Health Unit staff about the presence of contaminated groundwater beneath properties adjacent to 189 Adelaide Street South in the City of London. The building at 189 Adelaide Street South houses the ABC Child Care Centre and Absolutely Creative Training Solutions. The alert was prompted because one particular contaminant, tetrachloroethene (also known as perchloroethylene or PCE), was discovered to be present in the groundwater in amounts slightly above the MOE standard for that chemical. PCE (Appendix A) is a volatile substance that has the potential to vaporize out of the groundwater, through the soil and infiltrate buildings through openings or cracks in their foundations.

Health Unit staff (Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services; Mr. Iqbal Kalsi, Manager, Environmental Health and the Medical Officer of Health), in consultation with MOE staff, completed a thorough review of the available information. The review considered the location and depth of the contaminated groundwater, the level of contamination, the properties of the contaminant, the construction of the building at 189 Adelaide Street South, and how human exposure to PCE occurs. Based on the review, staff concluded that it was unlikely that the tenants of the building, in particular the children attending the daycare centre, had been exposed to PCE as a result of the neighbouring groundwater contamination. As an added precaution, the Health Unit arranged for indoor air (i.e., within the daycare centre) and soil sampling (i.e., of the daycare centre outdoor play area) to confirm that conclusion.

Indoor air and soil samples were collected and submitted to the laboratory between October 28 and 30, and results were received on November 4. Testing was conducted for PCE as well as several closely related chemicals. None of the chemicals of concern were found in the soil samples. The indoor air sample results were thoroughly reviewed by Health Unit staff and were compared to both Health Canada and World Health Organization standards. They were also reviewed by environmental health experts from the Environmental and Occupational Health Team of Public Health Ontario. All indoor air sample results for the chemicals tested were either below the accepted standard or within the acceptable range.

Throughout the process, Health Unit and MOE staff ensured the owner and the tenants of 189 Adelaide Street South, including the staff and parents/guardians of children attending the ABC Child Care Centre, were fully informed of the situation. In addition to sending out letters (Appendices B, C, D and E), the Health Unit and MOE staff provided several information sessions at the ABC Child Care Centre for both staff and parent/guardians to fully explain the situation and to answer any questions.

Next Steps

The MOE staff members are continuing their investigation to determine the source and scope of the groundwater contamination beneath the properties adjacent to 189 Adelaide Street South. They will continue to communicate regularly with Health Unit staff about the progress of the investigation. Health Unit staff will take whatever future action is warranted if and when it is necessary.

Conclusion

The ongoing working relationship between staff of the Ministry of Environment and the Health Unit facilitated the early identification, thorough investigation, and rapid resolution of a potential public health issue. Health Unit staff members were able to successfully fulfill their obligation to identify, investigate, and manage reported health hazards in the community.

This report was prepared by Mr. Iqbal Kalsi, Manager, Environmental Health and Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services.

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Heath Hazard Prevention and Management

MIDDLESEX-LONDON HEALTH UNIT

FACT SHEET

fact sheet

Information on Tetrachloroethene

OCTOBER 26, 2011

What is tetrachloroethene?

Tetrachloroethene (also known as perchloroethylene or ***PCE***) is a clear, colourless, non-flammable liquid at room temperature. There are no known natural sources of PCE. The principal uses of PCE are degreasing of metals and drycleaning. Other uses include the finishing and processing of textiles and production of paint strippers and printing ink. PCE is also found in some consumer products.

How does PCE get into the environment?

PCE evaporates easily and most PCE emissions are to air. PCE may also be emitted to water or soil if stored or transported improperly. In some circumstances, PCE in soil or ground water may form an underground plume that can travel underneath buildings. Some of the PCE in soil or ground water breaks down into a mixture of other chemicals (such as trichloroethylene and vinyl chloride). PCE does not appear to accumulate in fish or other animals that live in water.

How are people exposed to PCE?

People may be exposed to PCE by breathing air, drinking or bathing in water, or consuming food or breast milk that has been contaminated by PCE.

How does PCE enter indoor air?

In non-industrial buildings, there are three principal ways that PCE may enter indoor air:

1. PCE which is present in outdoor air may enter indoor air via the ventilation of a building.
2. Using consumer products containing PCE, or bringing home recently dry cleaned clothing, may introduce PCE into indoor air.
3. PCE in subsurface water or soil may evaporate and travel through small spaces between particles of soil. Upon reaching a utility conduit, a crack in a foundation, or any other opening, PCE may enter the indoor air of a building. This process is known as ***subsurface vapour intrusion***. The presence of a plume below or near a building does not necessarily mean that subsurface vapour intrusion is occurring. The extent to which indoor air may be contaminated by subsurface vapour intrusion varies depending on factors such as the concentrations of PCE in ground water, the type of soil underneath the building, and the type of foundation a building has.

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When indoor air contains only small amounts of PCE, it is often difficult to determine whether the PCE originated from outdoor air, use of consumer products, or from subsurface vapour intrusion.

What are typical concentrations of PCE in indoor air?

Health Canada recently surveyed concentrations of different chemicals, including PCE, in indoor air in Quebec City, Windsor and Regina. Typical (*i.e.*, median) concentrations of PCE in indoor air in these studies were less than 0.6 µg/m^3, and in outdoor air[1], less than 0.3 µg/m^3. These levels are lower than those reported in Canada in previous decades. Maximum concentrations in indoor air were below 200 µg/m^3.

Concentrations of PCE in indoor air may be higher if a building is near a point source of PCE emissions, *e.g.*, a factory or a dry cleaning facility using PCE. Different studies of PCE levels in apartments above dry cleaners have reported concentrations ranging from 100 µg/m^3 to greater than 10,000 µg/m^3 (the wide variation is probably related in part to the specific type of drycleaning process used below the apartments).

PCE concentrations in indoor air may also increase when dry-cleaned clothing is first brought home. In addition, dwellings occupied by people who work with PCE may have elevated PCE concentrations as a result of people exhaling some of the PCE to which they were exposed during the day.

What are the potential health effects of PCE?

Potential health effects of PCE differ depending on how much a person was exposed to, how long a person was exposed, how inherently susceptible a person is to the effects of PCE, and whether or not a person was also exposed to other stressors (*e.g.*, other chemicals) which may act in combination with PCE to elicit a health effect. Note that with the possible exception of some types of developmental toxicity, the health effects discussed here were observed following subchronic or chronic exposure (*i.e.*, exposures exceeding a month in duration).

Available human and animal studies have demonstrated that the central nervous system, liver, kidney, reproductive system and developing foetus are targets of PCE toxicity. Neurological effects, including cognitive deficits and decrements in vision or visuo-spatial function, have been observed across multiple human studies, in both occupational and residential settings. Occupational studies have also found associations between reproductive and developmental effects such as spontaneous abortion, liver and kidney effects. There is a lack of studies on chronic disabling neurological diseases, and only few studies of effects on the immune and endocrine systems.

The International Agency for Research on Cancer describes PCE as ‘probably carcinogenic to humans.’ Although exposure to PCE has been associated with different

[1] Concentrations of PCE in outdoor air were reported for Windsor and Regina, but not Quebec City

types of cancer in different studies, a causal link has yet to be established. Human studies on workers or on people exposed to PCE in drinking water have found associations between PCE and cancers of the lymphoid system. Occupational studies have also found associations between PCE and cervical cancer and esophagus, with more limited evidence of cancers of the bladder, kidney and lung.

Sources

The information in this memorandum was assembled from the following sources:

Agency for Toxic Substances Disease Registry. 1997. *Toxicological Profile for Tetrachloroethylene (PERC)*.

International Agency for Research on Cancer. 1995. *IARC Monographs on the Evaluation of Carcinogenic Risks to Humans*. Volume 63.

United States Environmental Protection Agency. 2008. External Review Draft. *Toxicological Profile of Tetrachloroethylene* (*Perchloroethylene*).

World Health Organisation. 2000. *Air Quality Guidelines for Europe*. 2nd Edition.

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

October 26, 2011

Dear Parents/Guardians of children attending ABC Child Care Centre,
189 Adelaide Street South, London, ON

The Middlesex-London Health Unit (MLHU) has become aware of groundwater contamination beneath neighbouring properties in the vicinity of 189 Adelaide Street South. The detection of these contaminants near the property boundary has a potential to impact 189 Adelaide Street South, which houses the ABC Child Care Centre. We would like to provide you with information about this situation.

The Ministry of Environment (MOE) has informed Health Unit staff of the detection of contaminated groundwater located on properties adjacent to 189 Adelaide Street South. One particular contaminant, tetrachloroethene (also known as perchloroethylene or PCE), has been found beneath Adelaide Street South to the East of the ABC Child Care facility, at levels exceeding the Ministry of the Environment Standards.

PCE is a man-made, colourless liquid used for a variety of purposes, its most common use being for dry cleaning fabrics. It is also present in some consumer products. It has a sweet odor detectable by most people at a concentration of 1 part per million (please see the attached Information Sheet).

MLHU staff has considered the available information, including the characteristics of PCE, the locations and concentrations of where it has been found and how human exposure occurs. Based on this assessment, Health Unit staff have concluded it is unlikely that children and staff at the daycare centre have been exposed to higher than acceptable levels of this chemical.

As an added precaution, the MOE and MLHU have arranged for additional testing.

Indoor air testing at ABC Child Care Centre will be conducted this weekend. Although the presence of contamination in subsurface soils and groundwater is not expected to impact surface soils, soil sampling will be carried out in the play ground area as a further precaution. Soil sampling will be done as soon as weather conditions allow. The results of these tests are expected next week and will be communicated to parents and staff as soon as they become available.

An information session for parents will be held at the ABC Child Care Centre tomorrow evening, Thursday, October 27th, at 6:00 p.m. Health Unit staff will be available at that time to answer any questions parents may have.

Yours sincerely,

Graham L. Pollett, MD, MHSc, FRCPC
Medical Officer of Health &
Chief Executive Officer

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BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

October 27, 2011

Dear Clients of Absolutely Creative Training Solutions,
3 - 189 Adelaide Street South, London, ON

The Middlesex-London Health Unit (MLHU) has become aware of groundwater contamination beneath neighbouring properties in the vicinity of 189 Adelaide Street South. The detection of these contaminants near the property boundary has a potential to impact 189 Adelaide Street South. We would like to provide you with information about this situation.

The Ministry of Environment (MOE) has informed Health Unit staff of the detection of contaminated groundwater located on properties adjacent to 189 Adelaide Street South. One particular contaminant, tetrachloroethene (also known as perchloroethylene or PCE), has been found beneath Adelaide Street South to the East of the building housing Absolutely Creative Training Solutions, at levels exceeding the Ministry of the Environment Standards.

PCE is a man-made, colourless liquid used for a variety of purposes, its most common use being for dry cleaning fabrics. It is also present in some consumer products. It has a sweet odor detectable by most people at a concentration of 1 part per million (please see the attached Information Sheet).

MLHU staff has considered the available information, including the characteristics of PCE, the locations and concentrations of where it has been found and how human exposure occurs. Based on this assessment, Health Unit staff have concluded it is unlikely that the staff and clients of Absolutely Creative Training Solutions have been exposed to higher than acceptable levels of this chemical.

As an added precaution, the MOE and MLHU have arranged for additional testing.

Indoor air testing of the building will be conducted on October 29th and 30th. The results of these tests are expected the following week and will be communicated to the clients and staff of Absolutely Creative Training Solutions as soon as they become available.

Should you have any questions regarding this matter, please contact Mr. Iqbal Kalsi, Manager of Environmental Health at the Middlesex-London Health Unit at 519-663-5317 extension 2650.

Yours sincerely,

Graham L. Pollett, MD, MHSc, FRCPC
Medical Officer of Health &
Chief Executive Officer

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BUREAU DE SANTÉ DE
MIDDLESEX-LONDON
HEALTH UNIT

November 9, 2011

Dear Parents/Guardians of children attending ABC Child Care Centre,
189 Adelaide Street South, London, ON

On October 26th, 2011, the Middlesex-London Health Unit (MLHU) advised you that indoor air and playground soil testing would be conducted as an added precaution to confirm that children and staff at ABC Child Care Centre have not been exposed to higher than acceptable levels of perchloroethylene (PCE). These precautions were taken as a result of the discovery of PCE contaminated groundwater beneath neighbouring properties in the vicinity of 189 Adelaide Street South.

Both the soil sampling and indoor air sampling are now complete. None of the chemicals of concern were found in the soil samples. The indoor air sample results have been thoroughly reviewed by MLHU staff and have been compared to both Health Canada and World Health Organization standards. They have also been reviewed by environmental health experts from the Environmental and Occupational Health Team of Public Health Ontario. Results from the sampling show levels are all below standards or within normal ranges for indoor air.

The Ministry of Environment (MOE) will continue with its investigation over the months ahead to determine the source and scope of the groundwater contamination. MLHU staff will communicate regularly with the MOE on the progress of the investigation and will take whatever actions are required, if and when they are necessary, to protect the health of the children and staff of the ABC Child Care Centre.

Information sessions for parents will be held at the ABC Child Care Centre tomorrow, Thursday, November 10th, at 9:00 a.m. and 6:00 p.m. Health Unit staff will be available at those times to answer any questions parents may have.

Yours sincerely,

Graham L. Pollett, MD, MHSc, FRCPC
Medical Officer of Health &
Chief Executive Officer

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BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

November 9, 2011

Dear Clients of Absolutely Creative Training Solutions,
3 - 189 Adelaide Street South, London, ON

In a letter dated October 27th, 2011, the Middlesex-London Health Unit (MLHU) advised you that indoor air testing would be conducted as an added precaution to confirm that clients and staff at Absolutely Creative Training Solutions have not been exposed to higher than acceptable levels of perchloroethylene (PCE). These precautions were taken as a result of the discovery of PCE contaminated groundwater beneath neighbouring properties in the vicinity of 189 Adelaide Street South.

The indoor air sampling is now complete. The results have been thoroughly reviewed by MLHU staff and have been compared to both Health Canada and World Health Organization standards. They have also been reviewed by environmental health experts from the Environmental and Occupational Health Team of Public Health Ontario. Results from the sampling show levels are all below standards or within normal ranges for indoor air.

The Ministry of Environment (MOE) will continue with its investigation over the months ahead to determine the source and scope of the groundwater contamination. MLHU staff will communicate regularly with the MOE on the progress of the investigation and will take whatever actions are required, if and when they are necessary, to protect the health of the clients and staff of Absolutely Creative Training Solutions.

Should you have any questions regarding this matter, please contact Mr. Iqbal Kalsi, Manager of Environmental Health at the Middlesex-London Health Unit at 519-663-5317 extension 2650.

Yours sincerely,

Graham L. Pollett, MD, MHSc, FRCPC
Medical Officer of Health &
Chief Executive Officer

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MIDDLESEX-LONDON HEALTH UNIT
REPORT NO. 123-11

TO: Chair and Members of the Board of Health
FROM: Graham L. Pollett, MD, FRCPC, Medical Officer of Health
DATE: 2011 November 17

Board of Health Training on Public Health Accountability Agreement and Organizational Standards

Recommendation

It is recommended that Report 123-11 re Board of Health Training on Public Health Accountability Agreement and Organizational Standards be received for information.

At the October 20, 2011, Board of Health meeting, Board members reviewed Report No 093-11 re Achieving the Ontario Public Health Organizational Standards and passed the following resolutions:

1. *That Board of Health members complete the Ministry of Health and Long-Term Care online training module for the Public Health Organizational Standards and Ontario Public Health Standards.*

2. *That the Board of Health meet for an education session to review the Organizational Standards and the Ontario Public Health Standards in greater detail.*

As follow up to resolution 2 above, on November 10, 2011, members of the Board of Health participated in training on the terms and conditions of the Public Health Accountability Agreement, as well as the Board of Health's current level of compliance with the Ontario Public Health Organizational Standards. A list of Board of Health members who attended the training is attached as Appendix A.

The training session was led by the Medical Officer of Health and Mr. Ross Graham, Manager, Special Projects (Records Management, Policy and Continuous Quality Improvement). The PowerPoint presentation is attached as Appendix B. Board of Health members directed staff to undertake the following:

1. Where the Board of Health is already in compliance, revise existing policies, procedures and bylaws to reflect same.

2. Where the Board of Health is not in compliance, staff members are to undertake the appropriate action to achieve compliance and report on same to the Board.

3. Staff to implement a regular Board of Health reporting process to ensure maintenance of compliance with the Organizational Standards.

This report was prepared by Mr. Ross Graham, Manager, Special Projects (Records Management, Policy and Continuous Quality Improvement).

Graham L. Pollett, MD, FRCPC
Medical Officer of Health

This report addresses the Public Health Accountability Agreement and the Ontario Public Health Organizational Standards (OS) at the Middlesex-London Health Unit.

Appendix A

Attendance List

Board of Health Training Session
Public Health Accountability Agreement and Organizational Standards

November 10, 2011
Room 3A
50 King Street

Present: Ms. Denise Brown
Ms. Patricia Coderre (Chair)
Mr. Al Edmondson
Dr. Francine Lortie-Monette
Ms. Doreen McLinchey
Mr. Marcel Meyer
Mr. Stephen Orser
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Mark Studenny

Regrets: Mr. Don Shipway

choose health!

MIDDLESEX-LONDON HEALTH UNIT

MIDDLESEX-LONDON HEALTH UNIT

Accountability and the **Organizational Standards**

November 10, 2011

choose health

MIDDLESEX-LONDON HEALTH UNIT

Health Protection and Promotion Act (HPPA)

choose health

Duty of Board of Health

(HPPA section 4)

Every board of health…

(a) shall superintend, provide or ensure the provision of the health programs and services required by this Act and the regulations to the persons who reside in the health unit served by the board; and

(b) shall perform such other functions as are required by or under this or any other Act. R.S.O. 1990, c. H.7, s. 4.

Mandatory Programs & Services

(HPPA section 5)

Every board of health shall superintend, provide or ensure the provision of health programs and services in the following areas:

- Community sanitation, to ensure the maintenance of sanitary conditions and the prevention or elimination of health hazards.
  - Incl. the provision of safe drinking water by small drinking water systems.
- Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults.
- Health promotion, health protection and disease and injury prevention, including the prevention and control of cardiovascular disease, cancer, AIDS and other diseases.
- Continued…

Mandatory Programs & Services

(HPPA section 5)

- Family health, incl.
  - counselling services, family planning services,
  - health services to infants, pregnant women in high risk health categories and the elderly,
  - preschool and school health services, including dental services,
  - screening programs to reduce the morbidity and mortality of disease,
  - tobacco use prevention programs, and nutrition services.
  - Collection and analysis of epidemiological data.
  - Such additional health programs and services as are prescribed by the regulations.

- Home care services that are insured services under the Health Insurance Act, including services to the acutely ill and the chronically ill.

R.S.O. 1990, c. H.7, s. 5; 1997, c. 30, Sched. D, s. 2; 2007, c. 10, Sched. D, s. 1 (3).

Guidelines (HPPA section 7)

The Minister may **publish guidelines for the provision of mandatory health programs and services** and every board of health shall comply with the published guidelines. R.S.O. 1990, c. H.7, s. 7 (1).

And they have… The Ontario Public Health Standards (program, foundational and organizational).

Performance/Accountability Agreement (HPPA section 81.2)

The Minister may **enter into an agreement with the board of health of any health unit for the purpose of setting out requirements for the accountability of the board of health and the management of the health unit**. 2007, c. 10, Sched. F, s. 16.

An agreement under subsection (1) may also provide for services which are to be provided by boards of health in addition to any services set out in this Act or the regulations. 2007, c. 10, Sched. F, s. 16.

And they have… The Accountability Agreement

Public Health Accountability Agreement (PHAA)

PHAA

Under the HPPA, the Province may provide grants to boards of health. The PHAA ties this funding to…

a) Performance on 14 indicators

b) Standards compliance & written compliance

Execution of PHAA (PHHA article 2.2)

The Board of Health represents and warrants that:

a) It has the full power and authority to enter into the Agreement;

b) It will fulfill the obligations set out in the Schedules to this Agreement in accordance with their terms;

c) It will deliver programs and services that meet the Ontario Public Health Standards published under section 7 of the Act, and will comply with the Organizational Standards;

d) It has taken all necessary actions to authorize the execution of the Agreement including, where required, passing a board resolution or municipal by-law authorizing the Board of Health to enter into the Agreement with the Province

Governance (PHHA article 2.3)

BOH represents and warrants and covenants that it has, and shall maintain, in writing, for the period during which the Agreement is in effect:

a) Procedures to ensure compliance with the Organizational Standards;
b) A code of conduct and ethical responsibilities for all persons at all levels of the Board of Health's organization;
c) Procedures to ensure the ongoing effect functioning of the Board of Health;
d) Procedures to ensure the ongoing effect functioning of the Board of Health;
e) Procedures to provide for the prudent and effective management of the Grant;

Governance (PHHA article 2.3)

BOH represents and warrants and covenants that it has, and shall maintain, in writing, for the period during which the Agreement is in effect:

f) Procedures to enable the successful completion of the obligations set out in the Schedules to this Agreement;

g) Procedures to enable the timely identification of risks to the Board of Health's ability to perform its obligations under this Agreement and strategies to address the identified risks;

h) Procedures to enable the preparation and delivery of all Reports required pursuant to Article 8; and,

i) Procedures to deal with such other matters as the Board of Health considers necessary to ensure that the Board of Health carries out its obligations under the Agreement

Supporting Documentation

(PHHA article 2.4)

Upon request, the Board of Health shall provide the Province with proof of the matters referred to in this Article 2

Performance Improvement

(PHHA article 5.1)

The Parties agree to adopt a proactive and responsive approach to performance improvement ("Performance Improvement Process"), based on the following principles:

a) A commitment to continuous quality improvement;
b) A culture of information sharing and understanding; and
c) A focus on risk-management

Implications of Boards of Health?

Events of Default

(PHHA article 14.1)

Each of the following events shall constitute an Event of Default:

a) In the opinion of the Province, the BOH breaches any representation, warranty, covenant or other material term of the Agreement, including failing to do any of the following accordance with the terms and conditions of the Agreement:

   i. Carry out its obligations in the Schedules;

   ii. Use or spend the Grant; and/or

   iii. Provide, in accordance with section 8.1, Reports or such other reports as may have been requested pursuant to section 8.1(b);

b) The BOH's operations, or its organizational structure, changes so that it no longer meets one or more of the applicable eligibility requirements of the program under which the Province provides the Grant; and

c) The BOH ceases to operate, is merged or otherwise dissolved.

Consequences of Events of Default & Corrective Action

(PHHA article 14.2)

If an Event of Default occurs, the Province may at any time, take one or more of the following actions:

a) Initiate any action the Province considers necessary in order to facilitate the successful continuation or completion of the Board of Health's obligations under this Agreement;
b) Provide the Board of Health with an opportunity to remedy the Event of Default;
c) Suspend the payment of the Grant for such period as the Province determines appropriate;
d) Reduce the amount of the Grant;
e) Cancel all further instalments of the Grant;
f) Demand the repayment of any amounts of the Grant remaining in the possession or under the control of the Board of Health;
g) Demand the repayment of an amount equal to any Grant the Province provided to the Board of Health; and/or
h) Terminate the Agreement at any time, including immediately, upon giving Notice to the Board of Health

PHAA Resolution

On September 15, 2011, the Board of Health endorsed the Accountability Agreement (report 080-11).

The Accountability Agreement comes into effect retroactively: Jan 1, 2011 until Dec 31, 2013

Ontario Public Health Organizational Standards

and current state of MLHU compliance

1) BOH Structure

1.1 Definition of a board of health

- *There shall be a board of health for each public health unit. (HPPA, s.48) A board of health is composed of the members appointed to the board under this Act and the regulations. (HPPA, s.49 (1)) The term of office of a municipal member of a board of health continues during the pleasure of the council that appointed the municipal member but, unless ended sooner, ends with the ending of the term of office of the council. (HPPA, s.49(7))* (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)

1.2 Number of members on a board of health

- *There shall be not fewer than three and not more than thirteen municipal members of each board of health. (HPPA, s.49(2))* (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)

1.3 Right to make provincial appointments

- *The Lieutenant Governor in Council may appoint one or more persons as members of a board of health, but the number of members so appointed shall be less than the number of municipal members of the board of health. (HPPA, s.49(3))* (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)
- *A member of a board of health appointed by the Lieutenant Governor in Council may be appointed for a term of one, two or three years. (HPPA, s.51(1))*

1.7 Election of the board of health chair

- *At the first meeting of a board of health in each year, the members of the board shall elect one of the members to be chair and one to be vice-chair of the board for the year. (HPPA, s.57(2))* (Does not apply to all municipalities – see HPPA s.55 for exceptions)

1.8 Municipal membership

- *The number of municipal members per municipality for specific boards of health is set out. (HPPA, Reg.559)*

1) BOH Structure

Bylaws, policies, practices = full compliance

R.R.O. 1990, REGULATION 559 - DESIGNATION OF MUNICIPAL MEMBERS OF BOARDS OF HEALTH - Middlesex-London Health Unit

- The Board of Health of the Middlesex-London Health Unit shall have six municipal members as follows:
  1. Three members to be appointed by the County Council of the County of Middlesex.
  2. Three members to be appointed by the Municipal Council of the City of London. R.R.O. 1990, Reg. 559, s. 15.

- Appointments by Lieutenant Governor in Council
  - The Lieutenant Governor in Council may appoint one or more persons as members of a board of health, but the number of members so appointed shall be less than the number of municipal members of the board of health. R.S.O. 1990, c. H.7, s. 49 (3).

1) BOH Structure (cont'd)

1.4 Board of health may provide public health services on reserve

- *A board of health for a public health unit and the council of the band on a reserve within the public health unit may enter into an agreement in writing under which (a) the board agrees to provide health programs and services to the members of the band; and (b) the council of the band agrees to accept the responsibilities of the council of a municipality within the public health unit. An appointment under this section may be for one, two or three years. (HPPA, s.50 (1) and (4))10*
- *The council of the band that has entered into the agreement has the right to appoint a member of the band to be one of the members of the board of health for the public health unit.*
- *The councils of the bands of two or more bands that have entered into agreements under HPPA, s.50(1) have the right to jointly appoint a person to be one of the members of the board of health for the public health unit instead of each appointing a member under HPPA, s.50(2). (HPPA, s. 50(2) and (3))*

3 reserves in Middlesex-London: Muncee, Oneida, Chippewa-on-the-Thames

Compliance in practice, but no written compliance. Bylaw/policy revision required. MLHU Board of Health tried to reach an agreement with the three reserves with no success.

1) BOH Structure (cont'd)

1.5 Employees may not be board of health members

- *No person whose services are employed by a board of health is qualified to be a member of the board of health. (HPPA, s.51(3))*

1.6 Corporations without share capital

- *Every board of health is a corporation without share capital (i.e., Corporations Act and Corporations Information Act do not apply). (HPPA, s.52(1) and (2)) (Does not apply to all municipalities – see HPPA s.55 for exceptions)*

Compliance in practice, but no written compliance. Bylaw/policy revision required.

2) Board Operations

2.1 Remuneration of board of health members

A board of health shall pay remuneration to each member of the board of health on a daily basis and all members shall be paid at the same rate. A board of health shall pay the reasonable and actual expenses of each member of the board of health. The rate of the remuneration paid by a board of health to a member of the board of health shall not exceed the highest rate of remuneration of a member of a standing committee of a municipality within the public health unit served by the board of health, but where no remuneration is paid to members of such standing committees the rate shall not exceed the rate fixed by the Minister and the Minister has power to fix the rate. (HPPA, s.49(4), (5), and (6)) (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)

HPPA, s.49(4) and (5) do not authorize payment of remuneration or expenses to a member of a board of health, other than the chair, who is a member of the council of a municipality and is paid annual remuneration or expenses, as the case requires, by the municipality. (HPPA, s.49(11))

Compliance in practice, but no written compliance. Bylaw/policy revision required (recommended by REPORT NO. 062-10)

2) Board Operations

2.2 Informing municipalities of financial obligations

A board of health shall give annually to each obligated municipality in the public health unit served by the board of health a written notice that complies with the following requirements:

- *The notice shall specify the amount that the board of health estimates will be required to defray the expenses referred to in HPPA, s.72(1) for the year specified in the notice.*
- *If the obligated municipalities in the public health unit have entered into an agreement under HPPA, s.72(3) respecting the proportion of the expenses referred to in HPPA, s.72(1) to be paid by each of them, the notice shall specify the amount for which the obligated municipality is responsible in accordance with the agreement.*
- *If the obligated municipalities in the public health unit have not entered into an agreement under HPPA, s.72(3) respecting the proportion of the expenses referred to in HPPA, s.72(1) to be paid by each of them, the notice shall specify the amount for which the obligated municipality is responsible in accordance with the regulations.*
- *The notice shall specify the times at which the board of health requires payments to be made by the obligated municipality and the amount of each payment required to be made. (HPPA, s.72(5))*

Compliance in practice, but no written compliance. Bylaw/policy revision required.

2) Board Operations

2.3 Quorum - *A majority of the members of a board of health constitutes a quorum of the board. (exceptions apply) (HPPA, s.54)*

2.4 Content of by-laws - *A board of health shall pass by-laws respecting, (a) the management of its property; (b) banking and finance; (c) the calling of and proceedings at meetings; and (d) the appointment of an auditor.*
A board of health may pass by-laws respecting, (a) the appointment, duties and removal of officers (other than the medical officer of health or an associate medical officer of health) and employees, and the remuneration, pensions and other benefits of officers and employees; and (b) any other matter necessary or advisable for the management of the affairs of the board of health. (HPPA, s.56(1) and (2))

2.5 Minutes, by-laws and policies and procedures - *A board of health shall keep or cause to be kept minutes of its proceedings and the text of the by-laws and resolutions passed by it. (HPPA, s.58)*

2.6 Appointment of a full-time medical officer of health - *Every board of health (a) shall appoint a full-time medical officer of health; and (b) may appoint one or more associate medical officers of health, of the board of health. If the position of medical officer of health of a board of health becomes vacant, the board of health and the Minister, acting in concert, shall work expeditiously towards filling the position with a full-time medical officer of health. (HPPA, s.62(1) and (2))*

Bylaws, policies, practices = full compliance

2) Board Operations

2.7 Appointment of an acting medical officer of health
…The board of health shall appoint forthwith a physician as acting medical officer of health. (HPPA, s.69(1))

Compliance in practice – no policy/bylaw
INSERT BOH report reference – David Colby discussion

2.8 Dismissal of a medical officer of health
A decision by a board of health to dismiss a medical officer of health or an associate medical officer of health from office is not effective unless, (a) the decision is carried by the vote of two-thirds of the members of the board; and (b) the Minister consents in writing to the dismissal. A board of health shall not vote on the dismissal of a medical officer of health unless the board has given to the medical officer of health (a) reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered; (b) a written statement of the reason for the proposal to dismiss the medical officer of health; and (c) an opportunity to attend and to make representations to the board at the meeting. (HPPA, s.66(1) and (2)) 13 Ontario Public Health Organizational Standards

Compliance in practice – no policy/bylaw

2) Board Operations

2.9 Reporting relationship of the medical officer of health to the board of health
The medical officer of health of a board of health reports directly to the board of health on issues relating to public health concerns and to public health programs and services under this or any other Act. The medical officer of health of a board of health is responsible to the board for the management of the public health programs and services under this or any other Act. (HPPA, s.67(1) and (3))

The medical officer of health of a board of health is entitled to notice of and to attend each meeting of the board and every committee of the board, but the board may require the medical officer of health to withdraw from any part of a meeting at which the board or a committee of the board intends to consider a matter related to the remuneration or the performance of the duties of the medical officer of health. (HPPA, s.70)

Compliance in practice - vague policy (possible revision required)

Current Policy 2-010 - 2.0 Responsibilities
…The Board delegates responsibility to administer these programs to the MOH in his/her capacity as the Executive Officer (HPPA, 1990, S.67(1)). The MOH reports regularly to the Board at monthly meetings on the conduct of the programs of the Board…

2) Board Operations (2.10)

The board of health shall develop and implement policies or by-laws as applicable regarding the functioning of the governing body, including:

- Use of sub-committees, which includes a process for establishing sub-committees and the requirement for the development of Terms of Reference (if sub-committees are used);
- Frequency of meetings;
- Rules of order for meeting procedures, including recognizing delegations to meetings and conditions for special meetings of the board;
- Preparation of meeting agenda and materials;
- Preparation of minutes and other record-keeping;
- Selection of officers (i.e., executive committee members)
- Selection of board members based on skills, knowledge, competencies and representativeness of the community, where boards of health are able to recommend the recruitment of members to the appointing body;
- Remuneration and allowable expenses for board members;
- Procurement of external advisors to the board, such as lawyers and auditors (if applicable);
- Conflict of interest;
- Confidentiality;
- MOH and executive officers (where applicable) selection process, remuneration, and performance review; and
- Delegation of the MOH duties during short absences such as during a vacation.

BOH shall ensure that bylaws, policies and procedures are reviewed/revised as necessary, at least every two years.

2) Board Operations (2.10)

Compliance in practice – missing policy/bylaw…

- Remuneration and allowable expenses for board members
- Procurement of external advisors to the board, such as lawyers and auditors (if applicable);
- Conflict of interest;
- MOH and executive officers (where applicable) selection process, remuneration, and performance review; and
- Delegation of the MOH duties during short absences such as during a vacation.

Not Applicable:

- Selection of board members based on skills…

3) Leadership

3.1 Board of health stewardship responsibilities

The board of health shall provide governance direction to the administration and ensure that the board remains informed about the activities of the organization on the following:

- The delivery of the OPHS and its Protocols;
- Organizational effectiveness through evaluation of the organization and strategic planning;
- Stakeholder relations and partnership building;
- Research and evaluations, including ethical review;
- Compliance with all applicable legislation and regulations;
- Workforce issues, including recruitment of the MOH and any other senior executives
- (i.e., CEO where applicable);
- Financial management, including procurement policies and practices; and
- Risk management.

Compliance in Practice – However, Vague Responsibility Policy (2-010)…

Policy 2-010 “Responsibilities”

- The Board of Health oversees the interpretation, implementation, management and advocacy for the health programs and services described in the HPPA for persons in the City of London and County of Middlesex.

- The Board of Health is accountable to the Minister of Health and Long-Term Care for interpretation of policies, the local administration and implementation of public health programs. The Board of Health appoints a Medical Officer of Health (MOH) who has been approved by the Minister of Health and Long-Term Care. The Board delegates responsibility to administer these programs to the MOH in his/her capacity as the Executive Officer (HPPA, 1990, S.67(1)). The MOH reports regularly to the Board at monthly meetings on the conduct of the programs of the Board.

- Individual Board members will represent the decision of the Board of Health to their respective appointing bodies. The Board of Health advocates for the Health Unit, which includes programs and services, budgetary issues and broader public health issues.

3) Leadership

3.2 Strategic plan - The board of health shall have a strategic plan and shall ensure that it:

- Expresses the philosophy/mission, a values statement, and the goals and objectives of the board
- of health;
- Describes how equity issues will be addressed in the delivery and outcomes of programs and
- services;
- Describes how the outcomes of the Foundational Standard in the 2008 OPHS (or as current),
- will be achieved;
- Establishes policy direction regarding a performance management and quality improvement
- system;
- Considers organizational capacity;
- Establishes strategic priorities for the organization that address local contexts and integrate local
- community priorities;
- Covers a 3 to 5 year timeframe;
- Includes the advice and input of staff, and community partners; and
- Is reviewed at least every other year and revised as appropriate.

Compliance in Practice – No Board Policy (and MLHU policy is vague)

4) Trusteeship

4.1 Transparency and accountability

The board of health shall operate in a transparent and accountable manner by ensuring that staff and community partners have access to information about board decisions and processes in a timely manner. The board of health shall develop and implement policies and practices regarding:

- Criteria for holding closed board or committee meetings;
- Public access to key organizational documents including the strategic plan, by-laws, policies and procedures, and minutes of board meetings.

Full Compliance – Bylaws 3.7, 3.5; policies 2-010, 2-030

4) Trusteeship

4.2 Board of health member orientation and training

The board of health shall ensure that board of health members are aware of their roles and responsibilities and emerging public health issues and trends by ensuring the development and annual implementation of a comprehensive orientation plan for new board members and a continuing education program for continuing board members.

Orientation and continuing education activities shall occur on an on-going basis and shall include information on the following topics:

Orientation/Training cont'd

- The structure, vision, mission goals and objectives of the public health unit;
- Overview of the strategic plan, the planning process, its relationship to the operational plan, and performance monitoring;
- Community demographics overview, including information on social and cultural diversity;
- Program and service overview, including organizational emergency preparedness planning;
- Provincial government structure and the funding streams of the three ministries;
- The duties and responsibilities of board members, including requirement to attend board meetings, advanced review of meeting materials, understanding of board of health policies and procedures, and understanding of public health issues;
- Board members' fiduciary responsibilities in terms of trusteeship, due diligence, avoiding conflict of interest, maintaining confidentiality, strategic oversight, ethical and compliance oversight, stakeholder engagement, MOH (and executive officers, where applicable) compensation, risk management oversight and succession planning; and
- Opportunities for board members to participate in conferences or seminars that are sponsored or hosted by other organizations.

Compliance in practice = no policy/bylaw

4) Trusteeship

4.3 Board of health self-evaluation

The board of health shall have a self-evaluation process of its governance practices and outcomes that is implemented at least every other year and results in recommendations for improvements in board effectiveness and engagement. This may be supplemented by evaluation by key partners and/or stakeholders. The self-evaluation process shall include consideration of whether:

- Decision-making is based on access to appropriate information with sufficient time for deliberations;
- Compliance with all federal and provincial regulatory requirements is achieved;
- Any material notice of wrongdoing or irregularities is responded to in a timely manner;
- Reporting systems provide the board with information that is timely and complete;
- Members remain abreast of major developments in governance and public health best practices, including emerging practices among peers; and
- The board as a governing body is achieving its strategic outcomes.

Near-Compliance in practice – No policy/bylaw. Self-evaluation must be mandatory and missing question(s) on legalisation compliance.

5) Community Engagement & Responsiveness

5.2 Stakeholder engagement

The board of health shall ensure that the administration develops and implements a stakeholder engagement strategy which includes:

- Establishing and participating in collaborative partnerships and coalitions which address public health issues with non-health sector partners such as community planning organizations, boards of education, social housing authorities, labour organizations, children and youth services and local chambers of commerce;
- Collaborative relationships with key health sector partners, including but not limited to the chief executive officer(s) of the local health integration network(s) (LHINs), hospital administrators, long-term care facility administrators, community health centre administrators and community care access centre administrators, to identify mechanisms for collaboration and coordination in
- planning and service delivery;
- Establishing relationships with schools of public health and/or other related academic programs to promote the development of qualified workers for public health; and
- Monitoring and evaluating these partnerships to determine their effectiveness and identify and address gaps.

Unsure of compliance in practice. No policy/strategy. Further work required to assess level of compliance.

5) Community Engagement & Responsiveness

5.1 Community engagement

The board of health shall ensure that the administration develops and implements a community engagement strategy which includes:

- The provision of information to the public on the board of health's mission, roles, processes, programs and activities to improve the health of its communities;
- The dissemination of results of population health assessments to its communities;
- Providing all information noted above in formats that are accessible to everyone in local communities, and are available through a variety of methods, including a website; and
- The recruitment and engagement of community partners and the public to participate in the development of the strategic and operational plans for the board of health, and in the evaluation of programs and services.

Unsure of Compliance in practice – No policy/strategy. Further work required to assess level of compliance.

5) Community Engagement & Responsiveness

5.3 Contribute to policy development

The board of health shall contribute to the development and/or modification of healthy public policy, as described in the Ontario Public Health Standards, 2008 (or as current), by facilitating community involvement and engaging in activities that inform the policy development process.

Compliance in practice –
Vague reference under policy 2-010…

"The Board of Health advocates for the Health Unit, which includes programs and services, budgetary issues and broader public health issues."

5) Community Engagement & Responsiveness

5.4 Public reporting

The board of health shall produce an annual financial and performance report to the general public, with a description of the mission, roles, processes, programs and operation of the public health unit and performance indicators, to ensure transparency and accountability.

Near-Compliance in practice – MLHU policy requires revision.

5) Community Engagement & Responsiveness

5.5 Client service standards

The board of health shall ensure the administration develops and implements a set of client service standards which will articulate the organization's commitment to provide services that are accessible and timely for clients, community partners and the general public. Client service standards shall include:

- Set times for responsiveness to enquiries;
- Accessibility of programs and services in terms of locations, hours of service, and language; and
- Provision of public information in a manner that is timely and accessible, in multiple formats.

Non-compliance in practice – MLHU policy required.

MIDDLESEX-LONDON HEALTH UNIT

6) Management Operations

Work underway to assess current level of compliance & policy compliance

choose health

MIDDLESEX-LONDON HEALTH UNIT

Next Steps

- CQI Committee undertaking gap analysis (assistance from UWO student)
- Administrative Policy Committee compiling list of policies/bylaws requiring review/creation.
- Leaders and Managers made aware of PHAA and Standards requirements
- Special Projects portfolio preparing workplans to address gaps.

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MIDDLESEX-LONDON HEALTH UNIT

Questions?

Thank you

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