AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH
SIDE ENTRANCE, (RECESSED DOOR)
Board of Health Boardroom

Thursday, 7:00 p.m.
2016 March 10

MISSION - MIDDLESEX-LONDON HEALTH UNIT

The mission of the Middlesex-London Health Unit is to promote and protect the health of our community.

MEMBERS OF THE BOARD OF HEALTH

Ms. Patricia Fulton
Mr. Jesse Helmer (Chair)
Dr. Trevor Hunter
Mr. Marcel Meyer
Mr. Ian Peer
Ms. Nancy Poole
Mr. Kurtis Smith
Mr. Mark Studenny
Mr. Stephen Turner
Ms. Joanne Vanderheyden (Vice-Chair)

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

Public Session – February 18, 2016 Board of Health meeting
March 3, 2016 Finance and Facilities Committee meeting

BUSINESS ARISING FROM THE MINUTES

DELEGATIONS

7:05- 7:25 p.m. Lesley James, Senior Manager Health Policy, Heart and Stroke Foundation re: Item #2 Impact of Sugar Sweetened Beverages (Report No. 016-16).

7:25 – 7:35 p.m. Ms. Trish Fulton, Chair, Finance and Facilities Committee re: Item #1 - Finance and Facilities Committee Meeting March 3, 2016 (Report No. 015-16).

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance and Facilities Committee Meeting March 3, 2016 (Report 015-16)		x	x		To receive information and consider recommendations from the March 3rd, 2016 FFC meeting
Delegations and Recommendation Reports						
2	Impact of Sugar Sweetened Beverages and Creating Supportive Environments (Report 016-16)		x	x		To request that the Board of Health endorse the Heart and Stroke Foundation Sugar, Heart Disease and Stroke Position Statement to complement existing Health Unit work in this area
Information Reports						
3	Income Security – The Effective Response to Food Insecurity (Report 017-16)	Appendix A Appendix B			x	To request that the Board of Health receive the Ontario Society of Nutrition Professionals in Public Health Position Statement on Responses to Food Insecurity for information
4	Summary Information Report for March 2016 (Report 018-16)	Appendix A			x	To provide a summary of information from Health Unit programs
5	Medical Officer of Health Activity Report – March (Report 019-16)				x	To provide an update on the activities of the MOH for March 2016
6	Verbal update on work with Syrian newcomers				x	To provide an update on MLHU's work with Syrian newcomers
7	Verbal update on TB case investigation				x	To provide an update on TB case investigation
8	Generative Discussion: Mayor's Advisory Panel on Poverty Draft Recommendations	Appendix A			x	To discuss the Poverty Panel's draft recommendations and how the issue of poverty can best be addressed in the communities that MLHU serves

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: Thursday, April 7, 2016 @ 9:00 a.m.
- Next Board of Health Meeting: Thursday, April 21, 2016 @ 7:00 p.m.

CONFIDENTIAL

The Board of Health will move in camera to discuss matters concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health and to approve minutes from its February 18, 2016 in camera session regarding a matter concerning potential litigation.

CORRESPONDENCE

a) Date: 2016 February 1(Received 2016 February 3)
Topic: Public Health Approach to Cannabis Legalization
From: Copy of correspondence from Windsor-Essex Health Unit, Gary McNamara Chair, Windsor-Essex County Board of Health, Gary M. Kirk, MPH, MD, Medical Officer of Health and CEO
To: The Right Honourable Justin Trudeau

Background:
Canada has one of the highest rates of cannabis use in the world with over 40% of Canadian adults having used cannabis in their lifetime. In Ontario, it is the most widely consumed illicit drug, with youth and young adults having the highest rates of use.

At the January 26, 2016 Middlesex-London Board of Health Meeting staff were directed to: 1) advocate for an evidence-based public health approach to Cannabis in the context of legalization, including strict regulation for the non-medical use of cannabis, as well as its production, distribution, product promotion and sale; and 2) Establish baseline data and mechanisms to monitor local use of cannabis in the coming years; and 3) Forward this report and appendices to the Association of Local Public Health Agencies, the Ontario Public Health Association, Ontario Boards of Health, the Ontario Minister of Health and Long-Term Care, the federal Minister of Health, and other elected officials as appropriate.

Recommendation:
Receive.

b) Date: 2016 February 1 (Received 2016 February 9)
Topic: Basic Income Guarantee
From: The Honourable Deb Matthews
To: Mr. Ian Peer (2015 MLHU Board of Health Chair)

Background:
The Board of Health considered a report at the September 17th meeting and approved that the Board: 1) Send a letter to the Prime Minister of Canada, the Premier of Ontario and the Ontario Minister Responsible for the Poverty Reduction Strategy requesting they prioritize consideration and investigation into a joint federal-provincial basic income guarantee; and 2) Send a letter to the Premier of Ontario requesting the province increase social assistance rates to reflect the rising cost of nutritious food & safe housing.

Recommendation:
Receive.

c) Date: 2016 February 5 (Received 2016 February 8)
Topic: Mental Health Promotion in Ontario Public Health Agencies
From: Peterborough County-City Health Unit, Scott McDonald Chair, Board of Health
To: The Honourable Dr. Eric Hoskins

Background:
The Middlesex-London Health Unit was one of three leads in a locally-driven collaborative project called: "Supporting Ontario Public Health Units to Promote the Mental Health of Children and Youth", which aimed to identify areas of focus regarding mental health promotion for children and youth. The report from this project reported that mental health service providers see that public health agencies have a role in mental health promotion leadership. There are currently no explicit and strategic directions in the Ontario Public Health Standards regarding this role.
Recommendation:
Receive.

d) Date: 2016 February 8

Topic: Canadian Cancer Society Youth 4 Action Program
From: Nancy Wirtz, Senior Coordinator, Cancer Prevention
To: All Health Units

Background:
The Canadian Cancer Society invites groups of youth ages 14+ to use their skills and creativity to educate their peers about cancer prevention and advocate for policy changes in their communities that support health.

Recommendation:
Receive.

e) Date: 2016 February 16
Topic: alPHa Board of Health Section Meeting Agenda Package
From: Linda Stewart, Association of Local Public Health Agencies
To: all Boards of Health, Board of Health members and senior management

Background:
The Association of Local Public Health Agencies (alPHa) seeks to assist local public health units in providing efficient and effective services that meet the needs of the people of Ontario. It also strives to assist in establishing, through collaboration with other organizations, a unified and powerful voice for public health in Ontario. The Board of Health section meeting was held on February 25, 2016 and featured sessions on Skill-Based Boards, Patients First and a Ministry Update from Dr. Bob Bell, Deputy Minister, Ministry of Health and Long-Term Care.

Recommendation:
Receive.

f) Date: 2016 February 8 (Received 2016 February 17)
Topic: Memorandum from Dr. Robert Kyle, Commissioner & Medical Officer of Health, dated January 12, 2016 re: Cannabis Regulation and Control
From: Debi A. Wilcox, Regional Clerk/Director of Legislative Services, Durham Region
To: The Right Honourable Justin Trudeau

Background:
See item (a) above.

Recommendation:
Receive.

g) Date: 2016 February 18 (Received 2016 February 19)
Topic: Patients First: A Proposal to Strengthen Patient-Centered Care in Ontario
From: Dr. A. Lynn Noseworthy, Medical Officer of Health, Haliburton, Kawartha, Pineridge District Health Unit
To: The Board of Health

Background:
Patients First: Action Plan for Health Care was announced in December 2015 and focuses on four key objectives:

1) *Access*: Improve access – providing fast access to the right care.

2) *Connect*: Connect services – delivering better coordinated and integrated care in the community, closer to home.
3) *Inform*: Support people and patients – providing the education, information and transparency they need to make the right decisions about their health.
4) Protect: Protect our universal public health care system – making evidence based decisions on value and quality, to sustain the system for generations to come.

The Middlesex-London Board of Health considered a report at the January 21, 2016 meeting and discussed potential changes to the public health funding model and boundaries and jurisdictions served by Local Health Integration Networks and how this might affect funding and direction of the Board of Health.

Recommendation:
Receive.

h) Date: 2016 February 8 (Received 2016 February 19)
Topic: Ontario Ministry of Health and Long Term Care's discussion paper: Patients First: A Proposal to Strengthen Patient-Centered Care in Ontario
From: Councillor Shad Qadri, Chair, Board of Health for the City of Ottawa Health Unit
To: The Honourable Dr. Eric Hoskins

Background:
See item (g) above.

Recommendation:
Receive.

i) Date: 2016 February 22
Topic: Basic Income Guarantee
From: James Chirico, Medical Officer of Health/Executive Officer, North Bay Parry Sound District
To: The Honourable Deb Matthews

Background:
See item (b) above.

Recommendation:
Receive.

j) Date: 2016 February 23
Topic: alPHa Board of Health Section Meeting Agenda
From: Susan Lee, alPHa
To: All Board of Health Members

Background:
See item (e) above.

Recommendation:
Receive.

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

ADJOURNMENT

PUBLIC SESSION – MINUTES

MIDDLESEX-LONDON BOARD OF HEALTH

2016 February 18

MEMBERS PRESENT:	**Mr. Jesse Helmer** (Chair) Mr. Marcel Meyer Mr. Ian Peer Ms. Viola Poletes Montgomery Ms. Nancy Poole Mr. Kurtis Smith Mr. Mark Studenny Mr. Stephen Turner **Ms. Joanne Vanderheyden** (Vice-Chair)
Absent	Ms. Trish Fulton
OTHERS PRESENT:	Dr. Christopher Mackie, Medical Officer of Health & CEO Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder) Ms. Mary Lou Albanese, Manager, Child Health Ms. Rhonda Brittan, Manager, Healthy Communities & Injury Prevention Ms. Laura Di Cesare, Director, Corporate Services Mr. Dan Flaherty, Manager, Communications Dr. Gayane Hovhannisyan, Associate Medical Officer of Health Ms. Donna Kosmack, Manager, South West Tobacco Control Area Network Ms. Heather Lokko, Director, Healthy Start Ms. Bernie McCall, Public Health Nurse, Healthy Communities & Injury Prevention Mr. John Millson, Associate Director, Finance Mr. Dave Pavletic, Manager, Food Safety & Healthy Environments Mr. Fatih Sekercioglu, Manager, Safe Water, Rabies & Vector-Borne Disease Ms. Linda Stobo, Manager, Chronic Disease Prevention & Tobacco Control Mr. Alex Tyml, Online Communications Coordinator Ms. Suzanne Vandervoort, Director, Healthy Living
MEDIA OUTLETS:	None

Chair Helmer called the meeting to order at 7:03 p.m.

Chair Helmer noted the following additions to the agenda: an appendix item for Report No. 008-16, 2016 Proposed Budget (Appendix C), a verbal update provided on Syrian Newcomers and an item requiring the Board of Health to move in camera to discuss a matter concerning potential litigation affecting the Middlesex-London Health Unit.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Helmer inquired if there were any disclosures of conflict(s) of interest. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden *that the **AGENDA** for the February 18, 2016 Board of Health meeting be approved with amendments.*

Carried

Dr. Mackie announced that it was Ms. Poletes-Montgomery's last meeting with the Middlesex-London Board of Health. Chair Helmer and Dr. Mackie acknowledged and thanked Ms. Poletes-Montgomery for her dedication to the Board of Health over the last 10 years.

APPROVAL OF MINUTES

It was moved by Ms. Poletes Montgomery, seconded by Ms. Vanderheyden *that the **MINUTES** for the January 21, 2016 Board of Health meeting be approved.*

Carried

It was moved by Ms. Poletes-Montgomery, seconded by Ms. Vanderheyden, *that the* **MINUTES** *for the January 14, 2016 Finance and Facilities Committee meeting be received.*

Carried

It was moved by Ms. Poletes-Montgomery, seconded by Ms. Vanderheyden, *that the* **MINUTES** *for the January 28, 2016 Finance and Facilities Committee meeting be received.*

Carried

BUSINESS ARISING FROM THE MINUTES - none

COMMITTEE REPORTS

1) Finance and Facilities Committee (FFC) Report, January 28th Meeting (Report No. 007-16)

Mr. Peer provided a summary of the 2016 budget process and updated the Board of Health on the recommendations from the January 28, 2016 Finance and Facilities Committee (FFC) meeting.

It was moved by Mr. Peer, seconded by Mr. Hunter *that the Board of Health receive the recommendations from the January 28, 2016 Finance and Facilities update Report No. 007-16 for information.*

Carried

It was moved by Mr. Peer, seconded by Mr. Meyer, *that the Board of Health receive the 2015 Board of Health Remuneration report for information.*

Carried

It was moved by Mr. Peer, seconded by Mr. Meyer *that the Board of Health receive the remaining information reports included in Report No. 007-16 for information.*

Carried

It was moved by Mr. Peer, seconded by Mr. Meyer *that the Board of Health receive the Finance and Facilities Committee recommendation to approve the components of the 2016 budget with amendments, as outlined in Report No. 007-16.*

Carried

2) 2016 Proposed Budget (Report No. 008-16)

Mr. John Millson, Associate Director, Finance, summarized the 2016 operating budget.

Mr. Turner arrived to the meeting at 7:20 pm.

The Board of Health thanked Health Unit staff and commended the 2016 budget process.

Discussion ensued about the Health Unit's budget model and the possibility of moving to a new funding formula and the business case for paying a living wage.

Chair Helmer clarified the decision that was to be made. Supporting this recommendation would certify the Health Unit as a living wage employer, advising that discussion about the broader implications could be discussed at a later time.

Mr. Hunter clarified what the approval of 2016 budget would mean for the decision to support a living wage.

Dr. Mackie clarified the business care for a living wage, advising that this was a business decision based on the case outlined in the Program Budget Marginal Assessment (PBMA) and the approval of the 2016 budget would allow the Health Unit to be certified as a living wage employer. Dr. Mackie also noted it is important to keep this concept separate from that of a minimum wage.

It was moved by Mr Peer, seconded by Ms Poletes-Montgomery, *that that the Board of Health:*

1) *Approve the 2016 Operating Budget in the gross amount of $34,865,737 as appended to Report No. 008-16 re: 2016 Proposed Budget; and further*

2) *Forward Report No. 008-16 to the City of London and the County of Middlesex for information; and*

3) *Direct staff to submit the 2016 Operating Budget in the Ministry of Health and Long-Term Care's Program Based Grant format, or whatever format the provincial funder requires.*

Carried

DELEGATION AND RECOMMENDATION REPORTS

1) City Strategic Investments Congruent with Promoting and Protecting the Health of our Community (Report No. 009-16)

Dr. Mackie summarized this report and noted areas in the City budget that are well-aligned with the Health Unit's mandate, acknowledging the Health Unit staff in attendance that authored the report.

It was moved by Mr. Meyer, seconded by Mr. Turner, *that the Board of Health*:

1) *Receive Report No. 009-16 re: City Strategic Investments Congruent with Promoting and Protecting the Health of our Community; and*
2) *Submit a letter to City of London Administration supporting specific Strategic Investments in the 2016 – 2019 Multi-Year Budget for the City of London that are relevant to the Middlesex London Health Unit's mandate.*

Carried

2) Southwest Tobacco Control Area Network Single Source Vendor (Report No. 010-16)

Dr. Mackie introduced Ms. Donna Kosmack who provided some brief comments on this report, noting the Agency's recent name change to: Rescue - Behaviour Change Agency.

It was moved by Mr. Peer, seconded by Mr. Studenny, *that the Board of Health waive the competitive procurement process and award a contract estimated at $89,947 to Rescue Social Change Group as detailed in Report No.010-16 re: "Southwest Tobacco Control Area Network Single Source Vendor."*

Carried

3) Vector-Borne Disease Program Request for Proposal (Report No. 011-16)

Dr. Mackie advised that Mr. Fatih Sekercioglu was in attendance to answer any questions.

It was moved by Mr. Turner, seconded by Mr. Hunter, *that Report No. 011-16 re Vector-Borne Disease Program – Request for Proposal be received for information and,*

> *1) That G.D.G. Environnement be awarded the contract for the Vector Borne Disease Program – Part A - Larval Mosquito Surveillance & Control in the amount of $129,870.00 (before taxes); and further*
>
> *2) That Entomogen Incorporated be awarded the contract for the Vector Borne Disease Program – Part B - Mosquito Identification and Viral Testing in the amount of $22,080.00, (before taxes).*

Carried

INFORMATION REPORTS

1) MLHU Social Media: Activities and Audiences (Report No. 012-16)

It was moved by Ms. Vanderheyden, seconded by Ms. Poletes Montgomery, *that Report No. 012-16 re MLHU Social Media: Activities and Audiences be received for information.*

Carried

2) Summary Information Report for February 2016 (Report No. 013-16)

It was moved by Ms. Vanderheyden, seconded by Ms. Poletes-Montgomery, that Report No. 013-16 *re Summary Information Reports for February 2016 be received for information.*

Carried

3) Medical Officer of Health Activity Report – February (Report No. 014-16)

It was moved by Ms. Vanderheyden, seconded by Ms. Poletes Montgomery, *that Report No. 014-16 re Medical Officer of Health Activity Report be received for information*.

Carried

OTHER BUSINESS

Dr. Gayane Hovhannisyan provided an update to the Board of Health on the status of Syrian Newcomers and the screening that the Health Unit has been doing to address the health needs of Syrian Newcomers.

Chair Helmer invited a motion to receive Dr. Hovhannisyan's verbal update on Syrian Newcomers.

It was moved by Mr. Studenny, seconded by Mr. Turner, *that the Board of Health receive Dr. Hovhannisyan's verbal update on the status of Syrian Newcomers.*

Carried

CORRESPONDENCE

It was moved by Mr. Studenny, seconded by Ms. Vanderheyden *that the Board of Health receive correspondence items a) through l).*

Carried.

Upcoming meetings

Finance and Facilities Committee – Thursday, March 3, 2016, 9:00 a.m.
Board of Health – Thursday, March 10, 2016 7:00 p.m.

At 7:58 p.m. Chair Helmer invited a motion to move in camera to discuss a matter related to potential litigation affecting the Middlesex-London Health Unit.

At 7:58 p.m. it was moved by Ms. Vanderheyden, seconded by Mr. Studenny *that the Board of Health move in camera to discuss a matter concerning potential litigation affecting the Middlesex-London Health Unit.*

Carried

At 8:01 p.m. all Health Unit staff, except Dr. Mackie, Dr. Hovhannisyan and Elizabeth Milne, left the meeting.

At 8:26 p.m. it was moved by Mr. Turner, seconded by Mr. Studenny *that the Board of Health rise and return to public session to adjourn the meeting.*

Carried

At 8:26 p.m. the Board of Health returned to public session.

ADJOURNMENT

At 8:26 p.m., it was moved by Ms. Poletes-Montgomery, seconded by Mr. Studenny *that the meeting be adjourned.*

Carried

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JESSE HELMER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

DRAFT - PUBLIC MINUTES
Finance and Facilities Committee
50 King Street, Room 3A
MIDDLESEX-LONDON BOARD OF HEALTH
2016 March 3, 9:00 a.m.

COMMITTEE MEMBERS PRESENT:
Ms. Trish Fulton **(Committee Chair)**
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Jesse Helmer

Absent
Ms. Joanne Vanderheyden

OTHERS PRESENT:
Dr. Christopher Mackie, Medical Officer of Health and CEO
Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder)
Ms. Laura Di Cesare, Director, Corporate Services
Mr. John Millson, Associate Director, Finance

At 9:00 a.m., Chair Fulton called the meeting to order.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Fulton inquired if there were any disclosures of conflict of interest to be declared. None were declared.

2. APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Mr. Helmer *that the* ***AGENDA*** *for the March 3, 2016 Finance and Facilities Committee meeting be approved.*

Carried

3. APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Mr. Helmer *that the* ***MINUTES*** *from the January 28, 2016 Finance and Facilities Committee meeting be approved.*

Carried

4. NEW BUSINESS

4.1 2015 Fourth Quarter Budget Variance Report and Factual Certificate (**Report No. 07-16FFC**)

Mr. John Millson summarized and provided context to this report, noting some issues that were built into the projections.

Discussion ensued and questions were asked about the following items:

- Any legal responsibility or accountability issues that may be associated with covering the costs for the dental treatment program from cost-shared program surplus.
- Why the reserve fund is not being used to cover this cost, including clarification of the primary purpose of the reserve fund as a risk-mitigation step in case of closing costs for the clinic.

- The circumstances that have caused the dental treatment program to go into deficit, which include decreased revenues from operational costs associated with missed appointments and no increase in revenue from reimbursement, which still draws from the 2010 fee guide.
- Clarification on approving this recommendation as a one-time use of surplus funds to cover the costs, rather than it becoming a policy.

Dr. Mackie clarified and advised that the Health Unit is able to set the budget to achieve its legislated mandate. The Health Unit is interpreting the public health legislation to use surplus funds to cover this cost since the Health Protection and Promotion Act indicates that the Board of Health can set budgets to achieve their mandate. With the budget that has been set, the Health Unit is using funds to achieve this mandate. Health Unit staff continue to look at how to improve the profitability of the clinic, such as adjusting staff hours and trying to reduce missed appointments, with the hope that these measures will address the deficit over the next year.

Chair Fulton inquired about item 9 of Appendix B (Factual Certificate), and Dr. Mackie advised this question could be answered when the committee moves in camera; the matter concerns an identifiable individual.

It was moved by Mr. Helmer, seconded by Mr. Meyer *that the Finance and Facilities Committee receive Report No. 07-16FFC "Fourth Quarter Budget Variance Report & Factual Certificate" for information*.

Carried

It was moved by Mr. Peer, seconded by Mr. Helmer *that the 2015 Dental Treatment program deficit be funded by general Cost-Shared program surplus.*

Carried

4.2 2015 Vendor and Visa Payments (**Report No.08-16FFC**)

Mr. Millson provided context to this report and answered questions about staff use of corporate cards and the cost increase in materials and supplies.

It was moved by Mr. Meyer, seconded by Mr. Peer, *that the Finance & Facilities Committee receive Report No. 08-16FFC, "2015 Vendor / Visa Payments" as information.*

Carried

5. CONFIDENTIAL

The Finance and Facilities Committee will move in camera to discuss the following:

- A matter concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health.
- A matter concerning an identifiable individual and litigation involving the Middlesex-London Health Unit.

At 9:43 a.m. Chair Fulton invited a motion to move in camera to discuss a matter concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health.

It was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance and Facilities Committee move in camera to discuss a matter concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

DRAFT

At 10:02 a.m. it was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance and Facilities Committee rise and return to public session.*

Carried

6. OTHER BUSINESS

6.1 Next meeting: Thursday April 7, 2016 9:00 a.m. Room 3A.

7. ADJOURNMENT
8.

It was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance and Facilities Committee meeting be adjourned.*

At 10:02 a.m. Ms. Fulton *adjourned the meeting.*

Carried

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TRISH FULTON
Committee Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

DRAFT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 015-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 March 10

FINANCE AND FACILITIES COMMITTEE MEETING MARCH

The Finance and Facilities Committee met at 9:00 a.m. on March 3, 2016 (**Agenda**).
The following items were discussed at the meeting and recommendations made:

Reports	Recommendations for Board of Health's Consideration
2015 Fourth Quarter Budget Variance Report and Factual Certificate (Report 07-16FFC)	Following discussion about items in this report Chair Fulton invited a motion to amend the recommendations and approve each item separately. There were no contentions to this amendment. It was moved by Mr. Helmer, seconded by Mr. Meyer *that the Finance and Facilities Committee receive Report No. 07-16FFC "Fourth Quarter Budget Variance Report & Factual Certificate" for information.* Carried It was moved by Mr. Peer, seconded by Mr. Helmer *that the 2015 Dental Treatment program deficit be funded by general Cost-Shared program surplus.* Carried
2015 Vendor and Visa Payments (Report 08-16FFC)	It was moved by Mr. Meyer, seconded by Mr. Peer, *that the Finance & Facilities Committee receive Report No. 08-16FFC, "2015 Vendor / Visa Payments" as information.* Carried

The Finance and Facilities Committee moved in camera to discuss a matter concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health and matters concerning an identifiable individual .

The next meeting of the Finance and Facilities Committee has been scheduled for Thursday, April 7, 2016 at 9:00 am.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 016-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health and CEO

DATE: 2016 March 10

IMPACT OF SUGAR SWEETNENED BEVERAGES AND CREATING SUPPORTIVE ENVIRONMENTS

It is recommended that the Board of Health:
1. ***Receive report No. 016-16 re Impact of Sugar Sweetened Beverages and Creating Supportive Environments; and***
2. ***Endorse the Heart and Stroke Foundation Sugar, Heart Disease and Stroke Position Statement to complement existing Health Unit work in this area.***

Key Points

- Intake of sugar sweetened beverages has been linked to obesity and several other health conditions.
- Sugar sweetened beverages are energy dense, contain little or no nutrient value and are high in sugar.
- Offering healthier alternatives and creating more supportive environments allows the healthy choice to be the easy choice.

Background

A growing body of credible research indicates an increased incidence of a number of health risks associated with consumption of sugar sweetened beverages (SSB's). The consumption of SSB's has been linked to obesity, type 2 diabetes, cardiovascular disease, dental caries, dyslipidemia and metabolic syndrome. Studies have also shown that the consumption of SSB's is associated with lower consumption of nutrient dense beverages. The free sugars associated with these beverages may also contribute to the development of dental caries, especially in teenagers.

SSB's include soft drinks, fruit drinks, sports drinks, tea and coffee drinks, energy drinks, sweetened milk or milk alternatives, and any other beverages to which sugar has been added. Although some fruit drinks and sweetened milks have some nutrients, their benefit is offset by the harms of the sugar.

In 2010, an estimated 1,598 deaths were attributable to SSB consumption via cardiovascular disease, diabetes or cancer. In children, higher intake of SSB's have been found to be associated with a 55% increased risk of being overweight or obese compared to children with lower intakes.

Healthy weights are an issue of public health importance across Canada and within our region. The most recent Canadian Community Health Survey identifies that approximately 23% of London and Middlesex County children aged 12-17 are obese or overweight. Youth who are overweight and obese are at higher risk of being overweight or obese in adulthood and are at increased risk for serious health problems. Recent statistics report that nearly 60% of London and Middlesex County adults are also overweight or obese.

The amount of sugar in one can of pop is on average about 40 grams or 10 teaspoons of sugar. These beverages offer no health or nutritional benefit. Over time, the portion sizes of these beverages have also increased, contributing to the increased volume consumed. Over 30% of males aged 5-19 and over 23% of females report drinking SSB's daily in the Canadian Health Measures Survey.

The consumption of SSB's increases with age, and is more pronounced in males than females. The World Health Organization (WHO) recommends that the consumption of free sugar, both added and natural sugars, be limited to 10% of total energy intake to reduce the risk of overweight, obesity and tooth decay. SSB's account for approximately 7-8% of daily energy intake for Canadian adolescents.

In 2012, the Ontario government set a target to reduce childhood obesity by 20% over 5 years. Given the relationship between SSB consumption and obesity, implementing strategies to decrease SSB intake are of public health importance. In 2010, the Public Health Agency of Canada released the *Curbing Childhood Obesity Report* recommending several measures which included creating supportive environments to make the healthy choice the easy choice.

The *No Time to Wait: Healthy Kids Strategy* report makes several recommendations including changing the food environment to make healthy choices easier. The next theme for the Healthy Kids Community Challenge in London and Middlesex County is to promote water consumption as the preferred and healthy beverage choice. The ultimate objective of this strategy is to reduce SSB consumption.

Opportunities for Action

Comprehensive community-level interventions that incorporate education, skill building and public policies aimed at improving the nutrition environment are needed to help reduce the consumption of SSB's.

Health Unit Registered Dietitians work with various stakeholders within the community to help create more supportive environments for healthy eating, including reducing consumption of SSB's. Some of the initiatives the dietitians are currently involved with include:

- Supporting food literacy programming
- Collaborating with the City of London and Middlesex County Healthy Kids Community Challenge initiatives on municipal policy directions regarding increased water consumption
- Exploring the inclusion of water bottle filling stations in pilot schools
- Supporting the implementation of the Ontario School Food and Beverage Policy (PPM 150)
- Advocacy related to menu labelling (Board Report 012-15)
- Supporting the establishment of a Middlesex-London Food Policy Council (Board Report 52-15)

The Heart and Stroke Foundation's position statement, Sugar, Heart Disease and Stroke Position Statement, outlines the health risks associated with sugar and SSB's. It also identifies recommendations for many stakeholders including: the general public; federal, provincial and municipal governments; workplaces; school boards; and the food and beverage industries. Recommendations include an excise tax on sugar sweetened beverages, restricting the marketing of foods and beverages to children, supporting food literacy, accessible potable drinking water in public facilities, and strengthening food policies within schools. It is recommended that the Board of Health endorse the Heart and Stroke Foundation Position Statement.

This report was prepared by the Middlesex-London Health Unit Registered Dietitians.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health and CEO

This report addresses the following requirements of the Ontario Public Health Standards (2015): Foundational Standard 1, 3, 4, 5, 8; Chronic Disease Prevention 1, 3, 4, 5, 6, 11; Child Health 1, 4.

MIDDLES4EX-LONDON HEALTH UNIT

REPORT NO. 017-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health and CEO

DATE: 2016 March 10

INCOME SECURITY – THE EFFECTIVE RESPONSE TO FOOD INSECURITY

Recommendations

It is recommended that the Board of Health receive the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) Position Statement on Responses to Food Insecurity for information.

Key Points

- Food insecurity greatly impacts health, wellbeing and healthcare costs. Lack of sufficient income is the root cause of food insecurity.
- The OSNPPH Position Statement on Responses to Food Insecurity calls for the implementation of a basic income guarantee as an effective, long term solution to reduce food insecurity.
- In September 2015, the Board of Health endorsed the need for the provincial and federal governments to prioritize consideration and investigation into a joint federal-provincial basic income guarantee.
- Health Unit staff will inform OSNPPH that the Middlesex-London Board of Health endorses investigation of a basic income guarantee as a response to food insecurity.

Background

March is Nutrition Month and March 16, 2016, is National Dietitians' Day. During the month and throughout the year, Canadian Registered Dietitians promote the importance of healthy eating and its positive effect on health and well-being. This year's theme is *Take a 100 meal journey. Make small changes one meal at a time*. Providing food literacy opportunities to help support Middlesex-London residents to improve diet quality is important; however, for many residents, diet quality and quantity is not only about a lack of food literacy, but the inability to afford healthy food.

Household food insecurity -- inadequate or insecure access to food because of financial constraints -- is a serious social and public health issue. In 2011, nearly 26 000 Middlesex-London residents aged 12 years and older were estimated to be food insecure. As reviewed in the September 2015 Board Report 50-15, from 2014 to 2015, local food prices increased 7% for a family of four. Food prices are expected to continue to increase, especially for healthy foods, as a result of the lowered value of the Canadian dollar and challenging growing conditions due to weather.

Food insecurity greatly impacts health, wellbeing and healthcare costs. An Ontario study reported that annual healthcare costs were about $2,300 (120%) higher per adult in households with severe food insecurity compared to food secure households. Adults who are food insecure have poorer self-rated health and are more likely to suffer from chronic conditions such as diabetes, high blood pressure and anxiety. Children who experience food insecurity have an increased risk of developing asthma and depression.

The Nutritious Food Basket survey, conducted annually by all public health units in Ontario, repeatedly demonstrates that incomes are inadequate for our most vulnerable Middlesex-London residents to afford basic needs. As part of the September 2015 discussion of the Nutritious Food Basket report, the Board of Health endorsed a recommendation to request the provincial and federal governments prioritize

consideration and investigation into a joint federal-provincial basic income guarantee and for the provincial government to increase social assistance rates to reflect the rising cost of basic needs.

OSNPPH Position Statement on Responses to Food Insecurity

In November 2015, The Ontario Society of Nutrition Professionals in Public Health (OSNPPH) released a Position Statement on Responses to Food Insecurity (Appendix A) and accompanying infographic (Appendix B). The position statement calls for the implementation of a basic income guarantee as an effective, long-term solution to reduce food insecurity.

A common community response to food insecurity is food charity programs, including food banks and soup kitchens. Charitable food provision began as temporary relief in the 1980s, but has become a well-established and valuable part of our community's emergency food supply response. Unfortunately, community need exceeds the capacity of charitable food organizations, and charitable food provision does not address the root cause of food insecurity, which is a lack of sufficient income. Only about 25% of people who are food insecure access food banks. Food banks do as much as they possibly can and work tirelessly to try to address the issue of food insecurity, but they have limitations. The growth of food charity has also coincided with a reduction in government social programs. Food Banks Canada stated in their Hunger Count 2015 report that a basic income guarantee, affordable housing, job skills training and more accessible and affordable food in northern communities are what is needed to significantly reduce the need for food banks and address food insecurity.

Lack of sufficient income is the root cause of food insecurity. Almost 60% of Ontario families who are food insecure are part of the labour force, but working in low paying or unstable jobs. Improved incomes are the most important and effective response to food insecurity and must be foremost of advocacy efforts. The incomes of the lowest income earners affect the entire society. Evidence supports that the larger the gap between the lowest income earners and the highest income earners, the poorer the health outcomes for everyone.

Opportunities for Action

OSNPPH is calling on Ontario Boards of Health to officially endorse its *Position Statement on Responses to Food Insecurity*. The position statement has been endorsed by the Association of Local Public Health Agencies, the Ontario Public Health Association and various Ontario Boards of Health, including Chatham-Kent, Elgin St. Thomas, Haldimand-Norfolk, Huron County, Perth District and Peterborough County. Health Unit staff will inform the *Ontario Society of Nutrition Professionals in Public Health (OSNPPH)* that the Board of Health endorses investigating a basic income guarantee as a response to food insecurity.

This report was prepared by Ms. Kim Leacy, Registered Dietitian, and Ms. Linda Stobo, Manager, Chronic Disease Prevention & Tobacco Control Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health and CEO

This report addresses the following requirements of the Ontario Public Health Standards (2015): Foundational Standard 3, 4; Chronic Disease Prevention 2, 11.

Ontario Society of Nutrition Professionals in Public Health

La société ontarienne des professionnel(le)s de la nutrition en santé publique

www.osnpph.on.ca
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Position Statement on Responses to Food Insecurity

November 2015

Background

Food insecurity – inadequate or insecure access to food because of financial constraints – is a serious social and public health problem in Ontario. In 2013, 624,200 Ontario households (12.5%) experienced food insecurity.[1] This translates into 1,598,200 people, of which 485,700 were under the age of 18 (Valerie Tarasuk, PhD, email communication, August 27, 2015).

The root cause of food insecurity is poverty.[2] The magnitude of poverty in the country contravenes Canada's commitment to ensure the basic human right to food for all citizens.[3] The majority (57.5%) of Ontario families struggling to put food on the table are part of the labour force but trapped in low-paying or unstable jobs.[1] Food insecurity affected 64.5% of Ontario households reliant on social assistance in 2012.[4]

It is the position of the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) that food insecurity is an urgent human rights and social justice issue for local, provincial and federal public policy agendas. Food charity is an ineffective and counterproductive response to food insecurity because it does not address the root cause which is poverty. An income response is required to effectively address food insecurity.

The Ontario Society of Nutrition Professionals in Public Health (OSNPPH) is the independent and official voice of over 200 Registered Dietitians working in Ontario's public health system. OSNPPH provides leadership in public health nutrition by promoting and supporting member collaboration to improve the health of Ontario residents through the implementation of the Ontario Public Health Standards.

Adults in food insecure households have poorer self-rated health, poorer mental and physical health, poorer oral health, greater stress, and are more likely to suffer from chronic conditions such as diabetes, high blood pressure, and anxiety.[5] Food insecurity also makes it difficult to manage chronic diseases and conditions through diet. Household food insecurity increases the risk of mental health problems in children and puts teenagers at greater risk of depression, social anxiety and suicide.[6] Being food insecure is strongly associated with becoming a high-cost user of health care.[7,8]

While the terms 'food insecurity' and 'hunger' may be used interchangeably, they are not the same thing. Food insecurity has been defined as, "household-level economic and social condition of limited or uncertain access to adequate food," while hunger has been defined as, "an individual-level physiological condition that may result from food insecurity."[9]

The Food Charity Response

Food charity is not new, and in most cultures offering food to hungry people is considered the right thing to do. Currently, food charity in Canada includes a variety of ad-hoc community-based programs, including food banks and meal programs.

Food banks are the primary community response to household food insecurity. They were originally intended as temporary food relief operations necessitated by the recession in the early 1980s; however, demands for charitable food assistance did not diminish as the economy improved and numbers using food banks continued to expand.[10] Over the past 30+ years, food banks have become a well-established part of the fabric of many communities across Ontario and Canada. Food banking has grown and evolved into an extensive charity-based secondary food distribution system specifically for impoverished people.

The growth of food charity has been linked to a reduction in social programs, as governments abandon previously held responsibilities for the well-being of citizens and rely on community-based charities to fill the gap.[10,11,12] People in need of food are routinely directed to charitable food programs by government websites, case workers and health care providers.

In March of 2014, Ontario food banks were visited by 374,698 adults and children.[13] The number of households accessing food banks for the very first time increased by 20%, from 14,206 in 2013 to 17,182 households in March 2014.[13] Although a considerable number of people go to food banks, they represent only a small proportion – about 25% – of those who experience food insecurity.[14,15] For this reason, food bank usage statistics are not a valid measure of food insecurity.[16]

Food banks operate under many constraints, relying on volunteers and inconsistent food and monetary donations from the public and corporate sponsors.[10,17] Demand for food always exceeds the supply. Balance between supply and demand is achieved only when the amount of food provided per visit and/or the frequency of visits is restricted.[17] Because of

supply limitations, food banks are typically not able to meet the preferences, religious restrictions, nutritional or health-related dietary needs of clients.[10,15,18,19] Access can be challenging with limited operating hours, long line-ups, and lack of transportation to get to a food bank.[15] Despite the best intentions of volunteers and staff, the experience of accessing food banks undermines people's dignity.[11,15] All of these limitations and challenges may explain, at least in part, why only a minority of people who experience food insecurity access food banks. In summary, food banks are an ineffective response to food insecurity.

The government plays a supportive role in the charitable food model by permitting and encouraging donations while absolving donors of liability for the safety of donated food.[20] Food Banks Canada has lobbied the federal government to provide tax credits to corporate donors but this proposal has not been adopted.[11] However, Ontario's Local Food Act, introduced in 2013, includes tax credits for farmers who donate agricultural produce to community food programs.[21]

Corporations exert significant control and influence over charitable food programs in many ways, while reaping the benefits of participating in corporate social responsibility initiatives. Corporations participate as board members for food charity organizations at the provincial and national levels[22,23] and provide significant food and monetary donations.[19,22,24] Corporations directly benefit from supporting food charity, as market research has shown that companies who contribute to a good cause build brand loyalty, attract new customers, drive word of mouth advertising and grow revenue.[25] They also benefit from donating unsaleable food by avoiding landfill disposal fees.[24] Corporate self-promotion of their food charity efforts and associated media coverage further promote the public perception that food charity is an acceptable and appropriate response to food insecurity.[12,22]

The media perpetuate a positive illusion of the benefits of food charity.[12,22] Actively drawing attention to fund-raising and food drive efforts enables people to 'feel good' when they contribute. However, the media rarely acknowledge the inadequacies of food charity or that the underlying problem of persistent poverty is the root cause of food insecurity. Well-intentioned people are persuaded to believe that those who don't have enough food are in the good hands of charity.[22]

By contributing to the institutionalization of food charity and feeding the public perception that food insecurity is a matter for charity, the media and corporations have become a major obstacle in advancing public policy to address poverty and food insecurity.[22] The current charitable food model absolves governments of their responsibility to ensure the basic right to food security for all.[12]

The Income Response

Current evidence indicates the need for targeted and sustainable approaches to address the root causes of food insecurity.[26] Implementation of a basic income guarantee (also known as guaranteed annual income) would ensure income at an adequate level to meet basic needs and for people to live with dignity, regardless of work status.[27]

A basic income guarantee has the potential to eliminate poverty and spending on its consequences. The Guaranteed Income Supplement (GIS), a form of guaranteed income for Canadians 65 years and older, has resulted in a substantial decline in seniors living below the poverty line and one of the lowest rates of elder poverty in the world.[26] The rate of Canadians experiencing food insecurity has been found to be fifty percent less among low income people aged 65 to 69 compared to those aged 60 to 64, and self-reported rates of physical and mental health improved significantly after moving from low-wage, insecure employment to a guaranteed income at the age of 65.[28] Implementing a guaranteed income program for those of working age would reduce steep income inequalities and contribute to better health and fewer societal problems, leading to long-term savings in health care and other public services.[29]

Guaranteed income is a simpler and more transparent approach to social assistance than the current system. Furthermore, it would extend protection to those who are currently not covered or poorly covered by social assistance programs.[30]

The cost of implementing a basic income program would involve substantial government spending.[31] However, even conservative estimates of the indirect costs of poverty (e.g., health care, remedial education, crime, and social assistance programs) are far higher than the costs of actually lifting people out of poverty.[32]

Position

It is the position of the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) that food insecurity is an urgent human rights and social justice issue for local, provincial and federal public policy agendas. Food charity is an ineffective and counterproductive response to food insecurity because it does not address the root cause which is poverty. An income response is required to effectively address food insecurity.

OSNPPH calls on:

- Ontario Public Health Units to promote and support implementation of the "Income Security - the effective response to food insecurity"campaign.
- Ontario Boards of Health to officially endorse OSNPPH's Position Statement on Responses to Food Insecurity
- Municipal governments to urge provincial and federal governments to prioritize and investigate a basic income guarantee.
- Individuals to contact or meet with local politicians at all levels about their concerns with the food charity response to food insecurity and the potential benefits of a basic income guarantee.
- Schools, faith-based organizations, emergency services, local businesses, and community organizations to become aware of and promote income security as the effective response to food insecurity.
- Media to support campaigns for adequate income security, affordable social housing and child care, enhanced mental health services, together with an integrated national food policy, instead of food drives.
- Federal and provincial governments to consider and investigate a basic income guarantee as a policy option for reducing poverty and income insecurity and for providing opportunities for people with a low income.

Additional Information

"Food insecurity is a serious public health problem" infographic http://www.osnpph.on.ca/

Income-Related Policy Recommendations to Address Food Insecurity. Ontario Society of Nutrition Professionals in Public Health, September 2015. http://www.osnpph.on.ca/

Public Health Support for a Basic Income Guarantee. Association of Local Public Health Agencies Resolutions, June 2015. http://www.alphaweb.org/?page=alPHa_Resolutions click on: Resolutions passed at the most recent AGM

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Basic Income Canada Network http://www.basicincomecanada.org/

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Graphic design provided by City of Hamilton Public Health Services.

Food insecurity is a serious public health problem

1.6 million Ontarians or 1 in 8 households do not have enough $ to buy food

When income is too low, people do not have enough $ for **rent, bills AND food**

Food Insecurity

Higher rates of

- Diabetes, high blood pressure & poor oral health in adults
- Mental health problems
- Health care use

What is the solution?

Food charity (food banks, soup kitchens)	OR	**Adequate income** (basic income guarantee)
• Offers temporary hunger relief – but food insecurity does not go away		• Addresses the root cause of food insecurity – not enough money
• Has limited reach – 3 out of 4 food insecure households do not go to food banks		
• Has limited operating hours and restricts the number of visits and the amount of food provided		• Gives all households the means to choose how, when and what food to buy
• Does not meet people's daily needs for nutritious food		
• Undermines people's dignity		• Preserves dignity when people have enough money to buy food
• Excuses decision makers from ensuring the basic right to food		• Ensures the basic right to food by governments addressing the root cause of food insecurity

OSNPPH urges governments to prioritize and investigate a basic income guarantee. The only solution to food insecurity is an INCOME response.

Ontario Society of Nutrition Professionals in Public Health

La société ontarienne des professionnel(le)s de la nutrition en santé publique

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Content of this infographic is based on: Ontario Society of Nutrition Professionals in Public Health ... Responses to Food Insecurity, November 2015.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 018-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 March 10

SUMMARY INFORMATION REPORT FOR MARCH 2016

Recommendation

It is recommended that Report No. 018-16 re: Summary Information Report for March 2016 be received for information.

Key Points

- The library subscribes to a variety of electronic resources, and collaborates extensively with other public health libraries to enhance resource sharing

Background

This report provides a summary of information from Health Unit programs. Additional information is available on request.

Electronic Resources Available through the Middlesex-London Health Unit Library

The MLHU library has access to many electronic resources. Along with Public Health Ontario (PHO) and other Shared Library Services Libraries, the library coordinates journal subscription purchases to maximize the number of titles available and participates in resource sharing with other Ontario public health libraries. The library currently subscribes to 27 journal titles, 37% of which are available electronically, and has invested in 11 e-books with plans to purchase additional titles. Substantial additional online content is available through the Virtual Library, provided by PHO. The library also participates in Docline, an automated system that facilitates reciprocal interlibrary loans across North America. More details about the MLHU library's electronic resources are included in Appendix A to this report.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

Electronic & print resources in the MLHU Library

eBooks in the MLHU Library

In 2014 the library introduced ebooks into its collection purchasing 11 titles outright, representing just under 30% of total library book purchases for that year. The books are accessible via the Virtual Library for MLHU and client health unit staff. Upon logging into the Virtual Library 'eBook collection' is a choice in the listing of databases. The following titles are available electronically:

- Handbook of health behavior change, c2014
- Basic guide to oral health education and promotion, c2014
- Pediatric nursing care: best evidence-based practices, c2014
- The first-time manager, c2012
- The power of presence: unlock your potential to influence and engage others, c2012
- Lead with purpose: giving your organization a reason to believe in itself, c2012
- Sexually transmitted diseases sourcebook: basic consumer health information about sexual health and the screening, diagnosis, treatment, and prevention of common sexually transmitted diseases (STDs), including Chancroid, Chlamydia, Gonorrhea, Herpes, Hepatitis, Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS), Human Papillomavirus (HPV), Syphilis, and Trichomoniasis, c2012
- Domestic violence sourcebook: basic consumer information about intimate partner abuse, stalking, sexual harassment, and human trafficking, including facts about risk factors, warning signs, and forms of physical, sexual, mental, emotional, and financial abuse in women, men, adolescents, recent immigrants, elders, and other specific populations, c2012
- Health places, healthy people: a handbook of culturally informed community nursing practice, c2011
- Occupational and environmental health: recognizing and preventing disease and injury, c2011
- Public health and infectious diseases, 2010

Journals in the MLHU Library

The library currently subscribes to 27 journal titles, 10 of which are available electronically, representing 37% of the collection. The decision to purchase print or electronic journals entails a variety of factors including licensing agreements (which dictate how journal articles can be shared with other Ontario public health professionals), cost, and whether the back issues are owned in perpetuity. Table 1 below portrays the library's subscriptions for 2016, pending completion of negotiations.

MLHU Library's Access to Additional Resources

Public Health Ontario (PHO) and the four Shared Library Services Partnership (SLSP) libraries coordinate journal subscription purchases to avoid duplication and ensure resource sharing across the province. In addition, the library participates in Docline, an automated interlibrary loan system that allows for free reciprocal interlibrary loans from health libraries across North America. In order to participate in Docline a library must maintain a minimum of 25 journal subscriptions and actively participate in sharing

their collection. There is seldom a journal article request that cannot be obtained for free and shared electronically across the organization under the library's Access Copyright License.

A great deal of additional online content is available through the Virtual Library which is paid for by PHO. For example, the *Cochrane Library of Systematic Reviews* is completely full text while *CINAHL Plus with Full Text* provides the full text for more than 760 journals.

Although public health libraries are small, they operate collaboratively and are extremely well connected to provide a large suite of online products and resources.

Table 1: Middlesex London Health Unit library journal subscriptions, 2016

Journal Title	Online	Print + Online	Print Only
Accident Analysis & Prevention			✓
Addictive Behaviors			✓
American Journal of Health Education		✓	
American Journal of Preventive Medicine			✓
Birth		✓	
Breastfeeding Medicine	✓		
Canadian HR Reporter		✓	
Childhood Obesity	✓		
Critical Public Health		✓	
Family & Community Health			✓
Health Communication		✓	
Health & Place			✓
Health Education Journal			✓
International Journal of Hygiene & Environmental Health			✓
Journal of Human Nutrition & Dietetics			✓
Journal of Obstetrics and Gynaecology Canada			✓
Journal of Primary Prevention			✓
Journal of Public Health Dentistry		✓	
Journal of Public Health Management and Practice			✓
Journal of Rural Health			✓
Journal of Safety Research			✓
Journal of School Nursing		✓	
Journal of the Academy of Nutrition & Dietetics			✓
MCN: The American Journal of Maternal/Child Nursing			✓
Prevention Science			✓
Preventive Medicine			✓
Social Marketing Quarterly		✓	

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 019-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 March 10

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – MARCH

Recommendation

It is recommended that Report No. 019-16 re Medical Officer of Health Activity Report – March be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the February Medical Officer of Health Activity Report to March 4, 2016.

Another event that was planned was a Valentine's Day coffee break. Staff were encouraged to come down to the lunch room for a piece of cake or a cookie and purchase raffle tickets for 3 separate draws. All proceeds from this event also went directly to the United Way.

The MOH, Associate Medical Officer of Health, manager and several staff from the Infectious Diseases Team, and Communications staff spent significant time over the month working with London Health Sciences Centre and St. Joseph's hospital regarding TB exposures from a health care provider. Much of the initial work focused on tracing contacts and notifying them and staff at the hospitals that they have been in contact with someone who has TB. Once identified, the contacts will be tested for TB either at the hospital, a private lab, or the Health Unit.

The Medical Officer of Health and CEO also attended the following teleconferences and events:

February 9 Attended the Health Unit's Making Great Leaders Training

February 10 Met with Dr. Valerian Marochko of the London Cross Cultural Learning Centre in regards to Syrian refugees

February 11 Attended a meeting of the Youth Opportunities Unlimited Executive
Met with Ian Peer at London InterCommunity Health Centre in regards to Syrian Newcomers
Participated in the Winter 2016 South West Medical Officer of Health teleconference call

February 12 Met with Vanessa Ambtman-Smith, Aboriginal Health Lead at South West Local Health Integration Network

February 17 Met with Janette MacDonald, CEO and General Manager of Downtown London and her Public Realm committee
Met with City of London staff regarding the Mayor's Advisory Panel on Poverty (MAPOP)
Was interviewed by London Free Press reporter Jonathan Sher regarding living wage

February 18 Attended the MAPOP meeting at City Hall
Participated in a Health Human Development Table teleconference

February 19	Was interviewed by reporter Devon Peacock about living wage Participated in an interview with CBC Ontario Morning reporter Sandy Mowatt in regards to living wage
February 22	Met with Chairs of MAPOP Met with Heart and Stroke staff Brian Kellow and Lesley James to discuss sugar in beverages Met with Glen Pearson, Mike Moffat and Ross Fair to discuss living wage Attended a Town Hall meeting at Western University – *United for Refugees*
February 23	Met with Maureen Cassidy, City of London and Lori Runciman, London Community Foundation (LCF) to discuss LCF involvement in the MAPOP recommendations Met with MLHU staff to discuss and seek input to the draft MAPOP recommendations Met with Helene Berman, Professor - Arthur Labatt Family School of Nursing Attended the MAPOP Community Conversation at the Kiwanis Seniors Centre
February 24	Attended the alPHa Risk Management Workshop in Toronto Participated in an in-camera discussion with the Chief Medical Officer of Health (CMOH) re Transformation Agenda
February 25	By phone, participated in the YOU Board meeting Attended the COMOH Section meeting in Toronto with Dr. Bob Bell, Deputy Minister of Health and Long-Term Care Attended Budget Day at Queen's Park as a guest of Teresa Armstrong, MPP for London-Fanshawe.
February 26	Attended the MAPOP Community discussion at the White Oaks Family Centre

It wasn't all work at the Health Unit in February. The MOH and members of the Senior Leadership Team arrived very early on Pancake Tuesday to start flipping pancakes and frying sausages for staff. Approximately 100 staff attended one of the 3 sit down times and enjoyed the hot breakfast along with some fruit, coffee and juice. All money raised was donated to the United Way.

This report was prepared by Lynn Guy, Executive Assistant to the Medical Officer of Health.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses Ontario Public Health Organizational Standard 2.9 Reporting relationship of the Medical Officer of Health to the Board of Health

DRAFT RECOMMENDATIONS

MAYOR'S ADVISORY PANEL ON POVERTY

MAYOR'S ADVISORY PANEL ON POVERTY:
DRAFT RECOMMENDATIONS

February 2016

These draft recommendations represent a direction for our community to move to reach its full potential. This direction is not new; we listened to hundreds of Londoners, who pointed us to compelling research, new ideas, and the important work already happening in London. This community has momentum. We see it as our job to bring the many viewpoints together into one place.

We share these draft recommendations with the knowledge that there is more work to do. The final recommendations document will say much more about how we understand poverty, how we go about making the recommendations happen, and how we measure our progress as a community.

We are asking you to tell us whether these draft recommendations represent the right direction for London. If we work together to make them happen, will we see the change we want to see?

The draft recommendations include both short-term and long-term recommendations. Short-term recommendations are those that don't need a lot of "new money" or big system changes (e.g. provincial or federal policy changes). We can start making the short-term recommendations happen now. Long-term recommendations generally need additional planning, advocacy, and resources.

We included a lens of equity in three ways by: using existing research on poverty and equity to develop recommendations; calling for an equity lens in the implementation structure; and identifying targeted strategies for specific communities. We will need to better understand the impact these recommendations will have for indigenous, gendered, LGBTQ, ability, age, socio-economic, and ethno-cultural populations (among others). These understandings go beyond the timeline of the Mayor's Advisory Panel on Poverty's mandate, which is why the inclusion of diverse voices and an equity lens is so important for ongoing implementation.

Thank you for sharing your experience and wisdom with us.

The Mayor's Advisory Panel on Poverty

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INSTRUCTIONS

Please take the time to read through the draft recommendations.

At the end of each section, there is space for you to let us know if any more recommendations should be added to that section. Please feel free to focus on the sections that interest you most.

After you have read through all the recommendations, you will be asked to share your top 5 choices for the most *urgent* recommendations – those we need to tackle first. You will also be asked to share your top 5 choices for the most *important* recommendations – those that will make the biggest impact.

If you have any questions or need additional information on the draft recommendations or the Mayor's Advisory Panel on Poverty, please email povertypanel@london.ca.

PART A: CULTURE SHIFT

We understand poverty as a community-level challenge. To begin addressing poverty as a community, we need to think differently and act collectively. Some recommendations in this "culture shift" aren't about affecting poverty directly. What they are about, however, is community-building and building an even more caring and compassionate London.

1.0 CHANGING THE WAY WE THINK

SHORT TERM

1.1 Acknowledge that the system we have developed falls short of helping many people exit poverty and can sometimes trap them in it; it will continue to fall short until we decide to change it

1.2 Acknowledge that prosperity in life is not determined by individual choice alone; it is influenced heavily by circumstance and opportunity (e.g. stable home life, healthy food, access to good education)

1.3 Engage Londoners with lived experience to gather and share stories of the community and the impacts of poverty

1.4 Conduct more workshops, such as *Bridges out of Poverty*, to raise awareness and build community understanding of poverty

1.5 Develop a sustained social awareness campaign that:

- eliminates stigma toward, and recognizes the strengths of, Londoners living in poverty;
- demonstrates how the status quo is harmful to all of us, and is ultimately more costly;
- encourages community ownership of developing solutions to poverty in London; and
- provides resources for Londoners to learn about how they can help their neighbours

LONG TERM

1.6 Build a poverty-sensitive culture in all work environments by developing training tools that include the perspectives of, and where possible mentorship by, people with lived experience

1.7 Strengthen relationships and increase partnerships between municipal and indigenous leaders to work collaboratively to address poverty within indigenous communities

1.8 Strengthen relationships and increase partnerships between local and indigenous organizations to work collaboratively to address poverty within indigenous communities

1.9 Provide cultural safety / cultural competency training for all service providers to increase capacity to provide services with indigenous communities and other vulnerable / marginalized populations

1.10 Collaborate with school boards to develop new poverty-focused curriculum-related resources to help students understand the economic, social and health impacts of poverty, and to reduce stigma associated with people experiencing poverty

What recommendations need to be added to this section, if any?

2.0 CHANGING THE WAY WE LIVE

SHORT TERM

2.1 Support the continued implementation of the *London Strengthening Neighbourhoods Strategy*

2.2 Continue to develop neighbourhood action plans for all London neighbourhoods using a community development approach

2.3 Promote and expand key existing initiatives, such as *Circles*, as opportunities for Londoners to connect with, mentor, and support other Londoners

2.4 Recognize Londoners' commitment to volunteerism and a caring community and build upon these efforts

LONG TERM

2.5 Create a "Made in London" campaign that encourages residents to think and buy local in order to support the local economy and increase local employment

2.6 Continue to develop strategies to increase voter turnout among underrepresented populations

2.7 Accelerate the development of more public gathering spaces for community to come together

2.8 Promote charitable gift-giving toward programs with sustained, transformative impacts on poverty

What recommendations need to be added to this section, if any?

3.0 CHANGING THE WAY WE WORK

SHORT TERM

3.1 Develop an implementation plan for the recommendations that:

- fosters collaborative leadership with people with lived experience that respects their expertise and gives opportunities to influence decisions
- uses equity lenses, including indigenous, gender, LGBTQ, ability, age, socio-economic, and ethno-cultural to assess the impact of each recommendation on these populations
- includes the private sector, governments and funders as partners

3.2 Invest resources needed to create and support the ongoing implementation structure for these recommendations

3.3 Use these recommendations as London's mandate to advocate for policy change from provincial and federal governments

3.4 Review the poverty-focused tables, networks and strategies and determine how to coordinate and streamline efforts effectively

3.5 Promote London's "community hubs", such as Family Centres, resources centres and libraries as places to help families connect to supports and develop a related online portal

LONG TERM

3.6 Scale up supports and services that have been proven to be effective in the reduction or elimination of poverty (see Section B) and stop what isn't effective

3.7 Building on the results of 3.4, strengthen the culture of collaboration across all organizations and sectors

3.8 Develop strategies that increase service providers' capacity to provide individualized supports that respond to people's unique circumstances

3.9 Encourage London organizations (including the municipality, hospitals, and post-secondary institutions, school boards, London Police Service, etc.) to purchase services from organizations that employ individuals with barriers to employment

What recommendations need to be added to this section, if any?

PART B: SOCIAL DETERMINANTS OF HEALTH

The following recommendations use categories associated with the social determinants of health, with the addition of transportation. The recommendations are organized according to economic, social, and cultural dimensions. We acknowledge that there is significant overlap between all categories and dimensions and that people experiencing poverty are impacted in different ways.

ECONOMIC

4.0 INCOME AND INCOME DISTRIBUTION

SHORT TERM

4.1 Advocate to the provincial and federal governments for London to be a Basic Income Guarantee pilot site

4.2 Support further increases to provincial minimum wage

4.3 Advocate for increases to Canada Pension Plan

4.4 Advocate for increases to Ontario Works as recommended by the provincial Social Assistance Review Commission

4.5 Advocate for the replacement of predatory lending and provide supports to address bad credit by collaborating with the financial sector to provide banking alternatives

LONG TERM

4.6 Promote the business case for employers to pay a living wage

4.7 Recognize the growing collaboration of organizations working to pay a living wage

4.8 Encourage implementation of zero-interest loan programs for Londoners demonstrating need

4.9 Collaborate with employers to develop strategies to close the wage gap for indigenous, gendered, LGBTQ, differently-abled, and ethno-cultural populations

What recommendations need to be added to this section, if any?

5.0 UNEMPLOYMENT AND JOB SECURITY

SHORT TERM

5.1 Promote and invest in opportunities for entrepreneurs living with low income (e.g. *ImpactLoan*)

5.2 Implement *London's Community Economic Road Map* to promote a stronger local economy

5.3 Bring together business, non-profit, government, and education sectors to develop coordinated skills training programs that meet local labour market needs

5.4 Encourage employers to consider ability in the absence of credentials (e.g. diplomas and degrees)

5.5 Promote on-the-job training programs

5.6 Advocate for the elimination of the cost of expunging criminal records

LONG TERM

5.7 Develop strategies to encourage employers to hire locally

5.8 Support diverse hiring practices by:
- developing a community of practice
- providing incentives for employers
- recognizing what employers are already doing with respect to diversity

5.9 Create more supports for Londoners looking to develop new social enterprises

5.10 Develop programs that provide "soft skills" employment training

What recommendations need to be added to this section, if any?

6.0 EMPLOYMENT AND WORKING CONDITIONS

SHORT TERM

6.1 Support provincial efforts to strengthen employment standards

6.2 Advocate for paid personal days for working families

6.3 Develop coordinated “transition to work” strategies that provide wraparound supports for people exiting social assistance

6.4 Develop coordinated “employment with supports” strategies to help people keep employment

LONG TERM

6.5 Assess job creation strategies through a quality lens to increase the availability of full-time, permanent work with adequate pay

6.6 Increase sustainable employment through better pay and benefits

6.7 Design pathways to employment for individuals with complex issues including homelessness, addictions, and mental health challenges

What recommendations need to be added to this section, if any?

SOCIAL

7.0 EARLY LIFE

SHORT TERM

7.1 Advocate for increased investment by all levels of government in early years education and literacy programming

7.2 Support development of national childcare strategy

7.3 Advocate for affordable, quality childcare

7.4 Integrate cultural safety lens in childcare quality strategies

7.5 Support implementation of proven outreach-based programs, such as the *Nurse-Family Partnership*

7.6 Advocate for more licensed childcare spaces in London

7.7 Advocate for increases to childcare fee subsidy for low income families

LONG TERM

7.8 Create flexible childcare spaces outside of daytime working hours

7.9 Expand mentorship and support programs for new parents

What recommendations need to be added to this section, if any?

8.0 EDUCATION

SHORT TERM

8.1 Expand elementary school initiatives that increase awareness of post-secondary options (e.g. *REACH* program)

8.2 Develop strategies to increase supports for people with learning disabilities

8.3 Advocate for more financial assistance for post-secondary tuition fees in Ontario

8.4 Expand RESP matched savings programs to help families save for education

8.5 Increase availability of financial literacy and "basic life skills" training for all Londoners, including children and youth

8.6 Expand mentorship programs for individuals with lived experience who are returning to school

8.7 Advocate for appropriate actions to ensure that every elementary and high school student in London can succeed no matter what school he/she attends

LONG TERM

8.8 Implement coordinated wraparound approach to education, building on proven projects in London and other communities (e.g. *Pathways to Education, MAPP program*)

8.9 Develop a community strategy to eliminate financial barriers for school-based extra-curricular activities

8.10 Develop a community strategy to eliminate financial barriers to achieving GED

What recommendations need to be added to this section, if any?

9.0 HEALTH SERVICES

SHORT TERM

9.1 Develop and implement a coordinated local mental health and addictions strategy

9.2 Advocate for an expanded Ontario Drug Benefit program

9.3 Expand free local dental programs such as *Healthy Smiles*

9.4 Connect primary care providers accepting patients with Londoners who need care and live with low income

9.5 Advocate for increased health and dental benefit coverage for people receiving social assistance

9.6 Advocate for extended health benefits for a longer period of time for those transitioning off OW and ODSP

9.7 Advocate for the expansion of Community Health Centres

LONG TERM

9.8 Working with the Southwest Local Health Integration Network, use health equity lens to increase access to care for vulnerable people

9.9 Reduce the stigma associated with mental illness and addiction and encourage seeking help

What recommendations need to be added to this section, if any?

10.0 HOUSING

SHORT TERM

10.1 Continue to implement London's *Homeless Prevention and Housing Plan*

10.2 Support the *London Plan*'s call for mixed income and intensification housing development policies

10.3 Promote London becoming a Housing First community, including training assistance for agencies and supports for residents to achieve successful housing outcomes

10.4 Engage landlords, utility companies, and banks to develop a coordinated strategy that keeps more people housed

10.5 Work with older adults to develop attainable housing strategies responsive to their needs

10.6 Coordinate community assets to develop strategies focused on housing youth, women and girls

LONG TERM

10.7 End chronic homelessness in 10 years

10.8 Enhance social housing standards to improve safety

10.9 Invest resources needed to clear the social housing waitlist

10.10 Eliminate the waitlist system and reinvest resources in housing that keeps the waitlist clear

10.11 Streamline the process by which affordable housing is accessed

10.12 Developed coordinated wraparound supports for people transitioning between housing options

10.13 Expand the capacity of the Housing Stability Bank

10.14 Increase long-term investment in housing / housing supplements

10.15 Increase supply of attainable rental housing

10.16 Implement strategies to assist with start-up costs of housing (furniture, moving, household items)

10.17 Through the Housing Development Corporation, support the regeneration of social housing units across the community

What recommendations need to be added to this section, if any?

11.0 TRANSPORTATION

SHORT TERM

11.1 Include a lens of poverty in the development of the *Shift* transit strategy

11.2 Engage London Transit Commission and businesses regarding timing and routes to allow more Londoners to seek employment in harder-to-access areas of the city (e.g. industrial areas)

11.3 Expand innovative approaches to transportation, such as rideshare programs

11.4 Support safe, affordable transportation options, such as improved cycling lanes and cycling infrastructure

11.5 Change public transit subsidy to an income-based model available to all low-income adult Londoners

LONG TERM

11.6 Introduce discounted bus pass for youth

11.7 Allow children under 12 to ride free

11.8 Increase the availability of para-transit

What recommendations need to be added to this section, if any?

12.0 FOOD INSECURITY

SHORT TERM

12.1 Expand programs that support residents shopping and cooking together to save money, such as *Food Families* and collective kitchens

12.2 Expand local food literacy programs for all ages

12.3 Support local policies that encourage community gardens and urban farms

12.4 Support campaigns that promote healthy, local food

12.5 Support implementation of the London & Middlesex Food Policy Council

12.6 Expand sites and programs that accept *Harvest Bucks* fresh food voucher program

12.7 Increase availability of emergency food sources (locations and hours)

12.8 Work with farmers to provide more fresh food to emergency food sources

12.9 Develop strategy to reclaim usable food from grocery stores and restaurants

LONG TERM

12.10 Increase availability of gift cards/food cards that provide healthy, culturally appropriate food for people accessing emergency food sources

12.11 Work with food banks and resource centres to distribute seeds and soil during growing season

12.12 Recognizing the diligent work done by researchers and community partners on the presence of food deserts, support business models that address food deserts (e.g. markets, fresh food in convenience stores, etc.)

12.13 Implement breakfast/lunch programs in London schools

What recommendations need to be added to this section, if any?

13.0 DISABILITY

SHORT TERM

13.1 Advocate for liveable disability pensions

13.2 Promote that some individuals on ODSP are capable of working and want to work

LONG TERM

13.3 Increase physical accessibility in affordable housing

13.4 Work with employers to expand strategies for people with employment barriers to find work

13.5 Expand supportive housing approaches for people with disabilities

13.6 Increase the availability of para-transit (see recommendation 11.8)

What recommendations need to be added to this section, if any?

14.0 SOCIAL SAFETY NET

SHORT TERM

14.1 Advocate for changes that allow individuals to retain more of their assets before accessing social assistance

14.2 Provide coordinated wraparound supports through transition periods (e.g. shelter to housing, social assistance to work, incarceration to home)

14.3 Support the full implementation of the *Brighter Prospects: Transforming Social Assistance in Ontario* recommendations

LONG TERM

14.4 Continue to support the evolution of emergency shelters to improve diversion, rapid housing, and specialization

14.5 Reduce clawbacks for people moving from social assistance to paid employment

14.6 Reorganize individual social assistance funds, subsidies and vouchers to make it easier for people to access resources

What recommendations need to be added to this section, if any?

15.0 SOCIAL EXCLUSION

Social exclusion is a key impact area. Many strategies that address social exclusion are included in Part A: Culture Change, above. Additional strategies are below.

SHORT TERM

15.1 Invest in the *Circles* program to help more Londoners work together to address poverty (see recommendation 2.3)

15.2 Provide subsidized, structured recreation opportunities for Londoners living with low income

LONG TERM

15.3 Develop strategies to increase access to technology and close the 'digital divide' in London

15.4 Raise awareness of services and supports and reduce stigma to make it easier for people to ask for help

What recommendations need to be added to this section, if any?

CULTURAL

Poverty impacts everyone, and these recommendations are designed to address poverty universally. However, we know that some communities experience higher-than-average rates of poverty. No single factor explains all conditions for all people, but some communities have historical or structural challenges that would benefit from targeted strategies.

16.0 INDIGENOUS

SHORT TERM

16.1 Use an equity lens in the development of the implementation structure for these recommendations to assess the impact on indigenous communities

16.2 Include leadership of indigenous persons in implementation structure

16.3 Promote inclusion of indigenous leadership in networks and organizations addressing poverty

LONG TERM

16.4 Strengthen relationships and increase partnerships between municipal and indigenous leaders to work collaboratively to address poverty within indigenous communities (see recommendation 1.7)

16.5 Strengthen relationships and increase partnerships between local and indigenous organizations to work collaboratively to address poverty within indigenous communities (see recommendation 1.8)

16.6 Provide cultural safety / cultural competency training for all service providers to increase capacity to provide services with indigenous communities and other vulnerable / marginalized populations (see recommendation 1.9)

16.7 Support policies that connect indigenous communities to educational opportunities

16.8 Use the findings of the Truth and Reconciliation Commission to educate Londoners and address systemic racism and discrimination

What recommendations need to be added to this section, if any?

17.0 GENDER

SHORT TERM

17.1 Use an equity lens in the development of the implementation structure for these recommendations to assess the impact on gendered communities

17.2 Include leadership of women in implementation structure and recognize the value of gender diversity

17.3 Invest in the implementation of *London's Community Plan Regarding Street Level Women at Risk* and support the implementation of *Homes 4 Women*

17.4 Strengthen violence prevention programs

17.5 Advocate for gender income parity

17.6 Advocate for increased child support enforcement from noncomplying parents

LONG TERM

17.7 Support employment training programs in sectors underrepresented by women

17.8 Work with employers to increase flexibility in workplace for those with family responsibilities

What recommendations need to be added to this section, if any?

18.0 RACE

SHORT TERM

18.1 Use an equity lens in the development of the implementation structure for these recommendations to assess the impact on ethno-cultural communities

18.2 Include leadership of diversity in implementation structure

18.3 Increase employer awareness of cultural and religious holidays

18.4 Advocate for credential recognition for international newcomers

18.5 Provide support for initiatives aimed at reducing the high incidence of poverty among racialized groups (Canadian-born and immigrant) in London, such as recognition of non-Canadian education and work experience

LONG TERM

18.6 Develop programs that provide “soft skills” employment training (see recommendation 5.9)

18.7 Support policies that connect ethno-cultural communities to educational opportunities

What recommendations need to be added to this section, if any?

URGENT AND IMPORTANT RECOMMENDATIONS

Please help us understand what recommendations are most urgent and important by answering the following questions.

What are the top 5 most urgent recommendations to address poverty in London?

These are recommendations you think our community needs to tackle first. Pick from all the recommendations and list the numbers (e.g. "2.2", "12.10") in the spaces provided. You can add comments in the box provided.

______

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______

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______

Comments:

What are the top 5 most important recommendations to address poverty in London?

These are recommendations that you think will have the biggest impact. *Pick from all the recommendations and list the numbers (e.g. "2.2", "12.10") in the spaces provided. You can add comments in the box provided.*

______

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Comments:

What other feedback do you have for the panel?

Comments:

WHAT’S NEXT

The Mayor’s Advisory Panel on Poverty is asking Londoners to provide feedback on the direction of the draft recommendations. The panel will then incorporate the feedback to develop a final set of recommendations, including a proposed implementation structure.

Thank you again for your contribution to addressing poverty in London. We believe this community is ready for big change and we believe that, together, we can make it happen.