AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2016 April 21

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 – March 10, 2016 Board of Health meeting
Receive: January 21, 2016, Governance Committee
Receive: Draft April 7, 2016 Finance and Facilities Committee meeting

BUSINESS ARISING FROM THE MINUTES

DELEGATIONS

7:05 - 7:15 p.m.	Mr. Wally Adams, Director, Environmental Health & Infectious Diseases re: Item #6 - Recognition of Syrian Newcomer volunteer translators (Report No. 025-16).
7:15 - 7:25	Ms. Trish Fulton, Chair, Finance and Facilities Committee re: Item #1 - Finance and Facilities Committee Meeting April 7, 2016 (Report No. 021-16).
7:25 - 7:40	Chair –Elect, Governance Committee re: Item #2 – Governance Committee Meeting April 21, 2016.

7:40 – 7:50 Ms. Laura Dueck, Public Health Nurse and BFI Lead re: Item # 3 - Baby Friendly Initiative (Report No. 022-16).

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance and Facilities Committee Meeting April 7th (Report No. 021-16)	April 7, 2016 Draft minutes	x	x		To receive information and consider recommendations from the April 7th FFC meeting
2	Governance Committee Meeting April 21st (Verbal)	April 21 Governance Committee Agenda	x	x		To receive information and consider recommendations from the April 21st Governance Committee meeting
Delegations and Recommendation Reports						
3	Baby Friendly Initiatve (BFI) (Report No. 022-16)	Appendix A	x		x	To provide an update on the Health Unit's BFI Designation activities.
4	Association of Local Public Health Agency Resolution Report (Report No. 023-16)	Appendix A		x		To endorse the submission of resolutions on Sugar Sweetened Beverages to go forward to the alPHa Annual General Meeting June 2016.
5	Comments on the MOHLTC Proposal to Strengthen Ontario's Smoking and Vaping Laws (Report No. 024-16)	Appendix A Appendix B		x		To endorse the MOHLTC's Proposal to Strengthen Ontario's Smoking and Vaping Laws and direct staff to submit Appendix B to the Regulatory Registry for consideration.
Information Reports						
6	Syrian Newcomer Summary Information Update (Report No. 025-16)	Appendix A			x	To provide an update on MLHU activities related to Syrian Newcomers.
7	Summary Information Report for April 2016 (Report No. 026-16)	Appendix A			x	To provide a summary of information from Health Unit programs.
8	Medical Officer of Health Activity Report – April (Report No. 027-16)				x	To provide an update on the activities of the MOH for April 2016.

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: Tuesday May 3, 2016 @ 9:00 a.m.
- Next Board of Health Meeting: Thursday, May 19, 2016 @ 7:00 p.m.

CONFIDENTIAL

The Board of Health will move in camera to discuss the following items:

- A matter concerning an identifiable individual
- A matter concerning the security of property held by the Middlesex-London Board of Health
- To approve minutes from its March 10, 2016 in camera session regarding a matter of proposed or pending acquisition of land.

CORRESPONDENCE

a) Date: 2016 February 25 (Received 2016 February 26)
Topic: Herpes Zoster Vaccine
From: Peterborough County-City Health Unit
To: The Honourable Dr. Eric Hoskins

Background:
The Middlesex-London Health Unit offers Zostavax vaccine to provide protection against Shingles (also called the herpes zoster virus) for those over the age of 60. Individuals are charged a fee for this vaccination as it is not currently included in the list of publicly funded vaccines in Ontario.

Recommendation:
Receive.

b) Date: 2016 February 29
Topic: Patients First Response
From: Association of Local Public Health Agencies
To: The Honorable Dr. Eric Hoskins

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

- *Access*: Improve access – providing fast access to the right care.
- *Connect*: Connect services – delivering better coordinated and integrated care in the community, closer to home.
- *Inform*: Support people and patients – providing the education, information and transparency they need to make the right decisions about their health.
- 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 Association of Local Public Health Agencies prepared recommendations and finalized these at the alPHa Board meeting on February 26th. The five recommendations included:

1. Funding and Accountability – Provincial Public Health Funding and Accountability Agreements must continue to be negotiated directed between local boards of health and the MOHLTC.
2. Independent Voice of Board of Health – Board of health must be maintained as defined in the Health Protection and Promotion Act, directly accountable to the Minister of Health.
3. Integration of Local Population and Public health Planning with Other Health Services – The Ontario Public Health Standards and Organizational Standards, as required, should be modified to require boards of health to align their work and ensure that population and public health priorities inform LHIN health planning, funding and delivery.
4. Process for Determining Roles – The roles of boards of health, LHINS, and others must be determined through a transparent, inclusive and deliberate process informed by evidence.
5. Geographic Boundaries – LHIN boundaries should be re-configured to align with municipal, local public health, education and social service boundaries.

Recommendation:
Endorse.

c) Date: 2016 March 7
Topic: Enactment of Legislation to Enforce Infection Prevention & Control Practices within Invasive Personal Service Settings
From: Sudbury & District Health Unit

To: The Honourable Kathleen Wynne

Background:
On January 1, 2009, the OPHS and Protocols replaced the Mandatory Health Programs and Services Guidelines (MHPSG), 1997. Additional changes to the OPHS will take place in 2016 as a result of three initiatives: 1) Integrating the Healthy Smiles Ontario Program; 2) Amendments to the Smoke Free Ontario Act; and 3) Implementation of the Electronic Cigarettes Act.

Currently, there are no infection prevention and control training requirements for personal service setting operators. The recent changes to the Ontario Public Health Standards did not address the potential to implement legal requirements for infection prevention and control training and operator responsibility in personal service settings (PSS).

Recommendation:
Receive.

d) Date: 2016 March 3 (received 2016 March 8)
Topic: Implementation of the Nursing Graduate Guarantee
From: The Honourable Dr. Eric Hoskins
To: Mr. Ian Peer

Background:
The Nursing Graduate Guarantee Initiative is designed to support Canadian New Graduate Nurses (Registered Nurses and Registered Practical Nurses) by providing them with a full-time job opportunity.

The Ministry of Health and Long Term care provides funding to employers for temporary, full-time positions for 26 weeks for new nurse graduates (NNG). Under the conditions of the agreement, MLHU pays six-weeks of salary for each NNG as the organization is unable to offer immediate, full-time employment.

Recommendation:
Receive.

e) Date: 2016 March 7
Topic: Grey Bruce Health Unit Brief in Response to *Patients First* Discussion
From: Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Public Health
To: all Ontario Boards of Health

Background:
See item (b) above.

Recommendation:
Receive.

f) Date: 2016 February 22 (Received 2016 March 9)
Topic: Environmental Health Program Funding – BOH Resolution
From: Dr. James Chirico, Medical Officer of Health & CEO, North Bay Parry Sound District Health Unit
To: The Honourable Dr. Eric Hoskins

Background:
There have been several recent changes to legislation involving the work of environmental health teams throughout Ontario. These changes and the corresponding increases in services that are being provided have not come with commensurate resources or staff training.

Recommendation:
Receive.

g) Date: 2016 February 22 (Received 2016 March 9)
Topic: Bill 139: Smoke-Free Schools Act – BOH Resolution
From: Dr. James Chirico, Medical Officer of Health & CEO, North Bay Parry Sound District Health Unit
To: The Honourable Dr. Eric Hoskins

Background:
Bill 139: Smoke-Free Schools Act would amend the Smoke Free Ontario Act and the Ontario Tobacco Tax Act to prohibit the sale of tobacco in schools, increase fines for offenders caught selling contraband tobacco, suspend drivers licenses for those using a motor vehicle to transport contraband tobacco, allow the sharing of proceeds of disposition or forfeited property with police forces and for the province to establish a public education campaign regarding the risk of tobacco use.

This Bill was introduced into the Ontario Legislature by MPP Todd Smith (Prince Edward-Hastings) and has been referred to the Standing Committee on General Government.

Recommendation:
Receive.

h) Date: 2016 March 2 (Received 2016 March 10)
Topic: Basic Income Guarantee
From: Doug Auld, Board of Health Chair, Wellington-Dufferin-Guelph Public Health
To: The Honourable Jean-Yves Duclos

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.

i) Date: 2016 March 8 (received 2016 March 11)
Topic: Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act
From: Dr. David McKeown, Medical Officer of Health, Toronto Public Health
To: Ms. Peggy Sattler

Background:

In Canada, domestic and sexual violence is a real and pervasive experience that many people endure. There is currently no legal workplace recognition of the tremendous physical and emotional toll this takes on people and the corresponding impact this may have on employment.

Peggy Sattler, MPP (London West) introduced Bill 177 Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act to amend the Employment Standards Act, 2000 to provide leave and accommodation for victims of domestic or sexual violence and to amend the Occupational Health and Safety Act to provide information and instruction concerning domestic and sexual violence.

It provides up to 10 days of paid leave for employees who have experienced domestic or sexual violence. This act has been referred to the Standing Committee on Justice Policy.

Recommendation:
Endorse.

j) Date: 2016 March 15 (received 2016 March 16)
Topic: Legislation to enforce infection prevention and control practices within invasive personal service settings
From: Scott McDonald, Board of Health Chair, Peterborough County-City Health Unit
To: The Honourable Kathleen Wynne

Background:
See item (c) above.

Recommendation:
Receive.

k) Date: 2016 March 17 (received 2016 March 18)
Topic: Association of Local Public Health Agencies Announces Update to Officers for 2015-16
From: Linda Stewart, Executive Director, alPHa
To: all Ontario Board of Health

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.

Recommendation:
Receive.

l) Date: 2016 March 18
Topic: Petition to Update Ontario Fluoridation Legislation
From: Gary McNamara, Chairperson, Windsor-Essex County Board of Health
To: The Honourable Dr. Eric Hoskins

Background:
Fluoride is a naturally occurring mineral which is present in almost all water sources. Community water fluoridation is the process by which a water system operator adds fluoride in controlled amounts to raise naturally low fluoride levels to the optimal level of 0.7mg/L or 0.7ppm for dental health. Community Water Fluoridation is a municipal matter and decisions regarding the fluoridation of water systems are made by municipal councils.

Recommendation:
Receive.

m) Date: 2016 March 18 (Received 2016 March 23)
Topic: Smoke-Free Multi-Unit housing
From: Donald W West, CAO, Porcupine Health Unit
To: The Honourable Ted McMeekin

Background:

The Smoke-Free Ontario Act prohibits smoking in common areas and ensures that signage is posted in appropriate locations. However, people who live in multi-unit housing are at risk of being negatively affected by second-hand smoke from adjacent units. Few buildings designate their units to be smoke-free and tenants can have very little choice in their housing arrangements.

Public health units and organizations like the Non-Smokers Rights Association and Smoke-Free Housing Ontario advocate for tenant protection in these multi-unit dwellings through voluntary no-smoking policies and future development of governmental policy to facilitate the provision of smoke-free housing.

The Middlesex-London Health Unit Board of Health previously endorsed correspondence to The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care at the June 2015 Board of Health meeting.

Recommendation:
Receive.

n) Date: 2016 March 18 (Received 2016 March 23)
Topic: Relocation of First Nations communities in Northwestern Ontario
From: Donald W West, CAO, Porcupine Health Unit
To: The Honourable Kathleen Wynne

Background:
First Nations communities in Northwestern Ontario and the James Bay coast require seasonal evacuation and relocation on a nearly annual basis. This is done in a reactionary manner without a proactive strategy to resource and maintain evacuation centres in host municipalities.

Recommendation:
Receive.

o) Date: 2016 March 24
Topic: Herpes Zoster Vaccine
From: Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit
To: The Honourable Eric Hoskins

Background:
See item (a) above.

Recommendation:
Receive.

p) Date: 2016 March 24
Topic: Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings
From: Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit
To: The Honourable Kathleen Wynne

Background:
See item (c) above.

Recommendation:
Receive.

q) Date: 2016 March 24

Topic: Environmental Health Program Funding
From: Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit
To: The Honourable Eric Hoskins

Background:
See item (f) above.

Recommendation:
Receive.

r) Date: 2016 March 24
Topic: Bill 139: Smoke Free Schools Act
From: Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit
To: The Honourable Eric Hoskins

Background:
See item (g) above.

Recommendation:
Receive.

s) Date: 2016 March 29
Topic: alPHa Risk Management Workshops Proceedings
From: Susan Lee, Associations of Local Public Health Agencies
To: All Board of Health Members

Background:
The Middlesex-London Health Unit had several staff members and a Board member in attendance at this Risk Management Workshop. The Governance Committee reporting calendar outlines the consideration of risk management at the June / July Governance Committee meeting.

Recommendation:
Receive.

t) Date: 2016 March 29
Topic: alPHa 2016 Annual General Meeting Notice & Call for Resolutions
From: Susan Lee, Associations of Local Public Health Agencies
To: Board of Health Chairs

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 2016 Annual General Meeting of the Association of Local Public Health Agencies will be held in Toronto, Ontario, on Monday, June 6, 2016.

Recommendation:
Receive.

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

ADJOURNMENT

PUBLIC SESSION – MINUTES

MIDDLESEX-LONDON BOARD OF HEALTH

2016 March 10

MEMBERS PRESENT:

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

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
Mr. Daniel Brown, Western University
Ms. Laura Di Cesare, Director, Corporate Services
Ms. Paula Dworatzak, Western University
Mr. Dan Flaherty, Communications Manager
Dr. Gayane Hovhannisyan, Associate Medical Officer of Health
Ms. Lesley James, Heart & Stroke Foundation
Mr. Brian Kellow, Heart & Stroke Foundation
Ms. Kim Leacy, Dietician, Chronic Disease & Tobacco Control
Mr. John Millson, Associate Director, Finance
Mr. Chimere Okoronkwo, Manager, Oral Health
Ms. Linda Stobo, Manager, Chronic Disease & Tobacco Control
Mr. Alex Tyml, Online Communications Coordinator
Ms. Suzanne Vandervoort, Director, Healthy Living
Ms. Angie Woodcock, Canadian Cancer Society

MEDIA OUTLETS: None

Vice-Chair Joanne Vanderheyden called the meeting to order at 6:58 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

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

APPROVAL OF AGENDA

It was moved by Mr. Studenny, seconded by Ms. Poole *that the **AGENDA** for the March 10, 2016 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Hunter, seconded by Mr. Meyer *that the* **MINUTES** *for the February 18, 2016 Board of Health meeting be approved.*

Carried

It was moved by Mr. Hunter, seconded by Mr. Meyer *that the draft* **MINUTES** *for the March 3, 2016 Finance and Facilities Committee meeting be received.*

Carried

BUSINESS ARISING FROM THE MINUTES - none

DELEGATIONS

7:05- 7:25 p.m. Ms. Lesley James, Senior Manager Health Policy, Heart and Stroke Foundation
Ms. Paula Dworatzek, Western University, Ms. Angie Woodcock, Canadian Cancer Society, re: Item #2 Impact of Sugar Sweetened Beverages (Report No. 016-16)

Chair Helmer and Mr. Stephen Turner arrived at 7:02 p.m. Chair Helmer took over as Chair at 7:11 p.m.

Ms. Lesley James provided a summary of the Heart & Stroke Foundation's position on sugar and sugar-sweetened beverages; Ms. Paula Dworatzek provided a summary of research on the consumption of sugar sweetened beverages and the associated correlation with Type 2 Diabetes and obesity; and Ms. Angie Woodcock, Canadian Cancer Society, provided information on reducing overconsumption of sugar in order to prevent cancer. Following their presentations, the delegates sat as a panel and answered questions.

Discussion ensued about the following:

- Consumption patterns of sugary drinks based on socio-economic status and the long-term effects of consumption patterns
- The implications of taxing sugary beverages and the policy changes that could be made to facilitate change and the ability to make changes at the municipal level.
- Actions that Ontario municipalities can take at the local level which include: dis-allowing free refills and limiting portion sizes.

Chair Helmer invited a motion to receive Report No. 016-16 attached to this delegation.

It was moved by Mr. Meyer, seconded by Mr. Studenny *that the Board of Health receive the presentations and report No. 016-16 re: Impact of Sugar Sweetened Beverages and Creating Supportive Environments.*

Carried

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).

COMMITTEE REPORTS

1) **Finance and Facilities Committee (FFC) Report, March 3 Meeting** (Report No. 015-16)

Ms. Fulton provided a summary of the recommendations from the March 3, 2016 Finance and Facilities Committee (FFC) meeting outlined below:

Discussion ensued about the following:

- Dental Treatment program deficit, and how funding rules apply to the proposal to fund the deficit with surplus

- The cost challenges associated with running the clinic, how the clinic would be funded in future years and how the Finance and Facilities Committee will analyze the resources and function of the clinic moving forward

Ms. Fulton clarified to the Board of Health that this was a one-time decision; FFC will look at and have more discussion on this item moving forward.

Dr. Mackie clarified the origin of the dental clinic reserve and its use; advising that staff will take the FFC direction very seriously for future considerations in finding cost saving measures and running the dental clinic.

It was moved by Ms. Fulton, seconded by Mr. Turner, *that the Board of Health receive Report No. 07-16FFC "Fourth Quarter Budget Variance Report & Factual Certificate" for information as recommended by the Finance and Facilities Committee.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Peer *that the Board of Health approve that the 2015 Dental Treatment program deficit be funded by general Cost-Shared program surplus as recommended by the Finance and Facilities Committee.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Turner *that the Board of Health receive Report No. 08-16FFC, "2015 Vendor / Visa Payments" as information as recommended by the Finance and Facilities Committee.*

Carried

DELEGATION AND RECOMMENDATION REPORTS

2) Impact of Sugar Sweetened Beverages and Creating Supportive Environments (Report No. 016-16)

Discussion ensued about the implications of taxing sugar sweetened beverages, the potential consequences associated with taxation and the steps Board members can take to bring this forward to their associated councils.

The Board requested additional information from Health Unit staff on activities that can be carried out at the municipal level right away to move this position forward at the local level, and enquired about the possibility of having a resolution go forward to the AGM of the Association of Local Public Health Agencies (alPHa).

Chair Helmer noted that the Board approved the first recommendation following the delegation and requested a motion to approve the second recommendation, with the addition of a third item.

It was moved by Mr. Meyer, seconded by Mr. Studenny, *that 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, and further*
3. *Direct staff to bring forward additional information and action items to advance this position at the local level.*

Carried

INFORMATION REPORTS

3) Income Security – The Effective Response to Food Insecurity (Report No. 017-16)

It was moved by Mr. Turner, seconded by Mr. Peer, *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.*

Carried

4) Summary Information Report for March 2016 (Report No. 018-16)

It was moved by Mr. Vanderheyden, seconded by Mr. Smith, *that the Board of Health receive Report No. 018-16 re: Summary Information Report for March 2016 for information.*

Carried

5) Medical Officer of Health Activity Report – March (Report No. 019-16)

It was moved by Mr. Peer, seconded by Ms. Vanderheyden, *that Report No. 019-16 re Medical Officer of Health Activity Report – March be received for information*.

Carried

6) Verbal update on work with Syrian Newcomers

Dr. Hovhannisyan provided a summary update on the work the MLHU is doing to support Syrian Newcomers. Staff are working with Newcomers in areas of child health, preconception, reproductive health, oral health, tobacco control and infection prevention and control. The Vaccine Preventable Disease Team continues to work with Newcomers at immunization clinics and have provided 1500 doses of vaccine.

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

Carried

7) Verbal update on TB case investigation

Dr. Hovhannisyan provided a summary of the work moving forward with the Health Unit's TB contact investigation. All test results (17) to date have come back negative. The Health Unit will continue the investigation and expect remaining test results to come in by the end of March.

It was moved by Mr. Studenny, seconded by Mr. Hunter *that the Board of Health receive Dr. Hovhannisyan's verbal update on the Health Unit's TB case investigation.*

Carried

8) Generative Discussion: Mayor's Advisory Panel on Poverty Draft Recommendations

Dr. Mackie gave a brief update and summary of the draft recommendations.

Discussion ensued about identifying organizations to take the lead on recommendations, the health equity lens in which the recommendations are set, the composition and experience of panel members, addressing poverty-related issues within the school system and effects the final recommendations might have on Health Unit work going forward.

It was moved by Mr. Turner, seconded by Ms. Vanderheyden, *that the Board of Health receive the Mayor's Advisory Panel on Poverty Draft recommendations for information.*

Carried

OTHER BUSINESS

Upcoming meetings

- 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.
- Next Governance Committee Meeting: Thursday, April 21, 2016 @ 6:00 p.m.

CORRESPONDENCE

It was moved by Mr. Peer, seconded by Mr. Turner *that the Board of Health receive correspondence items a) through j).*

Carried

Dr. Mackie made two additional announcements:

- Mr. Wally Adams' retirement planned for June 2016.
- Introduced Mr. Daniel Brown, Western University Kinesiology student and Loran scholar.

CONFIDENTIAL

At 8:39 p.m. Chair Helmer invited a motion to 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.

At 8:39 p.m. it was moved by Mr. Studenny, seconded by Ms. Vanderheyden *that the Board of Health 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.*

Carried

At 8:40 p.m. all Health Unit staff, except Dr. Mackie, Dr. Hovhannisyan, Ms. Laura Di Cesare, Mr. John Millson, Mr. Wally Adams, Ms. Suzanne Vandervoort and Elizabeth Milne, left the meeting.

At 8:45 p.m. it was moved by Mr. Studenny, seconded by Mr. Meyer *that the Board of Health rise and return to public session to adjourn the meeting.*

Carried

At 8:45 p.m. the Board of Health returned to public session.

ADJOURNMENT

At 8:45 p.m., it was moved by Mr. Studenny, seconded by Mr. Meyer *that the meeting be adjourned.*

Carried

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JESSE HELMER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee

399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, January 21, 2016 6:00 p.m.

Committee Members Present:	Mr. Marcel Meyer Mr. Ian Peer Ms. Viola Poletes-Montgomery Mr. Mark Studenny (Chair)
Others Present:	Mr. Kurtis Smith, Board Member Ms. Joanne Vanderheyden, Board Member Dr. Christopher Mackie, Medical Officer of Health & CEO Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder) Mr. Jordan Banninga, Manager, Strategic Projects Ms. Laura Di Cesare, Director, Corporate Services

Mr. Mark Studenny, Chair of the Governance Committee, called the Committee meeting to order at 6:02 p.m.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Studenny 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. Smith *that the AGENDA for the January 21, 2016 Governance Committee meeting be approved.*

Carried

3. APPROVAL OF MINUTES

It was moved by Mr. Smith, seconded by Mr. Peer *that the MINUTES from the September 17, 2015 Governance Committee meeting be approved.*

Carried

4. BUSINESS ARISING FROM THE MINUTES - none

5. NEW BUSINESS

5.1 2016 Governance Committee Reporting Calendar (Report No. 01-16GC)

Ms. Laura Di Cesare, Director, Corporate Services, outlined the calendar and explained that some minor amendments have been made.

It was moved by Mr. Peer, seconded by Mr. Smith *that the the Governance Committee receive Report 01-16GC for discussion and approval of the proposed 2016 Governance Committee Reporting Calendar.*

Carried

5.2 2016 Medical Officer of Health and CEO Performance Appraisal (Report No. 02-16GC)

Ms. Di Cesare outlined the performance appraisal process and advised that forming the sub-committee for 2016 would initiate the process. A draft report will be completed and brought to the Board of Health in April.

Discussion ensued about the structure and membership of the sub-committee. Mr. Ian Peer, Mr. Marcel Meyer, Mr. Kurtis Smith and Mr. Mark Studenny brought their names forward to sit on the sub-committee to initiate the 2016 performance appraisal for the Medical Officer of Health and CEO, Dr. Christopher Mackie.

It was moved by Mr. Peer seconded by Ms. Poletes Montgomery that the *Governance Committee*

1) *receive Report 02-16GC; and*
2) *form a sub-committee consisting of Mr. Ian Peer, Mr. Marcel Meyer, Mr. Kurtis Smith and Mr. Mark Studenny to initiate the performance appraisal process for the Medical Officer of Health and Chief Executive Officer.*

Carried

5.3 Critical Elements of Board Governance - Review (Report No. 03-16GC)

Ms. Di Cesare outlined some of the areas identified by Mr. Graham Scott that the Governance Committee could consider and provide direction on.

Discussion ensued about the Board of Health Self-Assessment and how to provide support to individual Board members to enhance their contribution to Board work. Dr. Mackie advised that staff would look into at what a self-assessment individual Board members could look like.

It was moved by Ms. Poletes-Montgomery, seconded by Mr. Peer *that the the Governance Committee receive Report No. 03-16GC for information and discussion.*

Carried

5.4 Governance Committee Terms of Reference - Review (Report No. 04-16GC)

Ms. Di Cesare reviewed the Draft Terms of Reference and outlined the items that the Health Unit is looking to the Committee for direction on.
Discussion ensued about the Terms of Reference, including how to ensure attendance and the process for revising them for Board of Health committees.

It was moved by Ms. Poletes Montgomery seconded by Mr. Peer *that the the Governance Committee*

1) *receive Report No. 04-16GC for discussion; and further,*

2) *That staff integrate feedback from the Governance Committee, Mr. Graham Scott and changes to the Middlesex-London Health Unit Organizational Structure into a draft Terms of Reference for Governance Committee review.*

Carried

5.5 Board of Health Nomination and Appointment Process (Report No. 05-16GC)

Ms. Di Cesare reviewed the steps required to draft a nomination and appointment process to ensure that tools are aligned with work currently being done by the Board of Health.

Discussion ensued about the process to assess the Board's overall skill set when recruiting new members to the Board of Health.

It was moved by Mr. Peer, seconded by Mr. Smith *that the the Governance Committee:*

1) *receive Report No. 05-16GC for information; and*
2) *direct staff to draft a nomination and appointment process for the Board of Health and Standing Committees.*

Carried

5.6 **2016 Board of Health Self-Assessment** (Report No. 06-16GC)

Ms. Di Cesare outlined the draft assessment tool and recommended that the Board initiate the process for 2016.

Discussion ensued about the structure of the assessment, the possibility of adding a Likert scale, and adding a question to prioritize areas for development.

It was moved by Mr. Smith seconded by Mr. Peer *that the the Governance Committee*
1) *receive Report 06-16GC for discussion; and*
2) *Initiate the Board of Health Self-Evaluation Process for 2016, with amendments, the tool will be revised as per the Committee's input.*

Carried

6. OTHER BUSINESS

The next Governance Committee meeting is scheduled for Thursday, April 21, 2016 at 6:00 p.m.

At 7:03 p.m. it was moved by Mr. Smith, seconded by Mr. Studenny *that the meeting be adjourned.*

Carried

____________________________	____________________________
MARK STUDENNY Chair	CHRISTOPHER MACKIE Secretary-Treasurer

PUBLIC MINUTES
Finance and Facilities Committee
50 King Street, Room 3A
MIDDLESEX-LONDON BOARD OF HEALTH
2016 April 7, 9:00 a.m.

COMMITTEE MEMBERS PRESENT:	Ms. Trish Fulton **(Committee Chair)** Mr. Marcel Meyer Mr. Ian Peer Mr. Jesse Helmer 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) Mr. Jordan Banninga, Manager, Strategic Projects Ms. Laura Di Cesare, Director, Corporate Services Mr. John Millson, Associate Director, Finance

At 9:02 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 Ms. Vanderheyden *that the* ***AGENDA*** *for the April 7, 2016 Finance and Facilities Committee meeting be approved.*

Carried

3. APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Mr. Meyer *that the* ***MINUTES*** *from the March 3, 2016 Finance and Facilities Committee meeting be approved.*

Carried

4. NEW BUSINESS

4.1 Physical Assets and Facilities Update (Report No. 010-16FFC)

Mr. Helmer arrived at 9:09 a.m.

Mr. Jordan Banninga, Manager, Strategic Projects presented the MLHU Relocation Project Plan and answered questions.

Discussion ensued about the following items:
- The city's transit plans and how they may relate to the Health Unit's location moving forward.
- The one-time funding request (Appendix B), submitted in March 2016.

DRAFT

- Fees associated with weighing the buy, build, lease options and the importance of public consultations in this process.

Chair Fulton requested that the Committee consider the commitment that may be required at points in the relocation process in order to inform discussion on the Terms of Reference later in the meeting.

It was moved by Ms. Vanderheyden, seconded by Mr. Helmer *that the Finance and Facilities Committee:*

1. *Receive Report No. 010-16FFC Re: Middlesex-London Health Unit Relocation for information*
2. *Receive Appendix B re: one-time funding requests submitted to the Ministry of Health and Long-Term Care and,*
3. *Approve proposed Middlesex-London Health Unit Relocation Project Plan (Appendix A)*

Carried

4.2 2016 Board Member Remuneration (**Report No. 011-16FFC**)

It was moved by Mr. Peer, seconded by Mr. Helmer, *that the Finance & Facilities Committee make recommendation to the Board of Health to increase the Board of Health member compensation rate for a half day meeting to $149.25 retroactively to January 1st, 2016.*

Carried

4.3 Terms of Reference – Revisions (Report No. 012-16FFC)

Dr. Mackie and Ms. Di Cesare summarized the FFC Terms of Reference revisions and answered questions.

Discussion ensued about separating facilities work from the finance committee, moving forward. The Committee felt they were able to commit the necessary time to support this work and are well equipped with the background knowledge to give the Board advice on facilities going forward.

Additional discussion ensued about the following items:

- Membership timelines and the appointment process.
- Changing wording to reflect that the Committee sits until after the budget cycle.
- The feasibility of bringing the budget to the Board of Health for approval by the end of the calendar year versus the fiscal year.

It was moved by Mr. Meyer, seconded by Mr. Peer, *that the Finance & Facilities Committee:*

1) *Receive Report No. 012-16FFC for information; and*
2) *Recommend that the Governance Committee recommend to the Board of Health approval of the revised Terms of Reference attached as Appendix A.*

Carried

5. CONFIDENTIAL

It was moved by Mr. Meyer, seconded by Mr. Peer *that the Finance and Facilities Committee approve minutes from its March 3, 2016 in-camera session.*

Carried

6. OTHER BUSINESS

6.1 The next meeting date was changed to Tuesday May 3, 2016 at 10:00 a.m. due to quorum.

7. ADJOURNMENT

DRAFT

At 10:22 a.m. Chair Fulton *adjourned the meeting.*

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TRISH FULTON
Committee Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

DRAFT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 021-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 April 21

FINANCE AND FACILITIES COMMITTEE MEETING APRIL

The Finance and Facilities Committee met at 9:00 a.m. on April 7, 2016 (Agenda). The following items were discussed at the meeting and recommendations made:

Reports	Recommendations for Board of Health's Consideration
Physical Assets and Facilities Update (Report 010-16FFC)	It was moved by Ms. Vanderheyden, seconded by Mr. Helmer *that the Finance and Facilities Committee:* 1. *Receive Report No. 010-16FFC Re: Middlesex-London Health Unit Relocation for information* 2. *Receive Appendix B re: one-time funding requests submitted to the Ministry of Health and Long-Term Care and,* 3. *Approve proposed Middlesex-London Health Unit Relocation Project Plan (revised Appendix A)* Carried
2016 Board Member Remuneration (Report 011-16FFC)	It was moved by Mr. Peer, seconded by Mr. Helmer, *that the Finance & Facilities Committee make recommendation to the Board of Health to increase the Board of Health member compensation rate for a half day meeting to $149.25 retroactively to January 1st, 2016.* Carried
Terms of Reference – Revisions (Report No. 012-16FFC)	Discussion ensued about separating facilities work from the finance committee, moving forward. The Committee felt they were able to commit the necessary time to support this work, and well equipped with the background knowledge to give the Board advice on facilities going forward. It was moved by Mr. Meyer, seconded by Mr. Peer, *that the Finance & Facilities Committee:* 1) *Receive Report No. 012-16FFC for information; and* 2) *Recommend that the Governance Committee recommend to the Board of Health approval of the revised Terms of Reference attached as Appendix A.* Carried

The next Finance and Facilities Committee meeting has been re-scheduled to Tuesday, May 3, 2016 at 10:00 a.m. due to quorum.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 022-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 April 21

BABY-FRIENDLY INITIATIVE

Recommendation

It is recommended that Report No. 022-16 re: "Baby-Friendly Initiative" be received for information.

Key Points

- The Baby-Friendly Initiative (BFI) is a global evidence-based strategy that promotes, protects, and supports the initiation and continuation of breastfeeding. All Ontario Health Units are required to work towards achievement of Baby-Friendly designation.
- Middlesex-London Health Unit held their BFI External Assessment last fall, and has recently been awarded designation as Baby-Friendly.
- Our Baby-Friendly Organization Policy is reviewed annually and Board of Health members must complete an annual orientation to this policy.

Background

Breastfeeding increases the health and development of infants and children, and provides health, social, and economic advantages to women, families, and society in general. Current recommendations from the World Health Organization advise exclusive breastfeeding for the first six months, with continued breastfeeding up to two years and beyond. The Baby-Friendly Initiative (BFI) is a global evidence-based strategy that promotes, protects, and supports the initiation and continuation of breastfeeding.

The Ministry of Health and Long Term Care selected Baby-Friendly designation as an Accountability Agreement Performance Indicator for all public health units in Ontario. The Health Unit signed a Certificate of Intent to begin the implementation process in November 2011. The implementation process has clearly defined steps laid out by both the Ministry and the Breastfeeding Committee for Canada (BCC), the national designation authority. Over the past four years, the Health Unit has worked through the implementation steps and began the formal designation process in November 2013. In October 2015, the Health Unit reached the final step in the designation process.

Progress Update on the Implementation of the Baby-Friendly Initiative

The implementation process for the Baby-Friendly Initiative includes a comprehensive mix of policy implementation, staff education, review and revision of curricula and resources, practice changes, data collection, and community outreach. The Health Unit has worked through each of these requirements, and on October 28, 29, and 30th a team of four BFI Assessors from the BCC were on-site to assess whether or not the Baby-Friendly requirements had been satisfied.

The 3-day assessment included confirmation of the knowledge and skill of staff/managers/Directors from across the Health Unit, through more than 60 individual interviews as well as observation of clinical work (i.e., client phone calls, home visits, prenatal classes and postpartum clinics). The Assessment Team also interviewed the Board of Health Chair and key community partners, such as LHSC, La Leche League, and the Ontario Early Years Centre. As well as reviewing our system for collecting and monitoring local data on

breastfeeding initiation and duration rates, the Assessment Team interviewed 50 prenatal and postpartum clients.

The Assessment findings included:

1. There is evidence of considerable growth and development in the implementation of the Baby-Friendly Initiative;
2. The attitudes, knowledge, and skills are in place to support women to meet their breastfeeding goals; and
3. There are areas of practice to continue to develop (e.g., promotion of skin-to-skin for painful procedures).

In December, the final Assessment report was received, confirming the BCC's recommendation that Middlesex-London Health Unit receive Baby-Friendly Initiative designation.

Conclusion/Next Steps

On February 4th, 2016 the Health Unit held a celebration event at which time the formal announcement was made to the community that it had been awarded Baby-Friendly designation. As well as many staff and key community partners, Kathy Venter, Lead Assessor with the Breastfeeding Committee for Canada (BCC), was on hand to present the Health Unit with a plaque.

To maintain Baby-Friendly designation, it is required that an annual report be submitted to the BCC that provides an update on our efforts to maintain and improve the care and support that is provided to families regarding infant feeding. As a part of this process, we are strengthening our partnerships and continuity of care for clients by reviewing best practices in the community and at the hospital level with key individuals at LHSC. Local data will be monitored using the Middlesex-London Infant Feeding Surveillance System. We will also continue to provide an orientation to the Health Unit's BFI policy to all new staff, including the Board of Health, on an annual basis (Appendix A). Every five years, the Health Unit will be required to go through an assessment process in order to be re-designated as Baby-Friendly.

This report was prepared by Ms. Laura Dueck, Public Health Nurse, and Tracey Gordon, Program Manager, Reproductive Health Team, Healthy Start.

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

MIDDLESEX-LONDON HEALTH UNIT

ADMINISTRATION MANUAL

SUBJECT:	Baby-Friendly Organization	**POLICY NUMBER:**	**2-070**
SECTION:	Organization	**PAGE:**	1 of 6

IMPLEMENTATION:	October 18, 2012	**APPROVAL:**	Board of Health
SPONSOR:	Baby-Friendly Initiative (BFI) Lead	**SIGNATURE:**	
REVIEWED BY:	BFI Policy Work Group	**DATE:**	April 16, 2015

PURPOSE

The Baby-Friendly Initiative (BFI) is a global, population-based strategy that has been shown to increase the health and well-being of children and families through increased initiation and duration rates of breastfeeding. BFI ensures that all families have the information they need to make an informed infant feeding decision. The Middlesex-London Health Unit (MLHU) is committed to collaborate with healthcare providers and key organizations in our community to protect, promote and support breastfeeding through the Baby-Friendly Initiative.

“Breastfeeding provides nutritional, immunological, and emotional benefits to infants and toddlers. Breast milk is the best food for healthy growth and development. Healthy term infants should be exclusively breastfed to six months of age and then continue to be breastfed with appropriate complementary feeding to two years of age and beyond” (Health Canada, 2012).

POLICY

The MLHU will achieve and maintain Baby-Friendly designation by complying with the Breastfeeding Committee for Canada (BCC) BFI_10 Steps Practice Outcome Indicators which include adhering to the World Health Organization (WHO) International Code of Marketing of Breast Milk Substitutes and subsequent relevant Resolutions of the World Health Assembly (WHA).

PROCEDURE

Responsibilities

- **Human Resources & Labour Relations** is responsible for ensuring that all new staff and volunteers are aware of the BFI policy.
- **The BFI Task Force, in collaboration with managers,** will ensure new staff receive orientation to the policy, and will support breastfeeding education and training for their staff as appropriate to their role.
- **All Staff and volunteers** will be educated about the importance of breastfeeding, the risks of breast milk substitutes (infant formula), where to refer breastfeeding mothers for care and support, and to welcome breastfeeding in our offices as well as community sites where MLHU services are offered. All staff

and volunteers will provide client-centered care and support to all families including non-breastfeeding families.

- BFI Education Recommendations for Student/Intern Placements **have been developed.**
- **The Best Beginnings and Early Years Teams** are responsible for providing one-to-one breastfeeding care and will act as the point of first referral for mothers experiencing breastfeeding challenges.
- All direct care providers (PHNs in FHS working on the Reproductive Health, Best Beginnings, Early Years, and Young Adult Teams, as well as Prenatal Education) must meet the following documentation requirements as outlined in the BFI 10 Steps Practice Outcome Indicators:
    - Documentation shows evidence of support provided to clients for informed decision-making to supplement with breast milk substitutes for medical or personal reasons.
    - Documentation shows evidence of support in finding alternative solutions to the use of artificial teats or pacifiers, and for informed decision-making regarding their use.
    - Documentation reflects direct care provider's rationale for recommending supplements for medical indications, including medical reason and evidence of parental consent for supplementation.
    - Documentation shows evidence of medical indications for separation of mothers and babies, the length of separation and anticipatory guidance to protect, promote and support breastfeeding.
    - Documentation shows evidence that mothers receive information on cue-based feeding and continued breastfeeding.
    - Documentation shows evidence of a breastfeeding assessment when a nipple shield is recommended or provided, as well as support, information and follow-up provided to mother.
- **The BFI Lead** with support from the **BFI Task Force**, will provide overall coordination of BFI designation activities, report to the Ministry, act as a resource for staff, and evaluate and support ongoing compliance.

The Ten Steps

Step 1 - Have a written breastfeeding policy that is routinely communicated to all healthcare providers and volunteers.

Step 2 - Ensure all healthcare providers have the knowledge and skills necessary to implement the breastfeeding policy.

Everyone will receive appropriate orientation about this policy, and education about the importance of breastfeeding, as well as which Health Unit services provide direct breastfeeding care and support, and how to refer to Health Connection.

New staff will receive orientation to the policy and education appropriate to their role, within 4 months of their start date.

Staff that provides direct breastfeeding care and support will receive ongoing breastfeeding education to support breastfeeding best practices.

The policy summary will be visible in all public areas of MLHU offices in English and French. Spanish and Arabic versions will also be available. Other languages will be made available as needed.

Step 3 - Inform pregnant women and their families about the importance and process of breastfeeding.

Prenatal education will include information to help pregnant women and their families make an informed decision about infant feeding, as well as address the importance of exclusive breastfeeding, the basics of breastfeeding management and the risks and costs of not breastfeeding. Staff will not provide group prenatal or postnatal education about breast milk substitutes.

Step 4 - Place babies in uninterrupted skin-to-skin contact with their mothers immediately following birth for at least one hour or until completion of the first feeding or as long as the mother wishes; encourage mothers to recognize when their babies are ready to feed, offering help as needed.

All staff that provides direct breastfeeding care and support to pregnant women, mothers and their support persons will:

- Provide education about the importance of initiating skin-to-skin contact as soon as possible after birth, initiating breastfeeding within an hour of birth, responsive infant feeding, and rooming-in (unless medically contraindicated for mother or baby).

Step 5 - Assist mothers to breastfeed and maintain lactation should they face challenges, including separation from their infants.

All staff that provides direct breastfeeding care and support to pregnant women, mothers and their support persons will:

- Assess breastfeeding progress and provide care at each client interaction,
- Teach mothers about effective breastfeeding management including expression and storage of breast milk,

- Provide information on how to access community-based breastfeeding support,
- Inform parents about their right to have accommodations in the workplace that support and sustain breastfeeding, and
- On an individual basis, assist mothers to choose a feeding method that is acceptable, feasible, affordable, sustainable and safe for her situation. If a mother chooses to not breastfeed, or to supplement with a breast milk substitute, provide education about the correct preparation and storage of substitutes.
- For a mother who chooses to supplement with a breast milk substitute while she continues to breastfeed, provide information about the impact of supplementation on her breast milk supply.

Step 6- Support mothers to exclusively breastfeed for the first six months, unless supplements are medically indicated.

All staff that provides direct breastfeeding care and support to pregnant women, mothers and their support persons will:

- Provide information about the importance of exclusive breastfeeding for establishing and maintaining breastfeeding, and
- Provide information to support informed decision making about feeding their own expressed breast milk, human donor milk, or breast milk substitutes as appropriate. See medical indications for supplementation - Appendix 6.2 of the BFI Integrated 10 Steps Practice Outcome Indicators

Step 7- Facilitate 24 hour rooming-in for all mother-infant dyads, i.e., mothers and infants remain together.

All staff that provides direct breastfeeding care and support to pregnant women, mothers and their support persons will:

- Teach about the importance of mothers and infants remaining together from birth including once they are at home, and will encourage skin-to-skin contact for as long and as often as mothers desire. See RNAO Safe Sleep for Infants Best Practice Guideline.

Step 8 - Encourage baby-led or cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.

All staff that provides direct breastfeeding care and support to pregnant women, mothers and their support persons will:

- Teach mothers about the signs of effective breastfeeding and how to recognize and respond to their infant's feeding cues by breastfeeding,

- Encourage mothers to give their babies the opportunity to breastfeed frequently especially in the early weeks and inform them about how patterns of feeding change over time,
- Teach mothers about the signs of readiness for complementary foods and discuss the importance of continuing to breastfeed, and
- Teach mothers about their right to breastfeed in public spaces.

Step 9 - Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).

All staff that provides direct breastfeeding care and support to pregnant women, mothers and their support persons will:

- Support breastfeeding by not providing pacifiers or bottles to breastfeeding infants,
- Ensure that all breastfeeding mothers receive education about techniques such as settling infants without the use of artificial nipples,
- Review the risks of early artificial nipple and pacifier use. If the mother decides to use artificial nipples or pacifiers, she is encouraged to wait until breastfeeding is well established,
- Encourage appropriate alternate feeding methods such as lactation aids at the breast, finger feeding, cup feeding and spoon feeding when supplementation is necessary.

Step 10 - Provide a seamless transition between the services provided by the hospital, community health services and peer support programs.
Apply principles of Primary Health Care and Population Health to support the continuation of care and implement strategies that affect the broad determinants that will improve breastfeeding outcomes.

The Health Unit will:

- Foster partnerships with hospitals, midwives, doulas, peer support groups and key organizations that advance breastfeeding in Middlesex-London,
- Support research focused on increasing breastfeeding rates,
- Implement strategies that affect the broad determinants that improve breastfeeding outcomes, and
- Engage community members in breastfeeding promotion as well as the review of this policy.

Compliance with the International Code of Marketing of Breast milk substitutes and subsequent, relevant World Health Assembly (WHA) Resolutions.

The Health Unit will protect breastfeeding families by adhering to the World Health Organization (*WHO/UNICEF, 1981*) International Code of Marketing of Breast-Milk Substitutes and relevant WHA Resolutions, summarized as follows:

- No advertising of breast milk substitutes to the public,
- No free samples to pregnant women, mothers, and support people,
- No promotion of artificial feeding products in health care facilities, including the distribution of free or low-cost supplies,
- No company representatives to advise pregnant women, mothers, and support people,
- No gifts of personal samples to health workers,
- No words or pictures idealizing artificial feeding, including pictures of infants, on the labels of products,
- Information to health workers should be scientific and factual, and
- All information on artificial infant feeding, including the labels, should explain the importance of breastfeeding and all costs and risks associated with artificial feeding.

To operationalize the International Code of Marketing of Breast Milk Substitutes and Subsequent Resolutions as it relates to externally produced communications materials (e.g. pamphlets, booklets, magazines) refer to MLHU and WHO Code Implementation: External Communications Materials.

RELATED POLICIES

4-050 Donation Acceptance Policy
4-070 Corporate Sponsorship
5-185 Breastfeeding Workplace Policy (updated Dec. 2014)
5-190 Volunteer Services (updated and revised on HUB 2013)

REVISION DATES (* = major revision)**:**
December 2013
December 2014
April 16, 2015

MIDDLES4EX-LONDON HEALTH UNIT

REPORT NO. 023-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health and CEO

DATE: 2016 April 21

ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCY RESOLUTION

It is recommended that the Board of Health

1. ***Receive report No.023-16 re: Association of Local Public Health Agency (alPHa); and***
2. ***Submit the attached resolutions to go forward to the alPHa Annual General meeting in June 2016.***

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 high in sugar.
- On March 10th, the Board of Health endorsed the Health and Stroke Foundation Sugar, Health Disease and Stroke Position Statement.
- The Association of Local Public Health Agencies is an important ally to help move issues forward and advocate on behalf of local public health.

Background

On March 10th, 2016 at the Board of Health meeting the Heart and Stroke Foundation (HSF) presented evidence indicating that there is a growing body of credible research indicating an increased incidence of health risks associated with the consumption of sugar sweetened beverages (SSB). The consumption of SSB has been linked to obesity, type 2 diabetes, cardiovascular disease, dental caries, dyslipidemia and metabolic syndrome. As well the Senate Report on Obesity released in March 2016 identifies 21 recommendations to combat this growing epidemic. The recommendations include further taxation on SSB with additional tax revenue being put toward subsidies for healthy options such as fruits and vegetables.

Opportunities for Action

At the March meeting, the Board of Health endorsed the HSF position paper, directed staff to work with municipalities on this issue, and also identified the opportunity to bring a motion forward to the Association for Local Public Health Agencies (alPHa). The annual meeting for alPHa is in June, and the deadline for Boards of Health to submit resolutions is in April. Once a resolution is passed alPHa with sponsoring agency will move issue forward and advocate on behalf of stakeholders. This provides health units the opportunity to advocate on behalf of issues of public health with the support of alPHa.

Next Steps

Given the increasing evidence that supports the impact SSB is having on the health of children, further legislative action is required. As per the recommendations found in the Heart and Stroke Position Paper, taxation of SSB will impact consumption and the gained revenue can be used to subsidize healthy options such as fruits and vegetables. Sending forward a resolution as found in Appendix A to alPHa will play a role in the need for a comprehensive approach to enhance the health of our children.

Staff will bring forward a report about further steps at the municipal level and to describe the comprehensive approach currently being taken by the Health Unit at a Board of Health meeting later this spring.

This report was prepared by Mary Lou Albanese, Manager of Child Health, with input from all Health Unit dieticians.

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.

TITLE **Advocate for a comprehensive province-wide healthy eating approach integrating the recommendations in the Senate's Report on Obesity and the Heart and Stroke Foundation Sugar, Heart Disease and Stroke Position Statement, including taxation of sugar-sweetened beverages.**

SPONSOR Middlesex-London Board of Health

WHEREAS In Ontario, between 1978 and 2004 the prevalence of overweight children aged 12-17 increased from 14% to 29% and obese from 3% to 9% (Shields, 2006) Youth who are overweight and obese are at higher risk of being overweight or obese in adulthood (Singh, Mulder, Twisk, van Mechelen & Chinapaw, 2008).

WHEREAS The etiology of obesity is complex and involves interactions between genetics, social and environmental factors.

WHEREAS A comprehensive approach has been found to be most effective to bring about social change in order to improve health and wellbeing and reflected in the five elements of the Ottawa Charter for Health Promotion, World Health Organization(WHO), 1986, building healthy public policy, reorienting the health services, creating supportive environments, strengthening community action, developing personal skill.

WHEREAS As part of a comprehensive approach, specific policy measures such as taxation can have a measurable impact, particularly when they are large enough to affect consumer behaviour, and revenues are redirected toward prevention efforts (Sturm et al, 2010).

WHEREAS The Senate's Report on Obesity describes an innovative, whole-of-society approach to address this important issue — and urges bold but practical steps that can and must be taken to help Canadians achieve and maintain healthy weights (2016).

WHEREAS It is estimated that Canadians consume as much as 13% of their total calorie intake from added sugars (Brisbois et al, 2014).

WHEREAS In children higher intake of Sugar Sweetened Beverages has been associated with a 55% increased risk of being overweight or obese compared to children with lower intake (Te Morenga, Mallard & Mann, 2012).

WHEREAS WHO recommends 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 (2015).

WHEREAS The position paper, Sugar, Heart Disease and Stroke by the Heart and Stroke Foundation identifies a comprehensive approach to address the overconsumption of sugar, sweetened (energy dense, nutrient poor) beverages which evidence shows is linked to overweight and obese children (2014).

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario government to develop a province-wide comprehensive strategy to promote healthy eating taking into considerations the recommendations in the Senate's Report on Obesity and the Heart and Stroke Foundation Sugar, Heart Disease and Stroke Position Statement, including taxation of sugar-sweetened beverages.

References:

Brisbois, TD, Marsden SL, Anderson GH, Sievenpiper JL. Estimated intakes and sources of total and added sugars in the Canadian diet. Nutritents 2014:6:1899-1912.

Shields M. Measured Obesity Overweight Canadian children and adolescents, Statistics Canada, 2006.

Senate Report on Obesity - www.parl.gc.ca/content/sen/committee/421/SOCI/Reports/2016-02-25_Revised_report_Obesity_in_Canada_e.pdf.

Singh et al., Estimated Global, Regional, and National Disease Burdens Related to Sugar-Sweetened Beverage Consumption in 2010, available at http://circ.ahajournals.org.

Singh AS, Mulder C, Twisk JWR , van Mechelen W & Chinapaw MJM. Tracking of childhood overweight into adulthood: A systematic review of the literature. 2008 International Association for the Study of Obesity, obesity reviews 9, 474–4882008.

Sturm, R Powell, L Chriqui, J & Chaloupka F. Soda Taxes, Soft Drink Consumption, And Children's Body Mass Index, : http://content.healthaffairs.org/content/early/2010/04/01/hlthaff.2009.0061.full

Te Morenga L, Mallard S, & Mann J, Dietary sugars and body weight: systematic review and meta-analyses of randomised controlled trials and cohort studies. BMJ 2012; 345.

World Health Organization. Guideline: Sugars intake for adults and children. Draft guidelines on free sugars released for public consultation, 5 March 2014.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 024-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016, April 21

COMMENTS ON THE MINISTRY OF HEALTH AND LONG-TERM CARE'S PROPOSAL TO STRENGTHEN ONTARIO'S SMOKING AND VAPING LAWS

Recommendation

It is recommended that the Board of Health

1. ***Endorse Report No. 024-16 re: "Comments on the Ministry of Health and Long-Term Care's Proposal to Strengthen Ontario's Smoking and Vaping Laws" and***
2. ***Direct Health Unit staff to submit Appendix B and corresponding references to the Regulatory Registry for Ministry of Health and Long-Term Care consideration.***

Key Points

- In May 2015, the *Making Healthier Choices Act, 2015* *(MHCA)* received Royal Assent, strengthening the *Smoke-Free Ontario Act* by banning the sale of certain flavoured tobacco products, increasing the maximum fines for youth-related sales offences, and increasing smoking restrictions on hospital property.
- The *MHCA* also created new legislation, the *Electronic Cigarettes Act, 2015* (*ECA*), to regulate the sale, use, display, and promotion of e-cigarettes. On January 1, 2016, provisions in the *ECA* came into effect, prohibiting the sale or supply of e-cigarettes to people less than 19 years of age.
- The Ministry is proposing further legislative and regulatory amendments to strengthen smoking and e-cigarettes laws in Ontario, outlined in Appendix A.
- The Middlesex-London Health Unit is in support of the proposed amendments with some suggested revisions, attached as Appendix B, to enhance public protection. Ongoing, dedicated funding with inflationary increases is required from the Ministry to support this work.

Background

The Ministry of Health and Long-Term Care is committed to improving the health and wellness of Ontarians. In May 2015, the *Making Healthier Choices Act, 2015* received Royal Assent, strengthening the *Smoke-Free Ontario Act* by banning the sale of certain flavoured tobacco products, increasing the maximum fines for youth-related sales offences, and increasing smoking restrictions on hospital property. These provisions came into effect January 1st, 2016. The *Act* also created new legislation - the *Electronic Cigarettes Act, 2015* *(ECA)* – to regulate the sale, use, display, and promotion of e-cigarettes. On January 1, 2016, particular sections of the *ECA* came into force, prohibiting the sale or supply of e-cigarettes to people less than 19 years of age.

The ministry is proposing further legislative and regulatory amendments that would strengthen smoking and e-cigarettes (vaping) laws in Ontario. In summary, the Ministry's proposed amendments, if approved would:

1. Expand the *Smoke-Free Ontario Act's* "no smoking rules" to apply to medical marijuana;
2. Prohibit the use of e-cigarettes – including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes – in all enclosed public places, enclosed workplaces, and other specified outdoor areas;
3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes;
4. Expand the definition of "e-cigarette" to include "e-substance";
5. Expand the list of places where e-cigarettes are prohibited for sale;
6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.

The Ministry proposal is outlined in greater detail in their public consultation paper, attached as Appendix A.

Opportunity for Public and Stakeholder Input

The Health Unit has a vested interest in ensuring that the proposal will meet local public health needs, will contribute to a strengthened provincial tobacco control strategy, and is enforceable by the Health Unit's Tobacco Enforcement Officers. The Health Unit's comments on the Ministry's proposal and suggested revisions Ministry's approach are attached as Appendix B, and summarized as follows:

- The prohibition on the smoking or holding of lit tobacco should be expanded to include ***the smoking or holding of lit marijuana***, and not limit the prohibition to medical marijuana only
- The prohibition on the smoking or holding of lit tobacco should be expanded to include smoking hookah or water pipe devices, regardless of whether or not the substance smoked contains tobacco
- The proposed approach to prohibit the use of e-cigarettes in places where smoking is prohibited, including the e-cigarette retail environment is applauded. The exemption for the use of e-cigarettes in theatrical stage productions should not be permitted, and the definition of "electronic cigarette" should be amended to remove the requirement that the device contain a power or heating source.
- Parents, guardians or caregivers that supply an e-cigarette to a minor to consume medical marijuana can only do so if the device is purchased from a pharmacy or directly from the authorized licensed producers of medical marijuana under the Marihuana for Medical Purposes Regulations.
- Tobacco products should not permitted to be sold at retailers that choose to operate under the display, promotion and handling exemption outlined in the Ministry's proposal. The promotion and marketing of e-cigarettes and e-substances should also be strictly prohibited at places of entertainment, including bars, restaurants, special events, casinos, concerts and racetracks.

Health Unit staff shared the Ministry's announcement, the consultation paper and information on how to submit comments on the legislation with community and municipal partners to solicit community input.

This report was prepared by Ms. Linda Stobo, Program Manager, Chronic Disease Prevention & Tobacco Control.

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

This report addresses the Chronic Disease and Injuries Program Standards of the Ontario Public Health Standards #1, 3, 4, 6, 11, 12 and 13"

Strengthening Ontario's Smoking and Vaping Laws

Proposed changes to regulations made under the *Smoke-Free Ontario Act* and *Electronic Cigarettes Act, 2015*

Public Consultation Paper
March 10, 2016

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Purpose

This consultation paper aims to solicit feedback from businesses, retailers, employers, health care facilities, public health experts, medical marijuana users, physicians, medical organizations, and the general public on the impacts of the Ministry of Health and Long-Term Care's proposal to strengthen Ontario's smoking and e-cigarette (vaping) laws.

This paper outlines the ministry's proposal to make changes to Ontario's smoking and vaping laws that would restrict where people can smoke medical marijuana and vape an e-cigarette, where e-cigarettes can be sold, and how e-cigarettes can be displayed and promoted.

Feedback

Your feedback and comments will inform the development of proposed amendments to Ontario Regulation 48/06[1] made under the *Smoke-Free Ontario Act* (SFOA)[2] and Ontario Regulation 337/15[3] made under the *Electronic Cigarettes Act, 2015* (ECA)[4].

Comments on this public consultation paper are welcome until **April 24, 2016** and can be provided in three different ways:

- Complete the Response Form provided on the Regulatory Registry in connection with this paper at http://www.ontariocanada.com/registry.
- Email comments directly to SFOA-ECA-Consultations@ontario.ca quoting this paper "Strengthening Ontario's Smoking and Vaping Laws"
- Mail comments to:
  Population and Public Health Division
  Ministry of Health and Long-Term Care
  777 Bay Street, Suite 1903, 19th Floor
  Toronto, ON M7A 1S5

Please note that all comments received from organizations, including individuals indicating an affiliation with an organization, will be considered public information and may be used and disclosed by the ministry to help in developing its final proposal.

[1] Ontario Regulation 48/06 made under the *Smoke-Free Ontario Act* can be found here - https://www.ontario.ca/laws/regulation/060048
[2] The *Smoke-Free Ontario Act* can be found here - https://www.ontario.ca/laws/statute/94t10
[3] Ontario Regulation 337/15 made under the *Electronic Cigarettes Act, 2015* can be found here: https://www.ontario.ca/laws/regulation/150337
[4] The *Electronic Cigarettes Act, 2015* can be found here - https://www.ontario.ca/laws/statute/15e07

Comments from individuals who do not indicate an affiliation will also be considered public and will be used and disclosed by the ministry to help in developing its final proposal. However, any personal information, such as names or contact details, would be removed prior to disclosure of the comments.

Summary

The Ministry of Health and Long-Term Care (the "ministry") is committed to improving the health and wellness of Ontarians. In May 2015, the *Making Healthier Choices Act, 2015*[5] received Royal Assent, strengthening the *Smoke-Free Ontario Act* by banning the sale of certain flavoured tobacco products, and increasing the maximum fines for youth-related sales offences. The *Making Healthier Choices Act, 2015* also created new legislation - the *Electronic Cigarettes Act, 2015* – to regulate the sale, use, display, and promotion of e-cigarettes.

On January 1, 2016, provisions in the *Electronic Cigarettes Act, 2015* came into force, which prohibit the sale or supply of e-cigarettes to persons who are less than 19 years old.

The ministry is considering further legislative and regulatory amendments that would strengthen smoking and e-cigarettes laws. This proposal is outlined below:

1. Expand "no smoking rules" to apply to medical marijuana;
2. Prohibit the use of e-cigarettes - including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes – in all enclosed public places, enclosed workplaces, and other specified outdoor areas;
3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes;
4. Expand the definition of "e-cigarette" to include "e-substance";
5. Expand the list of places where e-cigarettes are prohibited for sale;
6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.

If approved, this proposal would have a variety of impacts on the public, businesses and employers in Ontario. The ministry is interested in hearing from stakeholders about these impacts, and welcomes continued input.

[5] The *Making Healthier Choices Act, 2015* can be found here - http://www.ontla.on.ca/bills/bills-files/41_Parliament/Session1/b045ra.pdf

Background

Electronic cigarettes

E-cigarettes are an emerging trend in Ontario. Concerns have been raised about the potential negative health effect of e-cigarettes. The World Health Organization recommends taking precautionary action on e-cigarettes, and jurisdictions around the world have put into place restrictions to protect people from potential health impacts. In Ontario, the government has also taken precautionary measures to protect people, especially youth, from exposure to e-cigarettes and potential harms through restrictions on e-cigarette sales to minors, restrictions on where e-cigarettes can be used, restrictions on where e-cigarettes can be sold, and restrictions on how they can be displayed and promoted in stores.

Medical marijuana

Possession of marijuana is a criminal offence under the federal *Controlled Drugs and Substances Act*. However, the federal government provides access to a legal source of marijuana for medical purposes under its *Marihuana for Medical Purposes Regulations* (MMPR) made under the *Controlled Drugs and Substances Act*. Health Canada has not approved marijuana as a therapeutic product.

In order to obtain marijuana for medical purposes, a person must have a medical document from a physician and obtain medical marijuana from a licensed producer. As of September 2015, there are just over 30,000 clients in Canada who were registered with licensed producers of marijuana under federal regulation.

Evidence about the use, forms, and effectiveness of medical marijuana is still evolving. Although methods of consuming marijuana are also rapidly evolving, smoking is the most common form of consumption[6]. People can also consume medical marijuana using a vaporizer, which is considered an "e-cigarette" under the *Electronic Cigarettes Act, 2015.*

While there are some laws that impact where a medical marijuana user may smoke, vape, or ingest marijuana for medical purposes, such as the *Liquor Licence Act* and driving laws, they do not address the specific forms of smoking or vaping in public places.

Proposal

The following summary outlines and explains the proposed rules to strengthen smoking and e-cigarette laws in Ontario. The ministry is soliciting feedback on how these rules

[6] Canadian Centre on Substance Abuse. "Clearing the Smoke on Cannabis: Respiratory Effects of Cannabis Smoking." J. Diplock and D. Plecas. 2015

would affect you and how they can be improved to protect the health of Ontarians. Note that the final regulation may be different from what is in this proposal.

1. Expand no smoking rules to apply to medical marijuana

Issue

Ontario's *Smoke-Free Ontario Act* (SFOA) currently only applies to tobacco. It includes prohibitions on the smoking of tobacco in all enclosed public spaces and enclosed workplaces (including movie theatres and restaurants) and a number of outdoor public spaces (including playgrounds, restaurant/bar patios). It does not address the smoking of marijuana or other substances.

There are few laws, such as liquor license and driving laws, which address where a medical marijuana user may smoke, vape, or ingest marijuana for medical purposes.

Proposed approach

The ministry is proposing to amend the SFOA and Ontario Regulation 48/06 made under the SFOA to establish that the "no smoking" rules apply to medical marijuana. This would provide reasonable and precautionary safeguards to employees, customers and bystanders from exposure to medical marijuana smoke.

This would mean that smoking medical marijuana would be illegal in the following locations in which the smoking of tobacco is prohibited:

- Enclosed public places (e.g. shopping malls, theatres, schools)
- Enclosed workplaces (e.g. retail stores, office buildings, factories)
- Schools and school grounds
- Common areas in condominiums, apartment buildings and university/college campuses
- Child care centres within the meaning of *Child Care and Early Years Act, 2014*
- Places where home child care is provided within the meaning of the *Child Care and Early Years Act, 2014*, whether or not children are present
- Reserved seating areas of outdoor sports or entertainment venues
- Motor vehicles while another person who is less than 16 years old is present
- Restaurant and bar patios
- Sheltered areas with a roof and more than two walls
- Children's playgrounds
- Publicly owned sporting areas
- Nine meters from any entrance or exit of a public hospital, private hospital, psychiatric facility, long-term care home, and independent health facility

- Outdoor grounds of public hospitals, private hospitals and psychiatric facilities
- Outdoor grounds of certain government of Ontario office buildings

However, under the proposal, a specific exemption would permit smoking medical marijuana in:

- Scientific research and testing facilities;

Other exemptions in the SFOA for smoking tobacco would not apply to medical marijuana, i.e. designated guest rooms in hotels, motels and inns, controlled smoking areas in residential care facilities (e.g. long-term care homes), and traditional use of tobacco by Aboriginal persons.

The proposal, if approved and implemented, would continue to be enforced by inspectors appointed under the SFOA. These inspectors are employees of local public health units.

Discussion

This proposal would have different impacts on medical marijuana users, employees, businesses, retailers, employers, hospitals, residential care facilities, and public health units.

- How would this proposal impact your current practices or policies?
  Do you have specific suggestions to improve this proposal?

2. Prohibit the use of e-cigarettes - including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes –in all enclosed public places, enclosed workplaces, and other specified outdoor areas

Issue

Though not yet in force, Ontario's *Electronic Cigarettes Act, 2015* and its regulation contain provisions that would prohibit the use of e-cigarettes (i.e. vaping) in enclosed workplaces, enclosed public places and a number of other prescribed places (e.g. restaurant and bar patios, playgrounds).

E-cigarettes are a relatively new and quickly evolving technology; the evidence concerning their potential health effects and implications for tobacco control efforts is in its early stages. The restrictions under the *Electronic Cigarettes Act, 2015* ensure that Ontarians are protected from the potential harms that vapour exposure could have on their health.

Vaporizers, which are considered e-cigarettes under the *Electronic Cigarettes Act, 2015*, can be used to consume medical marijuana. The current regulation, Ontario

Regulation 337/15, made under the ECA (which is not yet in force) includes an exemption for medical marijuana users, which would permit them to use an e-cigarette for medical marijuana in places where vaping is otherwise prohibited.

Proposed Approach

The ministry is proposing that vaping be prohibited in enclosed workplaces, enclosed public places, and other prescribed places. This would protect employees, customers and bystanders from any potential harms associated with exposure to e-cigarettes – no matter the substance being vaped. This proposal would require a change to the regulation.

This would mean that using an e-cigarette (vaping), including the use of a vaporizer to consume medical marijuana, would be prohibited in the following places:

- Enclosed public places (e.g. shopping malls, theatres, schools)
- Enclosed workplaces (e.g. retail stores, office buildings, factories)
- Schools and school grounds
- Common areas in condominiums, apartment buildings and university/college campuses
- Child care centres within the meaning of *Child Care and Early Years Act, 2014*
- Places where home child care is provided within the meaning of the *Child Care and Early Years Act, 2014*, whether or not children are present
- Reserved seating areas of outdoor sports or entertainment venues
- Motor vehicles while another person who is less than 16 years old is present
- Restaurant and bar patios
- Sheltered areas with a roof and more than two walls
- Children's playgrounds
- Publicly owned sporting areas
- Nine meters from any entrance or exit of a public hospital, private hospital, psychiatric facility, long-term care home, and independent health facility
- Outdoor grounds of public hospitals, private hospitals and psychiatric facilities
- Outdoor grounds of certain government of Ontario office buildings

However, under this proposal, specific exemptions for e-cigarettes would permit e-cigarette use/vaping, including the use of a vaporizer to consume medical marijuana, in the following places:

- Scientific research and testing facilities;
- Designated outdoor areas on hospital grounds and on the grounds of specific government of Ontario office properties (to be phased out by January 1, 2018).

The exemption permitting the use of e-cigarettes in theatrical stage productions under specified conditions, would not apply to vaping medical marijuana.

Note that under the ministry's proposal, there would not be an exemption to permit testing/sampling of e-cigarette devices or products in stores that sell e-cigarettes. Under this proposal, e-cigarette use inside stores would be prohibited, as stores are considered enclosed workplaces and enclosed public places. However, stores could continue to be able to display, promote and provide informational material about e-cigarettes under conditions that protect children and youth from exposure. (More details are provided under issue 6, with regard to Display and Promotion.)

The proposal, if approved and implemented, would be enforced by inspectors appointed under the ECA. These inspectors are employees of local public health units.

Discussion

This proposal would have different impacts on medical marijuana users, employees, businesses, retailers, employers, hospitals, residential care facilities, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes

Issue

As of January 1, 2016, Ontario's *Electronic Cigarettes Act, 2015* prohibits the sale or supply e-cigarettes to a person who is less than 19 years old. It also prohibits the sale or supply of e-cigarettes to a person who appears to be less than 25 years old without asking the person for identification and being satisfied that the person is at least 19 years old.

Vaporizers, which are considered e-cigarettes under the *Electronic Cigarettes Act, 2015*, can be used to consume medical marijuana. The current regulation (which is not yet in force) made under the *Electronic Cigarettes Act, 2015* includes an exemption for medical marijuana users and would permit a minor to buy or obtain an e-cigarette for medical marijuana purposes.

Proposed approach

The ministry is proposing to change the regulation to specify that a parent, guardian or caregiver would be permitted to *supply* (but not sell) an e-cigarette to a minor to consume medical marijuana, if the minor is authorized to possess medical marijuana under federal law.

As noted above, the ECA is enforced by inspectors appointed under the Act, who are employees of local public health units.

Discussion

This proposal would have different impacts on medical marijuana users, medical marijuana licensed producers, parents, guardians, caregivers, health care providers, physicians, hospitals, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

4. Expand the definition of "e-cigarette" to include "e-substance"

Issue

As of January 1, 2016, Ontario's *Electronic Cigarettes Act, 2015* prohibits the sale or supply e-cigarettes to a person who is under 19 years old and to a person who appears to be less than 25 years old without proof of identification. The ECA also contains provisions, which are not yet in force, which would restrict the display and promotion of e-cigarettes in places where they are sold.

Under the ECA,

"electronic cigarette" means any of the following:

1. A vaporizer or inhalant-type device, whether called an electronic cigarette or any other name, that contains a power source and heating element designed to heat a substance and produce a vapour intended to be inhaled by the user of the device directly through the mouth, whether or not the vapour contains nicotine.
2. A component of a device described in paragraph 1
3. Any other prescribed device or product.

The current definition of e-cigarette is a device designed to heat a substance. There is some confusion around whether the substance being heated in an e-cigarette (e.g. e-liquid) is a component of the device, and whether or not the substance is covered by the Act's restrictions on selling, displaying and promoting e-cigarettes.

Proposed approach

The ministry is proposing to clarify by regulation that the definition of "electronic cigarette" in the ECA includes "e-substance"; i.e. any substance manufactured or sold for use in an e-cigarette device (e.g. e-liquid).

This would mean that businesses selling e-cigarettes would not be able to sell or supply an e-substance to a minor. In addition, businesses would not be able to display and promote e-substances, except under certain circumstances (see Issue 6 "Prescribe conditions under which a business selling e-cigarettes could display or promote products").

As noted above, the *Electronic Cigarettes Act, 2015* is enforced by inspectors appointed under the Act who are employees of local public health units.

Discussion

This proposal would have different impacts on businesses that sell e-cigarettes or any substance meant to be used in an e-cigarette, as well as on e-cigarette users and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

5. Expand the list of places where e-cigarettes are prohibited from sale

Issue

Though not yet in force, Ontario's *Electronic Cigarettes Act, 2015* contains provisions that would prohibit the sale of electronic cigarettes in public hospitals, private hospitals, psychiatric facilities, long-term care homes, pharmacies, and grocery stores containing pharmacies. Ontario's *Smoke-Free Ontario Act* also prohibits the sale of tobacco in these places.

However, the *Smoke-Free Ontario Act* also prohibits the sale of tobacco in additional places set out in regulation, such as post-secondary institution campuses, independent health facilities, schools and school grounds (including private schools), child care centres, places where home child care is provided, and certain Government of Ontario office buildings.

Proposed approach

To ensure comparable rules for where tobacco and e-cigarettes may be sold, the ministry is proposing to prescribe the following additional places as places where e-cigarettes cannot be sold:

- Independent health facilities
- Schools and school grounds, including private schools
- Campuses of post-secondary institutions including universities and colleges,
- Child care centres within the meaning of the *Child Care and Early Years Act, 2014*
- Places where home child care is provided within the meaning of the *Child Care and Early Years Act, 2014*, whether or not children are present.
- Certain office buildings owned by the Government of Ontario and prescribed in the regulation under the *Smoke-Free Ontario Act*.

As noted above, the ECA is enforced by inspectors appointed under the Act who are employees of local public health units.

Discussion

This proposal would have different impacts on e-cigarette users, e-cigarette retailers, schools, colleges, universities, businesses, health care providers, physicians, hospitals, residential care facilities, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.

Issue

Though not yet in force, Ontario's *Electronic Cigarettes Act, 2015* contains provisions that would:

- prohibit the display of e-cigarettes in a way that would permit a consumer to view or handle an e-cigarette before purchasing it in a store; and
- prohibit the promotion of e-cigarettes at places where e-cigarettes or tobacco products are sold or offered for sale.

These restrictions would protect the well-being of children and youth by limiting their exposure to e-cigarette products.

Proposed approach

The ministry is proposing to permit certain signs/documents to be made available to inform the public that they have e-cigarettes for sale, and educate customers about the types of e-cigarettes available for sale and how to use them.

Signs/documents would need to meet the following conditions:

- A maximum of three (3) signs referring to e-cigarettes and/or e-cigarette product accessories. These signs must:
  - not exceed 968 square centimeters;
  - have a white background with black text;
  - not provide any information about a brand of e-cigarette (including its components and e-substances).
- Documents listing brands, specifications, instructions, or other details about products available for sale, could only be made available for viewing:
  - inside the store;
  - to adults over 19 years of age

The ministry is also proposing to permit the display and promotion of e-cigarette products (but not the testing or sampling of e-cigarettes) in places where they are sold, provided that the following conditions are met:

- Owner must inform its local public health unit in writing that it wishes to operate under the exemption;
- Products and promotional material must not be visible from the outside of the store;
- Individuals under the age of 19 would not be permitted to enter the shop;
- Customers could only access the store from outdoors or from areas in an enclosed shopping mall;
- Store could not be a thoroughfare (e.g. kiosk in a mall corridor).

As noted above, the ECA is enforced by inspectors appointed under the Act who are employees of local public health units.

Discussion

This proposal would have different impacts on e-cigarette users, e-cigarette retailers, distributors, manufacturers, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

BUREAU DE SANTÉ DE
MIDDLESEX-LONDON
HEALTH UNIT

Comments on the Proposed Amendments to Ontario Regulation 48/06 made under the *Smoke-Free Ontario Act* and Ontario Regulation 337/15 made under the *Electronic Cigarettes Act, 2015*

Middlesex-London Health Unit
Dr. Christopher Mackie, CEO and Medical Officer of Health

Date: Friday April 22nd, 2016

To: Roselle Martino, Assistant Deputy Minister
Population and Public Health Division
Ministry of Health and Long-Term Care

The following comments are from the Middlesex-London Health Unit concerning the proposed amendments to Ontario Regulation 48/06 under the *Smoke-Free Ontario Act* and Ontario Regulation 337/15 made under the *Electronic Cigarettes Act*. Our comments are based on our review of the Ministry of Health and Long-Term Care's Public Consultation Paper "Strengthening Ontario's Smoking and Vaping Laws".

Re: Expand Smoking Prohibitions to Apply to Medical Marijuana

While the possession of marijuana is a criminal offence under the *Federal Controlled Drugs and Substances Act,* the federal government provides access to legal sources of marijuana for medical purposes under the *Marihuana for Medical Purposes Regulations* made under the *Controlled Drugs and Substances Act.* The *Liquor Licence Act* and driving laws restrict the ingesting, smoking or vaping of medical marijuana; however, there is a lack of regulation regarding the smoking or vaping of medical marijuana in public places. The proposed approach to amend the *Smoke-Free Ontario Act* and Ontario Regulation 48/06 to prohibit the smoking of medical marijuana in all places where smoking or holding lit tobacco is currently banned and in noted additional locations (e.g. designated guest rooms in hotels, motels and inns, and controlled smoking areas in residential care facilities), with the noted exemption (scientific research and testing facilities) will help to ensure that Ontarians are protected from the harmful effects of second-hand smoke. Regular marijuana smoking has been associated with chronic bronchitis and reduced lung function. The combustion of marijuana creates a smoke that contains many of the same carcinogens as tobacco smoke. While there is some evidence that marijuana smoking can be a risk factor for lung, head, neck and throat cancers, the association is unclear because of dual use of marijuana and tobacco smoking. Exposure to second-hand marijuana smoke has been studied less than second-hand tobacco smoke; however, due to the similarities in composition between tobacco and marijuana smoke, marijuana smoke is likely to be a similar public health concern. Exposure in an unventilated room or enclosed vehicle can cause non-smokers to experience drug effects, including minor problems with memory and coordination, and in some cases, testing positive for the drug in a urinalysis. There are additional concerns regarding exposure to second-hand marijuana smoke that warrant public health consideration.

The proposed approach will be fraught with enforcement challenges. Individuals caught smoking marijuana in a prohibited place can claim that the consumption is for recreational, not medicinal purposes. Enforcement Officers do not have the legislative authority to compel individuals to provide the documents that authorize the individuals involved as medical marijuana users. The Enforcement Officer can advise the individuals to smoke elsewhere in the absence of the required documentation; however, cooperation may be difficult to obtain, especially in public areas like playgrounds, sports fields and spectator areas, and hospital grounds.

Recommended Revision to the Proposed Approach:

The prohibition on the smoking or holding of lit tobacco should be expanded to include ***the smoking or holding of lit marijuana***, and not limit the prohibition to medical marijuana only.

Public health approaches to tobacco and alcohol provide supporting evidence of the effective strategies that could be applied towards a public health approach to marijuana. The harmful health effects from exposure to second-hand marijuana smoke, regardless of whether or not the marijuana smoked is for medical purposes, warrants health protective legislation. The prohibition on smoking or holding lit tobacco in outdoor public places, including playgrounds, sports fields and spectator areas, patios, and hospital grounds under the *Smoke-Free Ontario Act* was enacted to protect people from exposure to outdoor second-hand smoke and to limit youth and young adult exposure to tobacco use. The application of the Social Norms Theory and the Social Learning Theory has been invaluable to explain tobacco initiation in young people. Tobacco use is increasingly influenced by social norms and what is viewed as acceptable, routine or "normal" behaviour. Children and young adults are likely to copy the behaviours they see; the less exposure they have to tobacco use due to protective environmental factors, like healthy public policy, the less likely they are to initiate tobacco use. The application of these theories to explain the initiation of marijuana use by young people has also been extremely important. In fact, Colorado lawmakers and voters prevent the modelling of substance use for children and youth by applying existing smoke-free policies and public consumption bans to the use of marijuana. The opportunity exists for Ontario to take a leadership role in protecting people from the harmful effects of second-hand tobacco and marijuana smoke exposure, and to make marijuana use less visible within our cultural landscape. This public health approach to the prohibition of marijuana use would also address the enforcement challenges that the specificity of the "medical marijuana" language will create.

Please refer to the Middlesex- London Board of Health Report #003-16 and Appendix A, "Cannabis: A Public Health Approach" , included within our submission, for a more detailed analysis on the public health considerations regarding exposure to second-hand marijuana smoke and exposure to marijuana use.

Re: Definition of Smoking Prohibition to Include the Use of Hookah/Shisha, whether or not the Substance Contains Tobacco

A hookah or water pipe is a device that is used to smoke a moist concoction of tobacco or non-tobacco (herbal) products known as shisha. Hookah and shisha use is becoming increasingly popular as it is often considered to be healthier than cigarette smoking; however, both tobacco and non-tobacco shisha smoke pose serious health risks to those who use the device and to the individuals exposed to second-hand smoke that the device and its users create. Under the *Smoke-Free Ontario Act* and its current definition, the prohibition on smoking applies to hookah use if the shisha contains tobacco. The *Smoke-Free Ontario Act* does not prohibit smoking of shisha that does not contain tobacco.

Water pipe smoking of shisha that does not contain tobacco undermines the success of the *Smoke-Free Ontario Act* because it creates an unsafe work environment, contributes to the social acceptability of smoking in public places and is difficult and expensive for Tobacco Enforcement Officers to ensure that shisha product being smoked in public places, including playgrounds, patios and water pipe cafes does

not contain tobacco. Studies of both tobacco-based shisha and "herbal" shisha show that the smoke from both preparations contains carbon monoxide and other toxic agents known to increase the risks for smoking-related cancers, heart disease and lung disease. A study of second-hand smoke exposure in Toronto water pipe cafes showed that indoor air quality values for $PM_{2.5}$, ambient carbon monoxide and air nicotine are hazardous for human health. Outdoor water pipe cafes showed less harmful levels than indoors; however, the $PM_{2.5}$ levels were still poor. Water pipe usage is increasing in Canada. According to the Canadian Tobacco Use Monitoring Survey, 10% or approximately 2.8 million Canadians aged 15 years and older reported having ever tried a water pipe in 2012, which is higher than the results from 2011 (8%) and 2006 (4%). Water pipe use was higher among youth and young adults, with 13% of Canadian youth aged 15 to 19 and 28% of young adults aged 20 to 24 reporting having tried a water pipe. The 2015 Ontario Student Drug Use and Health Survey indicated that approximately 14% of students in grades 7 to 12 had ever used a water pipe in the last year, with use significantly increasing with grade, peaking at 26% in grade 12. Public health concerns of greater risk of contracting tuberculosis, meningitis, hepatitis and herpes because of shared hoses and mouthpieces during a smoking session must also be considered.

Recommended Revision to the Proposed Approach:

The prohibition on the smoking or holding of lit tobacco should be expanded to include the smoking of hookah or water pipe devices, regardless of whether or not the shisha or substance smoked contains tobacco. This approach was adopted by New Brunswick (effective July 1, 2015), Nova Scotia (effective May 31, 2015) and Prince Edward Island (introduced June 9, 2015). The City of Toronto enacted a bylaw that came into effect on April 1st, 2016, that prohibits hookah smoking, regardless of whether or not the shisha contains tobacco, in all city-licensed businesses. The expansion of the *Smoke-Free Ontario Act* would: provide a level playing field for all businesses and municipalities across Ontario; provide consistent protection to all employees and patrons in all Ontario municipalities; and, provide a consistent message that smoking and exposure to smoke is harmful to one's health, normalizing a smoke-free culture. A restrictive approach to hookah prohibitions would also help to curb the growing perception among high-school-aged youth that shisha smoking is safe; 40% of Canadian high-school students believe that shisha smoking is not as harmful as tobacco, and that while tobacco use among this age cohort is decreasing, hookah use is increasing. There is an opportunity to create a healthy, smoke-free environment by prohibiting hookah use in all places where smoking is currently banned.

For a more detailed analysis on the need for health protective legislation to govern the use of hookah, please refer to the City of Toronto Board of Health Report, "Health Risks of Indoor Waterpipe Smoking."

For more information on hookah use prevalence and perceptions among Canadian youth, please refer to the article "Hookah use Prevalence, Predictors, and Perceptions among Canadian Youth: Findings from the 2012/2013 Youth Smoking Survey".

Re: The Prohibition of the Use of E-Cigarettes in All Enclosed Public Places and Enclosed Workplaces – including E-Cigarette Retail Establishments - and other Specified Outdoor Areas

E-cigarettes have been growing in popularity in North America since their patent in 2004, and are heavily marketed, using television, print, retail promotions and online, as: healthier alternatives to tobacco cigarettes; possible tobacco cessation aids; and, products that can be used to circumvent smoke-free legislation. According to a 2014 study (CAMH Monitor), past-year use of electronic cigarettes was 10% among adults 18 years and over. Young adults aged 18 to 24 were more than twice as likely to have used in the past year compared to 25 to 44 year olds (31% vs. 15%) and more than three times as likely than adults aged 45 to 65 (31% vs. 9%). The growing popularity and social acceptability of e-cigarette use, especially among young adults is concerning given the lack of regulations and the volume of sophisticated marketing by the e-cigarette industry to recruit new users.

There is a lack of public health consensus around the health benefits and risks of e-cigarettes. The evidence on the efficacy of e-cigarettes as a cessation aid are mixed and while many former smokers have reported that e-cigarettes helped them quit smoking, most report dual use, and the long-term health effects of single and dual use are unknown. There are many safety concerns associated with e-cigarettes and their use, due to the lack of manufacturing standards and packaging and labelling requirements. Therefore, there is little to no consistency in the composition and quality of the individual e-cigarette delivery systems, the substances added to the device, the levels of nicotine, the chemical makeup of the e-juice or e-substance, and the facilities where they are made. For example, some e-juice may be manufactured in laboratories, whereas some may be manufactured in residential basements or kitchens. In Canada, electronic smoking devices that contain nicotine are regulated under the federal *Food and Drugs Act*. E-cigarettes that contain nicotine have not been approved for sale in Canada, and it is illegal for e-cigarette packaging or promotion to make health claims. In 2009, Health Canada issued a statement cautioning Canadians that e-cigarettes have not been fully evaluated for safety, quality and efficacy, and that electronic smoking devices and e-juice should not be purchased due to unknown health risks. Despite this statement, nicotine e-juice is widely available in most communities across Ontario.

There is documented evidence that e-cigarette use has caused mouth and throat irritation, nausea, headaches and dry cough. E-liquids containing nicotine may have harmful effects on young people and during fetal development because of the negative impacts of nicotine exposure on brain development. Other recent studies have focused on the chemical composition of e-liquids, with researchers concluding that users of e-cigarettes are exposed to carbonyl compounds, aldehydes, fine particulate matter, metals, formaldehyde, volatile organic compounds, glycerol and propylene glycol. Health risks associated with chronic inhalation of the chemical vapour remain poorly understood because of the variability of the products in market due to lack of regulation within the e-cigarette industry; however, there is emerging evidence calling into question the safety of inhalation of the flavouring agents used in e-juice. Toxicological studies have confirmed that in occupational settings, the inhalation of diacetyl and 2,3-pentanedione, used in the creation of the "butter flavour" for microwave popcorn, and many other flavourings used in the creation of flavoured e-juice, has caused bronchiolitis obliterans, and other severe lung diseases, often referred to as "popcorn lung". The heating, vaporization and subsequent inhalation of the chemicals used in flavoured e-liquids are similar to the route of exposure that workers at microwave popcorn facilities experience, supporting the need for precautionary, health protective legislation to limit the inhalation of vapour in enclosed public places and workplaces.

Under the *Electronic Cigarettes Act*, an "electronic cigarette" is defined as:

1. A vaporizer or inhalant-type device, whether called an electronic cigarette or any other name, that contains a power source and heating element designed to heat a substance and produce a vapour intended to be inhaled by the user of the device directly through the mouth, whether or not the vapour contains nicotine.

2. A component of a device described in paragraph 1.

3. Any other prescribed device or product;

This definition will create enforcement challenges when attempting to enforce Section 10 of the *Act*; the prohibitions on the use of e-cigarettes in public places and workplaces. When a Tobacco Enforcement Officer observes someone using an e-cigarette in a prohibited place, the Officer must be able to prove all elements of the offence. The Officer would have to take the device from the person using it and take it apart to ensure that the device being used meets all requirements outlined in the definition, including the power source and heating element. An additional complicating factor is that the first generation products do not come apart; therefore, an Officer would not be able to make a determination that there is a battery or heating element. In addition, newer products on the market do not contain a battery or heat source, as they are ignited by a flame.

Recommended Revision to the Proposed Approach:

The proposed approach to limit exposure to the vapour is required due to the current state of evidence. Patrons, employees of e-cigarette retailers and enforcement personnel mandated to inspect e-cigarette retail establishments, including Public Health Unit enforcement officers and youth test shoppers, and Fire and Building Code Inspectors, should not be exposed to the vapour due to the emerging evidence of the health risks, and the unknown health impacts of inhalation of the chemical vapour.

The use of e-cigarettes in places where smoking is prohibited, combined with their growing availability and the savvy marketing strategies used by the e-cigarette industry, including candy- and fruit-flavoured e-juice, adjustable vapour cloud volume, personalized tanks and mouthpieces, and the hosting of events to promote the "vaping culture", undermine the current tobacco control policies in place. Those who have quit smoking or are trying to quit may be tempted to smoke by seeing others use e-cigarettes. Prohibiting e-cigarette use in all places where smoking is currently prohibited protects people from the unknown health effects of exposure to vapour and helps to prevent the initiation of e-cigarette use by decreasing the social acceptability of e-cigarette use. **To this end, the exemption for the use of e-cigarettes in theatrical stage productions should not be permitted.** Until e-cigarettes are regulated and confirmed to be safe for use, this precautionary approach is required.

To increase the enforceability of the prohibitions on the use of e-cigarettes, the definition of an e-cigarette needs to be prescribed further by Regulation 337/15 under the *Electronic Cigarettes Act*. The definition of e-cigarette under the *Act* works well for enforcement of the sales provisions prescribed within the *Act*; however, the definition does not suffice for enforcement of Section 10. Amending the definition of e-cigarette as follows would increase Enforcement Officers' ability to prove all elements of the offence:

- ☐ A vaporizer or inhalant-type device, whether called an electronic cigarette or any other name, ***that may or may not*** contain a power source and heating element, that heats a substance and

produces a vapour intended to be inhaled by the user of the device directly through the mouth, whether or not the vapour contains nicotine.

Re: Permit Parents, Guardians and Caregivers to Supply E-cigarettes to Minors for Medical Marijuana Purposes

The Ministry proposal to specify that a parent, guardian or caregiver would be permitted to supply (but not sell) an e-cigarette to a minor to consume medical marijuana, if the minor is authorized to possess medical marijuana under federal law is reasonable; however, the *Electronic Cigarettes Act* should specify that for these unique circumstances, the source of device should be prescribed.

Recommended Revision to the Proposed Approach:

Regulation 377/15 under the *Electronic Cigarettes Act* should specify that parents, guardians or caregivers are permitted to supply an e-cigarette to a minor to consume medical marijuana, if the minor is authorized to possess medical marijuana under federal law, only if the device is purchased from a pharmacy or directly from the authorized licensed producers of medical marijuana under the *Marihuana for Medical Purposes* Regulations.

Re: Expand the Definition of "E-Cigarette" to include "E-Substance"

Worldwide, there are now over 450 brands being marketed in over 7000 flavours. E-juice is manufactured predominantly in China and bottles are not subject to any legal safety standards for labelling or packaging such as those imposed on the pharmaceutical industry in the production of medication. In 2009, Health Canada's Public Notice Advisory to Canadians and Notice to Stakeholders instructing persons importing, advertising or selling e-cigarette products in Canada to stop doing so immediately as such activity was in contravention with the *Food and Drugs Act* has been unsuccessful in its attempt to curb the distribution and promotion of these products. Despite these warnings by Health Canada, every premise within the Middlesex-London jurisdiction that was reported to Health Canada for selling e-juice containing nicotine continues to do so without penalty or consequence. In fact, there has been an increase in the number of retailers selling e-cigarettes and e-juice containing nicotine in Middlesex-London over the last few years.

With an estimated median lethal dose between 1 and 13 mg per kilogram of body weight, 1 teaspoon (5 ml) of a 1.8% nicotine solution could be lethal to a 90-kg person. A 20ml bottle of e-juice contains on average 360 mg of nicotine - several times the lethal dose. Incidents of nicotine poisoning have risen substantially, especially in the United States. In Canada, the risks associated with unregulated nicotine e-juice compositions include variable concentrations of chemicals and nicotine, dangerous nicotine dose levels or undisclosed ingredients. According to laboratory testing commissioned by Health Canada, approximately one-half of all products labelled as nicotine-free contained nicotine. In addition, unsealed, leaky or non-child proof bottles containing a potent poison is a concern. In 2015, among all students in grades 7 to 12, 23% reported ever using an e-cigarette. In lieu of federal action, health protective regulation is required at the provincial level.

Recommendation Regarding the Proposed Approach:

For the reasons outlined above, and the health concerns regarding the safety of the devices and the chemical cocktail that is inhaled when an e-cigarette is activated, the expansion of the definition of "e-cigarette" to include "e-substance" is required to limit youth access.

Re: Establish Rules for the Display and Promotion of E-cigarettes at Places Where They are Sold

The Ministry's proposal to prohibit the display of e-cigarettes in a way that would permit a consumer to view or handle an e-cigarette before purchasing it in a store and to prohibit the promotion of e-cigarette at places where e-cigarettes or tobacco products are sold or offered for sale would protect the health and well-being of children and youth by limiting their exposure to e-cigarette products, and would also help to curtail that point-of-sale promotions at convenience stores, gas stations, grocery stores, and head shops currently bombarding the marketplace. Display bans have been extensively documented in the literature as an effective tobacco control policy which helps to reduce tobacco sales, prevent the promotion and marketing to children and youth, and supports those who have recently quit from impulse purchases of tobacco. The evidence regarding the potential risks and benefits of e-cigarettes remains mixed and inconclusive; therefore, a precautionary approach is required.

Recommended Revision to the Proposed Approach:

E-cigarettes are being heavily marketed as healthier alternatives to tobacco cigarettes and as an effective tool to support tobacco cessation. Under Regulation 337/15, the *Electronic Cigarettes Act* should prescribe that the allowable signs shall not make health claims, shall not promote the devices as a tobacco cessation device and/or shall not state or imply that e-cigarettes are a healthier alternative to tobacco products. The documents that are allowed inside the store to adults 19 years and older must be prescribed by regulation and limit the content to brands, specifications, and instructions for use; documents shall not make health claims, shall not promote the devices as a tobacco cessation device and/or shall not state or imply that e-cigarettes are a healthier alternative to tobacco products.

The proposed approach to permit the display and promotion of e-cigarette products (but not the testing or sampling of e-cigarettes) in places where they are sold is recommended and endorsed by the Middlesex-London Health Unit as long as there is an added condition:

- ☐ Tobacco products are not permitted to be sold at premises that are operating under this exemption.

In addition, the promotion and marketing of e-cigarettes and e-substances should be strictly prohibited at places of entertainment, including bars, restaurants, special events, casinos, concerts and racetracks to curb the savvy marketing practices that the industry are currently employing to market their product to new users.

If you wish to discuss any of the recommended revisions provided, please do not hesitate to contact the Middlesex-London Health Unit by calling Linda Stobo, Program Manager for Chronic Disease Prevention and Tobacco Control, at (519) 663-5317 ext. 2388 or linda.stobo@mlhu.on.ca.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 003-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 January 21

CANNABIS: A PUBLIC HEALTH APPROACH

Recommendation

It is recommended that the Board of Health:
1. ***authorize staff to 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.***

Key Points

- Canada has one of the highest rates of cannabis use in the world.
- Police associations and public health organizations have expressed support for a new approach, and the federal government has indicated that they will legalize cannabis in their current mandate.
- Cannabis use is associated with a variety of health harms. The most concerning occur among youth and chronic heavy users.
- A public health approach to cannabis policy is recommended, including a strong policy framework of strict regulations to minimize health and social harms.

Background

In July 2015, staff reported to the Board of Health on work being undertaken to develop an evidence-based position on cannabis policy (see Report No. 047-15 from July).

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. The debate about the regulation of cannabis for non-medical use has been ongoing for decades in Canada and has gained interest with the election of the new Liberal government. Despite decades of legislation and international conventions aimed at eliminating cannabis, use has continued to increase globally. In response, various countries have adjusted or are in the process of adjusting their approach to cannabis legislation and control.

Portugal decriminalized the possession of all drugs for personal use in 2001 while implementing a national drug strategy at the same time. In 2013, Uruguay became the first country to legalize the personal use and sale of cannabis. In the United States, 15 states have decriminalized the possession of small amounts for personal use and in 2012 Colorado and Washington State became the first two states to legalize recreational use of cannabis, followed by Alaska, Washington DC and Oregon.

A comprehensive review of what cannabis is, prevalence of use, history of law related to cannabis, cannabis associated harms, synopsis of trends away from prohibition and positions of other Canadian agencies can be found in the attached report, Cannabis: A Public Health Approach (see Appendix A).

Public Health Approach

While the scientific evidence suggests that cannabis has a smaller public health impact than alcohol and tobacco, cannabis is associated with health risks which generally increase with frequent heavy consumption and use at an early age. Public health considerations include cannabis impaired driving, effects on youth brain development and mental health, respiratory system effects, use during pregnancy and risk of dependence. Criminalization of cannabis possession and use has not reduced use and has paradoxically resulted in increased health and social harms.

A public health approach addresses the public health concerns of cannabis use while aiming to eliminate or reduce the health and social harms resulting from its criminal prohibition. The Canadian Public Health Association (CPHA) asserts that a public health approach based on principles of social justice, attention to human rights and equity, evidence informed policy and practice and addressing the underlying determinants of health is the preferred approach to criminalization.

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in its field. In 2014, following extensive review of the research, CAMH scientific staff released the report "Cannabis Policy Framework" concluding that Canada requires a strong policy framework for cannabis, recommending legalization with strict regulations.

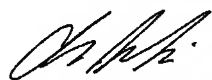
The policy framework by CAMH is consistent with the views of other agencies such as Canadian Public Health Association (CPHA) and the Canadian Centre on Substance Abuse (CCSA). Middlesex London Health Unit recommends an approach to cannabis policy that is consistent with CAMH. This recommended approach is also consistent with the Colorado Department of Public Health and Environment's public health framework for legal recreational marijuana. The federal government's approach to changing the legal framework around cannabis has also received support from such policing organizations as the Canadian Association of Chiefs of Police.

Conclusion

While there are recognized and important health harms to cannabis use, these are modest in comparison to the health impacts of other drugs such as alcohol and tobacco. Despite prohibition, prevalence of the recreational use of cannabis has increased, and moreover, criminal prohibition has resulted in well documented health and social harms. The Ontario Public Health Standards mandates boards of health to reduce the frequency, severity and impact of substance misuse; with regards to cannabis, criminal prohibition is a barrier to effectively meet these objectives.

In the context of coming legalization, strict regulation for the non-medical use of cannabis, i.e. a public health approach to cannabis production, distribution, product promotion and sale, is recommended to best prevent and reduce health and social harms associated with cannabis use. This approach acknowledges that cannabis is not a benign substance and that policy built upon evidence-based regulations and controls is the recommended best approach to minimize the risks and harms associated with use.

The report was prepared by Ms. Mary Lou Albanese, Manager and Ms. Rhonda Brittan, Public Health Nurse, Healthy Communities and Injury Prevention Team.



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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Prevention of Injury and Substance Misuse Standard Requirement #2.

Appendix A to Report # 003-16

Cannabis: A Public Health Approach

January 8, 2016

For information, please contact

Middlesex-London Health Unit
50 King St.
London, Ontario
N6A 5L7
phone: 519-663-5317
fax: 519-663-9581
e-mail: health@mlhu.on.ca

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Middlesex-London Health Unit
50 King Street
London, Ontario
N6A 5L7

Cite reference as: Middlesex-London Health Unit (2016).
Cannabis: A Public Health Approach. London, Ontario: Author.

Authors:

Mary Lou Albanese RN, BScN, MSA
Rhondda Brittan, RN, BScN, MPH, CCHN(C)

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1.0 Introduction

A public health approach to cannabis policy is needed in Canada. Despite prohibition, 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. While it is known that cannabis use has the potential for adverse health consequences, most notably for those who begin use at an early age and use it frequently, the current approach of criminalization has been shown to increase these harms while also causing significant social harm. Furthermore, data shows that Canada's possession laws are not enforced consistently across jurisdictions or populations, making criminal prohibition of cannabis possession an issue of health equity.

The debate about the regulation of cannabis has been ongoing for decades. Most recently the issue has gained momentum with the election of a Liberal government that made cannabis legalization part of its election platform. The December 4th, 2015 Throne Speech included a pledge to "legalize, regulate and restrict access to marijuana". Canadian public support for change to cannabis control has been growing, and internationally, the landscape of cannabis policy is changing at a rapid pace.

This report builds upon the report: *Cannabis – Health Implications of Decriminalization, Legalization, and Regulation*, which was provided to the MLHU Board of Health in July, 2015. This report will provide background information about cannabis and trends in use; provide an overview of the current evidence related to the health harms of cannabis and the harms stemming from the criminalization approach; briefly describe current law and the historic progression of Canadian law related to cannabis control, including how medical marijuana fits into the current regulatory landscape in Canada; and provide an overview of regulatory models that have moved away from prohibition and the lessons learned.

While taking into consideration the positions of leading Canadian organizations, this report will conclude with a recommendation for a regulatory approach to cannabis control that will reduce the risks of health and social harms.

2.0 Cannabis: What Is It?

Cannabis, more commonly called marijuana, is the dried flowers, fruiting tops and leaves of the cannabis plant, most frequently, *Cannabis sativa.* The cannabis plant contains several different *cannabinoids*, the psychoactive component being delta-9-tetrahydrocannabinol (THC). The level of THC varies depending on the part of the plant used, plant breeding, and product processing. Cannabis can be consumed by smoking, such as a "joint" or in a pipe or bong, ingested as an edible, or consumed in a liquid infusion (CCSA, 2015; Room et al., 2010).

Psychoactive substance is a name given to a classification of substances that affect mental processes such as mood, sensations of pain and pleasure, motivation, cognition and other mental functions. Cannabis can be considered in the context of other psychoactive substances which include alcohol, tobacco, some prescription medications, and even caffeine. Psychoactive substances, including cannabis, have been used both medically and non-medically by humans for thousands of years (CPHA, 2014; Health Officers Council of BC, 2011). People use cannabis for various reasons and it affects people in different ways. Typically it produces a state of relaxation, happiness and changes in perception. The level of THC in the product, the amount of product consumed, the user's previous experience with the drug, and mode of consumption will impact its effects. When smoked, effects will typically be felt by the user in about 10 minutes and rapidly dissipate; while when ingested, the effects of cannabis can take anywhere from 30 minutes to 2 hours to be felt, and can last several hours. (Monte, Zane & Heard, 2015).

3.0 Prevalence of Use

Globally: Cannabis is the most widely used illegal drug in the world. According to the United Nations Office of Drugs and Crime (UNODC) an estimated 160 million people - 4% of the global adult population used marijuana in 2005 (Room et al., 2010). Cannabis became popular in Western countries in the 1960's. While prevalence has shifted over years and decades, rates are highest among youth and young adults. Common patterns of use across countries suggest that penalties for personal use do not affect prevalence of use (Room et al., 2010).

Canada: Canada has one of the highest rates of cannabis use in the world, with more than 40% of Canadian adults having used cannabis in their lifetime and 10% reporting past year use. Youth have the highest prevalence of use, with 2012 data indicating that over 20.3% of youth aged 15-24 used marijuana in the previous year (Health Canada, 2014)

Ontario: Ontario use is consistent with Canada as a whole, with population surveys indicating that 14% of adults and 23% of secondary school students have used cannabis in the past year. While cannabis use is most common in youth and young adults, Ontarians aged 30 and over account for half of all use (CAMH, 2014).

The Ontario Student Drug Use and Health Survey (OSDUHS) is a population survey of Ontario students in grades 7 through 12. According to the 2015 OSDUHS, cannabis is the third most commonly used substance after alcohol and energy drinks. Cannabis use increases with each grade level, with 10.3% of 9th graders compared to 37.2% of 12th graders reporting past year use. Males and female rates of use are similar. While cannabis use has shown a gradual decline since 1999, about 2 % of students report using cannabis daily, which equals approximately 20,000 Ontario students. Age at first use has shown an increase over past decades. In 2015, the average age at first cannabis use reported among 12th-grade users was 15.3 years. For grade 7 students, less than 0.5% used cannabis for the first time before the end of grade 6, compared with 5% in 2003, and 7% in 1981 (Boak et al., 2015).

Middlesex-London: London and Middlesex data regarding prevalence of cannabis use is limited. Although the Ontario Student Drug Use and Health Survey (OSDUHS) does not analyse data at the county level, it does analyse data down the level of a Local Health Integration Network. Across regions, the OSDUHS did not find significant difference in student cannabis use (Boak et al., 2015).

4.0 History of Law Related to Cannabis

The laws and systems that have been put in place to manage substances, including cannabis, reflect the dominant social norms, beliefs and political stances of the times when they were created, rather than current scientific knowledge and evidence (CPHA, 2014).

Cannabis was added to the schedule of prohibited drugs under Canada's *Opium and Narcotic Drug Act* in 1923. While the first charge for cannabis possession was not laid until the 1930's, cannabis became a primary drug enforcement focus in the 1960's. By 1972 there were more than 10,000 arrests for possession and use, with many young Canadians receiving criminal convictions (Ontario Public Health Working Group, 2004). The *Controlled Drugs and Substances Act* was introduced during the 1990's and is the legislation that currently governs cannabis and other psychoactive drugs in Canada.

Globally, cannabis was widely used for medical purposes from the end of the 19th century continuing into the 1950's. In 1961 it was added to the strictest prohibition category of the 1961 Single Convention on Narcotic Drugs specifying that 'use of cannabis should be prohibited for all purposes medical and non-medical alike'. International prohibition of cannabis was further solidified in the 1988 Convention, making even possession a criminal offence under each signatory country's domestic law. Many countries, including Canada, are signatories to these international drug control Conventions, criminalizing the production, distribution, use and possession of cannabis (Room et. al., 2010).

Despite legislation and international conventions aimed at eliminating use of cannabis, by the early 1970's there was a growing realization that prohibition was not achieving its intended effect. Public inquiries and commissions occurred in several

countries, including Canada, concluding that the effects of criminalization were excessive and counterproductive and calling on lawmakers to eliminate or reduce criminal penalties for personal use (Room et al., 2010).

In Canada alone, the ineffectiveness and high cost of criminalization has been described, and a call to move away from absolute prohibition made, in several reports: the Le Dain Commission (1972); the Senate (1974); the Canadian Bar Association (1994); the Canadian Centre for Substance Abuse (1998); Centre for Addiction and Mental Health (CAMH) (2000); the Frasier Institute (2001); the Senate Special Committee on Illegal Drugs (2002); The Health Officers Council of British Columbia (2011); the Canadian Drug Policy Coalition (2013); the Canadian Public Health Association (2014) and CAMH (2014).

5.0 Current Canadian Law Related to Cannabis

Marijuana is classified as a Schedule II drug under the *Controlled Drugs and Substances Act* (CDSA). This means that it is illegal to grow, possess, distribute and sell marijuana. Convictions under the CDSA will result in a criminal record and may result in penalties ranging from fines to life imprisonment depending on the nature of the offence (CCSA, 2014).

In Canada in 2013, 58,965 incidents involving possession of cannabis were reported to police. Over 600,000 Canadians currently hold a criminal record related to cannabis possession (Canadian Drug Policy Coalition, 2015).

Marijuana is also regulated through international treaties to which Canada is a signatory (CCSA, 2014).

Drug-impaired driving is an offence under the Criminal Code of Canada (Beirness & Porath-Waller, 2015).

5.1 Medical Marijuana in Canada

The human body has naturally occurring endocannabinoids that act on the brain and nervous system. When the body's own endocannabinoids bind to specific receptors, symptoms, such as anxiety, convulsive activity, hypertension and nausea which can be caused by over-activity of the nervous system are reduced. When marijuana is consumed, these same cannabinoid receptors are activated. Although there are claims that marijuana can benefit a wide range of symptoms and diseases, more research is needed. Current evidence supports the medical use of cannabis for nausea, vomiting and chronic pain (Kalant & Porath-Waller, 2014).

Cannabis for medical use has been legal in Canada since 2001, initially under the *Marihuana Medical Access Regulations* (MMARs). Under the MMARs, legal access to marijuana for medical purposes could be granted to Canadians meeting certain requirements. Health Canada was responsible for issuing authorizations and approved individuals had the option of obtaining their medical marijuana through Health Canada, a designated grower, or growing their own (Kalant & Porath-Waller, 2014).

Effective 2014, the MMARs were replaced with the *Marihuana for Medical Purposes Regulations* (MMPRs). Individuals now must receive a prescription from a medical practitioner versus Health Canada, and users of medical marijuana no longer have the legal option of growing their own product (Kalant & Porath-Waller, 2014). There are limits to how much cannabis that an individual can possess at one time (Health Canada, 2015).

As of September 30, 2015 there were 26 Health Canada authorized, licensed producers in Canada under the MMPR, 14 located in Ontario. While some are licensed only to produce, others can both produce and sell. Licensed producers are highly regulated and routinely inspected by Health Canada. Licensing requirements are strict and include quality control standards, physical and personnel security measures, inventory management and stringent record keeping. Products must be shipped in child resistant packaging and meet labelling requirements with health warning messages as well as THC content (Health Canada, 2015).

6.0 Harms

While the scientific evidence suggests that cannabis has a smaller public health impact than alcohol and tobacco, cannabis, like other drugs, is associated with health risks. Evidence has shown that these health risks generally increase with frequent consumption (daily or nearly-daily) and when used at an early age.

6.1 Direct Health Harms

Cannabis-Impaired Driving: Research has shown that driving while impaired by cannabis is associated with performance deficits in tracking, reaction time, visual function, concentration, short-term memory, and divided attention which increases the risk of motor vehicle crashes (Beirness & Porath-Waller, 2015). Epidemiologic data suggests that cannabis users that drive while intoxicated have 2 to3 times the risk of motor vehicle crashes over a non-drug intoxicated driver and the higher the level of THC in the blood, the higher the risk of crash (Hall, 2014 & Colorado Department of Public Health and Environment [CDPHE], 2015). In comparison, intoxication with alcohol has been found to increase motor vehicle crash risk by 6 to15 times. The combination of cannabis with alcohol increases the risk of collision more than either substance on its own (Hall, 2014). CAMH currently has a study underway to determine the extent of relationship between cannabis consumption and driving ability.

The 2012 Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) found that 2.6% of drivers admitted to driving within two hours of cannabis consumption at least once in the previous year (Beirness & Porath-Waller, 2015). Among young drivers, driving after using cannabis is more prevalent than driving after drinking alcohol; with 1 in 10 drivers in grades 10 -12 reporting driving within an hour of cannabis use at least once in the past year (Boak et al., 2015). The issue of cannabis impaired driving is particularly of concern for youth, as data indicates that young adults are at highest risk of injury and death from motor vehicle crashes while are also the highest users of cannabis.

In contrast to alcohol, testing for drugged driving is more complicated, inconsistent, and there is not a specific level of cannabis consumption that leads to intoxication. A very real policy challenge therefore is to define a THC level in blood that can define impairment (Room et. al., 2010). Detection of cannabis–impaired driving is further complicated by the fact that cannabis can remain detectable in the blood and urine for days, long after the effects have worn off. Thus even in cases of motor vehicle collisions, the detection of cannabis in body fluids does not necessarily mean that someone was impaired at the time of collision (Hall, 2014; Room et al., 2010).

Brain Development: In addition to the risk of motor vehicle collisions, there is growing evidence that regular cannabis use in adolescence can cause harm to the developing brain. Regular cannabis use beginning in adolescence and continuing through young adulthood appears to produce cognitive impairment, with unclear evidence on whether this impairment is fully reversible (Hall, 2014). Early, regular cannabis use has been associated with low levels of educational attainment, diminished life satisfaction, higher likelihood of developing cannabis use disorder, and increased risk of developing mental health problems (CAMH, 2014). Additionally, some research shows that regular adolescent cannabis users are more likely to use other illicit drugs, although the association is not fully understood (Hall, 2014). Given that a large portion of cannabis users are youth, youth cannabis use is a significant public health concern.

Mental Health: Research has found that individuals who use cannabis, especially frequent and high potency users, are at increased risk for psychosis and psychotic symptoms. Regular cannabis use in adolescence has been associated with increased risk of being diagnosed with schizophrenia (CAMH, 2014, CCSA, 2014).

Dependence: Although much lower than the dependence rates for other drugs (e.g., nicotine, alcohol and cocaine), about 9% of cannabis users develop dependence (CAMH, 2014). Cannabis has remained the third most common identified drug of dependence (behind alcohol and tobacco) in both Canada and the United States over the past 20 years (Hall, 2014). Long term frequent users have higher risk of dependence than those who use occasionally (CAMH, 2014). For Ontario youth, the 2015 OSDUHS survey found that among past year users about 7% of students grade 9-12 report symptoms of dependence.

Pregnancy: THC can pass through the placenta, as does carbon monoxide when cannabis is smoked (CDPHE, 2015). Maternal cannabis use during pregnancy has been shown to modestly reduce birth weight (Hall, 2014). There is also some evidence that cannabis use during pregnancy can affect development and learning skills throughout childhood, including children's cognitive functioning, behaviour, substance misuse and mental health (Porath-Waller, 2015).

Respiratory Problems: Regular cannabis smoking has been associated with respiratory symptoms of chronic bronchitis and reduced lung function (Hall, 2014). Cannabis smoke contains many of the same carcinogens as tobacco smoke. Furthermore, cannabis smokers tend to inhale unfiltered smoke, inhale more deeply and hold smoke in their lungs (Room et al., 2010). While there is some evidence that smoking cannabis can be a risk factor for cancers of the lung and upper respiratory tract, this association remains unclear as many cannabis smokers have also smoked tobacco (Hall, 2014). With regards to second hand cannabis smoke, few studies have been conducted. However, because of the similarities in composition between tobacco and marijuana smoke, marijuana second hand smoke is likely to be a similar public health concern (Springer & Glanz, 2015).

Product quality: The quality of cannabis sold on the illegal market is questionable, however hard to qualify due to lack of testing. There have been accounts of contamination with molds, bacteria and pesticides as well as other contaminants, including other drugs. Unknown contamination is a potential risk for health problems and disease outbreaks. Licenced producers of medical marijuana in Canada are required to grow under strict conditions and batches must be tested for contaminants.

6.2 Indirect Harms

The public health impact of cannabis cannot be fully understood without consideration of the impact of the policies and legal sanctions that have been put in place to manage it. Relative to the health dangers of the drug itself, there has been a growing concern about the disproportionate social harms stemming from its prohibition. A conviction for a marijuana related offence results in a criminal record that can reduce opportunities for education, employment, and travel. From a public health lens, the illegality of cannabis has hindered the ability of health and education professionals to effectively prevent and address problematic use (CAMH, 2014).

The consequences of cannabis criminalization were well described over a decade ago by the Senate Special Committee on Illegal Drugs: "In addition to being ineffective and costly, criminalization leads to a series of harmful consequences: users are marginalized and exposed to discrimination by the police and the criminal justice system; society sees the power and wealth of organized crime enhanced as criminals benefit from prohibition; and governments see their ability to prevent at-risk use diminished" (Senate Special Committee on Illegal Drugs, 2002 , p. 42).

The cost to enforce the current cannabis law is significant. In 2002 the estimated annual cost in Canada of enforcing cannabis possession laws, including police, courts and corrections, was 1.2 billion dollars (CAMH, 2014).

The need for a public health approach to the management of cannabis is paramount. A balance between the health risks, social harms and legal ramifications is necessary.

7.0 A Public Health Approach...What Is It?

In May of 2014 the Canadian Public Health Association released a discussion paper entitled "A New Approach to Managing Illegal Psychoactive Substances in Canada", recommending a public health approach as the best alternative to prohibition and criminalization for the management of psychoactive substances.

A public heath approach addresses the public health concerns of cannabis use while aiming to eliminate or reduce the health and social harms resulting from its criminal prohibition.

A public health approach is "based on the principles of social justice, attention to human rights and equity, evidence informed policy and practice, and addressing the underlying determinants of health" (CPHA, 2014, p. 7).

The "Paradox of Prohibition" (Figure 1) provides a visual model demonstrating where a public health approach sits on a continuum of regulatory approaches. It proposes that supply and demand is best controlled and social and health problems are lowest when the extremes of complete prohibition and free market legalization and commercialization are avoided.

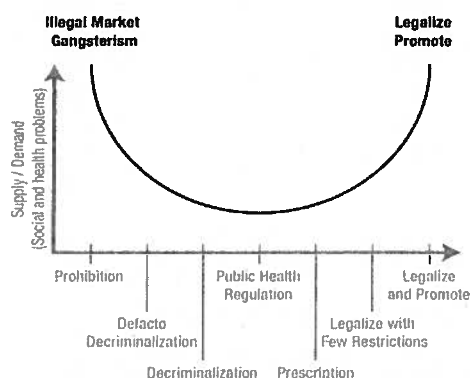

Figure 1: Paradox of Prohibition. Health Officers Council of British Columbia (2011). Reprinted with permission.

Public health approaches to tobacco and alcohol provide supporting evidence of effective strategies that could be applied toward a public health approach to cannabis.

Tobacco is a legal, but extremely harmful substance with no medical benefits, significant health harms, and is the focus of substantial public health efforts and government regulatory control aimed to dissuade consumption and reduce public harms. "Canada has been a world leader with regards to federal legislation about sponsorship restrictions, graphic packaging warnings and banning flavours" (Health Officers Council of BC, 2011, p.47). Provincially, the *Smoke-Free Ontario Act* puts in place many measures related to the sale, promotion and use of tobacco including prohibitions against the sale and supply of tobacco products to persons under the age 19, measures to control advertising such as banning displays, and indoor and outdoor smoking restrictions. Additionally, public health plays a role in tobacco use prevention, screening, brief intervention and cessation support for individuals that use tobacco products. The *Tobacco Tax Act* also provides substantial provincial control around the taxation and regulation of tobacco products from the production of raw leaf tobacco through to the sale of manufactured tobacco products.

Alcohol is legal and widely consumed but with clear evidence of health and social harms. Efforts to mitigate these harms include a combination of provincial and municipal regulatory approaches. These approaches include taxation, government based controls over production and distribution, minimum pricing, age restrictions for purchase, and restrictions retail outlet density and hours of sale. These are policies that have been shown to reduce alcohol related problems when implemented alongside targeted measures such as youth education, drinking and driving countermeasures, promotion of Canada's Low Risk Alcohol Drinking Guidelines, and screening and referral to treatment (Babor et al., 2010; CAMH et al., 2015).

Haden and Emerson (2014) have applied these public health based strategies to describe a public health model of cannabis regulation that incorporates evidence-based strategies from both tobacco and alcohol policy.

8.0 Trends Away From Prohibition

Evidence from other countries' experiences with cannabis policy approaches is incomplete. Furthermore, the policy and regulatory landscape within each jurisdiction is constantly evolving. When looking at the literature and reviewing related commentary, whether or not a certain cannabis policy is presented as a success or failure depends on the perspective of the writer. Outlined below are some of the key characteristics, differences and outcomes from countries that have moved away from a prohibition based approach.

8.1 The Netherlands

In the Netherlands a formal policy of non-enforcement has been in place since 1976 for the possession and sale of small amounts of cannabis. The intent of this policy was to separate cannabis from other hard drug use. Dutch policy and regulations continue to shift in response to emerging evidence related to cannabis, internal and external politics and lessons learned over time (MacCoun, 2011).

- Dutch 'coffeeshops' operate under strict licensing conditions, including age restrictions, limits on per person amounts, a ban on sales of alcohol and other drugs, and regulations related to shop appearance, signage and marketing.

- While purchase and use of cannabis is permitted, production is illegal. Thus, cannabis sold in coffeeshops comes from an illegal and unregulated production system (CCSA, 2014; Roles, 2014).

- There has been success in separating cannabis from the market for other illegal drugs (Room et al., 2010).

- During early commercialization, prior to advertising and age restrictions, there was evidence of more cannabis use by youth and an earlier age of first use. This trend reversed when increased regulations for coffeeshops were implemented in the mid-90's (Room et al., 2010).

- Evidence suggests that prevalence of cannabis use is lower in the Netherlands than in several neighboring countries as well as Canada and the US (MacCoun, 2011).

8.2 Portugal

Portugal decriminalized the possession of all drugs for personal use in 2001 at the same time as a national drug strategy was implemented aimed at providing a more comprehensive and evidence-based approach to drug use. This made possession and acquisition of personal amounts of drugs an administrative offence rather than a criminal offence.

- Offenders are referred to a Commission for the Dissuasion of Drug Addiction (CDT) who provide a range of sanctions ranging from a fines and community service to treatment (Hughes & Stevens, 2010).

- Early evidence suggests small increases in reported illicit substance use by adults, however reductions have been seen in problematic use, adolescent use, substance related harms, and criminal justice system burden (Hughes & Stevens, 2010).

8.3 Uruguay

In 2013 Uruguay became the first country to legalize the personal use and sale of cannabis. The law allows three ways to legally acquire marijuana: self-production of a limited number of plants by registered users, joining a cannabis club, or purchasing at a pharmacy. Households are permitted to grow up to six plants each. As written, the law states that to purchase from a pharmacy, people must be residents of Uruguay age 18 or over, and must be registered with a national database. Marijuana cannot be used in public places (CCSA, 2014). Change of Uruguay government since the law was initially passed has affected the extent and rate of implementation. Information on early outcomes is not readily available.

8.4 United States

While cannabis remains illegal for sale at the US federal level, there are significant differences in cannabis control policy across states. Fifteen states have decriminalized the possession of small amounts for personal use, with Oregon being the first state to do so. In 2012, Colorado and Washington State became the first two states to legalize recreational use of cannabis. Colorado began retail sales in January of 2014, while Washington State did so in July of 2014 (CCSA, Nov 2015). Since then, Alaska, Oregon and the District of Columbia have passed legislation allowing possession and personal use of cannabis for non-therapeutic purposes.

Colorado and Washington State are being looked to as a key source of information regarding legalization of cannabis and the resultant health, social, economic and public safety impacts. The early legalization experiences in these states will be highly informative to the development of Canadian policy. The Canadian Centre on Substance Abuse (CCSA) led a delegation in 2015 to both Colorado and Washington State with the aim to collect evidence to inform Canadian policy. Much of the data needed to evaluate the impact of legalization is not yet available. The CCSA will continue to monitor data from Colorado and Washington as it becomes available (CCSA, Nov 2015).

There are significant differences between how Colorado and Washington is implementing legalized cannabis, particularly related to the scope of government regulation. While Washington has a higher level of regulation, Colorado began with a more free-market approach.

8.4.1 Colorado

- Colorado took 1 year from voted legalization to implementation.

- Licensing body is Colorado Department of Revenue.

- Age restriction is 21 and over.

- Personal production of up to 6 plants permitted that must be in an enclosed locked space.

- Early legalization has been market driven, with new products and commercial branding.

- The extent of the edibles market was unanticipated and has become a large part of the market resulting in the need to address high potencies, child enticing packaging, and overconsumption.

- The Colorado Department of Public Health and the Environment (CDPHE) is responsible for monitoring changes in drug use patterns and health effects of marijuana. The CDPHE is also involved in the development of policies and regulations to protect public health and safety.

- Data on first year patterns of use and health outcomes is extremely limited. However, early data has shown increasing trends of poison centre calls, hospitalizations and emergency room visits possibly related to marijuana, and increase in hospitalization rates for children with possible marijuana exposure.

- The Rocky Mountain High Intensity Drug Trafficking Area (RMHIDTA) is concurrently tracking impact of marijuana legalization. While reported findings have been fairly widely quoted, this data should be interpreted with caution. RMHIDTA is a US Federally funded agency whose stance is to uphold US federal drug policy.

8.4.2 Washington State

- Washington took 18 months from voted legalization to implementation.

- Licensing body is Washington State Liquor and Cannabis Board.

- Age restriction is 21 and over.

- Personal production not permitted.

- In comparison to Colorado, Washington has stricter licensing laws: e.g. growers cannot sell and sellers cannot grow, limits on farm sizes, limited large corporate operations.

- Taxes are higher than in Colorado.

- The Washington State Institute for Public Policy (WSIPP) is responsible for evaluating legalization outcomes under the categories of public health, public safety, youth and adult rates of use and maladaptive use, economic impacts, criminal justice impacts and state and local administrative costs and revenues. While an evaluation plan is in place, initial outcome results are not expected until September 2017 (Darnell, 2015).

8.5 What are Canadians saying?

Canadian public opinion over the past several years has continued to shift away from a prohibitionist approach to cannabis. While there have been many polls, a recent poll conducted by Forum Research specifically surveyed Canadians about a model of cannabis legalization with regulation. According to this poll, 59 percent of Canadians support a change to law that would legalize tax and regulate recreational marijuana usage under some conditions. With regards to manufacturing and distribution if legalized, the largest proportion of respondents (40%) agreed with a model of corporations being licensed to grow marijuana, and sales controlled through government agencies where it could be restricted, regulated and taxed. However, 15% of respondents preferred an individual model where private consumers may grow their own product (Forum Research, 2015).

9.0 Policy Recommendation: A Public Health Approach

Legislative approaches to cannabis fall along a continuum, ranging from criminal prohibition at one end to unrestricted access and free market production at the other. Decriminalization and legalization (see definitions Appendix I) are approaches that have been used in other jurisdictions. The details within each legislative approach can vary widely. Limitations to the decriminalization approach have been previously described: Middlesex London Health Unit Report No. 047-15, July 2015.

The Center for Addiction and Mental Health's *Cannabis Policy Framework* (CAMH, 2014) provides a strong policy framework for cannabis, recommending legalization with strict regulation. The Canadian Centre on Substance Abuse's 2014 policy brief *Marijuana for Non-Therapeutic Purposes* as well as the

recommendations provided in the 2015 report *Cannabis Regulation: Lessons Learned in Colorado and Washington State* should also be considered key documents in the discussion of cannabis policy reform. Middlesex London Health Unit recommends an approach to cannabis policy that is consistent with many elements proposed by CAMH and CCSA. The positions of these organizations and others can be found in Appendix II.

Further, the Colorado Department of Public Health and Environment has developed a public health framework as a model to guide evidence based public health functions and activities including assessment, policy development and assurance (Ghosh et al., 2016).

The Ontario Public Health Standards mandates boards of health to reduce the frequency, severity and impact of substance misuse; with regards to cannabis, criminal prohibition is a barrier to effectively meet these objectives.

In the context of the coming legalization, strict regulation for the non-medical use of cannabis is recommended to best prevent and reduce health and social harms associated with cannabis use. A public health approach to cannabis would combine public education and awareness with regulations for production, distribution, product promotion and sale. This approach acknowledges that cannabis is not a benign substance and that policy built upon evidence is the recommended best approach to minimize the risks and harms associated with use.

9.1 Recommended considerations for public health focused regulations:

- Minimum age for access and use
- Regulations that address public consumption to the same extent as public smoking
- Regulations related to product formats, quality and THC potency
- Limits on marketing and advertising
- Labelling and packaging that clearly indicates dose and potential health harms
- Limit availability through measures including retail outlet density, business licencing, hours of sales
- Pricing and taxation at level that will curb demand while eliminating or minimizing black market access
- Public education about cannabis and potential health harms
- Targeted youth-focused prevention strategies aimed at preventing early use
- Drug –driving countermeasures that prevent and address cannabis impaired driving
- Access to treatment for problematic substance use that incorporates a harm reduction approach

9.2 Additional considerations:

- Sufficient time must be taken to develop regulations and build capacity to implement these regulations, ensure systems are in place to monitor patterns of use and health outcomes, and develop evidence based prevention and harm reduction messaging.
- Flexibility is paramount. Regulations must be responsive to new evidence as it becomes available.
- An incremental approach is warranted. It will take time to ensure that legalization is done well. Prior to full legalization, consideration should be given to the immediate decriminalization of possession of small amounts of cannabis as an interim step to mitigate the unintended health and social consequences of criminalization.
- Canada is a large and diverse country. Geographical, provincial, social, cultural, and other contextual factors must be taken into consideration in the development of Canadian policy.
- Sectors including but not limited to public health, enforcement, substance use, the medical marijuana industry as well as provincial and municipal levels of government should be consulted.
- Management of existing criminal records for cannabis possession should be a priority.
- Attention to unintended negative consequences is important. A health equity lens must be considered for any regulations that are put in place. For example, consequences of regulations that prohibit public consumption of cannabis will be disproportionately born by homeless or unstably housed populations.

- Investment in research and establishing an evidence base with ongoing data collection related to prevalence of use and health effects is paramount.

- Revenue gained through marijuana taxation should go towards education, prevention and treatment programs and relevant research.

In closing, despite prohibition, Canada has one of the highest rates of cannabis use in the world thus requiring a new approach to the issue. A public health approach is needed to minimize the health and social harms of cannabis. Moving forward in a proactive manner in the context of legalization of cannabis possession and use, strict regulations is the most promising approach to minimize harm.

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Appendix I - Glossary of Terms

Cannabis: Cannabis, more commonly called marijuana, is the dried flowers, fruiting tops and leaves of the cannabis plant, most frequently, Cannabis sativa (CCSA, 2015).

Criminalization: The production, distribution and possession of cannabis are subject to criminal justice sanctions ranging from fines to incarceration. Conviction results in a criminal record. (CCSA, Nov 2015)

Decriminalization: Non-criminal penalties, for example, civil sanctions such as tickets or fines, replace criminal penalties for personal possession. Individuals charged will not, in most cases, receive a criminal record. Most decriminalization models retain criminal sanctions for larger-scale production and distribution. (CCSA, Nov 2015). Decriminalization still leaves cannabis in an unregulated market of producers and sellers (Canadian Drug Policy Coalition, 2015).

Legalization: Criminal sanctions are removed. The substance is generally still subject to regulation that imposes guidelines and restrictions on use, production and distribution, similar to the regulation of alcohol and tobacco. (CCSA, Nov 2015)

Psychoactive Substance: A name given to a classification of substances that affect mental processes such as mood, sensations of pain and pleasure, motivation, cognition and other mental functions (CPHA, 2014).

Public Health Approach: "A public health approach ensures that a continuum of interventions, policies, and programs are implemented that are attentive to the potential benefits and harms of substances as well as the unintended effects of the policies and laws implemented to manage them...ensuring that the harms associated with interventions are not disproportionate to the harms of the substances themselves" (CPHA, 2014, p, 7).

Regulation: Regulation refers broadly to the legislative or regulatory controls in place with regard to the production, distribution and possession of cannabis. The term is, however, increasingly being used in reference to the guidelines and restrictions on use, production and distribution of cannabis under legalization approaches. (CCSA, Nov 2015)

Appendix II – Positions of Others

CAMH: CAMH recommends legalization with strict regulation, offering 10 basic principles to guide regulation of legal cannabis use.

CCSA: "CCSA promotes a national, evidence-informed, multi-sectoral dialogue to develop policy options that will reduce the negative criminal justice, social, and health impacts of marijuana use in Canada. Changes to marijuana policy should be made based on the principles of applying available evidence, reducing harms, promoting public health and equitable application of the law. Based on the evidence available, decriminalization provides an opportunity to reduce enforcement-related health and social harms without significantly increasing rates of marijuana use. This option also provides the opportunity to further investigate and learn from alternative models such as the legalization approaches being implemented internationally" (CCSA, Oct 2014).

CPHA: CPHA endorses a public health approach to the management of illegal psychoactive substances. They have no formal stance specific to cannabis, however endorse Low Risk Cannabis Use Guidelines and support "comprehensive approaches to addressing the use of psychoactive substance based on an accurate assessment and evaluation of the benefits and risks, with an appropriate balance and integration of the four pillars of prevention, harm reduction, treatment, and enforcement, and also needs to include adequate investments in health promotion, education, health protection, discrimination reduction, rehabilitation, research, and monitoring trends; and a public health approach to problematic substance use be central to the development and implementation of a proposed national framework for action on substance use and abuse in Canada."

Canadian Association of Chiefs of Police (CACP) Resolution #03-2013: Does not support the decriminalization or legalization of cannabis in Canada. Rather propose an amendment to the *Controlled Drug and Substances Act* and the *Contraventions Act* in order to provide officers with the discretionary option of issuing a ticket for simple possession (30 grams or less of cannabis marihuana or 1g or less of cannabis resin (CACP, 2013).

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 025-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 April 21

SYRIAN NEWCOMER ACTIVITY SUMMARY

Recommendations

It is recommended that:

1. ***Report No. 025-16 re: Syrian Newcomer Activity Summary be received for information; and further***
2. ***All volunteer Arabic speaking interpreters who assisted in the successful immunization of government assisted Syrian newcomers to the City of London be sent a letter of commendation from the Board in recognition of their significant contribution to this initiative.***

Key Points

- 559 of 915 (61.1%) Syrian newcomers were immunized for common communicable diseases, resulting in their protection and a reduced risk of the spread of these diseases in interim lodging sites and in the community.
- The volunteer Arabic speaking interpreters provided an invaluable service to the Middlesex-London Health Unit in assisting with the provision of the immunization clinics.
- Other public health services have been provided and steps are being taken to ensure the ongoing provision of appropriate services to Syrian newcomers in our community.

Background

Syrian newcomers began arriving in London in December 2015 as a part of Canada's commitment to receive 25,000 Syrian refugees by March 1, 2016. Under the coordination of the Southwest Local Health Integration Network and the guidance of the *Ontario Health System Action Plan: Syrian Refugees* (Appendix A), the Middlesex-London Health Unit (MLHU) partnered with other local and provincial agencies to form the Middlesex-London Health Care Planning Group for Syrian Refugees to prepare for their arrival.

Plans included the provision of temporary housing arranged by Cross Cultural Learner Centre (CCLC), London's federally-funded Resettlement Assistance Program site, which included interim lodging sites at local hotels while arrangements were being made for permanent family accommodations. In addition, the London Intercommunity Health Centre (LIHC) prepared to provide acute health care needs for the newcomers while families awaited connection with primary health care providers.

In mid-January, LIHC contacted MLHU with concerns about a potential outbreak of respiratory disease among the government assisted newcomers at interim lodging sites in London, and their capacity to handle the implications of such an outbreak. In fact there was no outbreak, however, there were concerns that newcomers were not being resettled into the community or being connected with primary health care providers as quickly as anticipated. As a result, large numbers of newcomers, many of whom were inadequately immunized for common communicable diseases, remained in relatively crowded living conditions for an extended period of time. The risk of the spread of communicable disease at the interim lodging sites was deemed unacceptably high and therefore the decision was made to begin offering these newcomers vaccinations that were felt to be the highest priority for those living in group settings.

Immunization

From January to March 2016, staff of the MLHU, CCLC and LIHC collaborated successfully in a short period of time to immunize almost all Syrian newcomers who remained in interim lodging sites at the time. Arrangements were made quickly to present vaccine information sessions at the interim lodging sites; set up and staff vaccination clinics; provide transportation to and from the clinics; and to obtain the services of Arabic speaking, foreign trained physicians as volunteers to assist in all of these activities. The contribution of these interpreters cannot be overstated – they voluntarily gave a great deal of their own time and without them, the success of this large scale immunization initiative would have been difficult to achieve.
Between January 25 and March 10, MLHU staff organized ten immunization clinics and immunized 559 Syrian newcomers, which represented 61.1% of the 915 government assisted newcomers who arrived in London between December 20, 2015 and March 6, 2016. There were 1,412 vaccine doses administered, providing protection against the following diseases: diphtheria, *Haemophilus influenzae* type b (Hib), influenza, invasive meningococcal disease, measles, mumps, pertussis (whooping cough), polio, rubella, tetanus, and varicella (chickenpox).

Other Public Health Services

Other public health services have been provided to support Syrian newcomers. MLHU's Health Care Provider Outreach staff assisted the Cross Cultural Learner Centre and London Intercommunity Health Centre in garnering support from and expediting linkages between primary health care providers. They are working collaboratively to develop resources to support health care providers in their work with Syrian newcomers. MLHU consulted with hotel management at interim lodging sites regarding on-site tobacco use, provided tobacco education for newcomers, and completed regular site inspections. Several sessions, with a focus on preconception and prenatal information and support, were provided to women who were pregnant and/or planning a pregnancy. Two dental screening sessions were provided; out of the 81 children screened, 43 were referred for urgent dental care in the Emergency and Essential Services Stream of Healthy Smiles Ontario (HSO) program, and those not considered as urgent were enrolled in the core HSO program for preventative and treatment services. CCLC provided education sessions to MLHU staff regarding cultural competence, with approximately 100 staff attending.

Next Steps

In anticipation of the arrival of approximately 4,400 additional Syrian newcomers to Ontario over the remainder of 2016, an internal working group has been established to explore what additional public health needs exist for Syrian newcomers and how those services and supports can best be provided. Internal coordination and external collaboration are both considered key in this process. MLHU and CCLC are planning for more, although less frequent, immunization clinics over the next several months. MLHU will participate in discussions with a group of community partners about developing a coordinated approach for ongoing parenting support. It is expected that the enhanced system of support put in place for Syrian newcomers will extend to the work MLHU engages in with all immigrants and refugees in London and Middlesex County.

This report was prepared with contributions from several staff involved in this initiative.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards (2008): Emergency Preparedness Program Standard; Infectious Diseases Program Standards – Vaccine Preventable Diseases;

Appendix A to Report No. 025-16

Ministry of Health and Long-Term Care

Ontario Health System Action Plan: Syrian Refugees

December 17, 2015

ontario.ca/syrianrefugees

Ontario

Ministry of Health and Long-Term Care

Copies of this report can be obtained from

INFOline: 1-866-532-3161

TTY 1-800-387-5559

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Acronym List

AFHTO	Association of Family Health Teams Ontario
AOHC	Association of Ontario Health Centres
CAMH	Centre for Addiction and Mental Health
CBSA	Canada Border Services Agency
CCIRH	Canadian Collaboration for Immigrant and Refugee Health
CHC	Community Health Centre
CMAH	Community Mental Health Association of Canada
CRC	Canadian Red Cross
DND	Department of National Defence
EMAT	Emergency Medical Assistance Team
FHT	Family Health Teams
GAR	Government Assisted Refugee
GOC	Government Operations Centre
HPOC	Health Portfolio Operations Centre
IFHP	Interim Federal Health Program
ILS	Interim Lodging Site
IME	Immigration Medical Examination
IPAC	Infection Prevention and Control
IRCC	Immigration, Refugees and Citizenship Canada
LGBTQI	Lesbian, Gay, Bisexual, Trans, Queer, and Intersex
LHIN	Local Health Integration Network
MCIIT	Ministry of Citizenship, Immigration and International Trade
MEOC	Ministry Emergency Operations Centre
MOHLTC	Ministry of Health and Long-Term Care
MOL	Ministry of Labour
NACI	National Advisory Committee on Immunization
NCC	National Coordination Cell
NPAO	Nurse Practitioners' Association of Ontario
NPLC	Nurse Practitioner-Led Clinic
OCFP	Ontario College of Family Physicians
OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association
OPI	Over the Phone Interpretation
PEOC	Provincial Emergency Operations Centre
PHAC	Public Health Agency of Canada
PHO	Public Health Ontario
PHU	Public Health Unit
PPE	Personal Protective Equipment
PSR	Privately Sponsored Refugee
PTSD	Post-Traumatic Stress Disorder
RAP	Resettlement Assistance Program
RNAO	Registered Nurses' Association of Ontario
UNHCR	United Nations High Commissioner for Refugees

Background and Context

The Crisis in Syria

Since the outbreak of civil war in Syria in 2011, over 4 million Syrians have fled the country. Most have taken temporary shelter in refugee camps in neighbouring countries of Lebanon, Jordan, and Turkey. The United Nations High Commissioner for Refugees (UNHCR) has called situation in Syria the largest humanitarian emergency of our era.

The UNHCR has issued an urgent appeal to the international community for assistance in resettling vulnerable refugees who have been displaced from Syria.

Canada is among several countries around the world that is responding to this urgent situation by taking in refugees from Syria for permanent resettlement.

Canada's Committment

The Government of Canada has committed to resettling 25,000 government assisted refugees from Syria. Government Assisted Refugees (GARs) are refugees that have been registered and identified by the UNHCR and referred to Canada. The federal government funds a network of settlement agencies to provide assistance and income support to GARs. Beyond this commitment, additional refugees will be arriving that are privately sponsored. Privately sponsored refuges (PSRs) are identified and supported by private sponsors of organizations or groups of individuals for their first year in Canada (this support includes income support and practical assistance).

On November 24, 2015, the Government of Canada released its plan for welcoming Syrian refugees to Canada. Under this plan, the Government of Canada wishes to bring in 25,000 refugees (government assisted and privately sponsored) by the end of February 2016.

Ontario's Responsibility

Ontario has a long and proud history of welcoming refugees and helping them settle and integrate in their new communities. In 2014, Ontario welcomed over 11,400 refugees to start a new life in our province.

Ontario will play a significant role in the resettlement of Syrian refugees.

Toronto’s Lester B. Pearson International Airport will be one of two entry points for refugees arriving in Canada. Montréal’s Pierre Elliot Trudeau International Airport will be the other point of entry. Refugees who arrive at either airport may be temporarily accommodated or settled in Ontario.

Temporary accommodation sites in Ontario and Québec will house refugees whose housing at their final destination community is not yet ready. These sites will provide important interim lodging for some refugees until they can be moved to a permanent host community.

As Canada’s largest province, Ontario will become home to a large proportion of the refugees. On September 12, 2015, the Government of Ontario announced funding to help bring 10,000 refugees to Ontario by the end of 2016, and it is possible that more than 10,000 may ultimately settle in Ontario. Cities and towns across the province will welcome Syrian refugees into their communities.

Ontario is committed to collaborating with the Government of Canada and other partners to support the permanent resettlement and integration of Syrian refugees in Canada.

Health System Considerations

The arrival of a large number of newcomers to Canada and Ontario requires consideration about potential impacts to the health system. Ontario’s health system will be engaged both in activities related to the initial arrival of refugees, and in their ongoing settlement as they begin their new lives. The health and well-being of the refugees, and of the Canadians who will be welcoming them into their communities, will be an important concern throughout the resettlement process.

This Health System Action Plan outlines the actions to be taken by Ontario’s health system to support the objectives of the resettlement effort. It outlines roles and responsibilities among the various partners who will be involved in this effort, and provides guidance to support seamless and coordinated operations.

This plan is based on the best available information and planning assumptions at time of publication. The planning activities for Syrian refugee resettlement remain fluid and dynamic, and it is likely that aspects of this plan will evolve as the process progresses. The health system will be kept up to date throughout the process. Some health stakeholders may be asked to contribute to certain response activities or the development of new solutions as the situation unfolds.

Even as the health system works together on addressing existing challenges, the successful resettlement of Syrian refugees in Ontario will require a truly coordinated effort among all health system partners. It will also require close collaboration across sectors with areas such as social services, education, housing and others that are all interdependent with health. Settlement services and other non-profit agencies play a

key role in connecting newcomers to Canada and have extensive programs designed for refugees. Effective information sharing and collaboration between health system partners and these agencies will be essential in supporting the health and well-being of refugees. Ontario has the ability to lead in this regard, and to play a key role in the overall humanitarian effort. Ontario's health system is up to the task.

Considerations related to Other Refugees in Ontario

The health needs of the Syrian refugee population are significant. It is important that the health system provides this group of refugees with high quality care. However, this *Health System Action Plan: Syrian Refugees* does not suggest that Syrian refugees should be given preferential treatment over refugees from other countries. Ontario welcomes thousands of refugees from around the world each year, all of whom deserve to receive the best health care our system can provide. The need for this Health System Action Plan is due to the scale of the effort to resettle such a large number of refugees within a short period of time.

Relatedly, nothing in this plan suggests the provision of special treatment to Syrian refugees over and above the treatment provided to other Ontarians.

Overview and Scope of Plan

Purpose of Ontario's Health System Action Plan for Syrian Refugees

This *Health System Action Plan: Syrian Refugees* has been developed to guide Ontario's health system in supporting the arrival and integration of Syrian Refugees in Ontario. It includes information and guidance related both to government assisted and privately sponsored refugees.

This plan is intended for health system stakeholders across the province, and provides a high-level summary of:

- Overall goal and objectives related to the resettlement of Syrian refugees in Ontario and Canada, focusing on the role of the health system.
- Actions that will be required to support refugee health and well-being, and to mitigate any potential public health risks.
- Guidance to support action by health system partners, including roles and responsibilities.
- Areas where local and/or sector plans, protocols, or processes may need to be developed.

This document does not include:

- All health system plans that may be put in place for specific local areas, sectors, organizations, services, or facilities.

This plan provides a framework and summary of actions. It will be supported by a series of annexes with more detailed guidance on specific topics and related roles and responsibilities. Annexes will be shared with relevant partners, and will be updated if new information becomes available or the situation changes.

Please note this plan contains references to third party websites for information purposes only. The Government of Ontario does not exercise control over the content of these websites and is not able to confirm that all information available on these sites is accurate or current.

Canada's National Strategic Plan for Syrian Refugee Resettlement

The Government of Canada is responsible for the development and implementation of the overall plan to bring Syrian refugees to Canada. It has outlined a five-phase process by which refugees will be identified, transported, and settled in Canada. The five phases are:

1. **Identifying Syrian refugees to come to Canada:**
   Canada will work with the UNHCR to identify people in Jordan and Lebanon, where they have an extensive list of registered refugees. Canada is implementing a similar process in Turkey, where refugees are registered with the state and not the UNHCR.

2. **Processing Syrian refugees overseas:**
   Interested refugees will be scheduled for processing in dedicated visa offices in Amman and Beirut. Visa processing capacity will also be enhanced in Turkey. Security and health screening is also conducted during this phase.

3. **Transportation to Canada:**
   Transportation via privately chartered aircraft, with military aircraft assisting if needed, will be organized to help bring refugees to Canada. Flights will be destined to either Montréal or Toronto.

4. **Welcoming in Canada:**
   Upon arrival in Canada, all refugees will be welcomed and Border Services Officers will oversee the process for admission of the refugees into Canada. This will include final verification of identity. All refugees will be screened for signs of illness when they arrive in Canada and treatment will be available if anyone is ill upon arrival.

5. **Settlement and community integration:**
   Syrian refugees will be transported to communities across Canada, where they will begin to build a new life for themselves and their family. They will be provided with immediate, essential services and long-term settlement support to ensure their successful settlement and integration into Canadian society.

The five phases involved in this operation involve many considerations that extend beyond health. Activities related to identity verification, security screening, immigration processing, transportation logistics, language services, and community integration are all key components of the plan being coordinated by the Government of Canada. While these aspects of the process are outside the scope of *Ontario's Health Action Plan: Syrian Refugees*, they will impact this plan.

There are health considerations involved in each of the five phases of the overall resettlement initiative, but many of these are also outside the scope of Ontario's health system. Health care activities involved in phases one, two, and three are being coordinated by the federal government. For example:

- Before refugees are approved for travel, medical personnel appointed and overseen by the federal government will complete an immigration medical examination (IME) for each individual. This examination will include screening for infectious and communicable diseases, including but not limited to tuberculosis for example.
- Before refugees board their flights, they will undergo a fit-to-fly assessment to ensure they are not ill at the time of boarding.
- In some cases, medical personnel may be assigned to accompany a flight to respond to any health concerns that may arise in transit. The Department of National Defence may provide military medical personnel for such flights.

Phases four and five of the resettlement initiative will require the active engagement of Ontario's health system. For example:

- When refugees arrive at Lester B. Pearson International Airport, Ontario health personnel will be required to respond in the event of illness identified during flight or during border screening.
- Following refugees' arrival, Ontario's health system will play a significant role in supporting their needs as they integrate into communities throughout the province. Ongoing monitoring of system capacity and its ability to address refugees' health needs as well as public health surveillance for infectious diseases, should they occur, will also be important to ensure that any health risks are mitigated.

Coordination of Health-Related Actions

The Government of Canada will coordinate all health screening and monitoring activities for refugees prior to their arrival in Canada. The Health Portfolio Operations Centre (HPOC), managed by the Public Health Agency of Canada (PHAC), will coordinate the health aspects of the federal response and liaise with provincial and territorial health ministries.

Ontario's Ministry of Health and Long-Term Care (MOHLTC) will coordinate health system activities to support the arrival and resettlement of refugees in Ontario. The Ministry's Emergency Operations Centre (MEOC) has been activated to provide a single point of contact and coordination for the provincial health system. The MEOC will collaborate and share information across levels of government as well as with system and local partners, including detailed guidance related to each component of this plan. Health system partners may direct questions to MEOC's Health Care Provider Hotline at 1-866-212-2272 or emergencymanagement.moh@ontario.ca.

Local health planning and activities will be coordinated by Local Health Integration Networks (LHINs), in collaboration with other local health system partners.

Coordination with Other Sectors

Supporting the ongoing health needs of the refugee population is just one aspect of a complex response involving many sectors. The education sector, social services sector, housing sector, and many others are also involved in the overall resettlement effort. Refugees' needs in these areas are interconnected, and the success of Ontario's resettlement effort will depend on how well these sectors work together. Health system integration with other key sectors and partners will be essential.

Cross-sector coordination and integration will occur at many levels:

- A federal National Coordination Cell (NCC), supported by the federal Government Operations Centre (GOC) is providing overall operational coordination across federal departments and with partners internationally.
- Cabinet Office of Ontario is providing overall strategic coordination of the provincial resettlement effort. An Executive Lead has been appointed to oversee this effort and a Syrian Refugee Resettlement Team has been established. A Strategic Advisory Table has been established with cross-sector representation to ensure Ontario is meeting the needs of the refugee population in a coordinated manner.
- Local cross-sector coordination efforts will occur in municipalities that are identified as final destination communities for Syrian refugees. It is important that local health sector partners are well integrated in each community effort, in coordination with their respective Local Health Integration Network (LHIN).
- Settlement services and other non-profit agencies play a key role in connecting newcomers to Canada and have extensive programs designed for refugees. Effective information sharing and collaboration between health system partners and these agencies will be essential in supporting the health and well-being of refugees.

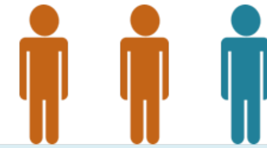
Planning Assumptions and Considerations

The following planning assumptions and considerations have been identified to guide Ontario's health system in planning to support Syrian refugees:

General Assumptions

- A total of 25,000 Syrian refugees will arrive in Canada by end of February 2016. Of these, 10,000 may arrive by December 31, 2015. The remaining 15,000 would arrive in January and February 2016. Both groups will contain a mix of government-assisted refugees (GARs) and privately sponsored refugees (PSRs).
- Up to two thirds of refugees could arrive at Lester B. Pearson International Airport.
- At least 10,000 of these refugees could ultimately settle in Ontario.

- Refugees will complete immigration processing before traveling to Canada. They will arrive in Canada with permanent residency status.
- The federal government will identify appropriate cities and communities for interim lodging and final destination of government assisted refugees, with appropriate input from Ontario.
- Planning and response will be carried out in consideration of cultural sensitivities, the dignity and privacy of the refugees and their family connections.



Two thirds of 25,000 refugees could arrive at Pearson Airport

Health-Related Assumptions

- The overall health of the refugee population is assessed as generally good, but many individuals will have specific health needs related to having experienced war in their country, and/or the difficult living conditions of refugee camps. Health needs could be physical (e.g., injury, chronic illness, nutritional deficits) or mental (e.g. post-traumatic stress, depression, anxiety). There will be a significant proportion of children (potentially up to half), for which paediatric care will be required.
- There is currently no indication of any significant risk of infectious diseases among the refugee population writ large. However, continued monitoring will be important to mitigate potential health risks.
- As part of immigration process, refugees will undergo a full immigration medical examination overseas prior to departure. They will also undergo a fit-to-fly assessment prior to boarding flights to Canada. Once they land in Canada, refugees will be screened for symptoms and signs of infectious disease by Canada Border Services Agency in accordance with the Quarantine Act.
- Refugees will be given a paper copy of their immigration medical examination (IME) results prior to departure for Canada, and will bring it with them to Canada.
- Arriving Syrian refugees will receive type 1 health benefits covered under the Interim Federal Health Program (IFHP), which is valid for 12 months following arrival. Refugees who settle in Ontario will be eligible for Ontario Health Insurance Plan (OHIP) coverage upon arrival.

Language Considerations

Many of the arriving refugees will not yet be fluent in English or French. Arabic or Kurdish will likely be the first language of most individuals. Wherever possible, health system partners should offer language assistance services at points of contact with Syrian refugees. Options to consider include in-person or over the phone interpretation (OPI) services, translation of core written messages, bilingual staff and students, and partnering with local sponsorship or community organizations. Access Alliance Multicultural Health and Community Services is one example of an organization that provides interpretation services for health care providers.

Cultural Considerations

Cultural sensitivity and awareness is important to consider when delivering health services to refugees. Considerations may include practices that respect modesty, such as providing long gowns that cover the lower legs, or ensuring access to gender-matched health care providers and interpreters, as appropriate.

The Ministry of Health and Long-Term Care is working with partners and subject matter experts to identify and share resources to support health sector partners in delivering culturally sensitive care. This information will be shared as part of education and awareness activities conducted by the ministry and other partners.

Considerations related to Lesbian, Gay, Bisexual, Trans, Queer, and Intersex (LGBTQI) Refugees

Research shows that LGBTQI individuals often have unique health needs and may delay or avoid seeking health care or choose to withhold personal information from health care providers due to past negative experiences. LGBTQI refugees may have faced persecution in their home country based on homophobia, biphobia, or transphobia, and may not feel comfortable disclosing their sexual orientation or gender identity.

Providing upfront information about LGBTQI resources and services is important to support LGBTQI refugees when they arrive in Ontario. Health care providers are encouraged to identify local LGBTQI organizations in their area that can provide resources to patients. In smaller municipalities, if LGBTQI organizations are not located in close proximity, information may be provided for services in the next closest municipality where they are available. Online resources may also be provided.

In Ontario, Rainbow Health Ontario works to improve the health and well-being of LGBTQI people, and to increase access to competent and LGBTQI-friendly health care. Their website offers an array of LGBTQI health related information including fact sheets, academic research articles, and other health services and resources.

Key Websites

Government of Canada

- Welcome Refugees – Immigration, Refugees and Citizenship Canada
- Interim Federal Health Program

Government of Ontario

- Syrian Refugees: How You Can Help (ontario.ca/syrianrefugees)
- Ministry of Citizenship, Immigration and International Trade
- Syrian Refugees: Information for Health Sector Partners

Ontario Health System Action Plan: Syrian Refugees

Goal

Ontario's health system must be prepared and ready to support the needs of arriving Syrian refugees. The goal of this plan is **to wrap health services around refugees at each stage of their resettlement journey.**

Objectives

To achieve the goal of this plan and to meet the health needs of Syrian refugees arriving in Ontario, three overall objectives will provide the framework for health system actions:

Understand	• Understand refugees' health status to assess needs
Prepare	• Prepare the health system to support refugees' health needs by providing necessary information, coordination, and outreach
Respond	• Respond to refugees' health needs upon arrival in the settings and communities they inhabit

The ministry will provide further information on the evaluation of these objectives.

Guidance to Support Action

Ontario's health system stakeholders will take specific actions to meet each of the above objectives.

The remainder of this document outlines the actions required, key partners involved, roles and responsibilities, and general guidance related to each action. More detailed information and guidance will be provided in a series of annexes to this plan. Annexes will be shared with relevant partners, and will be updated if new information becomes available or the situation changes.

1: Understand refugees' health status to assess needs

Refugee health profiles

Key Partners:

- Immigration, Refugees and Citizenship Canada (IRCC)
- Public Health Agency of Canada (PHAC)
- Public Health Ontario (PHO)
- Subject matter experts

Summary:

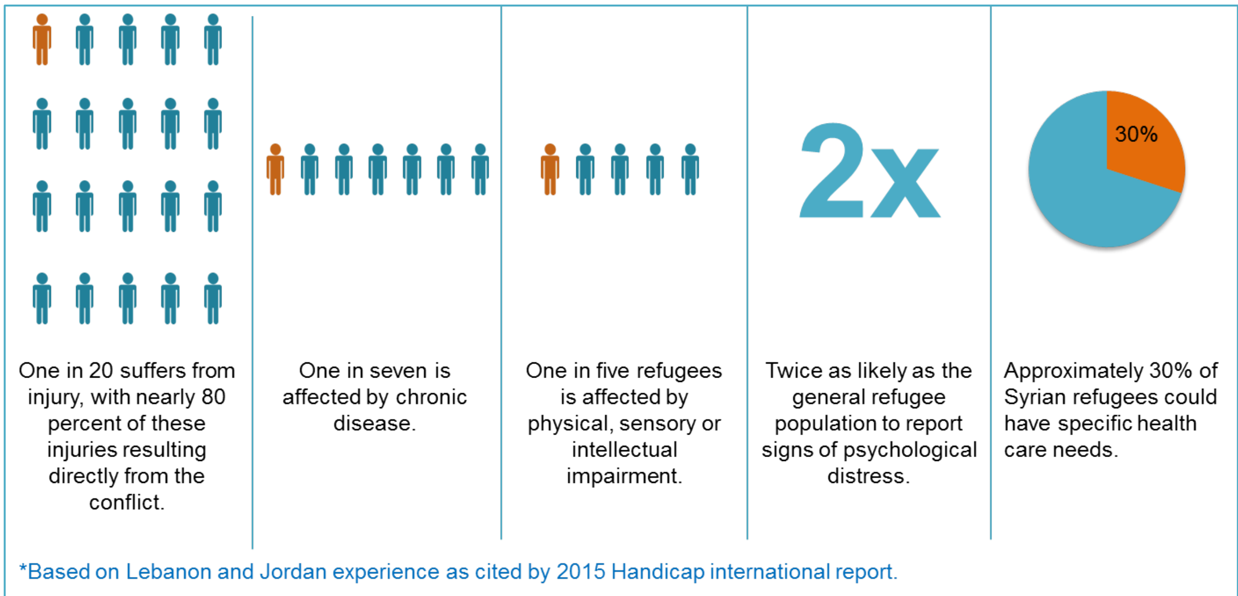
A health profile describes the general health characteristics and concerns of a population. It does not provide information about individuals, but rather about health issues that are likely to affect individuals within the population group. Health profiles can be used by health care providers to identify potential concerns when assessing their patients.

IRCC has published a population profile for Syrian refugees that includes a health profile.

More Information:

- Population Profile: Syrian Refugees – IRCC

Examples of Syrian Refugee Health Needs



Pre-arrival medical assessment information

Key Partners:

- Department of National Defence (DND)
- Immigration, Refugees and Citizenship Canada (IRCC)
- Public Health Agency of Canada (PHAC)

Summary:

Each Syrian refugee arriving in Canada will be provided with a paper record of their immigration medical examination (IME) completed by medical personnel overseen by the Government of Canada.

Individuals are not required to provide their immigration medical examination records to provincial agencies or to health care providers. However, they may do so upon request to support health service delivery.

The ministry will work with the federal government to develop a mechanism for receiving appropriate, aggregate information pertaining to the health status of arriving refugees that the ministry can share with relevant partners on a regular basis.

IRCC will report any case of a reportable disease identified during an IME to Public Health Ontario, who will notify the appropriate local public health unit, as per existing notification processes.

More Information:

- Immigration medical record report – sample available from MEOC

2: Prepare the health system to support refugees' health needs

Ministry Emergency Operations Centre (MEOC)

Key Partners:

- Local Health Integration Networks (LHINs)
- Public Health Units (PHUs)
- Health Care Provider Associations, Colleges, and Unions
- Provincial Emergency Operations Centre (PEOC)
- Health Portfolio Operations Centre (HPOC)

Summary:

The Ministry Emergency Operations Centre (MEOC) has been activated. It provides a single point of contact and coordination for the provincial health system in support of the Syrian refugee resettlement effort in Ontario. The MEOC will collaborate and share information across levels of government and with local partners, including detailed guidance related each component of this plan.

The MEOC will institute a regular business cycle of teleconferences and situation reports with the following groups, and will adjust the timing based on the situation:

- LHINs
- PHUs
- Associations, colleges, unions and other health stakeholders

MEOC Health Care Provider Hotline:

- Phone: 1-866-212-2272
- Email: emergencymanagement.moh@ontario.ca

Local planning to meet health service demands

Key Partners:

- Local Health Integration Networks (LHINs)
- Public Health Units (PHUs)
- Emergency Medical Assistance Team (EMAT)
- Local health providers and additional partners
- Canadian Red Cross (CRC)

Summary:

Local Health Integration Networks (LHINs) are responsible for local planning and coordination of health services. A coordination table should be created and led by each LHIN to guide local activities. Tables should be inter-professional and include local health system leaders and representatives from primary care, including paediatrics, mental health, public health, dental, emergency services, and other key areas likely to be involved in supporting refugee health care. It should engage persons with experience in providing care to refugees.

All health sector partners potentially involved in providing care or services to refugees should:

a) Anticipate services and supports provided by their organizations that may be accessed by or delivered to refugees
b) Prepare to deliver those services and supports in consideration of refugee needs (including culture and language considerations).
c) Connect with their local LHIN coordination table and stay up-to-date on ministry guidance provided.
d) Register for the Interim Federal Health Program.

Providers that are located in close proximity to Resettlement Assistance Program (RAP) centres, Interim Lodging Sites (ILSs), or Toronto's Lester B. Pearson International Airport may be required to undertake additional preparedness activities in coordination with local LHIN tables. Identified RAP centres in Ontario are located in Hamilton, Kitchener, London, Ottawa, Toronto, and Windsor. Identified ILSs in Ontario are military bases in Borden, Kingston, Meaford, Petawawa, and Trenton.

Primary care providers are often an individual's initial point of contact to the health system. They will play a key role in developing and supporting local coordination plans for required health services. Upon arrival, refugees may require transitional care and should present to a primary care provider for initial medical assessment and/or referral to other health services.

A Refugee HealthLine, that will develop and maintain a registry of health care providers, will be used to connect refugees to health service providers for transitional care. All health care providers interested in participating can contact toll-free **1-866-286-4770** to add their name, practice, location, service and the number of prospective patients/clients they are able to take on.

A full overview of roles and responsibilities for local health system coordination will be provided in an annex to this plan.

More Information:

- Annex: Local Health System Coordination

Refugee HealthLine:

- 1-866-286-4770

Health insurance coverage

Key Partners:

- ServiceOntario
- Immigration, Refugees and Citizenship Canada (IRCC)
- Public Health Agency of Canada (PHAC)
- Ministry of Citizenship, Immigration, and International Trade (MCIIT)

Summary:

At the current time, Syrian refugees who arrive in Canada on or after November 4, 2015 will receive an Interim Federal Health Program (IFHP) certificate upon arrival. The IFHP certificate is valid for 12 months and includes basic coverage, supplemental coverage (e.g. vision and dental care), and prescription drug coverage. The IFHP is administered by Immigration, Refugees and Citizenship Canada. Additional information is available on IRCC's website.

Health care providers who may be involved in managing the care of refugees should register for the IFHP. This may include physicians, nurse practitioners, dentists, optometrists, therapists, hospitals, paramedic services and others.

Refugees who are settling in Ontario will be eligible to apply for the Ontario Health Insurance Plan (OHIP) upon arrival. Convention refugees and protected persons are exempt from the usual 3-month waiting period. Individuals may apply for an OHIP card in person at a ServiceOntario Centre (see Health Insurance Coverage Annex for more information).

Refugees may initially utilize IFHP coverage when accessing primary health care services if they have not yet registered for OHIP. Once registered with OHIP, they will use OHIP for primary care services, but can continue to use IFHP coverage for supplementary benefits not covered by OHIP.

Some provincial health programs require OHIP coverage, and are not covered by IFHP, such as services provided by Community Care Access Centres.

Dental issues are a key health concern among the refugee population, particularly children. Partial dental coverage will be provided under the IFHP for the first 12 months following arrival. Local public health units, dental providers, and some Community Health Centres may also provide dental services under the Healthy Smiles Ontario program for low-income children beginning January 1, 2016.

More Information:

- Annex: Health Insurance Coverage
- Interim Federal Health Program (IFHP) certificate – sample available from MEOC
- IFHP – Immigration, Refugees and Citizenship Canada
- IFHP – Medavie Blue Cross (coverage provider)
- IFHP - Registration Information
- Verify a patient's IFHP coverage online or call 1-888-614-1880
- ServiceOntario
- Healthy Smiles Ontario

Information and resources for health care providers to support refugee care

Key Partners:

- Association of Ontario Health Centres (AOHC)
- Ontario College of Family Physicians (OCFP)
- Registered Nurses' Association of Ontario (RNAO)
- Public Health Ontario (PHO)
- Refugee Clinics
- Additional subject matter experts

Summary:

While several organizations and providers in Ontario have extensive experience providing services to refugee groups, some of the Syrian refugees may be resettled in communities that do not typically provide refugee-focused services.

The ministry is collaborating with key partners to develop education and awareness webinars and materials for the health sector to support refugee resettlement. These materials will help direct participants to existing resources to support local planning, address the care needs of the refugee population, and clarify health insurance benefits coverage.

Further details and scheduling of education and awareness webinars and materials by specific organizations (e.g. health care provider colleges and associations) will be provided when they are available.

Worker health and safety

Key Partners:

- Public Health Ontario (PHO)
- Ministry of Labour (MOL)

Summary:

There is currently no indication of any significant risk of infectious diseases among the Syrian refugee population. Health care workers who are providing services to refugees should be prepared to undertake routine practices and additional precautions for infection prevention and control (IPAC), appropriate to the scope of their duties. IPAC precautions include worker immunization, personal protective equipment (PPE), hand hygiene, and IPAC training.

The ministry has worked with Public Health Ontario to develop guidance for health worker safety based on the current risk situation. More information will be provided in an annex to this plan.

More Information:

- Annex: Worker Health and Safety and IPAC Practices in Clinical Care Settings

3: Respond to refugees' health needs upon arrival

Arrival at the airport

Key Partners:

- Canada Border Services Agency (CBSA)
- Public Health Agency of Canada (PHAC)
- Emergency Medical Assistance Team (EMAT)
- Peel Paramedic Services
- Toronto Paramedic Services
- Hospitals in the vicinity of the airport
- Public Health Units

Summary:

Lester B. Pearson International Airport in Toronto will be one of two points of entry to Canada for Syrian refugees. Appropriate health assessment and response capacity at the airport and local hospitals will be required to support each group of refugees as they arrive. The ministry will alert the health system of arriving flights with as much advance notice as possible.

The Canada Border Services Agency (CBSA) will conduct routine processing, which includes screening for signs of illness. Individuals who may be ill will be referred to a Public Health Agency of Canada (PHAC) quarantine officer. Quarantine officers will assess whether there is a need to apply measures authorized under the *Quarantine Act*.

A small component of the Emergency Medical Assistance Team (EMAT) will initially be stationed at the airport to provide on-site medical care to any refugees who have urgent or sub-acute medical conditions upon arrival. Whether there is a need for EMAT to have a continued onsite presence will be determined based on experiences from the first few incoming flights.

Paramedics and ambulances will be staged at the airport to provide care and transport to hospital in the event that any individuals require more definitive medical care. Hospitals in the vicinity of the airport should ensure appropriate emergency department staffing levels and translation services at times of flight arrivals to meet potential needs.

Public health units will work with quarantine officers in the event that a case of a reportable infectious disease is suspected.

More Information:

- Annex: Airport Health Services
- Emergency Medical Assistance Team

Temporary accommodation sites

Key Partners:

- Emergency Medical Assistance Team (EMAT)
- Department of National Defence (DND)
- Public Health Agency of Canada (PHAC)
- Canadian Red Cross (CRC)
- Local Health Integration Networks (LHINs)
- Public Health Units (PHUs)

Summary:

Most of the arriving refugees will travel directly to their new home communities. In the event that government-assisted refugees' permanent housing is not yet ready when they arrive in Canada, they will be housed temporarily in one of two types of sites.

Federal Resettlement Assistance Program (RAP) centres currently perform the function of providing temporary accommodation and transitional support to government-assisted refugees. There are six RAP centres identified in Ontario. They are located in Hamilton, Kitchener, London, Ottawa, Toronto, and Windsor. RAP centres will be the first choice for temporary accommodation. However, their capacity is limited and may be exceeded as refugees continue to arrive.

The federal government has identified six military bases that may provide additional temporary accommodation to refugees until housing at their final destination community is ready. These are referred to as Interim Lodging Sites (ILSs). Five of the six ILSs are located in Ontario: Borden, Meaford, Kingston, Petawawa, and Trenton. The sixth ILS is Valcartier in Québec. Kingston is expected to be the first ILS site to be activated.

Government-assisted refugees arriving at either Toronto's Pearson International Airport or Montréal's Trudeau International Airport may be temporarily housed at an ILS if required. Whether ILSs are used depends on many factors, including processing overseas, housing absorption, RAP capacity, and base readiness and capacity. If required, the Canadian Red Cross will perform overall site management at some or all ILSs.

A small component of the EMAT team may initially be deployed to the first ILS activated in Ontario. EMAT would provide onsite primary care to refugees, and would coordinate locally with the appropriate LHIN coordination table(s). EMAT would also work with local health care providers in the event that a refugee requires additional care outside of the ILS.

EMAT would likely provide onsite care to one ILS only. Therefore, should more than one ILS require onsite care, the ministry would likely work with the appropriate LHIN coordination table(s) to arrange onsite primary care using local providers. More information is provided in the Interim Lodging Sites annex to this plan.

Public health units may be asked to provide certain immunizations to refugees who are temporarily housed at ILSs to protect them before they move on to their final destination communities (See Immunization section of this plan for more information).

In addition to RAP centres and ILSs, other provincial and municipal properties may provide temporary accommodation in certain circumstances, if required.

More Information:

- Annex: Interim Lodging Sites

Health system information for refugees and sponsors

Key Partners:

- Public Health Ontario (PHO)
- Public Health Agency of Canada (PHAC)
- Ministry of Citizenship, Immigration, and International Trade (MCIIT)
- Health care providers

Summary:

Ontario has a long history of welcoming refugees. There are many existing resources and programs to support refugees and their sponsors to understand and access Ontario's health system. Many of these resources are made available through resettlement agencies and sponsoring organizations.

The ministry has developed an information package for Syrian refugees to support their access to health services in Ontario. This information package includes instructions on how to register for the Ontario Health Insurance Plan (OHIP), how to locate appropriate health care providers, and other information.

The information package will be posted online and distributed to settlement and sponsorship agencies throughout the province.

More Information:

- Fact Sheet: Refugee Health Care Options in Ontario

Primary and community care

Key Partners:

- Association of Ontario Health Centres (AOHC)
- Ontario College of Family Physicians (OCFP)
- Registered Nurses' Association of Ontario (RNAO)
- Nurse Practitioners' Association of Ontario (NPAO)
- Ontario Medical Association (OMA)
- Association of Family Health Teams Ontario (AFHTO)
- Refugee health clinics

- Community Health Centres (CHCs)
- Family Health Teams (FHTs)
- Nurse Practitioner-Led Clinics (NPLCs)
- Midwifery Practices
- Private practices
- Walk-in clinics

Summary:

Primary care providers are often an individual's initial point of contact to the health system. They will play a key role in supporting local coordination plans for required health services. Upon arrival, refugees may require transitional care and should present to a primary care provider for initial medical assessment and/or referral to other health services.

A Refugee HealthLine, that will develop and maintain a registry of health care providers, will be used to connect refugees to health service providers for transitional care. All health care providers interested in participating can contact toll-free **1-866-286-4770** to add their name, practice, location, service and the number of prospective patients/clients they are able to take on.

Refugee Health Clinics and Community Health Centres are experienced in providing care to refugee populations. They are a preferred option for providing transitional care and other services, where available. As a significant percentage of incoming refugees are expected to be children, access to paediatric care will also be necessary.

Once refugees have settled into their permanent accommodations, they will require regular health services. Having their health needs supported by the local health system will be an important component in their overall integration into Canadian society.

In addition to primary health care, newly arrived refugees are likely to require other supports and supplemental services. Dental and vision care needs may be identified as part of the transitional primary care assessment. Home and community care support services may also be required.

Refugee HealthLine:

- 1-866-286-4770

More Information:

- Annex: Local Health System Coordination
- Canadian Medical Association Journal: Evidence-based clinical guidelines for immigrants and refugees
- Canadian Medical Association Journal: Caring for a newly arrived Syrian refugee family
- The College of Family Physicians of Canada: Refugee Health Care
- Canadian Collaboration for Immigrant and Refugee Health (CCIRH): Migrant Health Knowledge Exchange Network

Immunization

Key Partners:

- Public Health Units
- Health care providers

Summary:

Given the deterioration of the Syrian health system beginning in 2011, it is estimated that many of the arriving refugees – particularly children – are not up-to-date on their immunizations. Immunization is not part of the standard immigration medical examination that is conducted prior to refugees' travel to Canada. Ontario Health care providers should conduct an assessment of immunization history and offer catch-up immunizations as required. Local public health units may advise health care providers regarding immunization, and may also be required to support the immunization of large groups of incoming refugees staying in Interim Lodging Sites (ILSs) or Refugee Assistance Program (RAP) centres across the province.

Some refugees may have documented immunization information as part of their health record provided by the United Nations Refugee Agency (UNHCR) or other records. Only documented evidence should be used to confirm immunization history. Individual recall of immunization or history of illness should not be considered reliable evidence of immunity. When an individual's vaccine record is unreliable or unavailable, vaccines should be provided as if the individual were not yet immunized.

Catch-up immunization schedules for children and adults are provided in Ontario's publicly funded immunization schedules, as well as by the National Advisory Committee on Immunization (NACI). If a number of vaccines are required, providers may need to prioritize which vaccines to give first. The immunization annex to this plan provides guidance on which vaccines should be given priority, depending on the client's age.

The immunization annex to this plan also provides information on vaccine schedules and products that were commonly used in Syria prior to 2011. This may be helpful to interpret immunization records that may be available.

More Information:

- Annex: Immunization
- Publicly Funded Immunization Schedules for Ontario
- Canadian Immunization Guide: Vaccination of Specific Populations

Mental health and addictions services

Key Partners:

- Local Health Integration Networks (LHINs)
- Community Mental Health Association of Canada (CMAH)
- Mental health and addictions service providers

Summary:

Individuals who have experienced war and have been forced to leave their homes will understandably experience symptoms of distress. Many refugees have lost friends and family in the conflict. Many have experienced periods in refugee camps, trauma, violence, and may experience post-traumatic stress disorder (PTSD) and other issues. All of them have lost their homes, possessions, routines, and community supports. They may experience anxiety and uncertainty about their future once they arrive in Canada. Many are likely to require specific mental health supports as they move beyond events of the past and become accustomed to their new lives in Canada.

A variety of mental health and addictions support services are available to refugees who need them. These include counselling and treatment, crisis intervention, and social rehabilitation services.

Due to cultural and language barriers, it is possible that discussions concerning mental health and mental illness may be interpreted or received differently by individuals. In order to provide the best possible care, providers should be sensitive to this.

Coordination of services is provided locally. Each Local Health Integration Network (LHIN) has a mental health lead who can help identify local mental health and addictions agencies and service providers.

Refugees and sponsors should be made aware of the supports available to them. They may be referred to the ConnexOntario Helplines below (which operates in 170 languages), or referred directly to an appropriate service provider. The Refugee HealthLine may also be used to connect to transitional care. Neither ConnexOntario nor the Refugee HealthLine are crisis lines, but can help connect refugees to services. Distress and Crisis Ontario also provides a listing of local crisis lines.

Coordination of appropriate language services will be particularly important for provision of mental health and addictions services.

More Information:

- ConnexOntario Mental Health Helpline: 1-866-531-2600
- ConnexOntario Drug and Alcohol Helpline: 1-800-565-8603
- Distress and Crisis Ontario
- Centre for Addiction and Mental Health (CAMH): Refugee Mental Health ToolKit

Infectious disease and health system surveillance

Key Partners:

- Health Care Providers
- Public Health Units
- Public Health Ontario (PHO)
- Public Health Agency of Canada (PHAC)

Summary:

The risk of infectious diseases spreading to the Canadian population as a result of the Syrian refugee operation is low. Refugees do not currently represent a threat to Ontario or Canada with respect to communicable diseases. However, refugees are a priority group for communicable disease prevention and control efforts because they are more vulnerable. This is particularly true in group accommodation settings.

Syrian refugees will arrive over the course of three months and will be housed in numerous communities across Canada. As such, the overall health system impacts of the resettlement effort are generally expected to be low. However, certain services may experience increased demands in some local areas. Clinics specializing in immigrant and refugee health, as well as primary care services in areas that receive a larger concentration of refugees, could be most impacted.

The ministry and Public Health Ontario are considering minor enhancements to routine surveillance processes to support the arrival of Syrian refugees. These activities would pertain only to surveillance of infectious diseases and health system impacts. It would not cover surveillance of chronic diseases, injury, or mental health issues at this time.

The refugees will arrive during influenza season, which is a period of natural surge in the health system. As such, it will be important for the ministry and health system partners to monitor the impact of the resettlement process on health care providers, and to be prepared to provide support if needed.

Additional information on surveillance will be made available in an annex to this plan.

More Information:

- Annex: Infectious Disease and Health System Surveillance
- Annex: Infectious Disease Case and Contact Management

Looking Ahead

In the months and years ahead, the Syrian refugees who settle in Ontario will build a new life for themselves and their families. They will become our neighbours, friends, colleagues, and community members. Their health and well-being will continue to be supported by our provincial health system, as it is for all Ontarians.

More Syrian refugees – in addition to the initial group of 25,000 – may continue to be resettled in Canada throughout 2016 and beyond. Ontario is committed to supporting this ongoing effort. We will continue to provide the necessary guidance and coordination that the health system needs to wrap health services around this population.

The actions that Ontario's health system takes now will provide a solid start for refugees as they settle and integrate into Ontario's communities. Our actions will also build a strong foundation for the health system to support future refugees that may arrive in Ontario.

When we look back, we will take pride in the work our health system did to support the arrival of Syrian refugees. We will know that we played a fundamental role in the overall humanitarian effort, and made a difference in the lives of thousands of new Ontarians.

Annexes

The following annexes to this plan will be made available through the Ministry of Health and Long-Term Care's Emergency Operations Centre (MEOC).

MEOC Health Care Provider Hotline:
Phone: 1-866-212-2272
Email: emergencymanagement.moh@ontario.ca

- Airport Health Services
- Health Insurance Coverage
- Infectious Disease and Health System Surveillance
- Infectious Disease Case and Contact Management
- Interim Lodging Sites
- Immunization
- Local Health System Coordination
- Worker Health and Safety and IPAC Practices in Clinical Care Settings

The following resources are also available from the MEOC:

- Fact Sheet: Refugee Health Care Options in Ontario
- Interim Federal Health Plan Certificate - Sample
- Immigration Medical Examination Report - Sample
- Population Profile: Syrian Refugees (Immigration, Refugees and Citizenship Canada)

Ontario

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 026-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 April 21

SUMMARY INFORMATION REPORT FOR APRIL 2016

Recommendation

It is recommended that Report No.026-16 re: Information Summary Report for April 2016 be received for information.

Key Points

- The "International Toronto Charter for Physical Activity (TCPA) Toolkit" was recently developed and disseminated to support local decision makers with encouraging residents to become more physically active through the development of supportive healthy public policies.
- The Middlesex-London Health Unit is co-leading a Locally Driven Collaborative Project (LDCP), funded by Public Health Ontario (PHO), called ***Measuring Food Literacy in Public Health***, attached as Appendix A**.**

Background

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

Toronto Charter for Physical Activity Toolkit

The Toronto Charter for Physical Activity (TCPA) is an advocacy tool with a call for action to create sustainable opportunities for physically active lifestyles for all. In 2010-2015 the MLHU received funding through the Ministry of Health & Long Term Care's (MHLTC) Healthy Communities Partnership grant to influence policy supporting enhanced opportunities for active living across the lifespan. A series of community stakeholder consultations in 2010/2011 identified endorsement of the Toronto Charter for Physical Activity (TCPA) as a strategic step toward moving healthy public policy for physical activity forward.

The MLHU Board of Health, City of London and seven of the eight Middlesex County municipalities endorsed the Charter, demonstrating commitment to making healthy active living a reality for all citizens. As an important investment toward implementation, the "International Toronto Charter for Physical Activity (TCPA) Toolkit" was developed in 2015 through Healthy Communities Partnership funds incorporating input from the 'Creating a Healthy Active Middlesex County Forum' and the Healthy Communities and Middlesex Active Communities (MAC) partnerships. The purpose of the Toolkit is to provide tips, action items, and resources for putting the TCPA into action and supports members of key sectors to implement supportive policies that encourage residents to become more physically active. Hardcopies of the Toolkit have been distributed to each of the endorsing County municipalities and an electronic version has been posted on the MLHU website and distributed through relevant portals. The Toolkit will be evaluated on its distribution and usefulness with partners in late 2016.

Measuring Food Literacy in Public Health

Public Health Units in Ontario are mandated to teach food preparation, cooking, and healthy eating skills to priority populations, including pregnant and postpartum women, people of low socio-economic status and youth. In order to do this, Public Health Units need to assess food literacy levels and evaluate the impact of the work that is being done in the community and in schools. Currently, there is no tool that has been developed to

help public health staff to: tailor programs to specific groups of people; determine the success of existing programs; measure food literacy among different populations; and advocate for food literacy resources.

In partnership with 18 public health units from across Ontario and PHO, the LDCP team will conduct the necessary research to create a tool for use by public health staff to measure different components that define food literacy. Currently, the LDCP team is conducting a scoping review of the literature to develop a thorough list of all possible components of food literacy. Next, a consensus-generating technique called Delphi will be implemented to solicit opinions from key stakeholders. Specifically, the LDCP team will ask a group of public health staff and other key informants and experts in the field of food literacy about what they feel should be included as food literacy attributes and to determine which components are most important for measurement. The aim of this approach is to reach group consensus and to have a rated list of food literacy components. Finally, the LDCP team plans to use these results to identify and develop key indicators that measure the components of food literacy. In 2018, the LDCP team plans to request multi-year funding from PHO to develop and test a tool with specific priority population groups to create a standard, validated instrument to measure food literacy. This instrument will be incorporated in the public health context in Ontario and it is anticipated it will be adopted and utilized globally.

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

2015 Locally Driven Collaborative Projects (LDCP)

Submission Form

Part 1. General Information

PROJECT INFORMATION	
Project Title: Measuring Food Literacy in Public Health	
Lay Title: Measuring Food Literacy in Public Health	
Funding Stream: ☒ **One year (with eligibility for renewal)** [$75,000 per year for a maximum funding of $75,000]	
Type of Project: ☒ **Applied Research Project** Keywords (4-6) scoping review, food literacy, food skills, attributes, Delphi Technique, consensus	
Total Amount Requested from Public Health Ontario: $75,000	
Project Start Date: March 1, 2016	**Project End Date:** February 28, 2017

CORE PROJECT TEAM	
LEAD (or **CO-LEAD***) HEALTH UNIT(S) ***If co-leads, please identify the Health Unit who will be the financial lead (receives and manages project funds from PHO)**	
Health Unit: **Haliburton, Kawartha, Pine Ridge District Health Unit ***(FINANCIAL LEAD & PROJECT LEAD)*** **Address:** 200 Rose Glen Road, Port Hope, ON, L1A 3V6	**Individual Name:** Elsie Azevedo Perry **Email Address:** eazevedoperry@hkpr.on.ca **Phone Number:** 1-866-888-4577 or 905-885-9100 ext. 1218
Health Unit: Middlesex-London Health Unit (Co-Lead) **Address:** 50 King Street, London, ON, N6A 5L7	**Individual Name:** Heather Thomas **Email Address:** heather.thomas@mlhu.on.ca **Phone Number:**519-663-5317 ext. 2222

CORE PROJECT TEAM	
CO-APPLICANT HEALTH UNITS	
Health Unit: Chatham-Kent Public Health Unit **Address:** 435 Grand Ave West Chatham, Ontario, N7M 5L8	**Individual Name:** Lyndsay Davidson **Email Address:** LYNDSAYD@chatham-kent.ca **Phone Number:** 519-352-7270 ext. 2478 **Individual Name:** **Email Address:** **Phone Number:**
Health Unit: City of Hamilton Public Health Services **Address:** 110 King Street West, 2nd floor, Hamilton, ON	**Individual Name:** Ruby Samra **Email Address:** Ruby.Samra@hamilton.ca **Phone Number:** 905-546-2424 ext. 3066 **Individual Name:** **Email Address:** **Phone Number:**
Health Unit: Northwestern Health Unit **Address:** P.O. Box 1317, 115 Main Street, Atikokan, ON	**Individual Name:** Julie Slack **Email Address:** jslack@nwhu.on.ca **Phone Number:** 807-597-6871 ext. 3713 **Individual Name:** **Email Address:** **Phone Number:**
Health Unit: North Bay Parry Sound District Health Unit **Address:** 681 Commercial Street, North Bay, Ontario P1B 4E7	**Individual Name:** Jessica Love **Email Address:** Jessica.Love@nbpsdhu.ca **Phone Number:** 705-474-1400 ext. 228 **Individual Name:** **Email Address:** **Phone Number:**

CORE PROJECT TEAM	
CO-APPLICANT(S) – ACADEMIC OR COMMUNITY ORGANIZATIONS	
Organization: Perth District Health Unit **Address:** 10 Downie Street, 2nd Floor, Festival Square, Stratford, ON	**Individual Name:** Shannon Edmonstone **Email Address:** sedmonstone@pdhu.on.ca **Phone Number:** 519-271-0375 ext. 777 **Individual Name:** **Email Address:** **Phone Number:**
Organization: Toronto Public Health - Central **Address:** 1530 Markham Road, 6th Floor Toronto, ON, M1B 3G4	**Individual Name:** Jessica Hambleton **Email Address:** jhamble@toronto.ca **Phone Number:** 416-338-7515 **Individual Name:** **Email Address:** **Phone Number:**
Organization: York Region Community and Health Services **Address:** 50 High Tech Road, 2nd Floor, Richmond Hill, ON	**Individual Name:** Rebecca Davids **Email Address:** Rebecca.Davids@york.ca **Phone Number:** 905-762-1282 ext:74672 **Individual Name:** **Email Address:** **Phone Number:**

Part 2. Lay Summary (500 words maximum)

Over the last few decades, there have been significant changes in cooking and food preparation resulting in an increased use of more processed foods, which involve fewer and/or different skills than traditional cooking from "scratch".

Home-prepared foods, which include fresh vegetables and fruit, have often been replaced by processed foods, which are higher in fat, salt and sugar. This trend has been linked to higher rates of diet-related chronic disease such as obesity, heart disease, and Type II diabetes. Improving food literacy has been shown to improve diet quality, mostly due to the greater use of vegetables and minimally-processed ingredients.

A previous Locally Driven Collaborative Project (LDCP) research project, Making Something out of Nothing: Food literacy among youth, young pregnant women and young parents who are at risk for poor health (2011), helped shed light on what food skills meant to these groups. The results from this study helped develop the definition for food literacy and a visual model of the different components of food literacy. However, a tool to measure food literacy in this population does not exist. Without a tool, public health professionals are not able to:

- Determine the extent of the problem;
- Tailor and target food literacy programming;
- Allocate resources effectively;
- Identify gaps in current programs;
- Determine impact of programs on food literacy and diet quality; and,
- Engage in advocacy efforts for more school- and community-based food literacy programs.

The proposed research project will lay the foundation to create a tool to measure food literacy and its attributes within the public health context.

In 2016, a LDCP team of public health professionals and a Research Consultant will work together to review the attributes of food literacy including food skills to develop a thorough list of all possible attributes or components of food literacy. Next, the Delphi Technique will be used, which is a well-planned consensus building method involving several rounds of questions to solicit opinion and come to a consensus on a topic. The target for the study will be public health staff in Ontario and other key informants involved in program or service delivery of food literacy including food skills. In round one, open ended questions will be sent using an online survey (e.g., fluid survey) to all participants to find out their opinions about the list of food literacy attributes and gaps in the list. Feedback about participants' opinions will be sent back to participants in rounds two and three and they will be asked to rank which attributes of food literacy, including food skills, are most important to them in their practice.

These preliminary steps will provide the essential foundation for the future development of a tool to measure food literacy in public health. Information from this year one study will be used to identify and develop key indicators that measure the attributes of food literacy including food skills. The LDCP team will apply for additional funding from Public Health Ontario to develop indicators in 2017, and then in 2018 to develop and test a measurement tool with specific priority population groups. This research will better inform public health practice to meet Ontario Public Health Standards.

Part 3. Project Introduction (6 pages maximum)

A. BACKGROUND AND RATIONALE

Chronic disease is greatly impacted by healthy eating. As many adults and youth do not have healthy diets, public health practitioners engaged in food skills and food literacy programming, research, and services focus primarily on nutrition and chronic disease prevention. Poor diet quality has been greatly influenced by a change in eating patterns whereby a greater proportion of foods are consumed away from home and more processed and pre-packaged foods are available in the environment. This has resulted in an increase in overall calorie consumption and a decrease in individuals' nutritional quality. Concurrent to this trend, time spent preparing food at home has declined along with a loss of domestic food preparation skills.

Food skills can be defined as a complex, interrelated set of skills including having nutrition knowledge, being able to plan and organize meals and having mechanical techniques for preparing food. Food skills is part of the broader definition of food literacy which also includes other external or environmental factors such as confidence in preparing food, a positive learning environment and access to food, money, cooking equipment and facilities. Food literacy and food skills are linked to chronic disease prevention; however, the measurement of food literacy including food skills is not known in this context as there is no sufficient, validated tool to measure the different attributes of food literacy including food skills. This research project addresses the need to first determine the key attributes of food literacy so a future measurement tool can be developed.

Chronic disease prevention is impacted by healthy eating

Chronic diseases, including cancers, cardiovascular disease, chronic respiratory disease and diabetes are the leading causes of death and disability. In 2007, nearly 60% of reported deaths in Ontario were attributed to unhealthy lifestyle behaviours such as poor diet, smoking, excessive alcohol consumption, physical inactivity, and high stress.[1] Diet quality has been identified as the most important risk factor for chronic disease.[2]

Canadians, including youth, do not have healthy diets

The eating patterns of Canadian youth and adults do not align with dietary recommendations according to Eating Well with Canada's Food Guide.[3] Fruit and vegetable consumption is an indicator of a healthy diet but half of adults do not consume a minimum of five servings of vegetables and fruit daily.[4] The adapted Healthy Eating Index assesses two aspects of diet quality: adequacy and moderation; with a score of 100 points approximating a high diet quality.[5] In 2004, the average score on the Canadian adaptation of the Healthy Eating Index was 58.8 for the total population aged 2 or older (and approximately 55 in the 14-to-30 years of age).[5]

Eating patterns have changed for Canadians, including youth

In addition to poor diet quality, there has been a change in eating patterns and the kinds of food available to Canadians to prepare and eat. Consuming pre-prepared and convenience food as in, foods that are packaged and more highly processed from their whole state, higher in fat, sugar, sodium, and/or preservatives has become normalized within the eating patterns for Canadian children of all ages and their families.[6] According to the Canadian Council of Food and Nutrition report, Tracking Nutrition Trends - VII (2008), a third to over half of Canadians eat a meal not prepared at home at least once a day.[7] Over the past 30 years, children and youth in the US have increased energy consumed away from home (23.4% to 33.9%), particularly through fast food and restaurant foods.[8] This is a concern as foods prepared away from home have been associated with increased energy intake and decreased nutritional quality.[9-11] Additionally, high consumption of processed foods is associated with poorer health

outcomes.[12-15] This shift in consumption has become a public health nutrition challenge, as the current food environment does not support healthy eating.

A decline in time spent preparing food and domestic cooking skills

In concert with the trend above, the amount of time spent to prepare meals has declined since the early 1900s.[16,17] Since 1900, there has been an eight-fold decrease (from 360 minutes per day in the 1900s to 45 minutes per day in 1985) in the average daily time spent on the task of meal preparation and cleaning up after the meal.[16,17] Overall, fewer people cooked in 2007-2008 compared to 1965-1966 across all income groups.[18] Women who cooked decreased from 92% to 68%; and those who cooked spent 112.8 minutes/day cooking in 1994-1996 compared to only 65.6 minutes/day cooking in 2007-2008.[18]

Although modern conveniences, such as microwaves ovens, have helped to reduce food preparation times, the predominant change in eating and meal preparation culture is due to most adults working outside the home, participation in busier lifestyles, and an increased number of hours spent at work during the week.[16,17] Typically, it has been shown that women (including adolescents, young adults and mothers) are primarily responsible for food preparation functions within the home; however, the time constraint placed on them through increased participation in the workforce has increased the need and reliance on convenience foods.[6] Traditionally, mothers passed their food skills onto their children, but because of this workforce realignment, children may be missing out on opportunities to learn cooking skills and enhance their food literacy in the process. A lack of cooking knowledge and skill decreases a person's propensity to cook; however, those who report being more involved in food purchasing and preparation or those who cook most often are more likely to meet dietary guidelines.[19,20]

DEFINING FOOD SKILLS AND FOOD LITERACY

Food skill development and healthy eating practices are requirements for the promotion of health and prevention of chronic disease. Specifically, health units in Ontario are required through the 2008 Ontario Public Health Standards (OPHS) to provide opportunities for skill development in the areas of food skills and healthy eating practices for priority populations.[21] The above evidence shows that there is a need for food skill development as eating patterns have changed and there has been a decline in domestic food skills.

There is no explicit or widely agreed upon definition for "food skills". Prior to 2011, authors used terms such as "cooking skills"[22,23] or "culinary skills"[24] while others discussed "food preparation".[13,22,25,26] In the Ministry of Health Promotion's Guidance Document: Healthy Eating, Physical Activity and Healthy Weights (2010), food skills is defined as a "complex, interrelated, person-centred set of skills that are necessary to provide and prepare safe, nutritious, and culturally-acceptable meals for all members of one's household".[27] This definition was based on a study conducted by Short (2003) with 30 domestic cooks living in England which derived a systematic framework for domestic cooking encompassing the following five general categories:[28]

- Knowledge (nutrition, label reading, food safety, food varieties, ingredients, substitution);
- Planning (organizing meals, budgeting, food preparation, teaching food skills to children);
- Conceptualizing food (creative thinking about leftovers, adjusting recipes);
- Mechanical techniques (preparing meals, chopping/mixing, cooking, following recipes); and
- Food perception (using your senses – texture, taste, when foods are cooked).

Beginning in 2011, the definition of food literacy emerged in the literature denoting a more comprehensive definition than the previously used "food skills". Current definitions of food literacy are broad and encompass environmental or external factors that impact the attainment of food skills at the individual level.[29-33] In a previous Locally Driven Collaborative Project (LDCP) eight health units in Ontario

conducted research to understand the meanings and practices of food skills among at-risk youth (teens aged 16 to 19 years, and young parents including pregnant women aged 16 to 25 years).[34] This research generated a definition and conceptual model of food literacy, as illustrated in Figure 1 (Appendix A), to inform public health interventions, advocacy, and program and policy development.

For the purpose of this study, the food literacy definition from the previous LDCP will be used for this project and is defined as follows:[34]

- ***Food literacy is a set of skills and attributes*** that help people sustain the daily preparation of healthy, tasty, affordable meals for themselves and their families;
- ***Food literacy*** builds resilience, because it ***includes food skills*** (techniques, knowledge and planning ability), the confidence to improvise and problem-solve, and the ability to access and share information; and,
- ***Food literacy requires external support*** with healthy food access and living conditions, broad learning opportunities, and positive socio-cultural environments.

As shown in Figure 1 (Appendix A), food literacy involves personal factors such as food and nutrition knowledge, food preparation skills and experience, organizational skills and experience (these three components constitute food skills as defined by the OPHS Guidance Document)[27] including psycho-social factors. As mentioned previously, food literacy includes broader environmental factors that determine an individual's capacity to prepare and cook food and include positive socio-cultural and learning environments as well as access to food and facilities, equipment, income, housing and employment. These ***personal and environmental factors*** operate synergistically to promote a culture of healthy eating and in the remainder of this proposal ***will be referred to as "attributes" of food literacy***.[34] These findings are supported by a number of recent studies and papers that have explored the concept of food literacy.[32,35-39] These studies are independent of each other and geographically dispersed, yet their results, models, and conclusions have overlapped considerably. Some have defined food literacy as more knowledge-based, such as the ability to choose healthier options from retail environments;[40] other studies recognize the technical, social, and psychological attributes of food literacy as being essential to healthy food preparation.[38,39] Additionally, food literacy attributes like food system awareness, knowledge about growing food, and network-building around food have been identified.[29]

In conclusion, although the term "food literacy" is not explicitly used in the OPHS Ministry of Health Promotion's Guidance Document, it does state that "regardless of the definition, all interventions undertaken to build food skills must be in line with the target population's level of access to healthy foods",[27] which is an example of an external factor in the food literacy definition. External or environmental factors that are referred to as attributes of food literacy (such as access to healthy foods, cooking equipment, social and economic factors, confidence, etc.) impact the attainment of cooking or food skills at an individual level that needs to be considered when planning, implementing and evaluating "food skills" programming. Since the completion of the previous LDCP project, significant knowledge exchange activities have been implemented with public health personnel to explain the recent evidence for the transition from food skills to food literacy. A "Call to Action" was developed for public health practitioners to implement the recommendations from the previous LDCP study including the use of the nomenclature food literacy rather than food skills (see Appendix B). It is also important to note that public health practitioners will be advocating that the term "food skills" be replaced with the term "food literacy" in a future revision of the 2008 OPHS.

RATIONALE AND SIGNIFICANCE FOR THE PROPOSED PROJECT

Healthy diets are influenced by many factors, one of which is postulated to be food literacy

There is evidence that healthy eating, cooking skills, and physical and mental health are linked;[41-46]

however, there is limited high quality research to demonstrate causation or impact of food literacy, including food skills on chronic disease risk.[24] Nutrition education alone is not adequate to improve dietary intake; it is theorized that having food skills and greater overall food literacy are necessary for a quality diet. Lang and Caraher (2001) proposed that limited awareness of food, cooking skills, and knowledge about how foods are grown and harvested, leads to barriers in healthy food consumption, and ultimately the achievement and maintenance of a healthy weight.[43]

Numerous factors such as age, sex, social class, knowledge, and attitudes can influence food skills, affecting food choice, and consequently health.[20] Chu et al. (2012) found that those who cook more frequently have a better diet characterized by favourable nutrient density.[47] Furthermore, the foods people cook, the food preparation skills they utilize, and where they cook are influenced by social, economic, and cultural contexts that are constantly changing and speaks to the broader definition of food literacy.[28,43,48] Independent of preparation skills, there are several factors that drive an individual's food selection including physiology, food availability, taste, price, marketing, convenience, social norms and cues.[49]

Barriers to developing individual food skills have been defined and include lack of time, attitudes, cost, confidence and lack of skills.[20] As previously mentioned, there is a decline in domestic food preparation skills (called "deskilling") due to a lack of introduction to and opportunity for the acquisition of cooking skills from parents, grandparents, and/or school environments.[22,43,44,48,50] This is supported by the previous LDCP research whereby those participants who had greater food skills had learned them primarily from parents, grandparents, siblings, or relatives.[34] Over half of these participants also indicated that the best way for young people to learn food skills, if they did not learn at home, were cooking classes, both in school and in the community. Learning these skills at an earlier age (seven to 12 years of age) was also found to contribute to a greater confidence in food preparation in later years.[34]

Some evidence does exist demonstrating a relationship between decreased use of traditional or basic food preparation skills, increased consumption of pre-prepared, packaged, and convenience foods, and decreased dietary quality.[6,51] While adolescents report involvement in food purchasing and preparation activities, the frequency of involvement is low (only one to two times per week) with the highest level of involvement and food skills among females and those from lower socio-economic groups.[6,31] And while parents of younger children rate the development of food/cooking skills as very or extremely important, participation remains low.[34,52] Low participation in food literacy activities may be a result of other skills like school, arts and sports taking precedence over cooking skills. In addition, parents perceive kitchen safety and time as barriers to involvement.[52]

Efficacy of food skills/literacy programs

In the majority of food skills interventions, most indicators focus on food skills but some include broader indicators such as self-efficacy, confidence and food security.[53] These broader indicators more specifically reflect food literacy, even if they are not defined as such. A review of 28 studies on nutrition and food skill interventions showed beneficial changes in intake of various nutrients, food groups and specific foods after intervention.[53] Of note are improvements in intakes of dietary sources of fat, fibre, sugar or sodium; improved dietary intake overall and reduced blood pressure; and, reduced BMI and weight gain in children.[53,54]

Researchers have found that cooking education has a positive impact on behaviours and attitudes toward cooking and healthy eating, such as increased consumption of vegetables and fruit, improved food safety behaviours, higher frequency of cooking, increased nutrition knowledge, higher self-efficacy, and less money spent on food.[12,25,48,50,55-61] Interventions show associations between more frequent involvement in food preparation activities among emerging adulthood and better dietary quality.[6,51]

Additionally, key findings from the previous LDCP were that there are positive psycho-social outcomes when youth and young parents who had moderate to advanced skills in preparing foods such as to improved physical and mental well-being, connecting with others, improved response to changes and challenges, and satisfaction in preparing food for oneself and others.[34] With evidence demonstrating a relationship between food skills and healthy food choices and consequently a link between food literacy, diet quality and mental health, interventions aimed at improving food literacy may be an effective population health approach.

Gaps in measuring food literacy

In all the studies reviewed, the indicators and their definitions were not consistent, making it difficult to generalize results. An in depth search of the literature also revealed a lack of reliable and valid tools specific to the measurement of food skills and other contextual attributes of food literacy including access to food, self-efficacy and confidence. This lack of a valid measurement tool inhibits the ability to: assess the scope of the problem; tailor and target programs; engage in advocacy efforts; allocate limited resources effectively; determine impact of programs on food literacy and diet quality; and, identify gaps in current programming. This proposed project builds on previous food literacy research in Ontario and will support evidence-informed public health initiatives to provide food literacy opportunities to priority populations.

This research proposal highlights the need to enhance the work of Ontario public health and non-public practitioners engaged in food literacy including food skills programming, advocacy and research. The connection between food literacy to chronic disease prevention is an important one; however, it is not fully understood due to the lack of public health measurement of the attributes of food literacy including food skills within this context. Background work to determine the relevant attributes is necessary such that in the future, a validated, meaningful food literacy measurement tool can be developed for use by public health practitioners and other key provincial agencies and groups.

PURPOSE OF STUDY AND HOW PRIORITY POPULATIONS WERE IDENTIFIED

As previously mentioned, the Ontario Public Health Standards (2008) require health units to provide opportunities for skill development in the areas of ***food skills and healthy eating practices for priority populations***. As stated in OPHS, this may include, but is not limited to, pregnant and postpartum women, individuals of low socioeconomic status, and youth.[21]

The limited body of evidence related to the context of cooking skills and food literacy for priority populations provided the impetus and rationale of the previous LDCP, which explored the meaning of food skills from the perspective of two priority populations in Ontario.[6,24,34] The first objective of this previous research project was to identify the two priority populations.

The LDCP team used a framework for identifying priority populations and developed a selection criterion to assist team members reach consensus when selecting and finalizing the priority populations.[62] Selection criterion was based on team members' knowledge of priority populations identified in the 2008 OPHS; expert knowledge of planning and delivering food and healthy eating programs; and an initial review of key literature (see Appendix C for selection criterion).

Priority populations were determined after extensive consultation with key stakeholders in public health.[63] Youth were described as "high risk" (or at risk for poorer health outcomes) if they had lower incomes, lower literacy levels, precarious housing, unstable family structures, etc. The age described for youth ranged from 10 to 24 years. Older teens were described as 14-15, 15-18 16-21, or under 21 years of age. Older teens were also described as "transitioning teens" that who are changing schools or

leaving home. Low-income pregnant young women or mothers were also identified as a priority and descriptors from the key informants for this population group mainly included "teen", "young", "and low-income". Age ranges indicated were 14-24, 16-21, 16-18 and 16-24 years. These findings were also supported by additional consultations with Ontario Society Nutrition Professionals in Public Health (OSNPPH) and the literature that was reviewed at that time.[63] Moreover, OSNPPH members identified low income parents and pregnant/postpartum females and/or females with children as a priority for food skills programming and two LDCP member health units identified young mothers as a priority for food skills programming.

After considering the information gathered along with the selection criterion, the following priority populations were chosen:[63]

1. High-school aged youth, at-risk, without kids, 16-19 years of age, male and female
2. Pregnant women or young women with children, 16-25 years of age, with at least one risk factor such as low-income or another Social Determinant of Health factor), may include newcomers or immigrants

After consulting with an academic advisor and other researchers, it was determined that the purpose of this new study would be to develop a tool to measure food literacy and its attributes within the context of public health practice with the same priority populations identified in the previous LDCP study (upon approval of renewed funding in year two and three, see research objectives below). By targeting specific population groups the requirement that opportunities for food skill development be provided to priority populations is being met. Furthermore, when a measurement tool is developed and ready to be tested, the criteria developed by the last LDCP will most likely apply again; for example, that the target populations are easily accessible through established relationships and community partnerships with public health staff, which will make the objectives for future research project specific, attainable and feasible.

B. RESEARCH QUESTION

Within the context of public health practice, how can we measure food literacy and its attributes, with a focus on specific high-risk groups of youth (16 to 19 years of age), young parents (16-25 years of age) and pregnant women (16 to 25 years of age)?

C. RESEARCH OBJECTIVES

Year 1 Funding:

1. To identify and summarize the attributes of food literacy including food skills in the literature.
2. To determine which attributes of food literacy including food skills, are priorities for measurement and tool development.

<u>The LDCP Team will apply for Year 2 and 3 renewed funding to accomplish the following objectives</u>:

3. To develop key indicators that measure food literacy including food skills attributes.
4. To develop a tool with questions reflecting these indicators.
5. To test the tool with the identified target populations, considering various facets of validity (e.g., attribute, face, and content) as well as reliability, sensitivity to change, and feasibility

Part 4. Methodology and Analysis Plan (6 pages maximum)

A. STUDY DESIGN

Overview of the LDCP Study Design

The first phase of the LDCP project is to conduct a scoping review of the literature using a systematic process to find and review relevant literature, both in published and grey literature that identifies attributes of food literacy including food skills. Data extrapolated from the literature will be collated and summarized into a comprehensive list of attributes which will be used in the next phase of this LDCP project which is to implement the Delphi Technique with an expert group of public health practitioners and other key informants involved in food literacy programming and delivery, including advocacy for food literacy and research, in the province of Ontario. Opinions from this expert group will be obtained and they will have the opportunity to reach consensus about the following: which attributes of food literacy are relevant in public health practice, the terms used to describe the various attributes of food literacy and to clarify terms used, any gaps in the list of attributes provided and which attributes are considered key or most important. The final outcome is to obtain a ranked list of key attributes of food literacy which will enable the LDCP team, upon renewed funding (year 2) to develop key indicators and a food literacy measurement tool that can be tested with identified priority populations (year 3).

Description of Phase One: Scoping Review

A scoping review is a type of literature review that "can be used to map the key concepts underpinning a research area as well as to clarify working definitions, and/or the conceptual boundaries of a topic".[64] This is an ideal method for the LDCP team to map the varying attributes of food literacy and to clarify and make sense of different terms used in the current definitions and/or conceptual models of food literacy. Also, as mentioned previously, varying definitions for food skills (i.e., food preparation, cooking skills, etc.) that may allude to or include the varying attributes of food literacy exist in the literature. This scoping review seeks to develop a "concept map" with the aim to explore how, by whom and for what purpose the term food literacy, including food skills (and/or derivatives of this term) are being used with the goal of determining how the term "food literacy" and/or "food skills" is used in the literature, what it refers to and what it encompasses (i.e., which attributes does it include).[65]

As described by Arksey and O'Malley,[65] scoping reviews are not guided by a highly focused research question (e.g., what is the effectiveness of food skills interventions) that lends itself to searching for particular study designs (as might be the case in a systematic review) but rather the scoping study method is guided by a requirement to identify all relevant literature regardless of study design. In this LDCP, ***the scoping review will build on identified key literature from the previous LDCP*** including the food literacy definition and conceptual model derived (see Appendix A), making this scoping review feasible.[34]

During the scoping review process, as team members become familiar with existing and new literature, search terms may be refined, other inclusion/exclusion criteria may be added making the process not linear but iterative. This type of research process requires researcher engagement at each step of the process and a flexibility and willingness to repeat steps to confirm comprehensive coverage of the evidence base.[65,66]

Research Question of the Scoping Review:

As discussed previously, a highly focused research question is not required,[65,66] however Levac and colleagues (2010) recommend that a research question be identified.[66] **For the purposes of this**

scooping review, the research question is objective #1 of this LDCP:

- To identify and summarize the attributes of food literacy including food skills identified in the literature.

Data Collection and Analysis of Scoping Review

The intention of the LDCP Team is to hire a Research Consultant who will conduct the research in collaboration with the LDCP Team and students. The step-by-step procedure to implement the scoping review is described in Table 1 (Appendix D) using the framework developed by Arskey and O'Malley and revised by Levac and colleagues.[65,66] The Research Consultant will commence in March 2016 once funding is approved; prior to this the literature will be selected and independently reviewed first by title and then by abstract by 2 individuals (e.g., one LDCP member and one student). Once the Research Consultant is hired, he/she will review full articles or full text literature along with one other LDCP team member independently. Individuals involved in the review of literature will be meeting to discuss approach and ensure consistency. A data extrapolation table will be developed and pilot tested by the Research Consultant and data will be will be extrapolated independently by the Researcher Consultant and one other LDCP team member (see Appendix D). The Research Consultant will conduct a qualitative thematic analysis; 1-2 LDCP team members will independently review data and thematic analysis findings for triangulation purposes. Research Consultant and LDCP members will meet and discuss findings and come to consensus regarding any disagreements. Findings will be shared and discussed with all members of the LDCP Team and a summary will result in a comprehensive list of food literacy attributes. Consultation from key stakeholders (who are also the knowledge users) will be obtained by implementing the Delphi Technique in the next phase of this study.

In addition to the review of literature, LDCP team members will be involved in the scoping review, for example:

- An Academic Advisor with expertise in scoping review process will provide consultation throughout the process;
- A designated librarian from a public health unit, will work collaboratively with the LDCP team to develop the search strategy and then search the databases and retrieve relevant articles;
- All LDCP team members will work together to develop search strategy including inclusion/exclusion criteria. As mentioned above, key articles and other literature have been identified and obtained as a result of the literature search and review that was conducted in the previous LDCP study on Food Literacy and the literature reviewed for this proposal.[34] The team will review the search terms and inclusion criteria that were previously used and add any new terms to ensure that all relevant published and unpublished literature has been retrieved for this scoping review. This will also add to the existing body of research/literature that already has been collected.
- Students include graduate level, undergraduate and Dietetic Interns. Many of the LDCP Team members have access to Masters level students and Dietetic Interns and supervise them on a regular basis and will have access to them for this project. Dietetic Interns are students who have completed their undergraduate degree and are currently meeting dietetic competencies through an internship to become a Registered Dietitian (RD). Typically in these placements, both the Master students and Dietetic Interns are not remunerated for their work. Students will be involved in assisting team members develop a search strategy, search terms and searching existing reference lists that have already been identified and independently reviewing selected studies/literature.

Description of Phase Two: Delphi Technique

The Delphi Technique is a structured, iterative process that utilizes a series of questionnaires or rounds administered to an expert panel to gather information and opinion with the purpose of reaching consensus on a problem.[67,68] This technique augments the rich discussion that is discovered from the literature, in this case, from the scoping review, by making it contextualized to public health in Ontario.

The Delphi Technique is a systematic and interactive method in which a panel of experts are provided with a series of questionnaires to which they respond. Through this process, information is gathered from the experts in the panel who are given the opportunity to review and re-evaluate their previous responses, taking into consideration the perspectives of other participants. During this series of questionnaires, responses, and synthesis of information gathered, the range of responses tends to decrease and the group congregates toward consensus. In order to reach consensus, three rounds of the Delphi Technique will be completed, as recommended by Keeney, Hasson, and McKenna.[68] Having no more than three rounds will also decrease the truancy of participants and ensure sufficient participation throughout the study.

The Delphi Technique allows the inclusion of a large number of individuals across a wide geographic location and expertise. A key advantage of this technique is that it gives every participant an equal voice and avoids the potential for one dominant voice to overtake the process, which can often be the experience in face-to-face consensus building exercises.[68]

The Delphi Technique will be implemented to meet objective #2 of this study: To determine which. attributes of food literacy including food skills, are priorities for measurement and tool development. A graphic overview of the Delphi Technique is provided in Figure 2 (see Appendix E).

Study Population for Delphi Technique:

The Expert Group will be a purposeful sample of possible participants that are key informants with expertise or knowledge in food literacy; including food skills, program delivery, advocacy and research both at a local and provincial level. Potential participants will be recruited from two groups, front line public health staff and non-public health key provincial external informants. Potential participants form these two groups may include but are not limited to the following:

Expert Group 1: Public health practitioners such as Registered Dietitians; food workers; peer workers; public health nurses; and public health promoters.

Expert Group 2: Non-public health practitioners such as Community Health Center Dietitians; academic researchers in food skills and food literacy; key informants from non-governmental agencies with a focus on food literacy (e.g., Community Food Centers; Sustain Ontario; Ontario Home Economics Association; Toronto Food Share); and key informants form educational agencies with a focus on food literacy (e.g., the Screaming Avocado secondary school culinary program, Growing Chefs Ontario).

Expert groups 1 and 2 will be combined to formulate one large expert group. Sampling different groups of experts may ensure a mixture of practitioners with an expertise in and/or knowledge about food literacy, including food skills. This is important to ensure the entire spectrum of opinion is determined. This expert group is also the target audience for an integrated knowledge exchange plan (see part 6) which means that these key informants of public health practitioners and other provincial experts are also the knowledge users and will be engaged throughout the project. This expert group will be directly affected by the research results and as such they may be more apt to participate in most or all rounds of the Delphi Technique as described in Table 2 (Appendix F).

Recruitment of Study Population
A step by step recruitment process is provided in Table 2 (Appendix F). Recruitment for both groups will occur simultaneously. Ideally, the total number of participants to secure for the Delphi Technique is 50. Attempts will be made to meet this goal by securing one person/representative per health unit for a total of 36 health unit participants to provide an aggregated response (when more than one staff person is involved in food literacy programming). LDCP team members have contact with other front line public health practitioners in their individual health units who are involved in food literacy programming and can coordinate an aggregated response for the fluid survey employed in the various rounds of the Delphi. Furthermore, two of the LDCP team members are co-leads of the larger provincial OSNPPH Food Literacy Working Group that represents 30 health units and can promote the study at bi-monthly meetings. Attempts will also be made to secure 10 to 15 external key stakeholders from Expert Group 2 above; again several of the LDCP team members do have professional relationships with several of these key stakeholders and will be the ones to personally reach out to them with a phone call and follow-up email. To assist in the recruitment of these participants a presentation of findings of the scoping review in an interactive and visually stimulating webinar for the purposes of sharing knowledge and to increase potential participants' interest, motivation, and commitment to participate in the study. Promotional posters and video will be developed to promote both the webinar and the upcoming study.

Data Collection Procedures and Analysis of Data:
Prior to commencing the Delphi rounds, the Research Consultant in collaboration with the Librarian and an Academic Advisor (with expertise in Delphi Technique) will be gathering of similar Delphi questionnaires with a focus in food literacy (e.g., City of Hamilton, New Zealand Research) and potential questions will be discussed in collaboration with the LDCP team members. Once the open-ended questionnaire tool is developed, it will be pilot tested with a similar sample (e.g., public health nurses). A LDCP team member(s) can assist with recruitment of participants for the pilot and to participate in pilot test to take debriefing notes. Open-ended questions serve as a foundation for soliciting specific information about additional food literacy attributes and opinions about the attributes already identified.

Information about the process for each of the three rounds and how the data will be analyzed is provided below and has been adapted from Hsu and Sandford (2007) and Keeney and colleagues (2001).[67,68] Data will be analyzed qualitatively, however quantitative data such as measures of central tendency (means, median, and mode) and level of dispersion (standard deviation and inter-quartile range) may be used to present information about the collection of responses and opinions of participants. This will be determined in consultation with the Research Consultant being hired for this project who will be required to have expertise and experience in primarily qualitative research and data analysis (and hopefully some quantitative data analysis).

As suggested in the literature the goal is to ensure 70% participation in each round which will involve LDCP team members sending reminder emails (with a promotional poster and/or video clip about the study) and if needed calls will be made, to participants between rounds to ensure their participation, as described in Table 2 (Appendix F).[67,68]

Round 1
The first round of the Delphi will commence in September 2016 as it is not feasible to begin a study during summer months. The questionnaire will be distributed online through Fluid Survey to all participants as potential participants are geographically dispersed throughout the province of Ontario. An online survey is also cost-effective and it provides anonymity of responses. Follow-up reminder emails to complete they survey will be provided weekly.

Qualitative data collected from the survey will be analyzed by the Research Consultant using a content analysis process and will involve using qualitative software (e.g., NVivo). Qualitative data collected from Round 1 will be analyzed by grouping similar items such as attributes together. When different terms are being used to describe a similar attribute, the researcher may group them together in an attempt to provide one universal description of the item. Using the classic Delphi analysis process, no item will be added during analysis and the wording used by the participants will remain verbatim. The findings will be used to develop a more structured questionnaire that will be implemented with participants in Round 2. To ensure the trustworthiness of the data being analyzed, a graduate level student will be hired to independently review and analyze the data collected and meet with the Research Consultant to discuss the process and any disagreements with the findings. Data analyzed will be shared and discussed with the LDCP team to obtain further feedback and to work collaboratively on the questions for round 2 of the Delphi. ***This process for data analysis will be similar for rounds 2 and 3 below (and roles and timing are further described in Table 2, Appendix F).***

Round 2

Each participant receives a second questionnaire and is asked to review the items summarized from Round 1. Participants are asked to rate or rank attributes to establish preliminary priorities among items. Participants will be asked to provide rationale with respect to their rating priorities among the attributes selected. Areas of agreement and disagreement will be identified in Round 2.

Round 3 .

Each participant receives a questionnaire that includes the ranked attributes summarized by the Research Consultant in collaboration with LDCP Team. Each participant is asked to revise his/her opinions or to provide a rationale for remaining outside the consensus. Further clarifications of both the information and opinions of the relative importance of each attribute will be made in this round with a Likert-type scale (with a rating of strongly agree to strongly disagree). Prior to implementing this round, the Research Consultant in collaboration with the LDCP team will need to discuss and come to a decision about the percentage of responses that need to fall within a prescribed or predetermined range. It suggested that 70-80% of the responses should fall within the top two points of a Likert scale.[67,68]

B. ETHICAL CONSIDERATIONS

All ethics submission forms will be provided by Public Health Ontario (PHO) and completed for ethical approval by PHO. If required, ethical review by individual health units will also be completed. All data gathered will be kept in secured computer files with all computer data encrypted and password protected. Only the LDCP members will have access to the data. All data collected will be used only in aggregate form. An information letter including consent will be provided to all individuals participating in the Delphi process. The participants may be known to one another but their judgments and opinions will remain anonymous (cited as "quasi anonymity") and participation voluntary (all information will be provided in the letter of information, see Appendix G). The Lead Health Unit will retain data 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.

During the data analysis process, a number of strategies will be employed to ensure the trustworthiness of the findings including member-checking, peer-debriefing, and multiple coders.[69] For example, during the scoping review literature will be reviewed independently by 2 individuals as well as the analyzed data from each round of the Delphi. During the independent reviews, individuals will meet to discuss the approach used to ensure consistency.

A. FEASIBILITY CONSIDERATIONS

Several members of the LCDP team have been involved in a Locally Driven Collaborative Project in the past. As a result, team members have had significant experience in the LDCP process (e.g., hiring a Research Consultant, conducting the research, meeting deliverables in a timely fashion, completing data collection and analysis, etc.). In-kind contributions from LDCP members also make this project feasible and include the following: content expertise in the area of the food literacy; skill and expertise in conducting research; financial support from individual health units for travel and other related expenses (most); and dedicated time. Some members have indicated an interest in professional learning development and want to work collaboratively with the Research Consultant to review literature and extrapolate data independently.

In addition to the in-kind contributions form LDCP team members above, the project will involve students to assist with both the scoping review and a graduate student will be hired to provide research assistance during the Delphi. Although, a scoping review may take a significant amount of time, this project builds on the previous LDCP project in that much of the relevant literature has been identified for review as a result of an extensive literature search conducted two years ago as a result LDCP team members do not anticipate to have an overwhelming amount of new literature to review.[34] Finally, the project objectives are very concise and succinct making them very feasible within the one year timeframe.

B. STUDY LIMITATIONS

There is a need to consider the potential for truancy with every round in the Delphi Technique. To mitigate the **possible challenge of low motivation/response rate**, an integrated knowledge exchange plan is being implemented, as the members of the expert group are the knowledge users (i.e., public health practitioners and other non-health unit key stakeholders) and will be inherently motivated to participate. Also, to engage participants from the beginning of the study and obtain their interest in participation, a webinar will be provided to share information about the scoping review and upcoming Delphi study and ongoing emails and calls will be sent or made prior to the start of and during the Delphi rounds. Secondly, although the selection of the study population is purposeful, **selection bias** is being mitigated by having an expert group of key informants that include both public health and non-public health participants. Additionally, each response from agencies engaging in this process is encouraged to be a collective response to elicit the opinions and perspectives from a variety of individuals rather than just from one. Thirdly, **subject bias** may occur because the participants will know the group's responses and may change their opinions to come align with what other participants' opinions; however the Delphi process provides the opportunity for participants to consider opinions they may not have thought of before and knowing others' responses may lead to consensus more easily. Finally, the **time required to conduct the Delphi Technique** can be time consuming and laborious. Because the Delphi Technique is iterative and sequential, it is necessary to dedicate a sufficient amount of time to share information, solicit participant feedback, analyze the feedback, and share the information back for subsequent rounds. To mitigate the limitation of time, LDCP team members will be responsible for all the recruitment and a graduate level student will be hired to provide assistance to the Research Consultant. A reasonable amount of time is being built, for example, five weeks have been allotted for each of the first two rounds and the final round has more flexibility for time (8 weeks but this could be extended).

Part 6. Knowledge Exchange Plan (1 page maximum)

*** Letters of Support are needed for each listed knowledge user and/or advisor** (See Section 9)

KNOWLEDGE USER(S) & ADVISORS*	
Organization: Windsor-Essex County Health Unit	**Individual Name:** Karen Bellemore **Email Address:** kbellemore@wechu.org
Address: 1005 Ouellette Avenue Windsor, ON N9A 4J8	**Individual Name:** **Email Address:**
Organization: Peterborough County-City Health Unit	**Individual Name:** Carolyn Doris **Email Address:** cdoris@pcchu.ca
Address: 10 Hospital Drive Peterborough, ON K9J 8M1	**Individual Name:** **Email Address:**
Organization: Oxford County Public Health	**Individual Name:** Kelly Ferguson **Email Address:** kferguson@oxfordcounty.ca
Address: 410 Buller Street Woodstock, ON N4S 4N2	**Individual Name:** **Email Address:**
Organization: Hastings Prince Edward Public Health	**Individual Name:** Elizabeth Finlan **Email Address:** efinlan@hpeph.ca
Address: 179 North Park Street Belleville, ON K8P 4P1	**Individual Name:** Diana Chard **Email Address:** dchard@hpeph.ca

Organization: Ottawa Public Health **Address:** 100 Constellation Cres. Ottawa, ON K2G 6J8	**Individual Name:** Sonia Jean-Philippe **Email Address:** sonia.jean-philippe@ottawa.ca **Individual Name:** **Email Address:**
Organization: North Bay Parry Sound District Health Unit **Address:** 681 Commercial Street North Bay, ON P1B 4E7	**Individual Name:** Alexandra Lacarte **Email Address:** Alexandra.Lacarte@nbpsdhu.ca **Individual Name:** Jessica Love **Email Address:** Jessica.Love@nbpsdhu.ca
Organization: Thunder Bay District Health Unit **Address:** 999 Balmoral Street Thunder Bay, ON P7B 6E7	**Individual Name:** Catherine Schwartz **Email Address:** catherine.schwartz@tbdhu.com **Individual Name:** Kim McGibbon **Email Address:** kim.mcgibbon@tbdhu.com
Organization: Grey Bruce Health Unit **Address:** 101 - 17th Street East Owen Sound, ON N4K 0A5	**Individual Name:** Laura Needham **Email Address:** l.needham@publichealthgreybruce.on.ca **Individual Name:** **Email Address:**
Organization: Nutrition Resource Centre at the Ontario Public Health Association **Address:** 44 Victoria St #502, Toronto, ON M5C 1Y2	**Individual Name:** Lynn Roblin **Email Address:** lroblin@opha.on.ca **Individual Name:** **Email Address:**

Organization: University of Waterloo *ACADEMIC ADVISOR	Individual Name: Sharon Kirkpatrick Email Address: sharon.kirkpatrick@uwaterloo.ca
Address: 200 University Avenue West Waterloo, ON, Canada N2L 3G1 Office: LHN 1713	Individual Name: Email Address:

As already mentioned in this proposal, this LDCP project is implementing an integrated knowledge exchange plan whereby the expert group of participants in the Delphi Technique are the end users of the information and knowledge obtained in which the final outcome is a ranked list of key attributes of food literacy that will be used to develop key indicators and a measurement tool. Furthermore, the members of the LDCP team are also knowledge users as explained below.

TARGET AUDIENCE OR KNOWLEDGE USERS

1. The expert group of potential participants for the Delphi Technique phase of this project that have expertise and/or knowledge in food literacy or are involved in food literacy, including food skills, program delivery, research and/or advocacy. Members of this expert group, who are also knowledge users, include the following:

- **Front line public health practitioners** such as Registered Dietitians, food workers, peer workers, public health nurses and public health promoters who are involved in food skills and/or food literacy programming planning and delivery including advocacy efforts to provide local programming.
- **Non-public health practitioners** such as Community Health Center Dietitians; academic researchers in food skills and food literacy; key stakeholders from non-governmental agencies with a focus on food literacy (e.g., Community Food Centers; Sustain Ontario; Ontario Home Economics Association; Toronto Food Share); and key stakeholders form educational agencies with a focus on food literacy (e.g., the Screaming Avocado secondary school culinary program, Growing Chefs Ontario)

2. Members of the LDCP team are also the knowledge users. Most of the members are front line public health practitioners assigned to food skills and/or food literacy programming and three members are involved in research and evaluation.

OBJECTIVES OF THE INTEGRATED KNOWLEDGE EXCHANGE PLAN:

1. To engage knowledge users throughout the project
2. To share findings from the scoping review and increase knowledge about the attributes of food literacy, including food skills found in the literature
3. To recruit knowledge users to participate in the Delphi Technique
4. To consult with knowledge users and gather their opinion about the list of food literacy attributes and reach consensus about the most important attributes

INTEGRATED KNOWLEDGE EXCHANGE APPROACH

- **To engage knowledge users throughout the project**: LDCP members have are engaged in the project from beginning to end for example, preparing this proposal, leading or supporting the implementation of the activities and providing consultation. In participating in this project, LDCP team members will increase their professional knowledge about attributes of food literacy in the literature and what is ranked as most important. Other public health practitioners and non-public

health practitioners will be invited to participate in a webinar and in the Delphi process.

- **To share findings from the scoping review and increase knowledge about the attributes of food literacy & to recruit knowledge users to participate in the Delphi process**: All knowledge users identified above will be invited to participate in a webinar; the webinar will also be a strategy to recruit knowledge users to participate in the Delphi process. Several members of the LDCP have a professional relationship with non-public health key stakeholders and can contact them personally as a recruiting strategy. LDCP members also have contact with other front line public health practitioners in their individual health units who are involved in food literacy programming and can recruit them to participate in the webinar and coordinate an aggregated response for the fluid survey employed in the various rounds of the Delphi.
- **To consult with knowledge users and gather their opinion about the list of food literacy attributes and reach consensus about the most important attributes**: The above knowledge users will be invited to participate in the Delphi Technique to gather their feedback about which attributes of food literacy are relevant in public health practice, the terms used to describe the various attributes of food literacy and to clarify terms used, any gaps in the list of attributes provided and which attributes are considered key or most important.

Part 7. Research Results (2 pages maximum)

A. EXPECTED OUTCOMES

After the completion of the scoping review a summarized comprehensive list of attributes of food literacy including food skills will be produced that will be used to obtain opinion from public health and non-public health practitioners of food literacy programming and/or service delivery, including advocacy and research, in Ontario. The outcome from implementing the Delphi Technique is a final ranking of key or priority attributes of food literacy reached by consensus of these experts who are also the end knowledge users of the information. Ranked list will be used to develop key indicators and measurement tool that can be tested with identified priority populations (year 2 and 3 of renewed funding).

B. TIMELINE

Milestone or Deliverable: RFP and other tools to hire a research consultant prepared

Description of Activity: Create RFP, revise screening tool/matrix to score RFPs (from last LDCP on Food Skills), develop interview questions for potential candidates.

Duration in Weeks: 6 weeks (starting Dec 2015) **Completion Date: Jan 4, 2016**

Milestone or Deliverable: 2 Research Consultants recruited and hired (one the scoping review and one for the Delphi Technique)

Description of Activity: Disseminate 2 RFPs, recruit and interview potential candidates. Research Consultant to conduct a scoping review could also be a PhD or post doctorate student that could be hired as a Research Consultant; to start mid-March. Research Consultant to conduct the Delphi to start beginning of Aug 2016.

Duration in Weeks: 8-10 weeks (starting Jan 2016) **Completion Date: By End of March, 2016**

Milestone or Deliverable: Consultation with a survey research unit/survey methodologist regarding the Delphi completed

Description of Activity: To source out a survey research unit and get a consultation regarding RFP for the Research Consultant, secondly to get input about the potential formats and uses for a measurement tool and a recommendation the purpose of the tool; and finally to get input about the methodology and data analysis for the Delphi.

Duration in Weeks: 10 weeks (starting Jan 2016) **Completion Date: End of March, 2016**

Milestone or Deliverable: Ethics Submission Form(s) submitted to PHO and Health Units

Description of Activity: Prepare ethics submission form and other information for ethics review such as revised sample letter of information and questionnaire for Delphi participants.

Duration in Weeks: 10 weeks (starting Jan 2016) **Completion Date: End of March, 2016**

Milestone or Deliverable: Promotional material for recruitment and KE event developed

Description of Activity: Small working group to work with a graphic designer and videographer (in-kind from HKPRDHU) to develop promotional poster and video for webinar and Delphi study and template slides for webinar

Duration in Weeks: 12 weeks (starting Jan 2016) **Completion Date: Apr 1, 2016**

Milestone or Deliverable: Relevant literature identified and selected for scoping review.

Description of Activity: LDCP team (and students) and Librarian develop search strategy, search terms and inclusion/exclusion criteria. Relevant literature is retrieved for review.

Duration in Weeks: 4-6 weeks (starting Jan, 2016) **Completion Date: End of Feb, 2016**

Milestone or Deliverable: Screening of selected studies and literature by title and abstract.

Description of Activity: 2 LDCP team members (or one LDCP team member and one student) will act as the two independent screeners who are trained and given clear inclusion/exclusion criteria– they concurrently screen titles and abstracts. A few pilots (e.g., the first of 20 then the next 40 and then after a 100 articles/literature) are conducted to check for consistency by discussing approach between screeners and coming to consensus and resolution about any difficulties and disagreements. Two screeners meet throughout the process with a third experienced person verifying the screening.

Duration in Weeks: 3 weeks (starting Feb, 2016) **Completion Date: Mid-Mar, 2016**

Milestone or Deliverable: Data extrapolation table developed and pilot tested

Description of Activity: In collaboration with the LDCP team, the Research Consultant will develop an extrapolation table with specific variables or data (to be determined for inclusion) and pilot tested with a few articles.

Duration in Weeks: 6-8 weeks (starting in Mar, 2016) **Completion Date: End of April, 2016**

Milestone or Deliverable: Review of full text articles/literature selected after first screening

Description of Activity: 2 LDCP team members concurrently screen the full text of that article/literature that passed the first screen above. Screeners will meet throughout the process with a third experienced person to verify the screening and ensure consistency (e.g., the LDCP Academic Advisor experienced in scoping reviews or the Research Consultant if he/she has experience).

Duration in Weeks: 4-6 weeks (starting in Mar, 2016) **Completion Date: End April, 2016**

Milestone or Deliverable: Data from selected articles and/or literature is extrapolated

Description of Activity: The final pools of selected articles/literature are divided between the Research Consultant and one LDCP team member who independently extrapolate data and populate the extrapolation table. This process occurs concurrently whereby both people extract data at the same time. Much verification and checking will occur throughout this process by a third experienced person (or more members of the LDCP team, TBD) to ensure the approach used is consistent and that the research question is being addressed by the literature selected for inclusion in the data extraction table.

Duration in Weeks: 4-6 weeks weeks (starting in Apr, 2016) **Completion Date: End of May, 2016**

Milestone or Deliverable: Thematic analysis completed and a comprehensive list of food

literacy attributes developed

Description of Activity: Research Consultant to complete a thematic analysis of the extrapolated data and to discuss findings with the LDCP team.

Duration in Weeks: 4-6 weeks (starting in May, 2016) **Completion Date: End of June, 2016**

Milestone or Deliverable: Study participants recruited

Description of Activity: Recruiting public health practitioners at monthly OSNPPH Food Literacy Working Group starting in April and at the May Nutrition Exchange Conference by promoting June webinar and follow-up with reminder emails and promotional poster and video clip for webinar. Concurrently, LDCP team members to recruit external key informants (non- public health unit staff) by email and follow-up phone calls and provide promotional poster and video clip for webinar in June.

Duration in Weeks: 12 weeks (starting in Apr, 2016) **Completion Date: End of June, 2016**

Milestone or Deliverable: KE webinar developed, hosted and recorded

Description of Activity: Research Consultant to provide findings from the scoping review to the webinar template and deliver webinar to all potential participants. Webinar participants (who are also knowledge users) will be invited to participate in the Delphi Process. Provide link to recorded webinar to those potential participants who cannot participate in the webinar at the end of June to view recording at their convenience between July-Sept 2016.

Duration in Weeks: 2-3 weeks (starting in June, 2016) **Completion Date: Last week of June, 2016**

Milestone or Deliverable: Develop a summary report of the scoping review

Description of Activity: Research Consultant produces a summary report describing research methodology and key findings including list of food literacy attributes. Research Consultant and/or Student works collaboratively with the LDCP team to provide drafts for review and make edits as required.

Duration in Weeks: 6-7 weeks (starting end of June) **Completion Date: Mid-August, 2016**

Milestone or Deliverable: Data analysis plan for data collected from the Delphi rounds

Description of Activity: Develop and a data analysis plan describing any quantitative data measures that need to be conducted, measure of agreement between the different definitions of the food literacy attributes and how post grad/master student will be employed to assist with increasing the trustworthiness of the qualitative data analyzed

Duration in Weeks: 4 weeks (starting in Aug) **Completion Date: End of August, 2016**

Milestone or Deliverable: Masters/Post Grad student to assist with qualitative data collection and analysis hired

Description of Activity: Disseminate RFP, recruit and interview potential candidates.

Duration in Weeks: 20 weeks (starting in April, 2016) **Completion Date: End of August, 2016**

Milestone or Deliverable: Delphi questionnaire developed and pilot tested for round 1

Description of Activity: Develop and pilot test open ended question for round 1 of Delphi with a similar group of health professionals (e.g., public health nurses not part of the study)

Duration in Weeks: 4 weeks (starting in Aug, 2016) **Completion Date: September 9th, 2016**

Milestone or Deliverable: Study participants confirmed and letter of information provided

Description of Activity: Follow-up with webinar participants and other health unit practitioners and external experts that did not participate in the webinar. Send out promotional material for the study each week after the webinar (and potential video clip). Confirm list of participants for the study and provide link to webinar and letter of information/ consent. Send out reminder email about study at the beginning of September.

Duration in Weeks: 10 weeks (starting in June) **Completion Date: September 9, 2016**

Milestone or Deliverable: Round 1 of Delphi data collection and analysis completed

Description of Activity: Disseminate questionnaire via fluid survey starting Sept 12, sending out reminder emails prior to implementing round 1 and a weekly email after dissemination of questionnaire. Research Consultant in to analyze data and in collaboration with the LDCP team prepare feedback & revised questionnaire for round 2.

Duration in Weeks: 5 weeks (starting in Sept, 2016) **Completion Date: October 14th, 2016**

Milestone or Deliverable: Round 2 of Delphi data collection and analysis completed

Description of Activity: Disseminate questionnaire via fluid survey starting Oct 17th, sending out reminder emails prior to implementing round 2 and a weekly email after dissemination of questionnaire. Research Consultant to analyze data and in collaboration with the LDCP team prepare feedback & revised questionnaire for round 3.

Duration in Weeks: 5 weeks (starting in Oct, 2016) **Completion Date: Nov 18th , 2016**

Milestone or Deliverable: Round 3 of Delphi data collection and analysis completed

Description of Activity: Disseminate questionnaire via fluid survey starting Nov 21st, sending out reminder emails prior to implementing round 3 and a weekly email after dissemination of questionnaire. Research Consultant in to analyze data with the assistance of a student and to discuss findings with LDCP Team.

Duration in Weeks: 6 weeks (starting in Nov, 2016) **Completion Date: End of December, 2016**

Milestone or Deliverable: Ranked list of food literacy attributes completed

Description of Activity: Research Consultant completes final thematic analysis and derives a list of ranked key attributes.

Duration in Weeks: 8 weeks (starting in Nov, 2016) **Completion Date: Mid-January, 2017**

Milestone or Deliverable: Summary Report completed

Description of Activity: Research Consultant produces a summary report describing research methodology and key findings including list of ranked key attributes and works collaboratively with the LDCP team to provide several drafts for review and make edits as required.

Duration in Weeks: 8 weeks (starting in Jan, 2017) **Completion Date: Feb 29, 2017**

Milestone or Deliverable: KE products developed and KE events attended

Description of Activity: Research Consultant in collaboration with LDCP team will write

abstracts for KE events that target end knowledge users and work collaboratively with the LDCP team on the development of other KT products, e.g., peer reviewed journal article(s), info graphic, etc.	
Duration in Weeks: 6 months (starting in Jan, 2017)	**Completion Date: June, 2017**

Part 8. Core Project Team (1 page maximum)

This LDCP research team comes to the table with an extensive background in food literacy. Every member in the core team has food skills and/or food literacy as a key portfolio component in their work in public health. Moreover, several core team members participated in the previously funding LDCP Food Literacy project. This team is well resourced with key members of the core team having significant graduate level education (both Masters' degrees and one member has her PhD). As such, this team utilizes a research focus and critical thinking when approaching research projects for the public health context. The two co-leads for this project (Elsie Azevedo Perry and Heather Thomas) have received permission to have a significant amount of dedicated time to this specific project. As such, there is confidence that the deliverables are accomplished in a timely fashion and the entire team is kept on schedule. Details about each core team member's role on the project are below:

Elsie Azevedo Perry (Financial & Project Lead)

- Leads the day-to-day activities of project implementation
- Administers and effectively manages project funds
- Submits interim and final activity and financial reports to PHO
- Ensures all milestones are met
- Serves as the signatory to the transfer payment agreement
- Lead for the previous LDCP
- Involved in the Study Design Working Group, Budget and overall review

Heather Thomas (co-lead)

- Member of Healthy Eating Core Team
- Involved in Study Design Working Group and Literature Review Working Group
- Liaise with OSNPPH Food Literacy Working Group (and past Chair of OSNPPH)
- Provide assisting in managing the project implementation

Rebecca Davids (core)

- Member of Healthy Eating Core Team
- Member of Literature Review working group and past Chair of OSNPPH

Lyndsay Davidson (core)

- Member of the Healthy Eating Core Team

Jessica Love (core)

- Member of the Healthy Eating core team and OSNPPH Food Literacy working group
- Involved in Knowledge Exchange Working Group

Ruby Samra (core)

- Member of the Healthy Eating Core Team
- Has expertise in budgeting and experience with conducting the Delphi Technique
- Co-chair the Ontario Society of Nutrition Professionals in Public Health Food Literacy Working Group (along with Elsie Azevedo Perry).

Julie Slack (core)

- Member of the Healthy Eating Core Team
- Involved in the Literature Review Working Group

Amy Faulkner (knowledge user)

- Lead librarian on the project
- Will contact the librarians from the other health units involved in the project for support

Lynn Roblin (knowledge user)

- Representative of the Nutrition Resource Center, OPHA
- Focus on knowledge exchange and capacity building related to healthy eating

<table>
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- Involved in the Study Design Working Group
- Co-chair of the Food Security Workgroup for OSNPPH

Shannon Edmonstone (core)

- Member of the Healthy Eating Core Team
- Involved in the Study Design Working Group

Jessica Hambleton (core)

- Member of the Healthy Eating Core Team and OSNPPH Food Literacy working group
- Involved in the development of the research question and the objectives
- Member of Literature Review working group

</td><td>

nutrition policies and programs at the local and provincial level

- Ares of work include food systems, food environment, food literacy, and healthy children

Sharon Kirkpatrick (academic advisor)

- Expertise and knowledge in scoping reviews and conducting research
- Member of the Study Design Working Group

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Other Knowledge Users:

- **Kelly Ferguson** provided consultation regarding study design
- **Carolyn Doris** has extensive experience in advocating for and implementing food literacy programming (health unit has peer workers)
- **Catherine Schwartz, Karen Bellemore, Elizabeth Finlan and Alexander Lacarte** are supporting the project by providing consultation and review of work being completed. Also, Catherine works with Kim McGibbon, RD who has experience in developing a validated tool (i.e., NutriStep) and can liaise with her colleague to get more input and information.
- **Sonia Jean Phillippe** has research experience and is interested in being involved in the providing input and consultation regarding implementing the scoping review and Delphi and reviewing data

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Part 9. Attachments

Please indicate whether you have attached the following items:

Budget (REQUIRED): see attached

Letters of Support (REQUIRED – please list): By Oct 26th

Tables and Figures (optional – please list if included):
Appendix A –Figure 1: What determines food literacy?
Appendix B- Food Literacy: A Call to Action
Appendix C- Selection Criterion for Priority Populations
Appendix D- Table 1: Scoping Review Procedure
Appendix E- Figure 2: Overview of the Delphi Process
Appendix F- Table 2: Delphi Technique Procedure
Appendix G- Sample Information Letter

Other (e.g., references, questionnaires, consent forms - please list if included):

See Appendix G for Sample Information Letter

Part 10. Signatures

LEAD HEALTH UNIT - AUTHORIZED REPRESENTATIVE

I warrant that the information in this submission form is complete and accurate to the best of my knowledge and that it reflects the collective intentions of the collaborative team. I acknowledge that as the lead health unit, my organization has the intention to enter into a Transfer Payment Agreement with Public Health Ontario that reflects the roles and responsibilities of the lead health unit as described by the Locally Driven Collaborative Projects (LDCP) and the Cycle 3 LDCP Participation Guidelines.

Lead-Applicant Name: Elsie Azevedo Perry **Title: Public Health Nutritionist**	**Signature of Lead Health Unit- Official Representative:** **Date:** **Name:** **Title:**

SUPPORTING HEALTH UNIT - AUTHORIZED REPRESENTATIVE

(include additional signature boxes, if required)

I warrant that the information in this submission form is complete and accurate to the best of my knowledge and that it reflects the collective intentions of the collaborative team.

Co-Applicant Name: Dr. Heather Thomas **Title: Public Health Dietitian**	**Signature of Supporting Health Unit Official Representative:** **Date:** **Name:** **Title:**

CO-APPLICANT HEALTH UNIT - AUTHORIZED REPRESENTATIVE

(include additional signature boxes, if required)

I warrant that the information in this submission form is complete and accurate to the best of my knowledge and that it reflects the collective intentions of the collaborative team.

Co-Applicant Name: **Title:**	**Signature of Co-Applicant Health Unit Official Representative:** **Date:** **Name:** **Title:**

CO-APPLICANT ACADEMIC OR COMMUNITY ORGANIZATION - AUTHORIZED REPRESENTATIVE

(include additional rows, if required)

I warrant that the information in this submission form is complete and accurate to the best of my knowledge and that it reflects the collective intentions of the collaborative team.

Co-Applicant Name: **Title:**	**Signature of Co-Applicant Academic or Community Organization Official Representative:** **Date:** **Name:** **Title:**

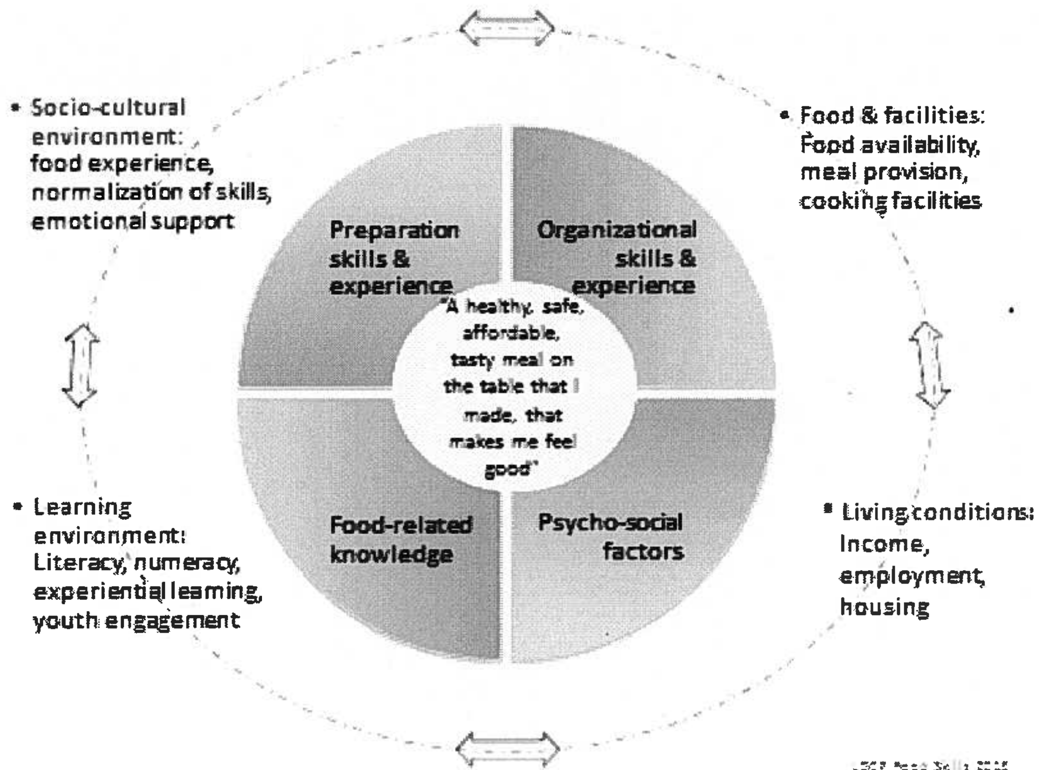
DEADLINE

The LDCP Submission Form is due to Public Health Ontario on **October 30th, 2015 at 4:00 pm EDT**. Please send **ONE** email with all of the submission documents to: LDCP@oahpp.ca

-APPENDIX A-

Figure 1: What Determines Food Literacy?

(Desjardins et al. 2013)



APPENDIX B- Food Literacy: A Call to Action

"Food Skills" – A requirement for Ontario Public Health Units

Food skill development and healthy eating practices are requirements for the promotion of health and prevention of chronic disease in the 2008 Ontario Public Health Standards (OPHS) (1). Specifically, health units in Ontario are required to provide opportunities for skill development in the areas of food skills and healthy eating practices for priority populations (1).

In the Ministry of Health Promotion's Guidance Document: *Healthy Eating, Physical Activity and Healthy Weights* (2), food skills is defined as a "complex, interrelated, person-centred set of skills that are necessary to provide and prepare safe, nutritious, and culturally-acceptable meals for all members of one's household" (3). This definition was based on Short's qualitative study with 30 domestic cooks living in England which derived a systematic framework for domestic cooking. According to Short (3), food skills encompass the following five general categories:

- Knowledge (nutrition, label reading, food safety, food varieties, ingredients, substitution);
- Planning (organizing meals, budgeting, food preparation, teaching food skills to children);
- Conceptualizing food (creative thinking about leftovers, adjusting recipes);
- Mechanical techniques (preparing meals, chopping/mixing, cooking, following recipes); and,
- Food perception (using your senses – texture, taste, when foods are cooked).

The importance of food skills

Food skills have been cited in the literature to be important for several reasons with respect to health including knowledge, empowerment, engagement, culture, food security and fun (4-7). There is some evidence that healthy eating, cooking skills, and health are linked (4-7), however, the assumption is often made that increased or enhanced food skills and greater food preparation from raw ingredients can lead to improved health outcomes. To date, there is limited high quality research to demonstrate this direct cause and effect (8). Nutrition education alone is likely not adequate to improve dietary intake, in fact, In 2010, Health Canada reported that "food skills interventions may be a useful starting point for initiating dietary change" (9)

The decline in food skills or "deskilling"

In North America, cooking skills are eroding, or at the very least, are in transition. That is, the foods people cook, the food preparation skills they use, and where they cook are influenced by social, economic, and cultural contexts (5, 6, 11), which are constantly changing. The reported decline in food skills in North America (12) could be attributed to several factors including but not limited to: an increase of and normalization of pre-prepared, packaged and convenience foods (9), as well as a high consumption of processed foods (e.g., foods that are packaged and more highly processed than their whole state and as a result are higher in fat, sugar, sodium, and/or preservatives) that are generally associated with poorer health outcomes (13, 14-16).

Eating away from home has replaced cooking in the home as Canadians are reporting eating in restaurants or take-out two to three times weekly (17, 18). In addition, the amount of time spent to prepare meals has been declining significantly since the early 1900s (19, 20) as an eight-fold decrease (from six hours to 45 minutes) has been observed in the average daily time spent on meal preparation (19, 20). Although modern conveniences, such as microwaves ovens, have helped to reduce food preparation times, the predominant change in eating patterns and meal preparation culture can be attributed to other factors. The main influencers of the erosion of food skills include the majority of adults working outside of the home, a general increase in work-week hours, busier lifestyles, and a change in social norms, values, and attitudes (19, 20).

As well, some researchers contend that a decline in domestic food preparation skills has resulted in a "deskilling", due to a lack of introduction and opportunity to acquire cooking skills from parents, grandparents, or school environments (3, 5, 11, 21). This is supported by the recent research conducted in Ontario with youth and young parents whereby participants who had greater food skills had learned them primarily from parents, grandparents, siblings, or relatives (22). Learning these skills at an earlier age (seven to 12 years of age) was also found to contribute to a greater confidence in food preparation in later years (22). Over half of the participants in a study by Desjardins and colleagues (22) also indicated that the best way for young people to learn food skills if they did not learn at home were cooking classes, both in school and in the community.

Some experts also theorize that other factors such as changes in the physical environment, food system, and types of food available have an impact on perceived food skills (5). A few studies have examined food skills and/or literacy knowledge in the context of local farms and farmers' markets including how the local food context facilitated the ability to select, prepare, cook, store, and enjoy foods prepared from raw ingredients or from 'scratch' (i.e., fresh ingredients that are not pre-packaged or prepared by a food manufacturer) (23, 24, 25).

From food skills to food literacy

In the Guidance Document: Healthy Eating, Physical Activity and Healthy Weights (2), the focus of food skills is on skill development and education, yet in reference to the food skills, it does state that "regardless of the definition, all interventions undertaken to build food skills must be in line with the target population's level of access to healthy foods (2)." While describing cooking skills, Short contends that it is "incorporating more than just practical, technical ability" but rather a complex interrelationship among cooking practices and abilities, skills, approaches to cooking and that cooking equipment plays a role (3). Furthermore, a food skill is multidimensional and demands special attention when applied to unique populations such as youth, low-income, and pregnant or post-partum women (3). Though the term "food literacy" is not used, cooking is referred to as a complex interrelationship between cooking skills and approaches. Reference is being made to a broader context that needs to be considered in this field. Previous literature also cites that there are various personal, social, and economic factors, including attitudes, beliefs, and confidence, that impact food choice and preparation (8).

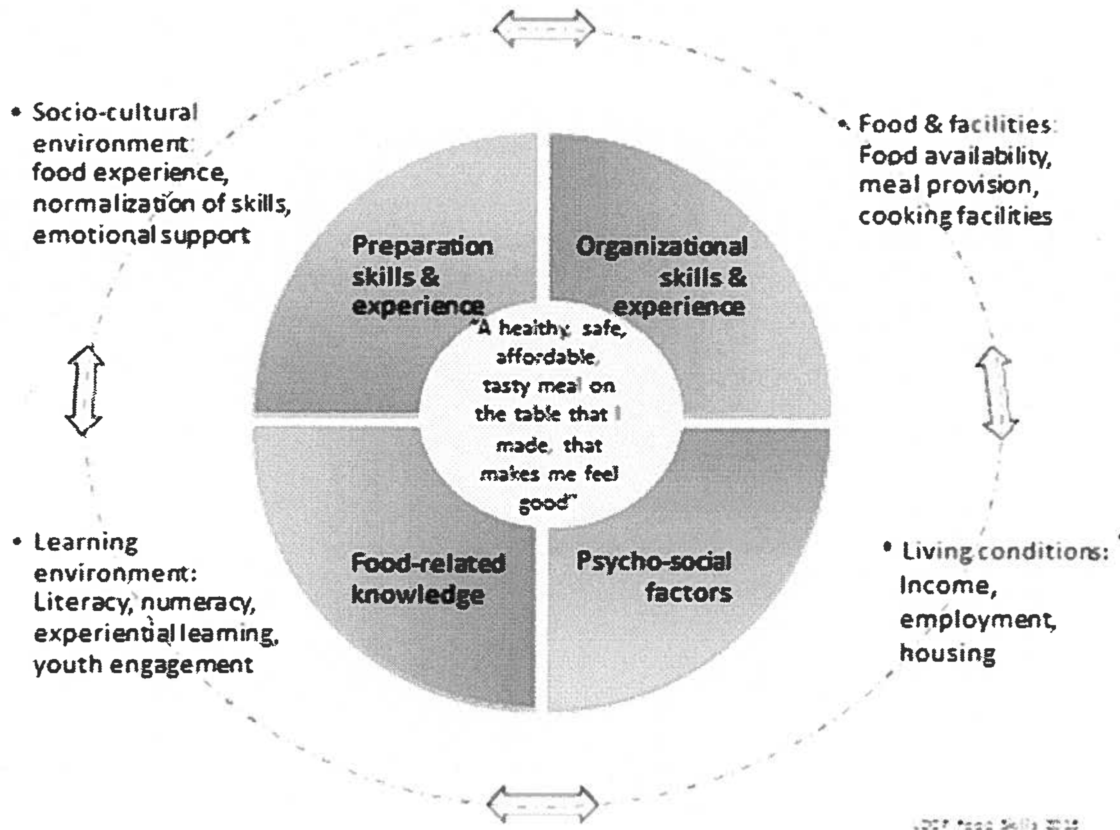
The information above illustrates two things. First, that there is no explicit or widely agreed upon definition for the concept of "food skills" or an expanded concept like food literacy. Authors in most of the literature prior to 2011 use terms such as "cooking skills" (3, 11) or "culinary skills" (8), and others discuss "food preparation" (3, 13, 26, 27) or "food skills" (2, 9). Secondly, although the term "food literacy" is not used explicitly ***in the previous cited literature, there is some hint or tendency towards the concept of food literacy*** because there is the mention of other external or environmental factors (e.g., access to healthy foods, cooking equipment, social and economic factors, confidence, etc.) that impact cooking or food skills at an individual level and that needs to be considered.

The word **'literacy'** is more than the ability to read or interpret the written word. In the health context, it is being redefined to include ***a broader set of attributes*** that enable people to understand, navigate and function within various environments in a health-enhancing way. A systematic review of definitions and models of health literacy found that "enhancing health literacy can allow for great autonomy and empowerment, leading towards greater quality of life" (28). Health literacy builds on the idea that both health and literacy are critical resources for everyday living and that our level of health literacy directly affects our ability to not only to act on health information but also to take more control of our health as individuals, families and communities.

The term "food literacy" has emerged in the literature and from practice based research mostly since 2011 as a relatively new concept. A Locally Driven Collaborative Research Project (LDCP) with eight health units in Ontario was conducted with at-risk youth (teens aged 16 to 19 years, and young parents including pregnant women aged 16 to 25 years) to understand the meanings and practices of food skills (22). The findings generated a definition and a conceptual model of "food literacy" that can inform both policy development and public health as well as school-based and community programming (Figure 1). The definition of food literacy proposed by the LDCP research team is as follows (22):

- Food literacy is a set of skills and attributes that help people sustain the daily preparation of healthy, tasty, affordable meals for themselves and their families;
- It builds resilience, because it includes food skills (techniques, knowledge and planning ability), the confidence to improvise and problem-solve, and the ability to access and share information; and,
- It requires external support with healthy food access and living conditions, broad learning opportunities, and positive socio-cultural environments.

Figure 1: What Determines Food Literacy?



The aforementioned systematic review on health literacy showed an overlap between health systems and the individual's food capacity skills (28), suggesting that the broader environment may impact on people's ability to prepare and cook food. As depicted in the above model, food literacy involves both personal factors such as nutrition knowledge, organizational, and mechanical skills but also broader environmental factors which determine if individuals are able to prepare and cook healthy, safe, affordable tasty food for themselves and others.

These findings are supported by a number of recent studies and papers that have explored the concept of food literacy (24, 25, 29-32). These studies have been geographically dispersed and independent of each other, yet their results, models, and conclusions have overlapped considerably. Some have defined food literacy as more knowledge-based, such as the ability to choose healthier options from retail environments (34), but observations based on interviews with non-industry, community-based groups additionally have recognized the technical, social, and psychological elements of food literacy that are essential to healthy food preparation (24, 32). Other organizations have identified food literacy components like food system awareness, knowledge about growing food, and network-building around

food (35). Overall, the recent research on food literacy supports several personal and environmental dimensions that operate synergistically to promote a culture of healthy eating. A summary of current definitions of food literacy from various groups worldwide are listed in Table 1 (Appendix A).

Food Literacy: A Call to Action

As identified here, food skills are part of the broader definition of food literacy and fall within the mandate of Public Health, therefore, it is essential that health units in Ontario respond to this identified need to enhance food literacy for all Ontarians. There is an important role for the ***Food Literacy Workgroup*** of the **Ontario Society of Nutrition Professionals in Public Health** to support Ontario Public Health units to implement food literacy programs and services in their respective jurisdictions. To achieve this, **Public Health must advocate for:**

- Age-appropriate programs and classes at elementary, alternatives, and high schools, as well as after-school and community programs that enhance food literacy and align with the curriculum topics;
- Programs to be practical, experiential, confidence-building, skill-related, and learning-level-related;
- Adequate funds to cover expenses for equipment, facilities, leaders' wages, and food;
- Funding for safe, approved kitchens for community use – e.g., in schools universities, community venues, shelters and community food hubs or community food centres;
- Additional and newly developed affordable housing with functional kitchens;
- Affordable public transportation, healthy corner stores, Good Food Box, mobile markets, community gardens; and,
- Living wages and an adequate food allowance for social assistance.

Public Health can work with partners to:

- Create/nurture strong social networks to share food skills and use the Youth Engagement Principles to promote peer-led food skill programs;
- Include food literacy as part of resiliency skill building activities in Public Health programs focused on youth;
- Promote eating and cooking together and healthy food prep as a normal life skill for all in school and community food programs;
- Train teachers and food skills facilitators to combine food literacy programs with self-esteem building, body weight acceptance, and referral for counseling if necessary;
- Provide training and support for facilitators re food skills, youth engagement training, sensitivity training (e.g., for teachers, public health Registered Dietitians, public health nurses, Healthy Babies Healthy Children home visitors, peers workers, and community workers);
- Provide Registered Dietitian-led grocery store tours with priority groups;
- Implement the Community Food Advisor program or similar programs across Ontario, targeted specifically to youth;
- Ensure that community programs are offered in rural areas;
- Provide resources that aid food skill development such as slow cookers, Basic Shelf Cookbooks (37), spice kits, grocery hampers with ingredients, "meals in a bag" including kitchen implements;
- Create programs that build job skills, e.g. incubator kitchens, culinary training, food service, catering, food handler courses;

- Assist with establishing free or low cost community kitchen programs ; and,
- Help with establishing meal programs at hostels & shelters for youth who are homeless, in transition, upgrading, or finishing high school.

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Appendix A: Definitions of food skills and food literacy	
Source	**Definition and components**
Ontario Ministry of Health Promotion (2010) *Healthy Eating, Physical Activity &Healthy Weights Guidance Document* (Short, F., 2003a and Vanderkooy, 2009)	**Food Skills:** ***Knowledge*** (nutrition, label reading, food safety, food varieties, ingredients, substitution); ***Planning*** (organizing meals, budgeting, food preparation, teaching food skills to children); ***Conceptualizing food*** (creative thinking about leftovers, adjusting recipes); ***Mechanical tech-niques*** (preparing meals, chopping/mixing, cooking, following recipes); ***Food perception*** (using your senses – texture, taste, when foods are cooked.
Short, F. (2006) *Kitchen Secrets: The Meaning of Cooking in Everyday Life* (Berg, Oxford)	The types of skills involved in today's cooking are mechanical, technical, perceptual, conceptual, organizational and academic. "Rather than our technical skills, it is our *approach* to cooking that influences what and how we cook", i.e. "the attitudes and beliefs about cooking that we share with others, our personal identifications as people who cook and our confidence in cooking and the degree to which we find it an effort, arising in part from our tacit, unseen skills and academic knowledge"
City of Hamilton Expert Panel – Delphi process	**Food skills** comprise: 1. ***Food and nutrition knowledge***: Canada's Food Guide, label reading, nutrient-rich healthy choices, where food comes from; 2. ***Planning***: Meal planning, budgeting, grocery list, meal organization per family size; 3. ***Preparation including mechanical and cooking techniques***: Cutting, washing, measuring, cooking, following recipes, use of leftovers, time management, safe knife practices, use of utensils, ingredient substi-tution, cooking times; 4. ***Food safety and storage***: cross contamination, shelf life, expiry dates, sanitizing measures, safe cooking and storage temperatures, waste management; 5. ***Self-Efficacy***: Confidence in the kitchen, recognizing areas of improvement/skill enhancement opportunities, how to seek assistance, ability to teach cooking skills, food perceptions.
Vanderkooy (April 2011) TOPHC conference presentation	**Food skills:** "A complex, interrelated, person-centred set of skills necessary to provide and prepare safe, nutritious, culturally acceptable meals for all members of one's household"
Vidgen & Gallegos (2011) *What is Food Literacy and Does It influence What We Eat: A Study of Australian Experts*	**Food literacy:** "the relative ability to basically understand the nature of food and how it is important to you, and how able you are to gain information about food, process it, analyse it and act upon it"
Vidgen & Gallegos (2012) Defining Food Literacy, Its Components, Development and Relationship to Food Intake: A Case Study of Young	**Food literacy**: "A collection of inter-related knowledge, skills and behaviours required to plan, manage, select, prepare and eat foods to meet needs and determine food intake." "**Food literacy** is the scaffolding that empowers individuals,

Appendix A: Definitions of food skills and food literacy

Source	Definition and components
People and Disadvantage (Australia)	households, communities or nations to protect diet quality through change and support dietary resilience over time".
Sustain Ontario Backgrounder (2012), 4 pages	**Food literacy** means "understanding where food comes from, the impacts of food on health, the environment and the economy, and how to grow, prepare, and prefer healthy, safe and nutritious food". It is "a valuable tool in reducing the incidence of childhood obesity and other diet-related illnesses in their future".
Topley,A. (2013) *At the Table: A Case for Food Literacy Coordination,* Victoria, BC,36 pages	The term **'Food Literacy'** captures 3 ideas: 1. ***Food Confidence*** -- an individual's knowledge, skills, ability and belief to be food self-reliant; 2. ***Food Savvy*** -- the applicability and importance of food from personal, community and environmental perspectives; 3. ***Food Connections***-- the appreciation that food serves social, community and cultural needs.
European Commission www.food-literacy.org	**Food Literacy** is the ability to organize one´s everyday nutrition in a self-determined, responsible and enjoyable way.

Appendix B: Recommended Interventions& Supports for the Health Unit Level

Determinant Area 1	Barriers to food literacy	Interventions/supports to overcome challenges to food literacy
Social and psychological environment	Social isolation Lack of role models for healthy food preparation Weight concerns, depression, stress, lack of self-esteem	◆ Promote strong social networks to share food skills ◆Use the *Youth Engagement Principle* to promote peer-led food skill programs (e.g. cooking, gardening) ◆ Include food literacy as part of resiliency skill building activities in Public Health programs focused on youth ◆ In school and community food programs, promote eating and cooking together and healthy food prep as a normal life skill for all ◆ Train teachers and food skills facilitators to combine food literacy programs with self-esteem building, body weight acceptance, and referral to counseling if necessary.
Determinant Area 2	**Barriers to food literacy**	**Interventions/supports to overcome challenges to food literacy**
Learning environment	Low literacy, numeracy Food classes are absent, are poorly taught, or are not geared to needs or interests	◆ Advocate for programs and classes (at school and in the community) that • enhance food literacy • are practical, experiential, confidence-building, skill-related, learning-level-related. • align with curriculum topics ◆ Provide training and support for facilitators re food skills, youth engagement training, sensitivity training (e.g. for teachers, PH RDs, PHNs, HBHC home visitors, peers, community workers) ◆ Provide Registered Dietitian-led grocery store tours with priority groups ◆ Implement the *Community Food Advisor* program across Ontario ◆ Ensure that community programs are offered in rural areas.
Determinant Area 3	**Barriers to food skills**	**Interventions/supports to overcome challenges to food literacy**
Food, food preparation facilities and	Poor housing with limited cooking and food storage facilities Lack of implements & ingredients for	**Engage with community partners to:** ◆ advocate for funding for kitchens for community use – e.g. in schools, universities, community venues, shelters, and community food hubs or centres ◆ provide resources that aid food skill development such as:

food environment	home cooking Poor access to healthy food	• slow cookers • Basic Shelf Cookbooks • spice kits • grocery hampers with basic shelf ingredients • "meals in a bag" including kitchen implements ◆ advocate for more affordable housing with functional kitchens ◆ advocate for affordable public transportation, healthy corner stores, Good Food Box, mobile markets ◆ Promote school and community gardens
Determinant Area 4	**Barriers to food skills**	**Interventions/supports to overcome challenges to food literacy**
Living conditions	Low income, unemployment, household food insecurity	**Work with community partners to:** ◆ create programs that build job skills, e.g. incubator kitchens, culinary training, food service, catering, food handler courses ◆ establish free or low cost community kitchen programs ◆ establish meal programs at hostels & shelters for youth who are homeless, in transition, or upgrading or finishing high school ◆ advocate for living wages for people and adequate food allowance for social assistance ◆ provide vouchers to buy food at farmers markets ◆ promote school and community gardens

-APPENDIX C-

For the first LDCP (Desjardins et al., 2013), the priority populations had to reflect the following:

- be a priority population for each of the eight participating LDCP Team Members;
- be populations applicable in terms of being deemed a "priority" to many, if not all, public health units throughout Ontario;
- be populations accessible through established health unit programs (e.g., Healthy Babies, Healthy Children, Canadian Prenatal Nutrition Program, Smile Ontario, food skills groups, etc.);
- be populations accessible through established working relationships and rapport with health unit staff and community partners; and
- be individuals at higher risk for health disparities and outcomes.

(Sourc: Azevedo E, Davidson L, Dunbar J, Samra R, MacDonald A, Thomas H, et al. Summary report: How two priority populations were identified? A locally driven collaborative project on food skills. Toronto, ON: Public Health Ontario; 2014)

APPENDIX D-Scoping Review Procedure

Table 1: Systematic steps in the scoping review, using the framework developed by Arskey and O'Malley, 2005 (65) and revised by Levac and colleagues, 2010 (66)

Step in Scoping Review	Description of Scoping Review Implementation Process	Role(s)	Date (2016)
1. Identifying the research question.	What are the attributes of food literacy including food skills identified in the literature?	LDCP Team	Oct 2015
2. Identifying relevant studies.	***Develop a search strategy*** to identify any new and relevant studies, including reviewing previous search terms used and adding new search terms.	All LDCP Team members, including Librarian & Academic Advisor	Jan 2016
	Develop inclusion/exclusion criteria, for example: • peer reviewed and grey literature • all literature in English • time span more to be discussed and determined	↓	↓
	Retrieve relevant literature, specifically, search will include:		Jan 2016
	•Electronic databases (e.g., MEDline, pubMed, etc.)	Librarian Student (s)	
	• Reference lists identified in the previous LDCP study Desjardins et al. 2013).		↓
	•Hand-search key journals (e.g., International Journal of Home Economics; Canadian Journal of Dietetic Practice and Research; Health Behaviours and Health Education; Journal of Human Nutrition and Dietetics; Appetite; Journal of Nutrition Education and Behaviour)	Student(s)	↓ ↓
	•Select reports and literature from existing networks, relevant organizations, and conferences (e.g., Ontario Society of Nutrition Professionals in Public Health, Ontario Public Health Association, Nutrition Resource Centre, and Canadian Public Health Association).	Student (s) & LDCP team members	

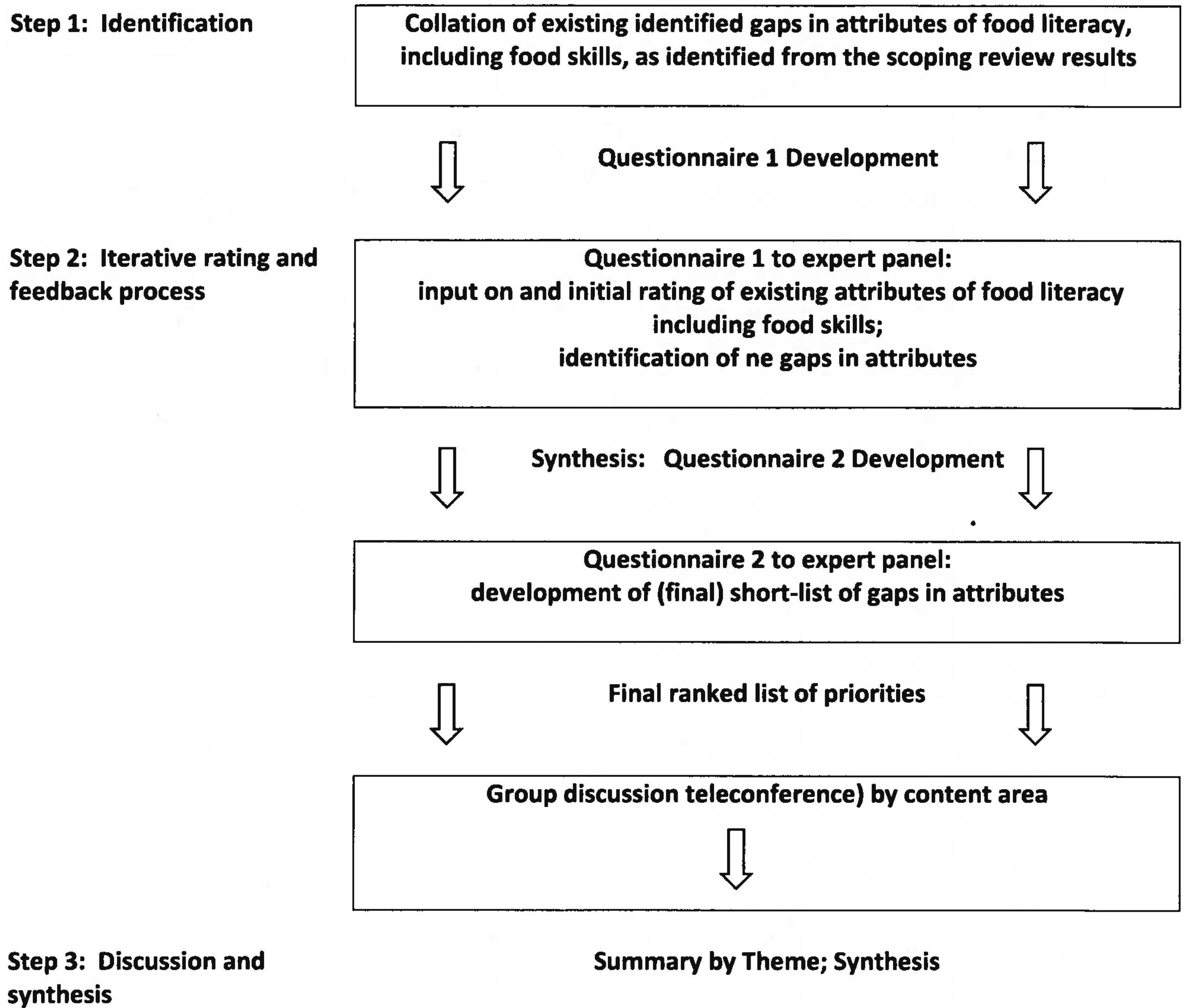
Step in Scoping Review	Description of Scoping Review Implementation Process	Role(s)	Date (2016)
3. Study selection.	***Select studies/literature based on the inclusion/exclusion criteria*** for study selection.	Librarian LDCP team members (and their student or students) LDCP team member (s) (and their student or students)	Jan 2016
	Independent review of titles, then <u>abstracts</u> for inclusion (LDCP Team member will meeting with students at several points during the process to discuss approach for the review and to ensure it is consistent among the reviewers (i.e., students) by discussing challenges and uncertainties related to the study selection and review, to come to consensus and resolution about any disagreements and if needed to further refine the search strategy.	1-2 LDCP team member (may include 1 -2 students)	Feb 2016
	Independent review of <u>full</u> articles and/or literature (e.g., reports) selected Same process as above– 1 LDCP team member and 1 student working together (TBD) plus one other LDCP member who is independently reviewing. Along the way meeting with the Research Consultant to ensure discuss review, ensure consistency and resolve any disagreements	Research Consultant, 1 LDCP team member (may include a student)	March 2016
4. Charting the data.	***Develop data extrapolation form/table*** –in collaboration with the LDCP team with specific variables or data ***to be determined for inclusion*** in the chart (e.g., authors, year of publication, location of study, if food literacy definition is included, if specific attributes of food literacy are described, description of specific attributes listed or provided, etc.) ***Pilot test the data extraction form/table with a few articles selected***	Researcher Consultant LDCP team members Research Consultant	March -April 2016

Step in Scoping Review	Description of Scoping Review Implementation Process	Role(s)	Date (2016)
	Extract the data from the first few studies selected for full review using the data extraction form; two individuals will independently work simultaneously	Research Consultant One LDCP member	
	Individuals meet to discuss data extraction process- i.e., the approach they are using for data extraction to ensure the approach used is consistent and that the research question is being addressed by the literature selected for inclusion in the data extraction tool.	Research Consultant and LDCP Team member	
5. Collating, summarizing, and reporting results. **(Data Analysis)**	***Conduct a qualitative thematic analysis of data extracted.***	Research Consultant	April - May 2016
	Independently review thematic analysis by specific LDCP team members for triangulation purposes.	1-2 LDCP Team members Research Consultant	↓
	Meet to discuss findings and disagreements.	1-2 LDCP Team members Research Consultant	↓
	Share and discuss analysis with the LDCP Team making additional revisions to the thematic analysis.	Research Consultant and LDCP Team	↓
	Summarize findings and produce a comprehensive list of food literacy attributes.	Research Consultant	May-June 2016
6. Consultation	***Develop a webinar to share findings from scope of literature.***	Key stakeholder s/ knowledge users	May-June &
	Plan and implement the Delphi Technique	Expert	Sept-

Step in Scoping Review	Description of Scoping Review Implementation Process	Role(s)	Date (2016)
	(SEE objective #2– Delphi Technique below) -to obtain input from expert group who are also the knowledge exchange users regarding the list of attributes, gaps in the information, opinion about terms used to describe attributes and which attributes are relevant to public health practice and which ones are most important to measure.	Group who are the key stakeholders and knowledge users identified to participate in the Delphi Technique	Dec 2016

-APPENDIX E-

Figure 2: Overview of the Delphi Process as suggested by Wathen et al, 2012



Source: Wathen DN, MacGregor JCD, Hammerton J, Coben JH, Herrman H, Stewart DE, & MacMillan HL. (2012). Priorities for research in child maltreatment, intimate partner violence and resilience to violence exposures: results of an international Delphi consensus development process. BMC Public Health; 12: 684.

APPENDIX F-Delphi Technique Procedure

Table 2: Steps in the Delphi Technique, using a modified framework as suggested by Keeney, Hasson, & McKenna, 2001

Step in Delphi Technique	Description	Role (s)	Timeline
Identification of Study Population	***LDCP team members to work collaboratively to identify and purposely select key stakeholders and knowledge users to be a part of the Expert Group.*** (see potential participants for Expert Group 1 and 2 above) **Note**: Once the total number of experts is determined from both groups, they will be referred to "participants" in the Delphi Technique.	LDCP Team Research Consultant	Mar-April 2016
Recruitment of Study Sample	**Recruitment Step 1:**		
	To recruit participants for Expert Group 1, the Co-Chairs of the OSNPPH Food Literacy Working Group will promote the study at a regularly scheduled meeting and upcoming webinar to share scoping review findings.	2 LDCP Team members	April 2016
	To recruit participants for Expert Group 2: LDCP Team members who identify potential Expert Group 2 members or who have a professional connection/relationship will reach out in a personal phone call to explain the study, provide a letter of information, and invite them to participate in the upcoming webinar and study.	LDCP team members	↓
	Additional snowball sampling during recruitment to add potential participants using publicly available contact information will be employed.	↓	↓
	Recruitment Step 2: After the initial introduction to the study is made, the co-chairs of the OSNPPH Working Group will send out a reminder email and promotional PDF poster for the webinar	LDCP Team members	April-May 2016

Step in Delphi Technique	Description	Role (s)	Timeline
	to members on this working group to invite them to participate in the webinar and the Delphi Technique in the Fall. A reminder email will also be sent to potential participants of Expert Group 2.		
	Recruitment Step 3: Two weeks following the email reminder, follow-up phone calls will be made to members of the OSNPPH Working Group and to potential participants of Group 2 who have not responded.	LDCP Team members	April -May 2016
	Recruitment Step 4: Develop and implement a webinar to share findings of scoping review and recruit participants for the Delphi.	Research Consultant LDCP Team Student(s)	May-June 2016 (Webinar in beginning of June)
	Recruitment Step 5: Follow up emails to potential participants in each group will be sent out approximately 1 week after the webinar initial contact with them to confirm or deny participation in the study. Information letter about study will be sent to those who have confirmed participation.	LDCP Team Members	June 2016
	Recruitment Step 6: Confirm participation in the study and send out any necessary details (contact information, dates, etc.)	LDCP Team Members	June-July & again in early Sept 2016
DEa Collection Process	***Develop and pilot test questionnaire*** – Before the first round of the Delphi Process similar Delphi questionnaires about food literacy will be reviewed and gathered; potential questions will be discussed in collaboration with the LDCP team and pilot testing of an open-ended questionnaire with a similar sample (e.g., public health nurses).	Research Consultant, Academic Advisor, Librarian LDCP team	June-July 2016
Round 1	***Distribution of online questionnaire*** ***Analyze pen ended questions using qualitatively (some quantitative analysis)***	LDCP Team Research Consultant; Grad student	

Step in Delphi Technique	Description	Role (s)	Timeline
	Discuss and share analysis with LDCP & work collaboratively to develop questionnaire for round 2	Research Consultant; Grad student LDCP Team	
Round 2	***Email or call participants*** reminding them of round #2 ***Distribution of online questionnaire*** ***Analyze pen ended questions using qualitatively (some quantitative analysis)*** ***Discuss and share analysis with LDCP & work collaboratively to develop questionnaire for round 2***	LDCP Team LDCP Team Research Consultant; Grad student Research Consultant; Grad student LDCP Team	
Round 3	See round 2 above	See round 2 above	
		LDCP Team Delphi Participants	December 2016
Collate, summarize and report results	Research Consultant to prepare a summary report that will be shared with and reviewed by the LDCP Prepare brief summaries of the research in collaboration with LDCP Team members	Research Consultant LDCP Team Student LDCP Team	Jan-Feb 2017 Dec '16-Feb 2017

APPENDIX G-Sample Information Letter with Consent

LDCP Food Literacy Measurement Study: Letter of Information

Background:

A previous Locally Driven Collaborative Project (LDCP) research project, Making Something out of Nothing: Food literacy among youth, young pregnant women and young parents who are at risk for poor health (2011) **(available at...)**, helped shed light on the meaning of food skills among youth, young pregnant women and young parents.

The results from this study helped to develop the definition for food literacy and a visual model of the different attributes of food literacy **(see enclosed resource that defines both food skills and food literacy)**. This year, a LDCP research team of public health professionals and a Research Consultant conducted a scoping review to develop a comprehensive list of food literacy attributes found in the literature. This list will be shared with key informants to get their opinions.

What will happen in this study?

In this study, the Delphi Technique, a well-recognized consensus building method, will be used to determine what key informants consider to be the most important food literacy attributes and what possible gaps there may be in attributes describing food literacy. The technique will involve three rounds of questions to solicit opinion and come to a consensus on a topic. The target for the study will be public health staff in Ontario and other key stakeholders involved in program or service delivery of food literacy programming including food skills. In round one, open ended questions will be sent using an online survey (e.g., fluid survey) to all participants to learn their opinions on the list of food literacy attributes including potential gaps. Feedback will be collected in aggregate form and summarized then sent back for further input in October and in November for refining and ranking those attributes of food literacy most important to their practice.

Possible benefits and risks to you for participating in the study:

As a study participant, there are no known risks to you. . Possible benefits for you include the opportunity to help us develop key indicators and questions that measure the refined list of food literacy attributes. The LDCP team will be eligible to apply for additional funding from Public Health Ontario to develop indicators in 2017, and then in 2018 to develop and test a measurement tool with specific priority population groups. This final measurement tool can be used to assess, evaluate, report on and advocate for food literacy programming in public health and community nutrition practice throughout Ontario.

Alternatives and your right to withdraw from the study:

Your participation in this study is voluntary. That means you may refuse to participate, refuse to answer any questions or withdraw from the study at any time. Your decision will not influence your current or future access to or involvement in community programs or services.

Confidentiality:
We will keep all information confidential and secure. Your name will not appear on any written or other information generated during the course of this study. The Haliburton, Kawartha, Pine Ridge District Health Unit as the lead health unit of this study will keep all data safe and secure for five years after the study results have been published at which time all computer data will be erased and all written/paper data and notes will be securely shredded.

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 give your contact information to those listed below. We may present the results at conferences, on webinars and/or in professional journals. Your name will never appear in any of these knowledge exchange activities. .

Contact persons should you have any further questions about the study:

Researcher (TBD)

Elsie Azevedo Perry, M.Sc., RD
Haliburton, Kawartha, Pine Ridge District Health Unit
1-866- 888- 4577 or (905) 885-9100 ext. 218
eazevedo@hkpr.on.ca

Heather Thomas, PhD, RD
Middlesex-London Health Unit
519-663-5317 ext. 2222
heather.thomas@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 Public Health Ontario Ethics at ....or by email at ....

This letter is for you to keep.

By agreeing to participate in this Delphi Study you consent to participate in the study.

I have read the Letter of Information, (have had the nature of the study 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	Name of person responsible for obtaining informed consent (please print)	Signature

Co-Applicants of the study:
Lyndsay Davidson, RD, Chatham-Kent Public Health Unit
Jessica Hambleton, RD, Toronto Public Health
Jessica Love, RD, North Bay Parry Sound District Health Unit
Ruby Samra, RD, City of Hamilton Public Health Services
Shannon Edmonstone, RD, Perth District Health Unit
Magda Wasilewska, Program Evaluator, Toronto Public Health
Rebecca Davids, RD, York Region Community and Health Services

Knowledge Users of the study:
Karen Bellemore, RD, Windsor-Essex County Health Unit
Carolyn Doris, RD, Peterborough County-City Health Unit
Kelly Ferguson, RD, Oxford County Public Health
Elizabeth Finlan Hastings, RD, Prince Edward County
Sonia Jean-Philippe, RD, Ottawa Public Health
Alexandra Lacarte, RD, North Bay Parry Sound District Health Unit
Kim McGibbon, RD, Thunder Bay District Health Unit
Laura Needham, RD, Grey Bruce Health Unit
Lynn Roblin, RD, Ontario Public Health Association
Julie Slack, RD, Northwestern Health Unit
Catherine Schwartz-Mendez, RD, Thunder Bay District Health Unit
Marie Traynor, RD, Leeds, Grenville & Lanark District Health Unit

Academic Advisor: Sharon Kirkpatrick, University of Waterloo

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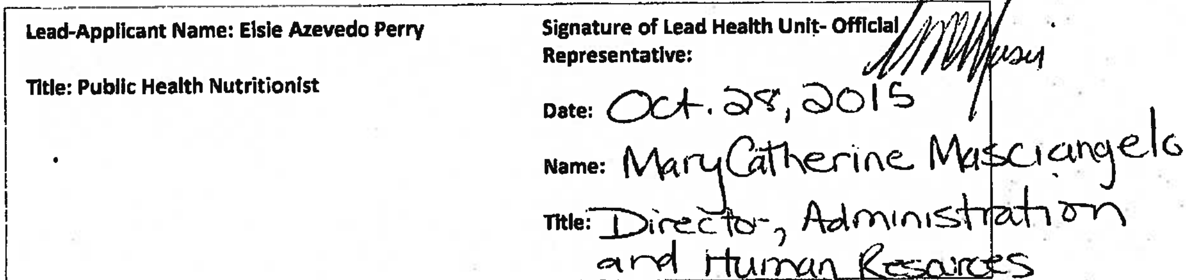
Part 10. Signatures

LEAD HEALTH UNIT - AUTHORIZED REPRESENTATIVE

I warrant that the information in this submission form is complete and accurate to the best of my knowledge and that it reflects the collective intentions of the collaborative team. I acknowledge that as the lead health unit, my organization has the intention to enter into a Transfer Payment Agreement with Public Health Ontario that reflects the roles and responsibilities of the lead health unit as described by the Locally Driven Collaborative Projects (LDCP) and the Cycle 3 LDCP Participation Guidelines.



Lead-Applicant Name: Elsie Azevedo Perry **Title: Public Health Nutritionist**	**Signature of Lead Health Unit- Official Representative:** **Date:** Oct. 28, 2015 **Name:** MaryCatherine Masciangelo **Title:** Director, Administration and Human Resources

SUPPORTING HEALTH UNIT - AUTHORIZED REPRESENTATIVE

(Include additional signature boxes, if required)

I warrant that the information in this submission form is complete and accurate to the best of my knowledge and that it reflects the collective intentions of the collaborative team.

Co-Applicant Name: Dr. Heather Thomas **Title: Public Health Dietitian**	**Signature of Supporting Health Unit Official Representative:** **Date:** **Name:** **Title:**

Part 10. Signatures

LEAD HEALTH UNIT - AUTHORIZED REPRESENTATIVE

I warrant that the information in this submission form is complete and accurate to the best of my knowledge and that it reflects the collective intentions of the collaborative team. I acknowledge that as the lead health unit, my organization has the intention to enter into a Transfer Payment Agreement with Public Health Ontario that reflects the roles and responsibilities of the lead health unit as described by the Locally Driven Collaborative Projects (LDCP) and the Cycle 3 LDCP Participation Guidelines.

Lead Applicant Name: Elsie Azevedo Perry **Title: Public Health Nutritionist**	**Signature of Lead Health Unit-Official Representative:** **Date:** **Name:** **Title:**

CO-LEAD APPLICANT HEALTH UNIT - AUTHORIZED REPRESENTATIVE
(include additional signature boxes, if required)

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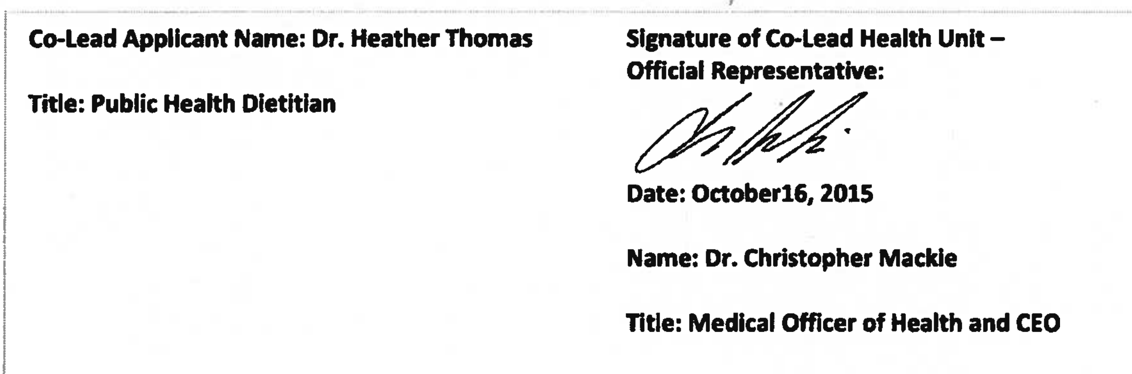

Co-Lead Applicant Name: Dr. Heather Thomas **Title: Public Health Dietitian**	**Signature of Co-Lead Health Unit – Official Representative:** **Date: October16, 2015** **Name: Dr. Christopher Mackie** **Title: Medical Officer of Health and CEO**

CO-APPLICANT HEALTH UNIT - AUTHORIZED REPRESENTATIVE
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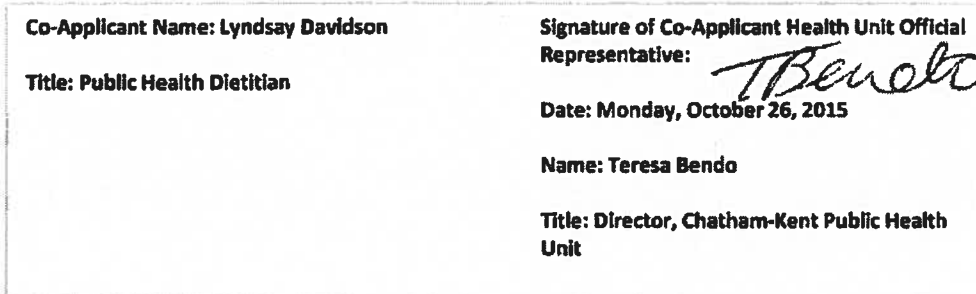

Co-Applicant Name: Lyndsay Davidson **Title: Public Health Dietitian**	**Signature of Co-Applicant Health Unit Official Representative:** **Date: Monday, October 26, 2015** **Name: Teresa Bendo** **Title: Director, Chatham-Kent Public Health Unit**

CO-APPLICANT ACADEMIC OR COMMUNITY ORGANIZATION - AUTHORIZED REPRESENTATIVE
(include additional rows, if required)

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Co-Applicant Name: **Title:**	**Signature of Co-Applicant Academic or Community Organization Official Representative:** **Date:** **Name:** **Title:**

DEADLINE

The LDCP Submission Form is due to Public Health Ontario on **October 30th, 2015 at 4:00 pm EDT.** Please send **ONE** email with all of the submission documents to: LDCP@oahpp.ca

CO-APPLICANT HEALTH UNIT - AUTHORIZED REPRESENTATIVE

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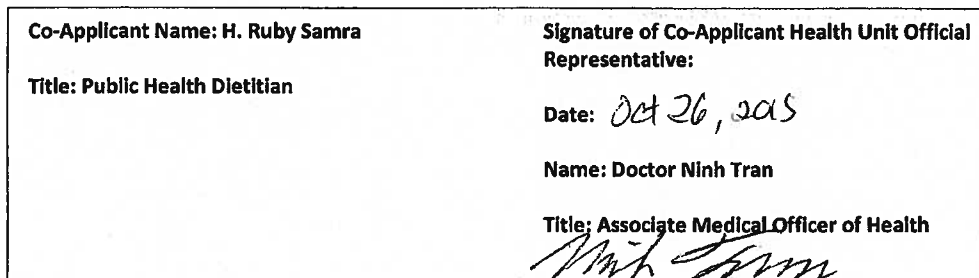

Co-Applicant Name: H. Ruby Samra **Title: Public Health Dietitian**	**Signature of Co-Applicant Health Unit Official Representative:** **Date:** Oct 26, 2015 **Name: Doctor Ninh Tran** **Title: Associate Medical Officer of Health**

CO-APPLICANT ACADEMIC OR COMMUNITY ORGANIZATION - AUTHORIZED REPRESENTATIVE

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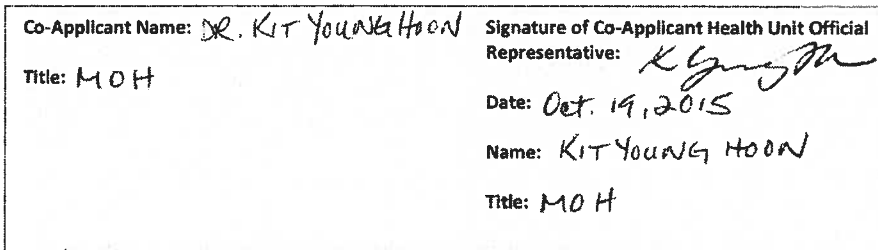

Co-Applicant Name: DR. KIT YOUNG HOON **Title:** MOH	**Signature of Co-Applicant Health Unit Official Representative:** [signature] **Date:** Oct. 19, 2015 **Name:** KIT YOUNG HOON **Title:** MOH

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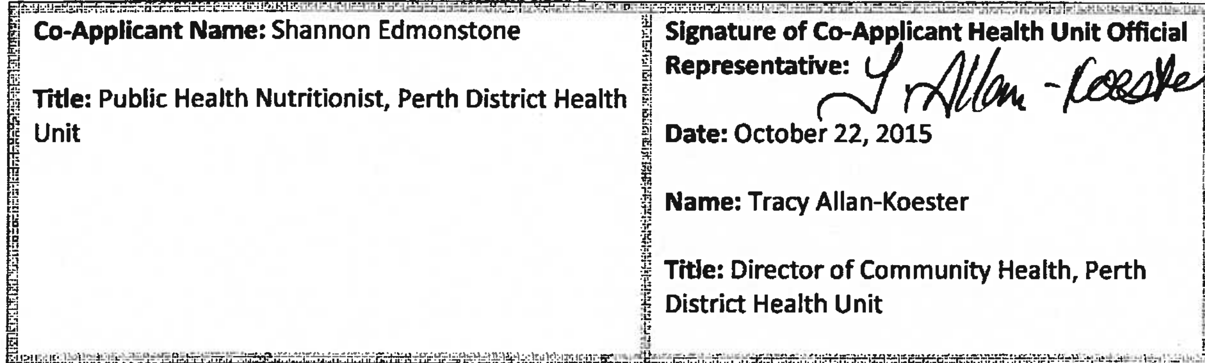

Co-Applicant Name: Shannon Edmonstone **Title:** Public Health Nutritionist, Perth District Health Unit	**Signature of Co-Applicant Health Unit Official Representative:** T Allan-Koester **Date:** October 22, 2015 **Name:** Tracy Allan-Koester **Title:** Director of Community Health, Perth District Health Unit

CO-APPLICANT ACADEMIC OR COMMUNITY ORGANIZATION - AUTHORIZED REPRESENTATIVE

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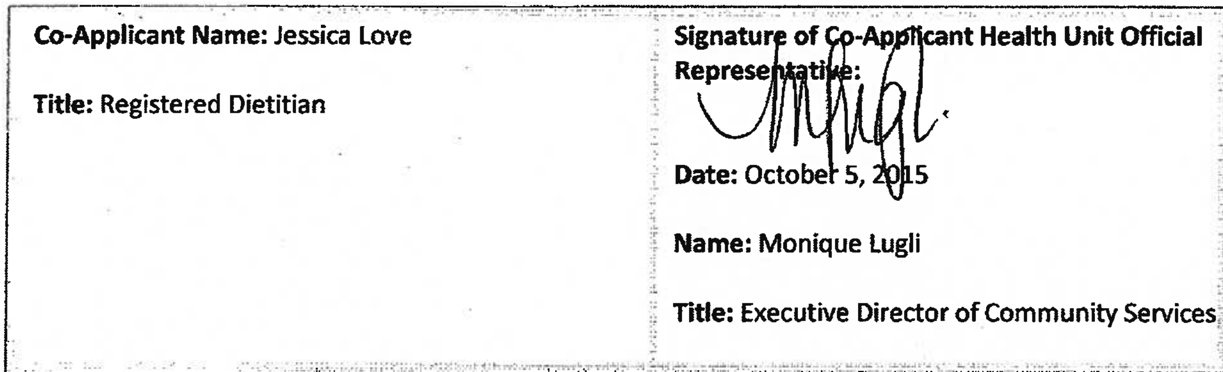

Co-Applicant Name: Jessica Love **Title:** Registered Dietitian	**Signature of Co-Applicant Health Unit Official Representative:** **Date:** October 5, 2015 **Name:** Monique Lugli **Title:** Executive Director of Community Services

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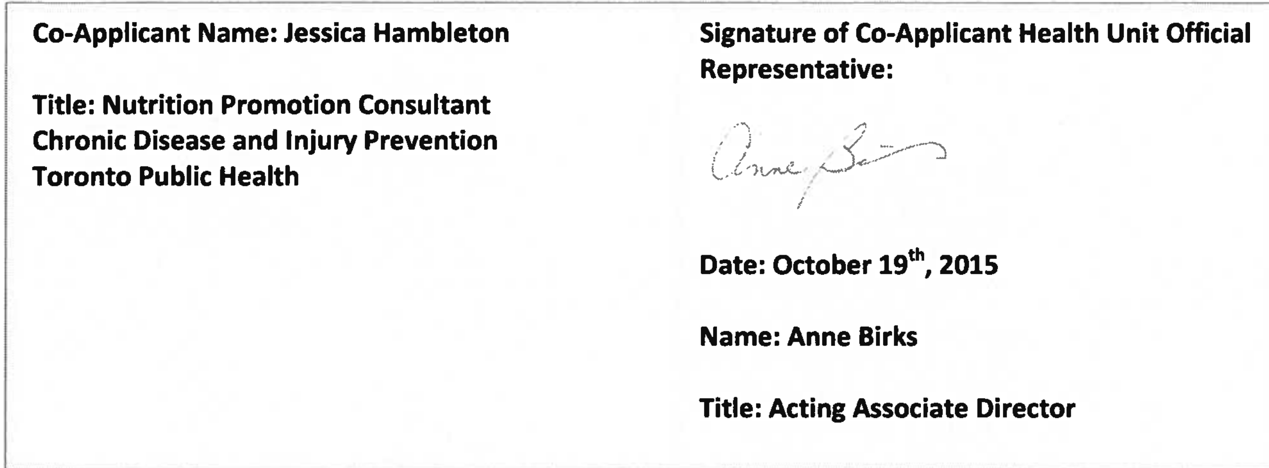

Co-Applicant Name: Jessica Hambleton **Title: Nutrition Promotion Consultant** **Chronic Disease and Injury Prevention** **Toronto Public Health**	**Signature of Co-Applicant Health Unit Official Representative:** **Date: October 19th, 2015** **Name: Anne Birks** **Title: Acting Associate Director**

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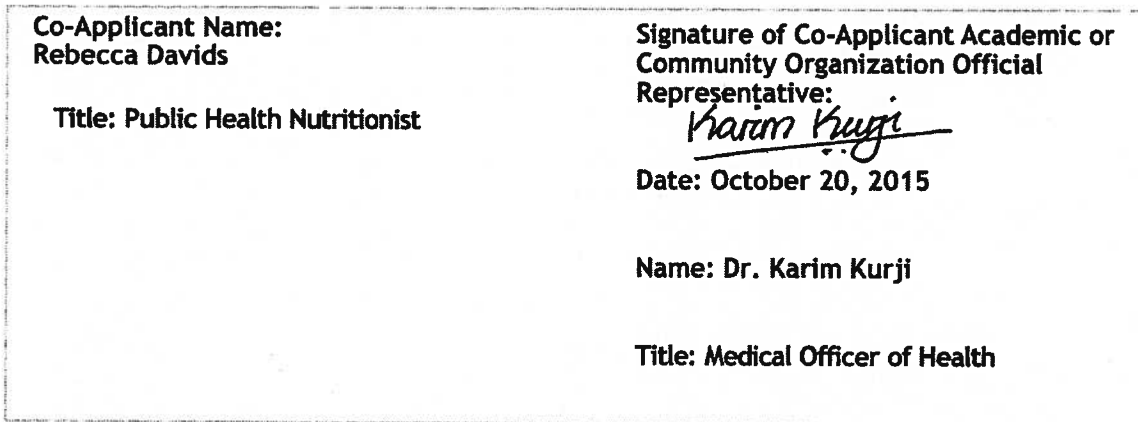
I warrant that the information in this submission form is complete and accurate to the best of my knowledge and that it reflects the collective intentions of the collaborative team.



Co-Applicant Name: **Rebecca Davids** **Title: Public Health Nutritionist**	**Signature of Co-Applicant Academic or Community Organization Official Representative:** Karim Kurji **Date: October 20, 2015** **Name: Dr. Karim Kurji** **Title: Medical Officer of Health**

DEADLINE

The LDCP Submission Form is due to Public Health Ontario on **October 30th, 2015 at 4:00 pm EDT**. Please send **ONE** email with all of the submission documents to: LDCP@oahpp.ca

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 027-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 April 21

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – APRIL

Recommendation

It is recommended that Report No. 027-16 re: Medical Officer of Health Activity Report – April be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the March Medical Officer of Health Activity Report to April 8, 2016.

The MOH and many Health Unit staff attended The Ontario Public Health Convention (TOPHC) conference at the Allstream Centre in Toronto in early April. This conference is hosted jointly by Public Health Ontario (PHO), the Ontario Public Health Association (OPHA) and the Association of Local Public Health Agencies (alPHa). The conference aims to advance public health by increasing knowledge and skills in the workforce.

The MOH presented at several sessions, including:

- *Realizing Our Potential: Maximizing public health's role in supporting poverty reduction in Ontario*
- *Leadership and influence: Achieving public health goals through public policy*
- *Hot TOPHC 2016: Public health in a transformed Ontario health system*

Other Health Unit staff who presented at the conference include:

- Chimere Okoronkwo and Brooke Twohey – Small Change. Big Results (fluoride varnish)
- Chris Blain and Deb Fenlon – Effective strategies for public health providers engaging in a rapid review process
- Anne-Maria Quin and Fatih Sekercioglu – Geared towards compliance: Using evidence-informed strategies to teach pool and spa operators

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

March 7 Mayor's Advisory Panel on Poverty MAPOP discussion with Chief John Pare, London City Police
Met with MAPOP representatives to discuss the draft recommendations
Attended a YOU Executive meeting

March 8 Attended an MLHU Leadership meeting to review the new Employee Assistance Program provider

March 9 MAPOP presentation at the Thames Valley District School Board
Met with City Councillor Phil Squire to discuss the MAPOP recommendations
Attended a MAPOP presentation at the White Oaks Family Centre
Delivered opening remarks at the "We're Better Together" event which was organized by the Middlesex-London Community Early Years Partnership and the Healthcare Provider Champion

March 11	Attended a meeting of the Community Health Collaborative – Steering Committee
March 21	All day MAPOP meeting
March 22	Met with Michele McKenzie and Barb Petterson from the United Way for a campaign debrief Interview with CTV in regards to safe injection sites
March 23	Met with MPP Jeff Yurek to discuss MAPOP and the Patients First initiative
March 24	Attended a Youth Opportunities Unlimited Board meeting Participated in a video shoot for London Cares Participated in the SWMOH Journal Club session
March 29	Attended a Senior Leadership Planning day
March 31	Participated in a teleconference call with Shireen Roy at the Ministry of Health and Long-Term Care
April 1	Attended a meeting of MOH's, AMOH's and LHIN staff to discuss the Patients First initiative
April 7	Attended the Finance and Facilities Committee meeting With the AMOH, met with Dr. Salimah Shariff and Amit Garg at Clinical Evaluative Sciences (ICES) at Western University
April 8	Initial meeting with Dr. Steven Harrison, newly hired CEO for the Canadian Mental Health Association (CMHA) Middlesex

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