AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

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

Thursday, 7:00 p.m.
2016 November 17

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. Maureen Cassidy
Ms. Patricia Fulton
Mr. Jesse Helmer (Chair)
Dr. Trevor Hunter
Ms. Tino Kasi
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Kurtis Smith
Ms. Joanne Vanderheyden (Vice-Chair)

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

October 27, 2016 Board of Health meeting

DELEGATIONS

7:05 – 7:15 p.m. Ms. Trish Fulton, Chair, Finance and Facilities Committee (FFC) re: Item #1 - Finance and Facilities Committee Meeting November 3, 2016 (**Report No. 061-16**).

Receive: November 3, 2016 Finance and Facilities Committee draft meeting minutes

7:15 – 7:25 Mr. Trevor Hunter, Chair, Governance Committee (GC) re: Item #2 – Governance Committee Meeting Novmber 17, 2016 (Verbal Update)

Receive: July 21, 2016 Governance Committee meeting minutes

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance and Facilities Committee Meeting November 3, 2016 **(Report No. 061-16)**	Receive: November 3 Draft FFC Minutes	x	x		To receive minutes and consider recommendations from the November 3 FFC meeting.
2	Governance Committee Meeting - November 17, 2016 (Verbal Update)	Receive: July 21, 2016 GC Minutes	x	x		To receive minutes and an update from the November 17 GC Meeting.
Delegations and Recommendation Reports						
3	Opiod Addiction and Overdose **(Report No. 062-16)**			x		To endorse and recommend that when prescribing opiods patients should also be counselled on naloxone use to prevent fatal complications associated with overdose.
4	2016 Nutritious Food Basket Survey Results and Implications for Government Public Policy **(Report No. 063-16)**	Appendix A		x		To provide an update on 2016 Nutritious Food Basket Survey results, actions and policy recommendations.
Information Reports						
5	Salmonella Typhimurium Outbreak Investigation **(Report No. 064-16)**	Appendix A			x	To provide an update on the salmonella case investigation.
6	2015-2016 Influenza Season in Middlesex-London – Final Report **(Report No. 065-16)**	Appendix A			x	To provide a summary of Influenza Activity from 2015-2016.
7	A Comprehensive Nutrition Strategy for Middlesex-London **(Report No. 066-16)**				x	To receive an update on how Registered Dietitians utilize a comprehensive nutrition strategy to reduce health inequities in Middlesex-London.
8	Summary Information Report: November **(Report No. 067-16)**	Appendix A Appendix B Appendix C Appendix D			x	To provide a summary of information from Health Unit programs and services for November.
9	Medical Officer of Health Activity Report: November **(Report No. 068-16)**				x	To provide an update on the activities of the MOH for November.

OTHER BUSINESS

Next meetings:

- Next Finance and Facilities Committee Meeting: Thursday December 1 2016 @ 9:00 a.m.
- Next Governance Committee Meeting: To Be Determined
- Next Board of Health Meeting: Thursday December 8, 2016 @ 6:00 p.m.

CORRESPONDENCE

a) Date: 30 August 2016 (Received 23 June 2016)
Topic: Standards Modernization: Accountability Committee
From: Practice and Accountability Branch, Ministry of Health and Long-Term Care
To: All Health Units

Background:

The Accountability Committee held its third meeting on July 8th. Discussion focused on the lack of data provided by the Ministry limits the ability to demonstrate the full scope of program delivery and value for money. Also discussed were accountability practices to inform boards of health and municipalities. These include: program level dashboards, locally developed indicators, aligning achievements with the strategic plan, health status reports to identify local priorities, use of local data to understand value for money and developing and maintaining relationships with municipalities.

Recommendation:

Receive

b) Date: 13 September 2016
Topic: Standards Modernization: Practice and Evidence Program Standards
From: Practice and Evidence Program Standards Advisory Committee for the Standards Modernization, Practice and Accountability Branch, Ministry of Health and Long-Term Care
To: All Health Units

Background:

The Practice and Evidence Program Standards Advisory Committee for the Standards Modernization (the "PEPSAC") has met several time and formed program-specific sub-groups. Additional discussions were held regarding opportunities to address the needs of indigenous communities and the role of public health in mental health promotion. PEPSAC will discuss the recommended set of standards once work of the sub-groups has been completed.

Recommendation:

Receive

c) Date: 13 September 2016
Topic: Standards Modernization: Executive Steering Committee
From: Executive Steering Committee for Standards Modernization, Practice and Accountability Branch, Ministry of Health and Long-Term Care
To: All Health Units

Background:

The Executive Steering Committee for Standards Modernization has the goal of strengthening and enhancing accountability and transparency within the public health system. They are looking at opportunities for systems integration, emerging public health issues, revisions to the Ontario Public

Health Standards, and opportunities to address local needs. Recommendations from PEPSAC will be discussed at future meetings along with consultations strategies, value-for-money and transparency.

Recommendation:

Receive.

d) Date: 20 September 2016
Topic: Lyme Disease
From: Scott McDonald, Chair, Board of Health, Peterborough Public Health
To: The Honourable Jane Philpott, The Honourable Eric Hoskins

Background:

Lyme disease is an emerging public health issues in Ontario and Peterborough County and City. Current resource allocation for research, treatment, surveillance and education for Lyme disease is inadequate and the Board of Health is requesting increased funding for this issue.

Recommendation:

Receive.

e) Date: 22 September 2016 (Received 13 July 2016)
Topic: Basic Income Guarantee
From: Mark Lovshin, Chair, Board of Health for Haliburton, Kawartha, Pine Ridge District Health Unit
To: The Honourable Jean-Yves Duclos, Minister of Families, Children and Social Development

Background:

The Board of Health for Haliburton, Kawartha, Pine Ridge District has endorsed a position statement supporting the concept of a basic income guarantee and requests that the Government of Canada work with the Government of Ontario in developing and implementing poverty reduction strategies.

The Board of Health considered a report at the September 2015 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; 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; 3) Send a letter to all London and Middlesex County federal election candidates requesting they take Food Secure Canada's Eat Think Vote candidate pledge; and 4) Forward Report No. 50-15 re 2015 Nutritious Food Basket Survey Results and Implications for Government Public Policy to the City of London, Middlesex County & appropriate community agencies.

Recommendation:

Receive.

f) Date: 28 September 2016
Topic: Highlights from the August 31, 2016 Accountability Committee Meeting for Standards Modernization
From: Accountability Committee for Standards Modernization, Practice and Accountability Branch, Ministry of Health and Long-Term Care
To: All Health Units

Background:

The Accountability Committee received a presentation from Dr. Mackie regarding Program Budgeting Marginal Analysis (PBMA). There was also discussion of the substantial variation in the way health units track program expenditures in relation to outputs and outcomes. They also discussed a draft logic model of the Accountability Framework and a narrative to support its dissemination.

Recommendation:

Receive.

g) Date: 30 September 2016
Topic: Universal Hot Meal Program
From: Scott McDonald, Chair, Board of Health, Peterborough Public Health
To: The Honourable Jane Philpott, MP, The Honourable Scott Brison, MP, The Honourable Jean-Yves Duclos, MP, The Honourable Bill Morneau, MP, The Honourable Amarjeet Sohi, MP, The Honourable Mitzie Hunter, MPP, The Honourable Helena Jaczek, MPP, The Honourable Michael Coteau, MPP,

Background:

The Board of Health for the Thunder Bay District Health Unit endorsed a position paper that a universal hot meal program should be implemented in Ontario elementary and secondary schools to address food insecurity.

Recommendation:

Receive

h) Date: 10 October 2016 (Received 21 July 2016)
Topic: Changes to the HPV Immunization Programs
From: Scott McDonald, Chair, Board of Health, Peterborough Public Health
To: The Honourable Dr. Eric Hoskins

Background:

Human papillomavirus (HPV) is one of the most common sexually transmitted infections in the world. There are several types of HPV, some of which can cause cervical cancer and genital warts. The province currently offers the HPV vaccine free of charge to girls in Grade 8 at Ontario schools. This will be expanded to all student and begin to be offered in the 2016-2017 school year.

The Board of Peterborough Public Health urges the Ministry of Health and Long-Term Care to increase the annual funding for the Vaccine Preventable Disease Program in order to meet this mandate.

Recommendation:

Receive.

i) Date: 4 October 2016 (Received 10 October 2016)
Topic: Commitment to reintroduction of Patients First Bill
From: Dr. Eric Hoskins, Minister of Health and Long-Term Care
To: Health Systems Partner

Background:

Patients First Act, 2016 was introduced in the Ontario Legislature in June 2016. Due to the Legislature being prorogued, all bills will need to be reintroduced. The government is committed to the reintroduction to continue debate on this matter as soon as possible.

Recommendation:

Receive.

j) Date: 27 September 2016 (Received 17 October 2016)
Topic: Food Security in the District of Thunder Bay
From: Joe Faas, Chair, Chatham-Kent Board of Health
To: The Honourable Kathleen Wynne, The Honourable Chris Ballard, Chairs, Boards of Health

Background:

See item (g) above.

Recommendation:

Receive

k) Date: 27 September 2016 (Received 20 October 2016)
Topic: Bill 5 – Greater Access to Hepatitis C Treatment Act, 2016
From: Sylvia Jones, MPP Dufferin-Caledon
To: Chair Jesse Helmer and Members of the Board

Background:

Sylvia Jones, MPP from Dufferin-Caledon has introduced Bill 5, Greater Access to Hepatitis C to the Ontario Legislature. This legislation would provide treatment earlier than the current clinical criteria that demand and individual's liver is halfway to cirrhosis. The Bill passed first reading on September 13, 2016. The Member of Provincial Parliament encourages Boards of Health to write a letter of support to the Minister of Health and Long-Term Care to urge the adoption of this legislation.

Recommendation:

Receive.

l) Date: 31 October 2016
Topic: Cora AIT Strategy *(Slide deck and notice to inform about lobbying of local councils)*
From: Michael Perley, Ontario Campaign for Action on Tobacco (OCAT)
To: Chairs, Boards of Health, Medical Officers of Health

Background:

The Canadian tobacco industry actively lobbies against the taxation of tobacco as a way to curtail contraband tobacco. Michael Perley from Ontario Campaign for Action on Tobacco, a public health advocacy group, encourages Board of Health and municipal leaders to prevent these industry inspired lobby campaigns from coming forward at the municipal level.

Recommendation:

Receive.

m) Date: 21 October 2016 (Received 07 November 2016)
Topic: Release of Chief Public Health Officer's Report on the State of Public Health in Canada
From: Gregory Taylor, BSc, MD, CCFP, FRCPC, Chief Public Health Officer, Public Health Agency of Canada
To: Medical Officers of Health

Background:

This report explores why family violence is an important public health issue for Canadians in regards to the prevalence rates, the different types of family violence and the associated health impacts. The report also discusses the potential remedies for preventing family violence in Canada.

Recommendation:

Endorse.

n) Date: 04 November 2016 (Received 07 November 2016)
Topic: South West Local Health Integration Network governance education opportunities for health system partners: Governing for the Future, Rising to the Challenge of Collaboration
From: Marilyn Robbins, South West LHIN
To: Medical Officers of Health

Background:

This workshop discusses the foundations of good governance including: the role of the board, factors that make a high performing board, as well as partner collaboration, and guiding organizations to be more impactful in the community.

These sessions, being held by the LHIN on November 23, 26, and 30 are open to board members across the health sector.

Recommendation:

Receive.

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

CONFIDENTIAL

The Board of Health will move in camera to discuss matters regarding a proposed or pending acquisition of land by the Middlesex-London Board of Health and consider confidential minutes from its October 27 Board of Health and November 3 Finance and Facilities Committee meetings.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, October 27, 2016 5:00 p.m.

MEMBERS PRESENT:	**Mr. Jesse Helmer** (Chair) Mr. Trevor Hunter Ms. Trish Fulton Mr. Ian Peer Mr. Marcel Meyer Ms. Joanne Vanderheyden (Vice-Chair)
REGRETS:	Mr. Kurtis Smith Dr. Christopher Mackie, Medical Officer of Health & CEO
MEDIA:	Grant Demmie, XFM Fanshawe
OTHERS PRESENT:	Ms. Laura Di Cesare, Director, Corporate Services (Acting CEO & Secretary-Treasurer) Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder) Mr. Jordan Banninga, Manager, Strategic Projects Ms. Corrine Berinstein, Senior Audit Manager, Treasury Board Secretariat Dr. Gayane Hovhannisyan, Associate Medical Officer of Health Mr. Dan Flaherty, Manager, Communications Ms. Heather Lokko, Manager, Healthy Start Mr. John Millson, Associate Director, Finance Ms. Suzanne Vandervoort, Director, Healthy Living

Chair Helmer called the meeting to order at 5:02 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Helmer inquired if there were any disclosures of pecuniary interest. None were declared.

APPROVAL OF AGENDA

It was moved by Ms. Vanderheyden seconded by Mr. Meyer *that the **AGENDA** for the October 27, 2016 Board of Health meeting be approved.*

Carried

BOARD OF HEALTH DEVELOPMENT SESSION

The Board of Health participated in a risk management session facilitated by Ms. Corrine Berinstein, Senior Audit Manager, Treasury Board Secretariat, Ministry of Health and Long-Term Care.

CONFIDENTIAL

At 5:03 p.m., Chair Helmer invited a motion to move in camera to conduct the Board of Health risk management training, and also to discuss matters regarding identifiable individuals, a proposed or pending acquisition of land and consider in-camera minutes from it's September 15, 2016 Board of Health meeting and October 6, 2016 Finance and Facilities Committee meeting.

At 5:03 p.m., it was moved by Mr. Peer, seconded by Mr. Hunter *that the Board of Health move in camera to conduct the risk management training, and also to discuss matters regarding identifiable individuals, a proposed or pending acquisition of land and consider in-camera minutes from its September 15, 2016 Board of Health meeting and October 6, 2016 Finance and Facilities Committee meeting.*

Carried

At 5:03 p.m. all visitors and Health Unit staff, except Ms. Corrine Berinstein, Ms. Laura Di Cesare, Dr. Hovhannisyan, Mr. Jordan Banninga, Ms. Suzanne Vandervoort, Ms. Heather Lokko, Mr. John Millson, and Ms. Elizabeth Milne left the meeting.

At 6:52 p.m. it was moved by Mrs. Vanderheyden, seconded by Mr. Peer *that the Board of Health rise and return to public session.*

Carried

At 6:52 p.m. the Board of Health returned to public session.

Chair Helmer invited a motion to take a 5 minute recess before resuming the Board of Health meeting.

It was moved by Mr. Peer, seconded by Ms. Fulton *that the Board of Health take a 5 minute recess before resuming with the remaining agenda items.*

Carried

COMMITTEE REPORTS

1) Finance and Facilities Committee Meeting October 6, 2016 (Report No. 058-16)

Ms. Fulton provided a summary of the recommendations from the October 6, 2016 Finance and Facilities Committee (FFC) meeting.

It was moved by Ms. Fulton, seconded by Mr. Peer *that the Board of Health receive the October 6, 2016 Finance and Facilities Committee draft minutes.*

Carried

Health Unit Insurance Policy Review (Report No. 040-16FFC)

It was moved by Ms. Fulton, seconded by Mr. Peer, *that the Board of Health receive Report No. 040-16FFC, re: "Health Unit Insurance Policy Review" for information.*

Carried

2016 Budget – MOHLTC Approved Grants (Report No. 036-16FFC)

It was moved by Ms. Fulton, seconded by Mr. Hunter *that the Board of Health receive and approve the Board Chair to sign the Amending Agreement No. 5 to the Public Health Funding Accountability Agreement as appended to Report No. 036-16FFC.*

Carried

2016 PBMA Process Update Report (Report No. 037-16FFC)

It was moved by Ms. Fulton, seconded by Mr. Peer *that the Board of Health receive Report No. 037-16FFC, re: "2016 PBMA Process – Update Report" for information.*

Carried

2016 Public Health Financial & Accountability Agreement Indicators (Report No. 038-16FFC)

It was moved by Ms. Fulton, seconded by Mr. Hunter *that the Board of Health receive Report No. 038-16FFC 2016 Public Health Financial & Accountability Agreement Indicators for information.*

Carried

2017 Revised Budget Parameters (Report No. 039-16FFC)

It was moved by Ms. Fulton, seconded by Ms. Vanderheyden *that the Board of Health approve the revision of the previously approved 2017 budget parameters for provincial funding for Mandatory Programs to 1.5%.*

Carried

The next Finance and Facilities Committee meeting will be Thursday, November 3, 2016 @ 9:00 a.m.

INFORMATION REPORTS

2) Medical Officer of Health Activity Report – October (Report No. 059-16)

It was moved by Ms. Cassidy, seconded by Mr. Meyer, *that the Board of Health receive Report No.059-16 re: Medical Officer of Health Activity Report – October for information.*

Carried

CORRESPONDENCE

It was moved by Ms. Vanderheyden, seconded by Ms. Fulton *that the Board of Health endorse correspondence item a) Bill 17: Saving the Girl next door.*

Carried

OTHER BUSINESS

Chair Helmer reviewed the upcoming meetings:

- Finance and Facilities Committee Meeting: Thursday November 3, 2016 @ 9:00 a.m.
- Board of Health Meeting: Thursday November 17, 2016

APPROVAL OF MINUTES

It was moved by Mr. Meyer, seconded by Ms. Fulton, *that the **MINUTES** for the September 15, 2016 Board of Health meeting be approved.*

Carried

ADJOURNMENT

At 7:06 p.m., it was moved by Ms. Vanderheyden seconded by Mr. Peer *that the meeting be adjourned.*

Carried

JESSE HELMER
Chair

LAURA DI CESARE
Acting CEO & Secretary-Treasurer

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
399 Ridout Street North
MIDDLESEX-LONDON BOARD OF HEALTH
2016 November 3, 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 & CEO
Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder)
Ms. Laura Di Cesare, Director, Corporate Services
Mr. John Millson, Associate Director, Finance
Mr. Jordan Banninga, Manager, Strategic Projects

At 9:05 a.m., Chair Fulton called the meeting to order.

DISCLOSURES OF CONFLICTS OF INTEREST

Chair Fulton inquired if there were any disclosures of conflicts of interest.

Ms. Vanderheyden declared that she sits on the Board of Governors for the Western Fair District, regarding Report No. 042-16FFC, Appendix B, item 10.

APPROVAL OF AGENDA

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden *that the **AGENDA*** for the November 3, 2016 *Finance and Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Vanderheyden, seconded by Mr. Peer *that the **MINUTES** from the October 6, 2016 Finance and Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 Proposed Resource Reallocation for the 2017 Budget (Report No. 041-16FFC)

Mr. Millson introduced this report and provided a summary of the investments and disinvestments included in the appendices of this report. These items will be incorporated into the 2017 budget process.

A fulsome discussion ensued about many of the investment and disinvestment items, which included:

- What could change between now and the end of the year, unapproved proposals that will be brought forward by staff as an added layer of transparency and the incorporation of resource allocations into the Program Budget Templates for 2017.

- Further details were provided regarding the disinvestment of the Vector-Borne Disease Lab Technician and it was noted that this was a service identified as being provided by the province and service providers and therefore an in-house lab was no longer a requirement.
- Clarification of the student Public Health Inspector position, Public Health Dietician roles and the Drug Strategy Health Promoter role. Further details were also provided by staff on the cooling tower project, vulnerable occupancy inspection work, the Community Drug and Alcohol Strategy.

Mr. Helmer noted that staff could work with the city to receive support for vulnerable occupancy work going forward.

The Committee also had significant discussion around the HIV Prevention and Control Investment Proposal, which included:

- Timelines and next steps, how the outreach team will work within the current Health Unit structure and maintaining the safety of staff on this new team. It was noted that staff will add a sentence to this investment description to note that the outreach team will include a current full time staff member in its complement.
- The possibility of requesting 100% funding for this project from the Province or Local Health Integration Network and advocating for additional resources for HIV Prevention.
- The changes around anonymous HIV testing provided to clients and if these changes might drive deter clients from being tested. Staff will provide an update on this and bring it back to the Committee at a later date.
- Safe injection sites, the associated costs and the pending results from the feasibility study.

It was moved by Mr. Meyer, seconded by Mr. Peer, *that the Finance & Facilities Committee receive Report No. 041-16FFC re: Proposed Resource Reallocation for the 2017 Budget for information.*

Carried

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden *that the Finance and Facilities recommend that the Board of Health request funding from the Province and the Local Health Integration Network to support additional resources and funding for HIV Prevention, Outreach and Control.*

Carried

4.2 Third Quarter Variance Report (Report No. 042-16FFC)

Mr. Millson provided context to this report and summarized some items for discussion which included: applications for additional funding, additional resources which will be put into training and two additional rent invoices received from the second quarter, noting that utilities and maintenance costs have increased significantly.

Discussion ensued about the anticipated gapping budget and projections that indicate that the Health Unit will meet its full year gapping target.

Ms. Vanderheyden noted her abstention from this motion related to her possible conflict of interest.

It was moved by Mr. Helmer, seconded by Ms. Peer, *that the Finance & Facilities Committee review and recommend to the Board of Health to receive Report No. 042-16FFC re: "Q3 Financial Update & Factual Certificate" and appendices for information.*

Carried

CONFIDENTIAL

At 10:12 a.m. Chair Fulton invited a motion to move in camera to discuss items regarding a proposed or pending acquisition of land by the Middlesex-London Board of Health.

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

Carried

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden that the Finance and Facilities Committee return to return to public session.

At 11:24 a.m. the Finance and Facilities Committee returned to public session.

OTHER BUSINESS

Next meeting: Thursday December 1, 2016 at 9:00 a.m.

Ms. Fulton noted that she will not be able to attend the next meeting on December 1. Board of Health Chair, Mr. Helmer will take Ms. Fulton's place as Chair at this meeting.

ADJOURNMENT

It was moved by Ms. Vanderheyden, seconded by Mr. Meyer, that the Finance and Facilities Committee adjourn the meeting.

Carried

At 11:27 a.m. Chair Fulton *adjourned the meeting.*

_____ _____

TRISH FULTON
Committee Chair

DR.CHRISTOPHER MACKIE
Secretary-Treasurer

MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, July 21, 2016 6:00 p.m.

Committee Members Present: Mr. Trevor Hunter (Chair)
Mr. Jesse Helmer
Mr. Kurtis Smith

Others Present: Mr. Ian Peer
Ms. Joanne Vanderheyden
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

Chair Hunter called the meeting to order at 6:00 p.m.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Hunter 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. Helmer, seconded by Mr. Hunter *that the AGENDA for the July 21, 2016 Governance Committee meeting be approved.*

Carried

3. APPROVAL OF MINUTES

It was moved by Mr. Helmer, seconded by Mr. Hunter *that the MINUTES from the April 21, 2016 Governance Committee meeting be approved.*

Carried

4. NEW BUSINESS

4.1 Board of Health Development Session (Report No. 013-16GC)

Discussion ensued about risk mitigation, the importance of developing Board member skills and scheduling a date for the development session. Staff will poll Board members to find a date that works best for the majority.

Mr. Smith arrived at 6:04 pm.

It was moved by Mr. Smith, seconded by Mr. Helmer *that the the Governance Committee:*
1) Receive Report No. 013-16GC re: Board of Health Development Session for information; and
2) Recommend that the Board of Health approve the scheduling of a Board development session in the Fall.

Carried

4.2 2015-2020 Strategic Plan Update (Report No. 014-16GC)

Chair Hunter summarized the addition of a strategic objective that was made in the Strategic Plan, for Program Excellence. Discussion ensued around the importance of adding this strategic objective.

It was moved by Mr. Helmer seconded by Mr. Smith *that the Governance Committee:*
1) Recommend that the Board of Health approve the addition of a strategic objective for Program Excellence; and
2) Receive Report No. 014-16GC 2015-2020 Strategic Plan Update.

Carried

4.3 Nomination and Appointment Process Update (Report No. 015-16GC)

Chair Hunter introduced and provided some context to this report and why the diversity survey was developed.

Discussion ensued about the following items:

- The structure of questions on the survey and a request to add an open-ended text box at the end.
- The urgency in filling vacant positions to ensure full Board and sub-committee complement.
- How survey questions will be analyzed and weighted in order to fill vacant positions.
- The importance of ensuring that vacancies are advertised to a wide audience and pool of candidates.
- Discussion highlights the need for an open text box at the end of the survey.

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

1) Recommend that the Board of Health request that Board Members complete the updated diversity survey, attached as Appendix A;
2) Recommend that the Board of Health approve the forwarding of the anonymized results of the survey to the Ministry of Health and Long-Term Care for their consideration during the public appointments process and to other appointing bodies as appropriate; and
3) Recommend that the Board of Health provide direction to staff regarding the promotion of Board of Health position opportunities.

Carried

Chair Hunter flagged the current membership complement for discussion. Since the Board of Health is currently not functioning at capacity, the Governance Committee is missing a Provincial representative. The Committee agreed to appoint a Provincial representative on an interim basis. This request will be brought forward for discussion at the Board of Health meeting during the verbal update.

4.4 Review of 2016 Governance Meeting Dates (Report No. 016-16GC)

Chair Hunter suggested the Governance Committee meet at a different date or time to provide additional time to review reports when making recommendation to the Board of Health.

Discussion ensued about changing the date and time, creating a template to summarize Governance Committee motions and starting the meeting earlier.

Dr. Mackie advised that Committee meetings are set at the beginning of the year and additional meetings are at the call of the Chair. The next Governance Committee meeting identified by staff would be in November, since the October meeting would likely be replaced with the Board of Health development session.

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

1) *Receive Report No. 016-16GC; and*
2) *Set Governance Committee meeting time to 5:30 p.m., going forward.*

Carried

5. OTHER BUSINESS

The next Governance Committee meeting is scheduled for Thursday November 17 at 5:30 p.m.

Mr. Smith flagged the membership complement and Dr. Mackie advised that quorum is 50 percent of the member plus 1.

6. ADJOURNMENT

At 6:51 p.m. it was moved by Mr. Smith, seconded by Mr. Helmer *that the meeting be adjourned.*

Carried

_____ _____

TREVOR HUNTER
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 061-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 November 17

FINANCE AND FACILITIES COMMITTEE MEETING – NOVEMBER 3

The Finance and Facilities Committee met at 9:00 a.m. on Thursday November 3, 2016. A full summary of the discussion can be found in the Minutes.

The following reports were reviewed at the meeting and recommendations made:

Reports	Recommendations for Board of Health's Consideration and Information
Proposed Resource Reallocation for the 2017 Budget **(Report No. 041-16FFC)**	It was moved by Mr. Meyer, seconded by Mr. Peer, *that the Finance & Facilities Committee receive Report No. 041-16FFC re: Proposed Resource Reallocation for the 2017 Budget for information* Carried It was moved by Mr. Meyer, seconded by Ms. Vanderheyden *that the Finance and Facilities request additional funding from the Province and the Local Health Integration Network to support additional resources and funding for HIV Prevention, Outreach and Control.* Carried
Third Quarter Variance Report **(Report No. 042-16FFC)**	It was moved by Mr. Helmer, seconded by Ms. Peer, *that the Finance & Facilities Committee review and recommend to the Board of Health to receive Report No. 042-16FFC re: "Q3 Financial Update & Factual Certificate" and appendices for information.* Carried

The next Finance and Facilities Committee meeting will be Thursday, December 1, 2016 at 9:00 a.m.

This report was prepared by Elizabeth Milne, Executive Assistant to the Board of Health and Communications.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 062-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 November 17

OPIOID ADDICTION AND OVERDOSE

Recommendation

It is recommended that the Board of Health

1. ***Endorse Report No. 062-16 Re: "Opioid Addiction and Overdose" and***
2. ***Recommend to The College of Physician and Surgeons of Ontario (CPSO) that when prescribing opiates, patients should also be prescribed and counselled on use of naloxone to help prevent potentially fatal complications associated with opioid overdose.***

Key Points

- Between 2010 and 2014, the number of prescription opioids legally dispensed in Canada climbed almost 24 percent. More than 21.7 million prescriptions for opioids were dispensed last year in Canada.
- Opioid misuse is the third leading cause of accidental death in Ontario.
- Improved access to naloxone for all patients prescribed opioids is recommended to decrease life-threatening risks associated with overdose. Regulatory changes making naloxone more easily available mean there is greater opportunity to ensure that opioid users have it available if needed.

Background

Narcotic pain medications, also known as opioids, are prescribed by physicians for the treatment of pain and their distribution is tightly regulated through the Controlled Drug and Substances Act. Between 2010 and 2014, the number of prescription opioids legally dispensed in Canada climbed almost 24 percent with more than 21.7 million prescriptions dispensed last year. However, opioid misuse is the third leading cause of accidental death in Ontario.

An overdose of opioid drugs - such as fentanyl, morphine, heroin, methadone or oxycodone - can cause a person's breathing to slow or stop. Naloxone is a medication that can temporarily reverse this effect so that the person can breathe more normally and potentially regain consciousness. Timely administration of naloxone can provide precious time to seek emergency medical attention and treat the overdose.

Beginning in June 2014, emergency naloxone kits and training have been made available to people who inject drugs in Middlesex-London as a harm-reduction response to overdoses occurring in the community attributed to the recreational use of opioids. To ensure accessibility, client training and naloxone kit distribution is provided through several locations including the Needle Syringe Program at the Health Unit, Needle Syringe Program at the Regional HIV / Aids Connection and Hepatitis C Program at the London Intercommunity Health Centre.

Since implementation, there have been 163 people trained and provided with naloxone kits. These kits have been used in 13 successful resuscitations. Further to the resuscitations associated with naloxone kit use, Emergency Medical Services (EMS) in London-Middlesex administered 47 doses of naloxone last year and 31 doses as of October this year when responding to 9-1-1 calls for overdoses.

Recent Regulatory Changes

Last month, in recognition that opioid addiction and overdose is a serious public health concern, the Ministry of Health lifted restrictions on who could be provided with naloxone kits and allowed for sites that provide naloxone kits to begin training and providing kits to friends and family members, as well. Previously, the kits were available only to those who were at risk for overdose and were also clients of the needle exchange or Hepatitis C programs.

In response to calls from Ontario and other provinces and territories for Health Canada to remove the prescription status of naloxone, the National Association of Pharmacy Regulatory Authorities (NAPRA) also recently reclassified naloxone as a Schedule II drug when used in an emergency opioid overdose situation outside of hospital settings. This change was effective immediately in Ontario. As a result, naloxone can now be kept behind the counter in Ontario pharmacies and dispensed without a prescription or charge to those who are at risk of an overdose (as well as their concerned family members or peers). Additionally, pharmacists are able to provide training on how to safely administer the drug. There are currently forty-nine pharmacies in Middlesex-London that can dispense naloxone.

Next Steps

The Minister of Health has announced a comprehensive strategy to address opioid misuse and addictions. Risk of overdose is not limited to those who use opioids recreationally, but the risk is also quite present to those who are legally prescribed these medications. Actions will be focused on better informing Canadians about the risks of opioids, supporting better prescribing practices, reducing easy access to unnecessary opioids, supporting better treatment options, and improving the national evidence base. Part of this strategy aims to ensure Ontario health care providers have the tools, resources and information needed to provide the highest-quality care to patients. Patients look to their health care providers for leadership and guidance.

As part of the strategy, we believe it would be helpful for the Board of Health to recommend to the CPSO that, as a matter of best practice when physicians are prescribing opiates, they also provide the patient with a prescription for and information about how to access and use naloxone.

This report was prepared by Shaya Dhinsa, Manager of Sexual Health.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 063-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health and CEO

DATE: 2016 November 17

2016 NUTRITIOUS FOOD BASKET SURVEY RESULTS AND IMPLICATIONS FOR GOVERNMENT PUBLIC POLICY

Recommendations

It is recommended that the Board of Health:

1. ***Write to the Premier of Ontario and the Ontario Minister responsible for the Poverty Reduction Strategy and also direct staff to prepare a written submission to the Ontario Government's Basic Income Pilot Consultation recognizing the Government's commitment to a basic income pilot and urging that it be funded at a sufficient level to ensure adequate benefits and strong study design.***
2. ***Write to the Minister of Community and Social Services and local MPP's in support of Bill 6, Ministry of Community Social Services Amendment Act (Social Assistance Research Commission).***
3. ***Write to the Minister of Health and Long-Term Care supporting the inclusion of the Nutritious Food Basket standard in the modernized Ontario Public Health Standards with updates to the Nutritious Food Basket Guidance Document based on input from public health staff.***
4. ***Forward Report No. 063-16 re "2016 Nutritious Food Basket Survey Results and Implications for Government Public Policy" to Ontario Boards of Health, the City of London, Middlesex County & appropriate community agencies.***

Key Points

- The Nutritious Food Basket survey, conducted annually by all public health units in Ontario to monitor food affordability for various individual and family income scenarios, repeatedly demonstrates that incomes are not adequate for many Middlesex-London residents to afford basic needs.
- Social determinants of health (e.g., food access, income, housing and employment) explain part of the health inequities that exist within and across societies and are strongly influenced by public policy.

Background

Each year in May, Ontario public health units conduct the Nutritious Food Basket (NFB) survey in accordance with the Ontario Public Health Standards. The survey provides a measure of the cost of basic healthy eating. The NFB results are used to monitor food affordability by comparing the local cost of the food basket and rental costs to various individual and family income scenarios. Poor nutrition increases the risk of chronic and infectious diseases, and negatively impacts the growth and development of children.

Survey Results

In May 2016, the estimated local monthly cost to feed a family of four was $862.32. This is a $1.65 or 0.2% increase from the estimated cost in May 2015. Estimated food costs are a snapshot of the prices at the time. Any increase or decrease year to year may or may not represent a significant change, especially in context with other changes (e.g., utilities and housing costs, incomes). In general, food is affordable for Middlesex-London residents with adequate incomes. A family of four with average income spends only about 12% of their income after-tax on food. Individuals and families with low incomes spend up to 40% of their income on food, not because food costs too much, but because their incomes are too low.

Table 1 highlights scenarios for Middlesex-London residents, utilizing 2016 income rates, rental costs and food costs. This survey again shows that people with low incomes cannot afford to eat healthy after

meeting other essential needs for basic living. Appendix A, ***"Food Security in Middlesex-London (2016)"***, provides an overview of local food security, income adequacy and opportunities for community action.

Table 1 – Monthly Income and Cost of Living Scenarios for 2016

	Single Man Ontario Works	Single Man ODSP	Single Woman over 70 Old Age Security /Guaranteed Income Security	Family of 4 Ontario Works	Family of 4 Minimum Wage Earner	Family of 4 Average Income (after tax)
Income (Including Benefits & Credits)	$768	$1206	$1563	$2227	$2940	$7448
Estimated Rent**	$603	$781	$781	$1058	$1058	$1058
Food (Nutritious Food Basket)	289.73	289.73	$210.44	$862.32	$862.32	$862.32
WHAT'S LEFT?*	**-$124.73**	**$135.27**	**$571.56**	**$306.68**	**$1019.68**	**$5527.68**

* People still need funds for utilities, phone, transportation, cleaning supplies, personal care items, clothing, gifts, entertainment, internet, school supplies, medical and dental costs and other costs.

**Rental estimates are from *Canadian Mortgage and Housing Corporation Rental Market Statistics, Fall 2015*. Utility costs may or may not be included in the rental estimates.

Opportunities for Action

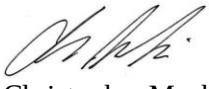
The social determinants of health, such as food access, income, housing and employment, are strongly influenced by government public policy decisions. Annually the Board of Health utilizes the NFB data and income scenarios to advocate for public policies that positively impact these determinants of health.

In 2015, the Board of Health supported basic income (Report 50-15). The Ontario government announced a basic income pilot in the 2016 budget and is seeking public input. This requires a strong research design and sufficient funding to ensure an appropriate sample size, an adequate benefit level for participants and an adequate pilot duration to effectively inform future policy decisions. Data collection requires sufficient details about changes in participants' behaviours and quality of life.

The Board of Health has repeatedly urged the province to increase social assistance rates to reflect the rising cost of food and housing (Report 50-15, Report 53-14). Bill 6, *Ministry of Community Social Services Amendment Act* (Social Assistance Research Commission), would establish an advisory group that annually recommends regional Ontario social assistance rates based on actual costs, including food, shelter, transportation. The Bill unanimously passed second reading in September and was referred to committee. Bill 6 could improve incomes for people on social assistance, which would substantially improve health.

In November 2015, the Minister of Health and Long-Term Care announced a review of the Ontario Public Health Standards (OPHS). Monitoring food affordability helps generate evidence-based recommendations for adequate incomes and should be included in the modernized OPHS; however, the Nutrition Food Basket Guidance Document requires revision, with input from public health dietitians, due to the changing nature of food products over time and Canadian consumption patterns.

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

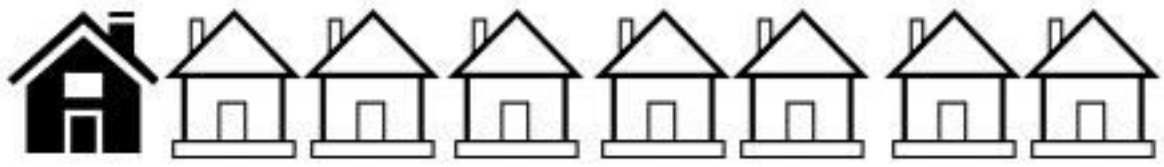


Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health and CEO

Food Security in Middlesex-London

2016

All residents should have access to a nutritious, adequate & culturally acceptable diet.



About 1 in 8 Middlesex-London households are food insecure

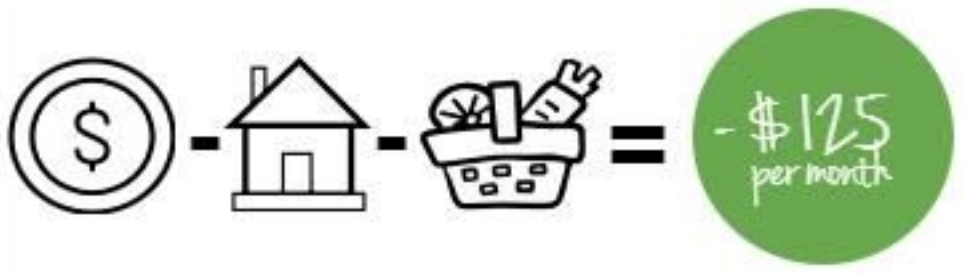
When money is tight, people cut food budgets to pay for other expenses.

They buy cheaper, less nutritious foods or skip meals.

Poor diets increase risk of infectious & chronic diseases (e.g. diabetes, heart disease, cancer).

Social assistance rates are NOT ENOUGH

Single people receiving social assistance do not have enough money for adequate housing and healthy food



Many incomes are NOT ENOUGH

3 out of 5 food insecure households have paid employment

What can you do?

- Advocate for basic income, living wage, increased social assistance
- Find out what type of community organizer you are www.ifyouknew.ca
- Read "London for All: A Roadmap to End Poverty"
- Support social enterprises and businesses that give back to the community
- Volunteer time, skills, food or money
- Volunteer as an ally, child minder or meal provider
  - Thrive crystal@wrrcsa.org
  - Bridges Out of Poverty / Circles sclarke@goodwillindustries.ca

www.healthunit.com/cost-of-healthy-eating

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 064-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 November 17

SALMONELLA TYPHIMURIUM OUTBREAK INVESTIGATION

Recommendation

It is recommended that Report No. 064-16 re "Salmonella Typhimurium Outbreak Investigation" be received for information.

Key Points

- From August 1 to September 30, 2016, 63 salmonellosis cases were reported to the Health Unit; 39 of these cases were related to a local food establishment. Based on historical data, the Health Unit would normally expect to be notified of 15 cases over this time period.
- Collaboration between staff and external partners resulted in rapid detection of a common source and implementation of control measures that prevented further disease in the community.

Epidemiological Summary

From August 1 to September 30, 2016, the Health Unit received reports of 63 potential salmonellosis cases (45 were confirmed, 14 were probable, and 4 did not meet case definition). An investigation into a potential cluster began on August 22, 2016 when six confirmed salmonellosis cases were reported to the Health Unit. The Infectious Disease Control (IDC) team lead investigator alerted Public Health Ontario (PHO) to determine if the increased number of cases was observed across the province.

A pizza and shawarma restaurant in London was identified as a common source for 39 locally reported cases (25 confirmed, 14 probable), in addition to five cases which were reported from other health units (4 confirmed, 1 probable). Symptom onset dates were from August 10 to Aug 28, 2016 (Figure 1, Appendix A). Exposures to this establishment were reported August 10 to August 26, 2016. The median age of outbreak-related cases was 27 years, with a range of 1 to 54 years. Females accounted for 52% of outbreak-related cases. Laboratory results indicated that the outbreak organism was Salmonella Typhimurium, Phage Type 108, PFGE STXAI.0312/STBNI.0022.

Case Investigation

Use of a unique interviewer to survey patients in the initial phase of the investigation allowed for the rapid identification of a potential link between clinical cases and a food premise. The investigator noted a common restaurant exposure that also had been identified by another health unit. Further case follow-up confirmed this establishment as a common exposure for several cases. Case addresses had also been mapped to identify potential geographic links before a common exposure had been identified (Figure 2, Appendix A).

Food Safety Investigation

Chicken shawarma was identified as the most likely source of the outbreak as it was the most commonly reported food item. It was hypothesized that the chicken was temperature-abused during transportation from the distributor to the restaurant and not cooked fully to a safe internal temperature before serving. Food

handling staff or contaminated equipment may have continued to infect the food and environment prior to an identification of the source of the outbreak being made. This may account for the extended exposure dates reported by cases. Following identification of the establishment as a common source, the Food Safety team supervised a thorough cleaning, after which no additional cases were reported. The operator of the establishment was cooperative throughout the investigation.

A weak link in the food production chain related to transportation and receiving of food deliveries was identified. Some independent food suppliers not associated with a manufacturer may not follow the same food safety standards as those suppliers who are directly associated with a manufacturer.

Internal and External Collaboration

Communication between the IDC team, Environmental Health Food Safety team, and the designated epidemiologist for this division, was instrumental in this outbreak response. Coordination between public health inspectors was efficient while conducting investigations at identified premises. This included collecting food samples, obtaining supplier information, and maintaining on-going surveillance at the identified establishment. Once the suspect source became evident, the IDC lead investigator coordinated with other members of the IDC team to contact the increased volume of identified cases. As well, the lead investigator and Epidemiologist worked closely to identify commonalities between cases and to prepare data to be shared both internally and with partner agencies. Internal communications also included immediate notification of the outbreak status to Medical Officer of Health and Senior Leadership Team.

The outbreak response involved coordination between Health Unit staff and partner agencies: Public Health Ontario (PHO), the PHO Laboratory, the Canadian Food Inspection Agency (CFIA), and the Ontario Ministry of Agriculture, Food and Rural Affairs (OMAFRA).

Transparency: Media Release

As it was difficult to establish a connection between cases in the early stages of the investigation, a media release indicating a spike in salmonellosis cases was issued on August 26, 2016 in advance of identifying a source. This was very effective in helping to identify additional cases which served to establish a more obvious linkage to the food establishment. A second media release was issued September 6, 2016 once the food establishment was identified as the likely source. The Health Unit received positive reviews for its proactive response and transparency with the community.

Next Steps

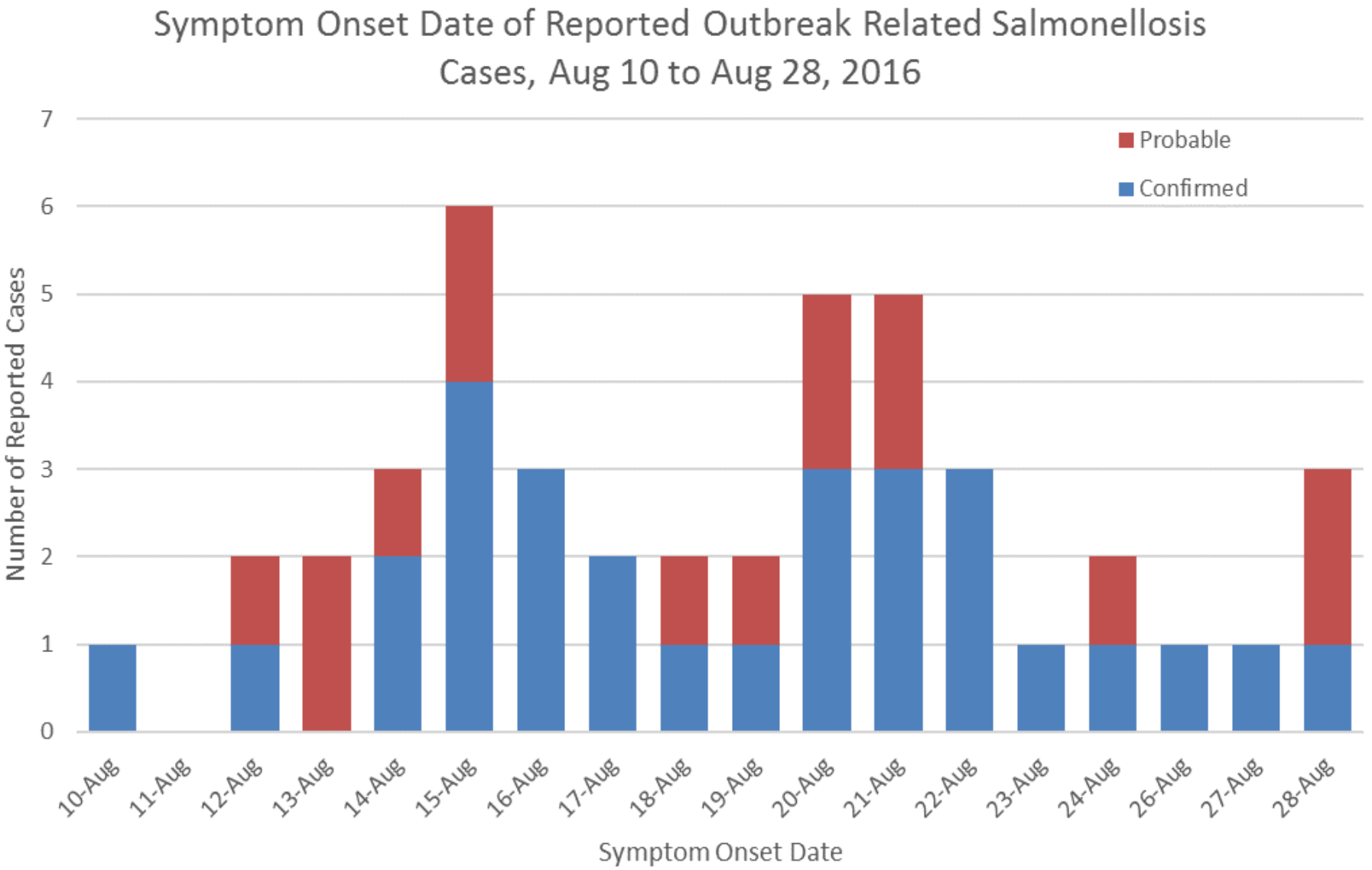
Food Safety staff are investigating alternative methods for cooking chicken shawarma, such as freezing the chicken prior to cooking, as well as addressing hand hygiene, sanitation, and internal cooking temperatures. Owners/operators will be encouraged to pay attention to food deliveries and thoroughly check the product before it is received; the Health Unit has created a webpage for owners/operators to access these recommendations: http://www.healthunit.com/food-delivery.

This report was prepared by Carrie Warring, Public Health Inspector, Food Safety Team; Joanne Dow, Public Health Nurse, Infectious Disease Control Team; and Theresa Procter, Epidemiologist, Foundational Standard.

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

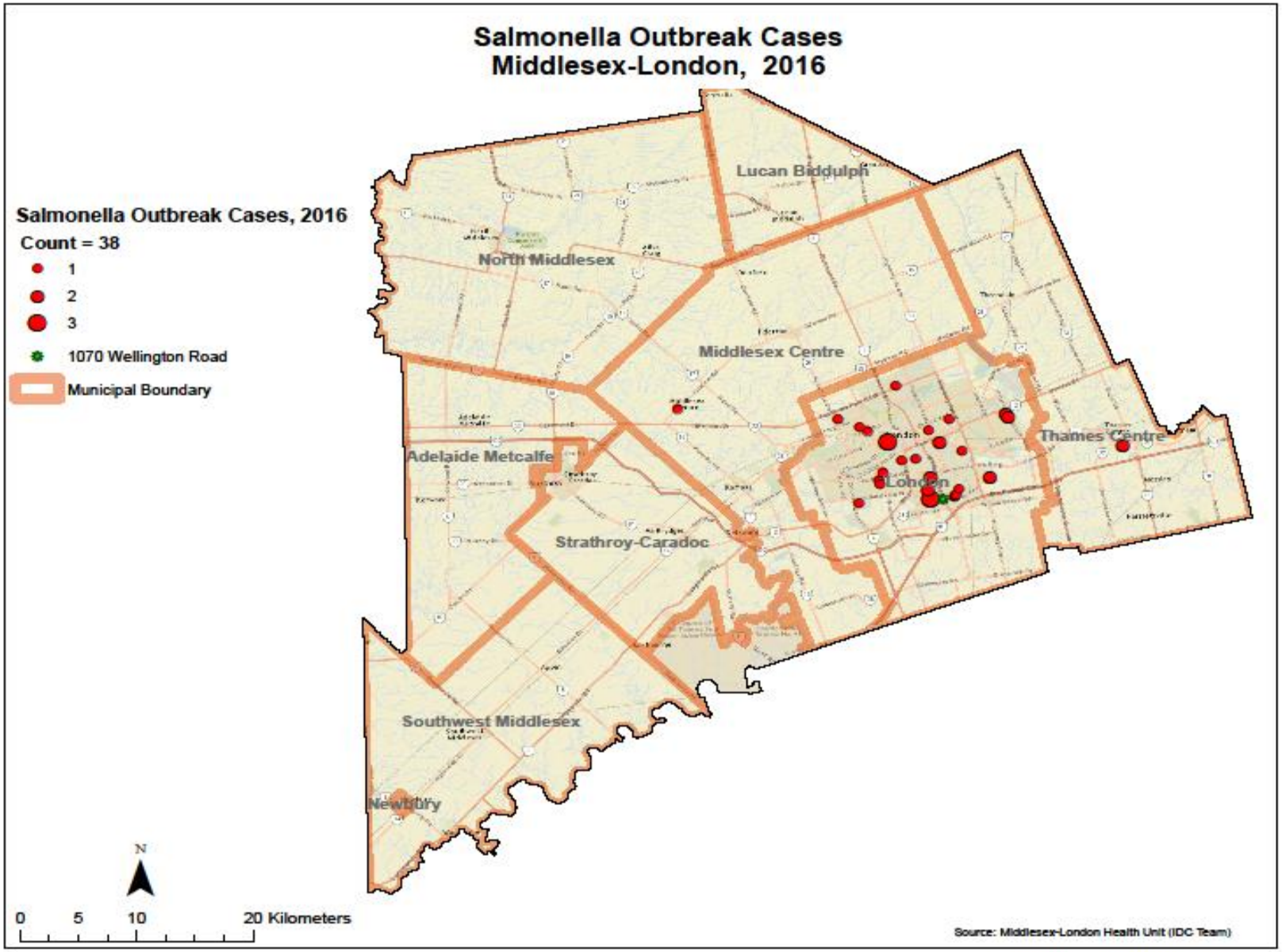
Appendix A to Report 064-16

Figure 1



Appendix A to Report 064-16

Figure 2



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 065-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 November 17

2015-2016 INFLUENZA SEASON IN MIDDLESEX-LONDON - FINAL REPORT

Recommendation

It is recommended that Report No. 065-16 re 2015-2016 Influenza Season in Middlesex-London– Final Report be received for information.

Key Points

- There were 489 laboratory-confirmed cases, 197 hospitalizations, 19 deaths and 12 confirmed facility influenza outbreaks during the 2015-16 Influenza Season; the number of laboratory confirmed influenza cases was higher than in previous seasons
- The predominant strain during the 2015-2016 influenza season was influenza A (H1N1)pdm09
- The Health Unit began distributing influenza vaccine for the 2016-2017 flu season to Health Care Providers in early October.

Overview

This report provides the final analysis of the 2015-2016 influenza season (see Table 1 for comparison with previous years). In total, 489 laboratory-confirmed cases of influenza were reported to the Health Unit during the 2015-2016 season. It should be noted that many more people may have been infected with influenza but did not have laboratory testing performed and so were not reported to the Health Unit. A graph outlining when laboratory-confirmed cases occurred is shown in Appendix A (Figure 1).

Table 1: Influenza Cases, Middlesex-London, 2011-2012 through 2015-2016 Influenza Seasons

	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Laboratory-confirmed Cases	106	477	407	381	**489**
Hospitalizations	34	301	206	161	**197**
Deaths	3	26	17	14	**19**
Outbreaks	6	40	19	40	**12**

Cases ranged in age from 13 days to 101 years old. For cases whose ages were known, those aged 65 years and older accounted for 31% (150/487) of cases, followed by those aged 20-49 years, who accounted for 29% (142/487) of cases. There were 197 individuals with laboratory-confirmed influenza who were hospitalized; this represents 40% (197/489) of laboratory-confirmed cases. Those aged 65 years and older accounted for 43% (85/196) of hospitalized cases. There were 19 deaths reported among individuals with laboratory-confirmed influenza. The number of deaths was highest amongst those 65 years of age and older, representing 63% (12/19) of deaths among reported influenza cases.

Influenza Outbreaks

During the 2015-2016 season, 12 influenza outbreaks were declared in facilities; nine in long-term care settings, one in a retirement home, one in a daycare, and one in a detention centre. Attack rates ranged from 3% to 77%. Duration of influenza outbreaks ranged from 6 to 18 days. Of the 12 outbreaks, influenza A was

identified in nine outbreaks and influenza B was identified in three outbreaks. Laboratory confirmed cases of influenza identified in facilities accounted for 9% (42/489) of cases. It should be noted that a number of cases associated with influenza outbreaks were identified but were not laboratory confirmed and are not included in this analysis. A graph outlining when outbreaks occurred is shown in Appendix A (Figure 2).

The rate of influenza by health unit within Ontario is shown in Appendix A (Figure 3). Median immunization coverage rates of staff at long term care homes and hospitals in the Health Unit and Ontario are shown in Appendix A (Figure 4).

Timing of the Season and Strain Typing

The influenza season typically occurs from October to April. The peak of the influenza season was later than in previous years. As indicated in Figure 1 of Appendix A, the first confirmed influenza case was reported to the health unit on October 7, 2015 and had an onset of symptoms on October 4, 2015. Influenza activity did not intensify until late January. The last case was reported on May 24, 2016. Of the 489 laboratory-confirmed cases in Middlesex-London, 66% (324/489) were influenza A, 34% (164/489) were influenza B, and 0.2% (1/489) were co-infected with influenza A and B. Both influenza A and B peaked at the same time in mid-March. Of the influenza A cases identified 23% (75/324) were typed as influenza A(H1N1)pdm 09, 1.2% (4/324) were typed influenza A(H3), 0.3% (1/324) were co-infected with influenza A(H1N1)pdm 09 and Influenza A (H3), and 75% (244/324) were not typed. Strain typing was conducted on 18 samples from Middlesex London. Eight cases were strain typed as influenza A/California/07/09-like, one was strain typed as A/Switzerland/97/15293/2013-like and four were strain typed as B/Phuket/3073/2013-like all of which were components of the 2015-2016 seasonal influenza vaccines. Five samples were typed as influenza B/Brisbane/60/2008-like which was a component of the 2015-2016 quadrivalent influenza vaccine.

Influenza Immunization

The Health Unit distributed 179,230 doses of influenza vaccine to Health Care Providers in London and Middlesex County in the 2015-2016 influenza season; distribution for the 2016-2017 season has begun. Those over 18 years of age are offered trivalent influenza vaccine which protects against three strains (two A and one B) of influenza viruses. Those aged 6 months through 17 years are offered quadrivalent vaccine which offers protection against two Influenza A strains and two Influenza B stains, as the burden of illness caused by Influenza B strains is highest in this age group. The Health Unit will be offering influenza vaccine during its regularly scheduled Immunization Clinics.

Conclusion

The number of confirmed cases during the 2015-2016 influenza season was higher than the previous season. Cases were reported from October 2015 to May 2016. Influenza A and B peaked in mid-March. The predominant strain of influenza identified this season was influenza A (H1N1)pdm09. The Health Unit will continue to encourage yearly influenza vaccination to reduce the risk of influenza infection in the population for the 2016-2017 season.

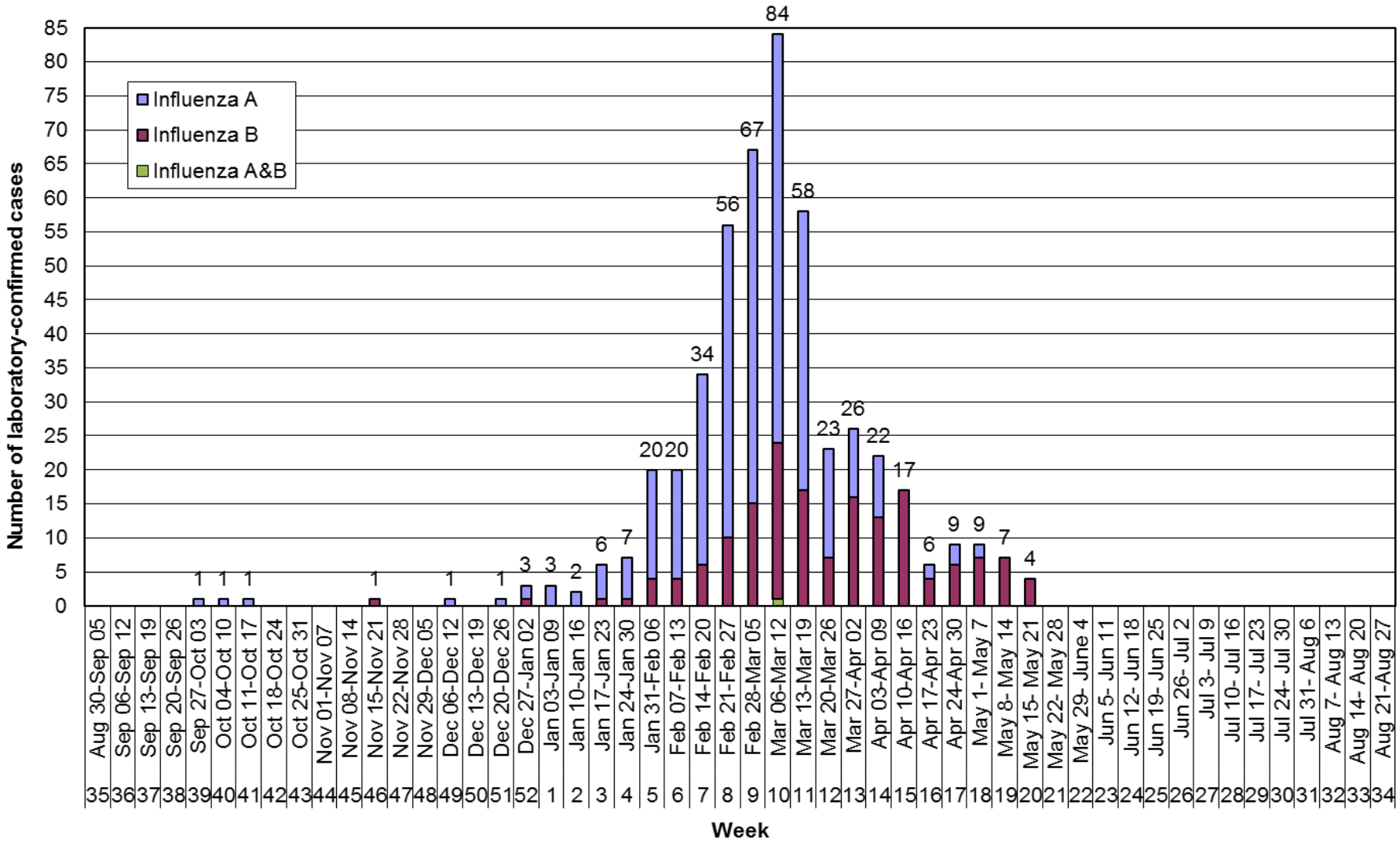
This report was prepared by Eleanor Paget, Public Health Nurse, Infectious Disease Control Team; Marlene Price, Manager, Vaccine Preventable Diseases Team; Theresa Procter, Epidemiologist, Foundational Standard.

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

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

Figure 1

Laboratory-confirmed influenza cases, by influenza date†
Middlesex-London 2015-2016 influenza season (N=489)



† Influenza date is the earliest of onset date, specimen collection date or reported date.

Appendix A to Report 065-16

Figure 2

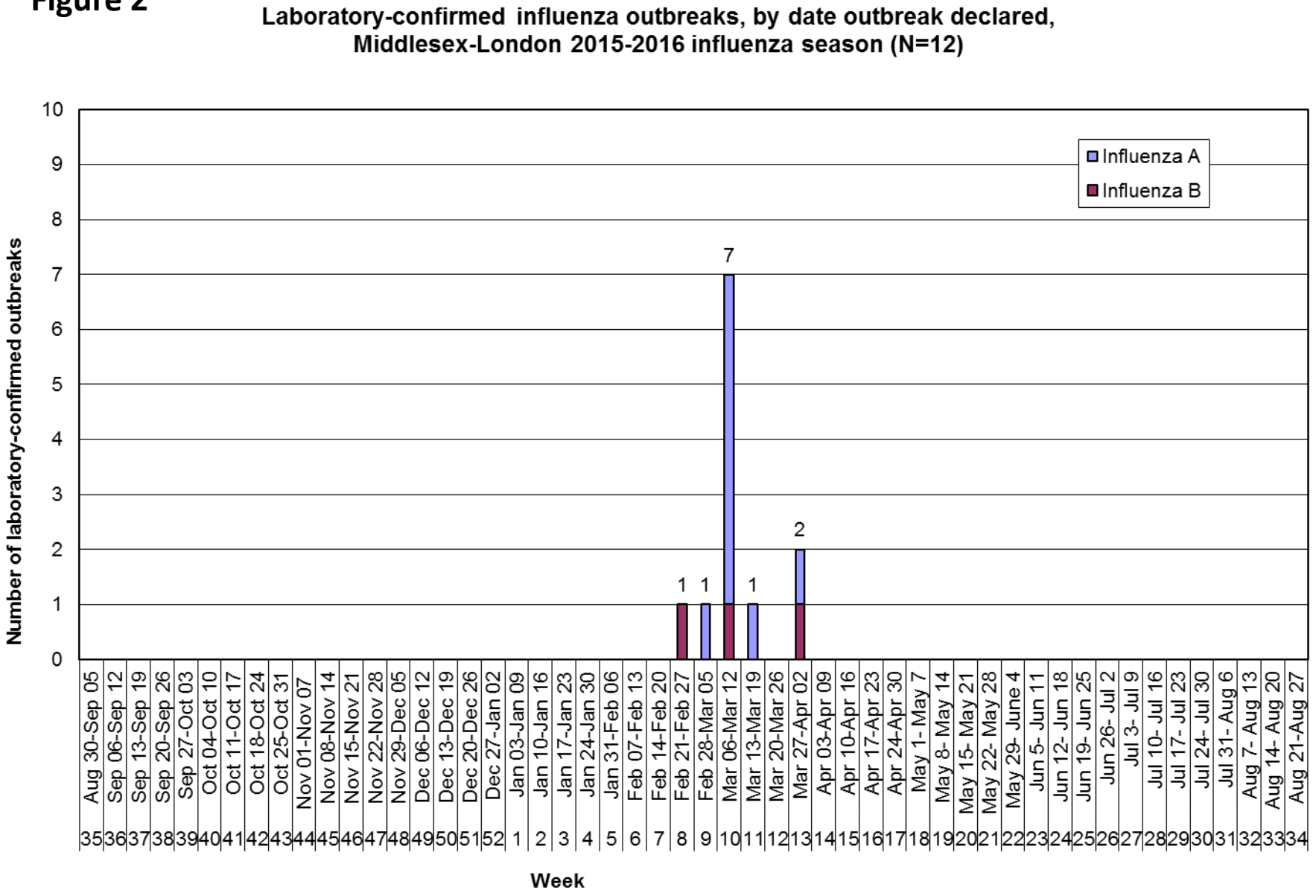
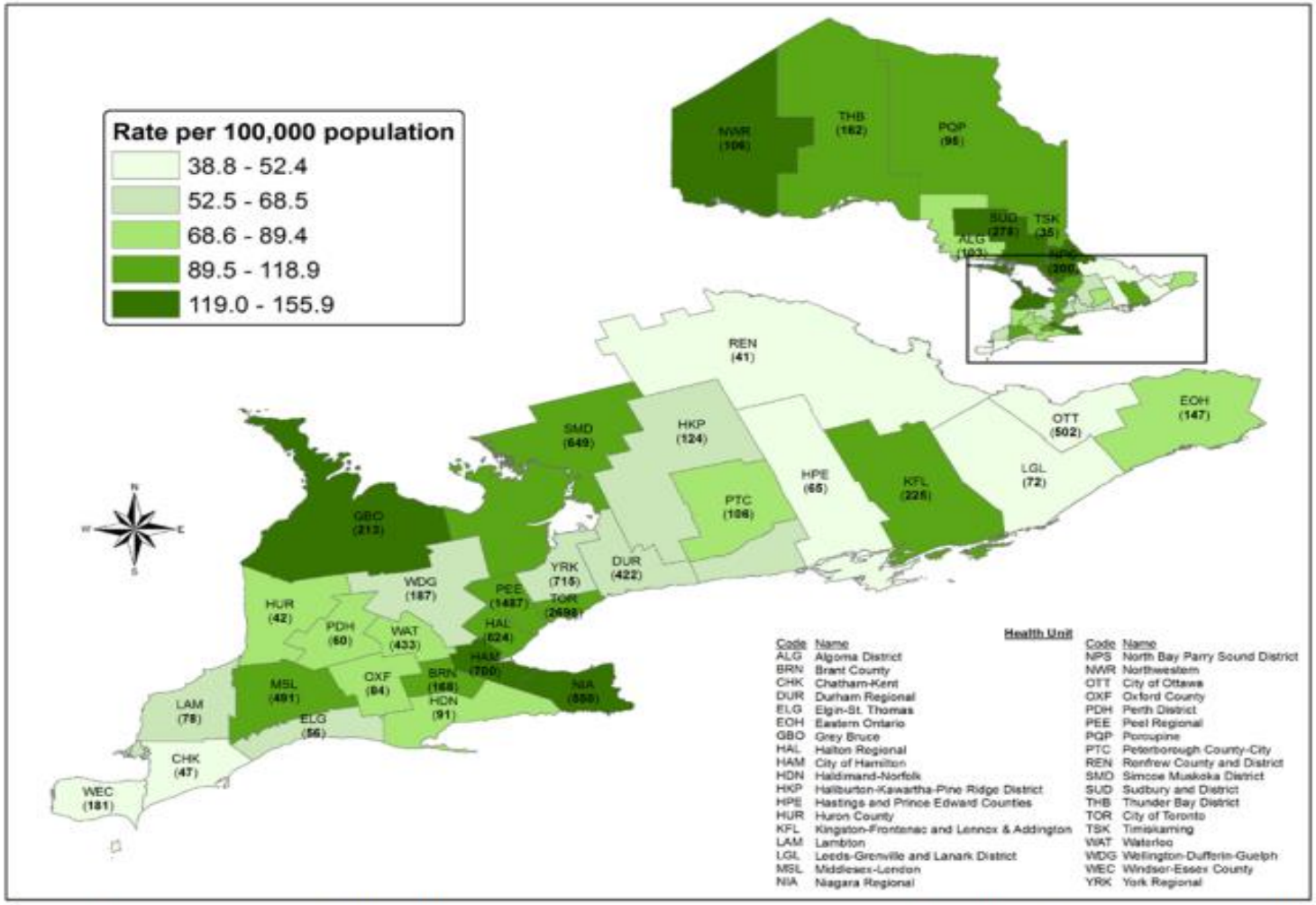


Figure 3. Rate of influenza per 100,000 population (and counts, in brackets), by health unit: Ontario, September 1, 2015 to August 31, 2016

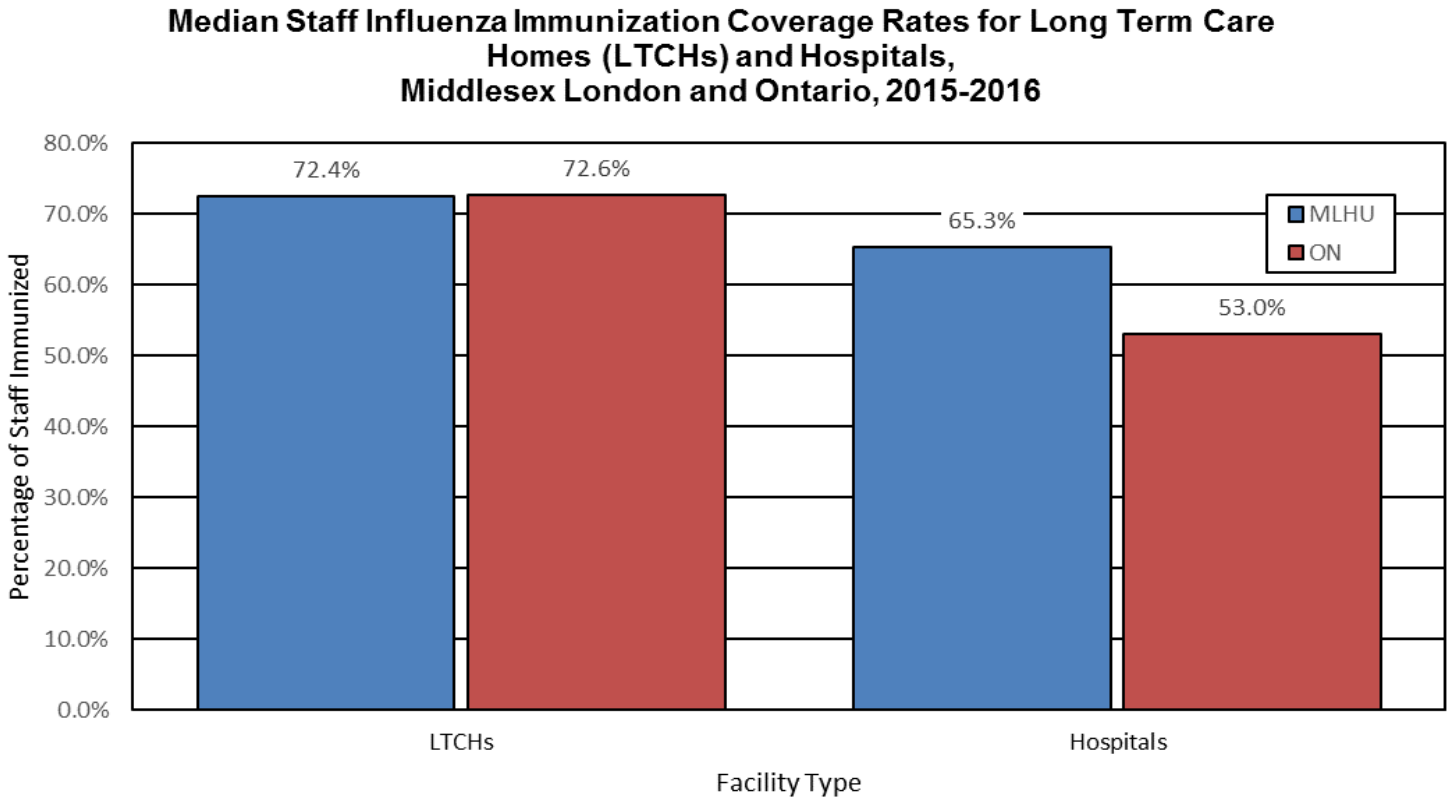


Source: Ontario Ministry of Health and Long-Term Care (MOHLTC), integrated Public Health Information System (iPHIS) database, extracted by Public Health Ontario [2016/10/19]. Population Projections [2015-16], Ontario Ministry of Health and Long-Term Care, Health Analytics Branch, Date Received: [2015/03/13].

From Public Health Ontario. Ontario Respiratory Pathogen Bulletin, 2015-16: Surveillance Season (September 1, 2015 – August 31, 2016). available at: http://www.publichealthontario.ca/en/DataAndAnalytics/Documents/Ontario_Respiratory_Pathogen_Bulletin-Season_Summary_-_2015-16.pdf

Appendix A to Report 065-16

Figure 4



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 066-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 November 17

A COMPREHENSIVE NUTRITION STRATEGY FOR MIDDLESEX-LONDON

Recommendation

It is recommended that Report No. 066-16 re: "A Comprehensive Nutrition Strategy for Middlesex-London" be received for information.

Key Points

- Middlesex-London Health Unit Registered Dietitians utilize a comprehensive nutrition strategy to promote the health of Middlesex-London residents and reduce health inequities.

At the March meeting of the Board of Health, Health Unit staff were directed to bring forward additional information to outline how the Health Unit collaborates with local and provincial partners, utilizing a comprehensive nutrition strategy, to create more supportive environments for healthy eating, including reducing health inequities.

Education and Awareness

Registered Dietitians work with local:

- Community partners to engage priority populations in hands-on education and awareness about food literacy, food skills, nutrition, and chronic disease prevention (e.g, Family Court Clinic, Residential Programs for Youth at Risk, Family Centres, Neighbourhood Resource Centres).
- Community partners to disseminate the Nutrition Screening Tool for Toddlers and Preschoolers (NutriSTEP®), which in turn provides parents with feedback about how their child is eating.
- Elementary and secondary school communities using the Foundations of a Healthy School by providing credible resources to create healthy school nutrition environments.
- Urban and rural partners to support local agri-food initiatives that empower residents and improve their knowledge of where food comes from.

Registered Dietitians provide evidence-informed information about food and healthy eating through:

- The production and distribution of a Health Unit monthly community meal calendar.
- Social media (Facebook, Twitter) and traditional media (television, radio, newspaper interviews).
- Written content on the MLHU website.
- The provision of ongoing training for and being a resource to colleagues and community partners.
- Research conducted to inform public health nutrition practice and policy.
- The promotion of the role of the Registered Dietitian in public health.

Policy and Advocacy

Registered Dietitians collaborate with colleagues from across the province to:

- Advocate for food security and adequate incomes for all Ontario residents.
- Conduct research to support municipal policy to support healthy beverage choices in facilities owned and operated by local municipalities.
- Improve the Ontario Public Health Standards through the modernization consultation process.

- Summarize the attributes of food literacy, including food skills, in the literature, and determine priorities for measurement and tool development.
- Develop key indicators that measure the attributes of food literacy including food skills.
- Develop and test a tool to measure food literacy with identified target populations, considering validity (e.g., attribute, face, and content), reliability, sensitivity to change, and feasibility.
- Ensure accurate, evidence-informed, and consistent nutrition messaging is shared provincially.

Registered Dietitians work collaboratively with local:

- Colleagues to develop policies to reflects the principles of the Baby Friendly Initiative.
- Community partners in establishing and supporting the Middlesex-London Food Policy Council.
- School boards to help support the School Food and Beverage Policy (PPM 150).
- Schools to implement school level policy that impacts healthy eating (e.g., school rewards, school celebrations, healthy fundraising using local food, and farm to school curriculum).
- Sports associations and sports teams to implement standards for healthy drinks and snacks.
- Workplaces to develop healthy eating policies that support healthy eating at work.

Skill Building

Registered Dietitians work with local:

- At-risk populations (e.g., youth in care, women living in poverty, young mothers, and new immigrants) to teach them food literacy skills that enhance life skills and improve mental and physical health and well-being.
- Community partners to train them to facilitate food literacy and food skill programming in schools and community agencies using a set program that includes cooking sessions and hands-on activities.

Supportive Environments

Registered Dietitians work collaboratively with local:

- Community partners, including municipal governments, post-secondary institutions, and agri-food organizations to assess and improve food environments to facilitate the healthy choice as the easy choice.
- Community partners to support Ontario Student Nutrition Programming in local elementary and secondary schools.
- Community partners to improve emergency food distribution and reduce the impact of poverty.
- Healthy Kids Community Challenge City of London and Middlesex County partners to develop resources and materials to support the nutrition related themes (e.g., “Water does Wonders”).
- Licensed child care centres regarding menu development in order to meet provincial requirements from the Child Care and Early Years Act 2014.
- School boards, schools, internal colleagues, and other health units to develop resources and materials with consistent messaging to create more supportive school nutrition environments.
- Workplaces to make changes to the workplace environment to help support healthy eating at work.

Middlesex-London Health Unit Registered Dietitians continue to evolve their nutrition activities over time, capitalizing on strategic partnerships and opportunities as they arise, while meeting community need, organizational priorities, and provincial standards and requirements.

This report was prepared by Abby Bryan-Pulham, Christine Callaghan, Ellen Lakusiak, Ginette Blake, Heather Thomas, and Kim Loupos, Health Unit Registered Dietitians, and reviewed by Anita Cramp, Linda Stobo, Mary Lou Albanese, and Tracey Gordon, Health Unit Managers.

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

This report addresses the following requirements of the Ontario Public Health Standards (Revised May 2016): Foundational Standards 1, 2, 3, 4, 5, 8, 9, 10, 11, 12; Chronic Disease Prevention 2, 3, 4, 5, 6, 7, 8, 11, 12; Reproductive Health 2, 4, 6; Child Health 4, 5, 7, 8, 11.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 067-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 November 17

SUMMARY INFORMATION REPORT FOR NOVEMBER 2016

Recommendation

It is recommended that Report No. 067-16 re: Summary Information Report for November 2016 be received for information.

Key Points

- Harvest Bucks, a vegetable and fruit voucher program coordinated by the Health Unit, had a successful fourth year and was supported by strong community partnerships. Program expansions for 2016 include adding the Downtown Strathroy Market, the first Middlesex County location, and the Old East Village Grocer, a community social enterprise.
- The report, Improving Safety of Active School Travel through Decreasing Traffic Speeds, summarizes a literature review and policy scan that was completed to identify effective measures for reducing traffic speeds in school zones, an identified barrier to active school travel.
- The Ministry of Child and Youth Services has released Implementation Guidelines/Markers for both Coordinated Services and Integrated Rehabilitation; local tables are developing Terms of Reference for their Steering Committees, with a phased 2-year implementation for Integrated Rehabilitation to begin in 2017.
- A modified version of the Ministry of Health and Long-Term Care's Health Equity Impact Assessment (HEIA) was conducted on a pre-existing food skills program on the Reproductive Health Team (RHT), resulting in downstream, midstream and upstream planning being developed in tandem, and enhancing internal and external collaborations related to addressing food insecurity.

Harvest Bucks

Based on *Eating Well with Canada's Food Guide* recommendations, 89% of Middlesex-London residents do not eat enough vegetables and fruit. Harvest Bucks, a vegetable and fruit voucher program coordinated by the Health Unit, helps to increase local access to and consumption of vegetables and fruit while promoting community connectedness through the farmers' market experience. In 2015, $31,160 Harvest Bucks were distributed by 21 community programs to 908 London households with $25,810 (83%) redeemed. The Harvest Bucks 2015 infographic is attached to this report as Appendix A. Program expansions for 2016 include adding the Downtown Strathroy Market, the first Middlesex County location, and the Old East Village Grocer, a community social enterprise of ATN Access for Persons with Disabilities Inc.

Improving Safety of Active School Travel through Decreasing Traffic Speeds

Active school travel (AST), such as walking or cycling to and from school provides children with up to ten opportunities a week to become more physically active. Local School Travel Planning (STP) data determined that parents and youth identify high traffic speeds and associated safety concerns as a top barrier to walking or cycling to school. A literature review and policy scan was completed to help determine the most successful interventions to reduce traffic speeds around schools, as well as the interventions currently used by municipalities in the Thames Valley region. The report (Appendix B) summarizes the results of this review as well as the implications for improving and increasing students' use of Active School Travel (AST), which is the objective of the Active and Safe Routes to School (ASRTS) partnership of Elgin-St. Thomas, London, Middlesex, and Oxford.

Ontario Special Needs Strategy (SNS) Update

This multi-Ministry SNS, to improve services for Ontario's children and youth with special needs, includes:

- A new standard developmental screen for preschool children
- Coordinated family-centred service planning for children and youth with multiple and/or complex needs
- An integrated approach to the delivery of rehabilitation services (speech-language therapy, occupational therapy and physiotherapy) for children and youth from birth to school exit

Proposal development tables for the Thames Valley Region for both Coordinated Services and Integrated Rehabilitation began meeting in December 2014. The proposals for Coordinated Services and for Integrated Rehabilitation were submitted on June 2015 and October 31, 2015 respectively. It is anticipated that MCYS will send a Letter of Agreement to the recommended local Coordinating Agency by December 2016. Implementation Markers have been released by the Ministry to support the Coordinating Agencies as they plan for and implement Coordinated Service Planning. Integrated Rehabilitation is targeted for 2017-2018, with a phased implementation including transition of services among providers, provincial policy changes and inter-ministerial funding transfers to support new local service delivery models. The local steering committee is currently developing administrative protocols and documents to support the local plan, which focuses on creating integrated, regionally-based therapy teams. Preschool speech and language services from birth to school entry will continue to be delivered by tykeTALK, with school boards assuming responsibility for these services after school entry.

Health Equity Impact Assessment (HEIA) - Reproductive Health Team Food Skills Program

The RHT Food Skills program was created to increase food literacy skills and consumption of fruit and vegetables. It is focused on women living in low income households who are of reproductive health age and are or may become pregnant. The program is a collaboration with community partners, co-facilitated by a Public Health Dietitian and a Public Health Nurse. It consists of eight skill building sessions. Evaluation of the pilot outlined positive short term outcomes (Appendix C) and further evaluation of longer-term impacts was completed through participant focus groups (Appendix D).

In 2015-2016, a modified version of the MOHLTC's HEIA was conducted on this program in an effort to identify potential enhancements. Unintended negative and positive impacts associated with the program were identified, and have led to enhanced opportunities for internal and external collaborations to advance food security efforts. By utilizing the modified HEIA processes, several evidence-informed strategies have been proposed to enhance program effectiveness at the downstream, midstream and upstream levels. An MLHU planning document outlining strategies to address food insecurity has been created and will be utilized to seek further collaborations among relevant key stakeholders to continue to advance this work. The proposed strategies are reflected within high level activities identified in this month's Report No. 063-16.

Members of the Reproductive Health Team presented "Combining the MOHLTC HEIA and NCCMT Methods & Tools to Achieve an *In Tandem* Approach to Advancing Health Inequities' at the OPHA Fall Forum 2016"

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

HARVEST BUCKS
Vegetable & Fruit Program 2015

89% of Middlesex-London residents did NOT meet their vegetable & fruit requirement based on Canada's Food Guide[1]

$31,160 Harvest Bucks distributed

13 Funded programs[2] + **8** Direct purchase programs[3]

908 London households received Bucks

6 Participating farmers' markets[4]

$25,810
Harvest Bucks redeemed

83%
redeemed

Interested in Donating?

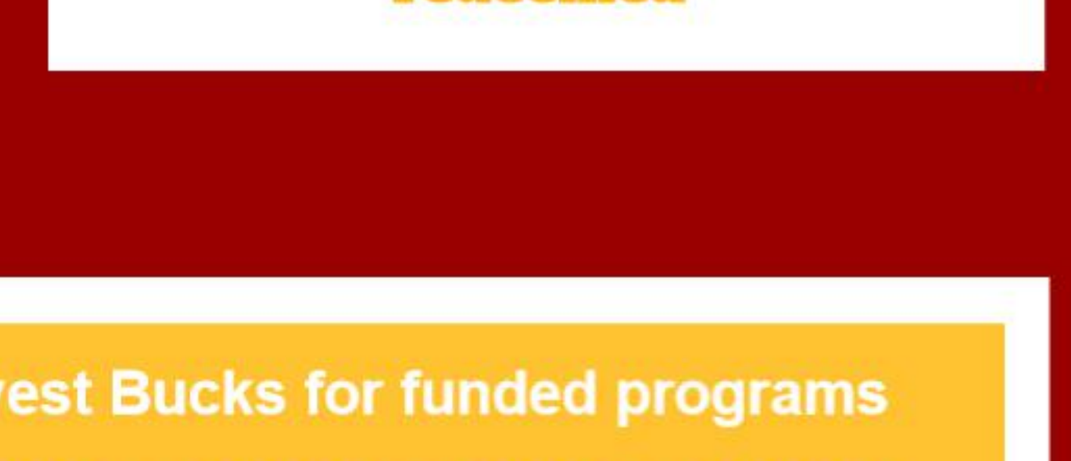
100% of donations purchase Harvest Bucks for funded programs

To learn more, please contact: kim.leacy@mlhu.on.ca

or visit: www.healthunit.com/harvest-bucks

Partnership of:

Covent Garden Market
Downtown Strathroy Market
Farmers' & Artisans' Market at the Western Fair
London's Child and Youth Network
Middlesex-London Health Unit
On the Move Organics
Southdale Farmers' and Artisans' Market



1 Source: Canadian Community Health Survey 2011 - Public Use Microdata File.

2 Programs apply for funding for Harvest Bucks

3 Programs directly purchase Harvest Bucks

4 Covent Garden Market (indoor and outdoor), EatGreen Organics (delivery only), Farmers' and Artisans' Market at the Western Fair, Masonville Farmers' and Artisans' Market, Southdale Farmers' and Artisans' Market, and Soho Market

Middlesex-London Health Unit, March 2016

Improving Safety of Active School Travel Through Decreasing Traffic Speeds

Literature Review and Policy Scan for the Active and Safe Routes to School (ASRTS) Partnership of
Elgin-St. Thomas, London, Middlesex, and Oxford

September 2016

For information, please contact

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Acknowledgements

Thank you to the members of the Active and Safe Routes to School (ASRTS) partnership of Elgin-St. Thomas, London-Middlesex, and Oxford, which includes:

Can Bike London
Child & Youth Network – Healthy Eating Healthy Physical Activity Priority (HEHPA)
City of London
City of St. Thomas
Elgin St. Thomas Public Health
Western University – Human Environments Analysis Laboratory (HEAL)
London Block Parent Program
London District Catholic School Board
London Police
Middlesex-London Health Unit
Oxford Public Health
Thames Valley District School Board

It is only through the joint effort and contributions of the partners that School Travel Planning and the ASRTS mission; to work in partnerships for the improvement of children's health, safety, and our environment through comprehensive health promotion strategies such as engagement, education, research, and policy development, are possible.

Executive Summary

Introduction

Active and Safe Routes to School (ASRTS) in the Thames Valley region, consisting of the cities and counties of Elgin-St. Thomas, London, Middlesex, and Oxford (ELMO), Ontario, is a community partnership working together to encourage children and families to choose active school travel (AST). AST is defined as using any human-powered mode of transportation, such as walking or cycling, to get to and from school, and provides children with up to ten opportunities a week to become more physically active. Through local School Travel Planning (STP) data collection, safety concerns relating to speeding traffic have been identified as a top barrier among parents and youth for using AST. A literature review and policy scan were conducted to determine determine the most successful interventions in other communities to reduce traffic speeds around schools, as well as the interventions currently used by municipalities in the Thames Valley region. This report provides a summary of the results in addition to contextual background information and a discussion of their implications for improving and increasing students' use of AST.

Key Findings

The literature review found physical traffic calming measures, particularly vertical deflections (e.g. speed humps), to be the most effective individual strategy to decrease traffic speeds. Speed enforcement cameras were relatively successful at decreasing speeds, but reduced speed limits had limited success unless combined with other strategies. Awareness raising interventions were the least effective on their own, but often increased success of other interventions when combined. Overall, all studies that evaluated a single strategy identified that incorporating additional strategies would move more towards a wider cultural change. Locally, the three most common types of policies or by-laws identified were physical traffic calming devices (engineering), reduced speed limits (enforcement), and community safety zones (enforcement), which are double fine zones for drivers who exceed the posted speed limit. Based on the literature, communities will be most effective at decreasing vehicle speeds if they combine a variety of interventions. This comprehensive strategy is called the 3E's and includes an element of Engineering, Education, and Enforcement.

Recommendations

Communities should consider the costs, benefits, and unexpected risks of traffic calming options prior to implementation. Municipalities can strengthen traffic calming policies by making them more specific and measureable, and ensuring there is a budget for implementation. It is important to be specific and provide guidelines as environments and scenarios differ across communities, as do the strategies to combat the variety of barriers. The results of the literature review identify that physical traffic calming measures are the most effective and sustainable measure to reduce traffic speeds but that they should be used in combination with other enforcement and education strategies to be most effective. While this approach is often more costly, utilizing a partnership approach can allow for a greater impact on a shared goal by combining organizational resources.

Conclusion

It is clear that change needs to happen to reverse the trend of fewer children using active modes of transport to and from school. For children and communities to experience the many benefits of AST, more work must be done to remove the barriers. Parental concerns around traffic speed and safety have been locally identified as a key barrier to AST. When trying to change the behaviours of parents and children to choose AST, barriers rooted in fact and reality cannot be addressed alone; those based on perceptions must also be targeted. ASRTS aims to decrease perceived barriers of traffic speed by influencing decisions that objectively reduce traffic speeds in school zones. The strength of ELMO ASRTS is the partnership itself and the fact that by working together, the common goal can be achieved sooner and with greater impact on the health and well-being of local children and society.

Introduction

Active and Safe Routes to School (ASRTS) in the Thames Valley region, consisting of Elgin-St. Thomas, London, Middlesex, and Oxford County (ELMO) in Ontario, is a community partnership working together to encourage children and families to choose active school travel (AST). Data is collected as part of ASRTS's overarching program, School Travel Planning (STP), to identify barriers preventing parents and children from using AST in the Thames Valley region. Based on the results from ten STP schools between 2013 and 2015, safety concerns relating to speeding traffic were identified as a top concern among parents. A literature review and policy scan was conducted by members of the ELMO ASRTS committee during the 2015/2016 school year to determine determine the most successful interventions in other communities to reduce traffic speeds around schools, as well as the interventions currently used by municipalities in the Thames Valley region. This report provides a summary of the results in addition to contextual background information and a discussion of implications for improving and increasing students' use of AST.

Background

Current State of Active School Travel (AST)

AST is defined as using any human-powered mode of transportation, such as walking or cycling, to get to and from school. It is important in today's society where physical activity levels of Canadian children have been declining steadily over the years with only 7% of children meeting the Canadian Physical Activity Guidelines (Colley et al., 2011). AST can provide children with up to ten opportunities a week to be more physically active and provides benefits to children's physical and mental health; they arrive at school more alert and ready to learn, feel more connected to their community, and there is reduced traffic around schools, which provides further environmental and economic benefits (Transport Canada, 2011). Unfortunately, the number of children using AST has declined by nearly 50% over the past 20 years (Buliung, Mitra, & Faulkner, 2009).

Parent and youth surveys conducted by ELMO ASRTS at ten STP schools between September 2013 and February 2015 found 42% of children self-reported walking to school (46% from school to home). When asked about modal preference, 57% of parents stated walking, 30% preferred busing, 9% car, and 3% cycling (See Table 1). Children's preferences differed greatly with 38% preferring to walk, 30% cycle, 17% bus, and 15% by car. In response to the question: "It is difficult for my child to walk or bike to school because…" the number one answer among parents was that "it feels unsafe due to traffic on the route". For children living within walking distance of school, "most drivers go too fast" was the greatest concern regarding neighbourhood safety. The concern for traffic speed as a barrier to AST was also identified through two further STP data collection methods: traffic counts and neighbourhood walkabouts.

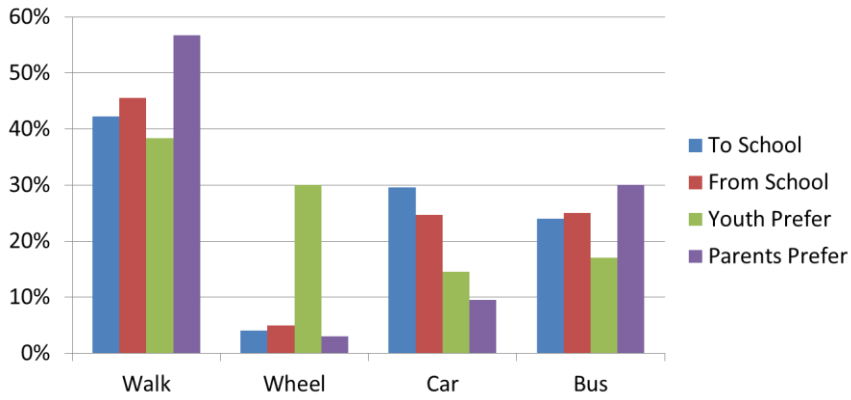

Table 1: Travel Mode Use vs. Parent & Youth Preference *(HEALab)*

Safety Perceptions

Perceptions of safety can either be rooted in reality or influenced by external factors, such as media, and not necessarily reflect reality. An example of a safety perceptions rooted in reality is "fear of a collision", based on motor-vehicle-collision data. On the other hand, "stranger danger", the abduction of a child by a stranger, is fear based on perceptions and exacerbated by the media. The fear of "stranger danger" is often greater than the fear of being injured in a motor-vehicle-collision even though the risk of the latter is much higher (Dalley & Ruscoe, 2003; Transport Canada, 2013).

Locally, the fear of neighbourhood traffic and traffic speeds is primarily based on perceptions, as statistically, there have been no recent incidents of children being hit by a speeding motor vehicle on their journey to school (Office of the Chief Coroner for Ontario, 2010). Objective traffic speeds are easy to measure; however, perceptions of traffic speeds are difficult to quantify because traffic speed is difficult to gauge by the human eye. A vehicle travelling at 50km/h could be perceived as speeding when travelling on a curvy, narrow road, but look like it is moving slowly on a straight and wide road. This skill becomes increasingly difficult with younger children as they can struggle to decipher the speed and distance of an approaching vehicle because their optical sensitivity to looming objects has not yet matured, a scenario that increases in danger the faster a vehicle is moving (Wann, Poulter, & Purcell, 2011; World Health Organization, 2004).

Decreasing vehicle speeds in school zones has the ability to impact both real and perceived safety concerns. ASRTS aims to decrease perceived barriers of traffic speed by influencing decisions that objectively reduce traffic speeds in school zones. Studies identify that the faster a car is travelling during a collision with a pedestrian, the greater the risks of injuries and fatalities (NICE Centre for Public Health Excellence, 2009). Therefore, slower vehicles in school zones provides children with more time to gauge whether there is a safe gap in traffic to cross the road, as well as decreased risk of injury and fatality in the serious event of a collision.

ASRTS wants to increase use of AST among families, but as long as active modes of travel are perceived as being less safe, these fears will direct decisions that often lead parents to drive children to school. More parents choosing to drive further contributes to the dangers inferred on all children in school zones caused by traffic. When trying to change the behaviours of parents and children to choose AST, barriers rooted in fact and reality cannot be addressed alone; those based on perceptions must also be targeted. The purpose of the literature review was to look at the effectiveness of interventions for objectively decreasing speeds in order to affect both real and perceived dangers.

Methodology

Literature Review

Search Question: What interventions have been successful at reducing traffic speeds in school areas or on residential roads?

The literature search was conducted between January and February 2016 through a variety of academic databases. Full articles of potentially relevant studies were obtained based on a scan of abstracts. Reference lists from eligible studies were also scanned for additional studies. Criteria were determined for inclusion / exclusion criteria based on the PICOS acronym (population, intervention, context, outcomes, and study design). The most precise criteria included the population of motorists and an outcome of reduced vehicle speeds. Following application of the inclusion / exclusion criteria and an appraisal of all studies through relevant tools to determine their strength, 14 final articles remained; 13 were primary studies and 1 was an umbrella review of systematic reviews.

Policy Scan

The policy scan was conducted to determine what policies and interventions are currently being utilized to decrease vehicle speeds in local school communities. The region consists of three counties and 25 municipalities; however, only 24 municipalities were explored as one does not have a school. Policies that address traffic speeds for school areas in the Thames Valley region were collected. A manual online search was first conducted to find land use planning documents and by-laws that were available on county and municipal websites. Emails were sent to municipal clerks requesting information that may have been missed through the online search. A variety of documents were scanned, but for the purpose of this report, the term “policy” will be used to encompass all findings throughout county and municipal documents such as Official Plans, contents of master plans, municipal resolutions, manuscripts, and by-laws. Policies were collected and categorized into three emergent themes: physical traffic calming devices, speed limits less than 50km/h, and community safety zones.

Summary of Results

Literature Review

Several communities and organizations target injury prevention, including road safety, through the 3E's: Engineering, Education, and Enforcement. This approach is more comprehensive, and therefore, has a greater chance of creating change. Five themes emerged from the literature based on similar interventions and are presented according to their relation to the 3E's:

Engineering: physical traffic calming devices

Education: awareness raising devices

Enforcement: 30km/hr (20mph) speed limits / zones; speed enforcement cameras

3E's Approach: combination of all three interventions

The interventions, methodologies, and evaluations differed across the studies, making comparison difficult; however, all studies included traffic speed reduction as an outcome. Studies and themes were compared by looking at their reduction in mean speed (the average speed of all recorded vehicle speeds on the road during the study time period), 85th percentile speed (the speed motorists feel most comfortable travelling, and therefore, the most likely speed to be driven on that road), and whether vehicle speeds were successfully reduced to equal or below the posted speed limit. The following results summarize the key findings from each of the studies by theme.

Engineering: Physical Traffic Calming Measures

Physical traffic calming devices are common engineering interventions for reducing speeds. They are used in short segments of road and can be categorized as vertical deflections (change in pavement height such as speed cushion or raised crosswalk), horizontal deflections (prevent travel in a straight line such as a curb extension or roundabout), or obstructions (involve some extent of road closure such as right-in/right-out island or one-way) (City of London, 2015).

Two of the studies specifically evaluated physical traffic calming measures and found good results with lowering both the mean and 85th percentile speeds as well as meeting the posted speed limit (approximately 50km/h in both studies). Mountain, Hirst, and Maher (2005) compared the impact of engineering measures (both vertical and horizontal deflections) and speed enforcement cameras on vehicle speeds and found that all three were generally effective, but that "vertical deflections have the greatest average impact on the mean, 85th percentile speed, and the percentage of drivers speeding" (p. 750). Cameras were the second most effective, followed by horizontal features. Leden, Wikstrom, Garder, and Rosander (2006) assessed the effectiveness of a variety of traffic calming measures (central refuge islands, broad flagstone pedestrian crossing, street lights and railings, roundabout, 2-directional cycle track) and road reconstruction on vehicle speeds and safety. The researchers found a modest decrease in 85th percentile speeds (2.8 - 4.12 km/h) but identified several other positive outcomes including an increase of pedestrians present ($p<0.001$), decline in students being driven to school ($p=0.026$), and increase in students cycling to school ($p=0.008$). These findings could represent an increase in perceived safety.

Enforcement: Speed Limit Changes, Speed Enforcement Cameras

Physical traffic calming devices are one of two types of traffic calming; the other being passive traffic calming measures. Passive measures are the simpler option and are usually implemented over an entire road segment. Examples of passive and mitigating measures include lane reductions, textured pavement, line markings and/or signage, speed display signs, targeted enforcement, and community education (Education and Enforcement). (City of London, 2015)

The primary enforcement measures evaluated through the reviewed literature were decreased posted speed limits and speed enforcement cameras. Retting, Farmer, and McCartt (2008) evaluated the initial effects of camera enforcement on traffic speeds and assessed public attitudes on residential streets with speed limits of 35mph or less and in school zones in Maryland, USA. The study saw a 70% decrease in motorists traveling more than 10mph

over the posted speed limit when warning signs and speed cameras were used in conjunction. The warning signs included a 30 day "Safe Speed" education campaign and warning period prior to the program going live; an added educational element. The researchers found highly visible automated enforcement to be beneficial in promoting community-wide changes in driver behaviour.

Kattan, Tay, and Acharjee (2011) assessed the impact of 30km/h speed limits on reducing vehicle speeds in school zones and playgrounds in Calgary, Alberta. While a statistically significant reduction in mean and 85th percentile speeds were identified, 54.4% of drivers continued to travel over the posted 30km/h speed limit. Speeds were found to be lower in school zones than playground zones, on two lane roads than four lanes, roads with fencing, and sites with speed display devices (educational and engineering devices incorporated). Lazic (2003) studied the effectiveness of reducing speed limits from 50km/h to 30km/h in Saskatoon school zones where the speed reductions were in effect in all elementary and secondary school zones from September 1 to June 30 and between 8:00am and 5:00pm Monday to Friday. The average 85th percentile speed reduction was quite significant at 10km/h (54.4km/h to 44.5km/h); however, there was only a compliance rate of 23% to the newly posted speed limit. No significant change in speed was observed outside the restricted hours and weekends. Lazic identified "the observed low compliance shows that posting a reduced speed limit alone does not guarantee the desired change in driving speeds. It is only one method that can be used as part of a pedestrian safety program around schools" (p.2). These findings are consistent with the umbrella review conducted by Cairns, Warren, Garthwaite, Greig, and Bambra (2014) that included 5 systematic reviews looking at the effects of 20mph speed limits and speed zones, the latter consisting of additional physical traffic calming measures. Overall, the reviewers found convincing evidence that the measures effectively reduce traffic speed as well as improve perceptions of safety. However, in the discussion they identify that more aesthetically pleasing and intensive street designs and accompanying health promotion and educational interventions around physical activity would do more for moving towards a wider cultural change.

Education: Awareness Raising Devices

The majority of studies evaluating educational components looked at awareness raising devices; of which, the elements and results of the five studies were mixed. In their study of the effectiveness of speed monitoring displays in a reduced school speed zone, Lee, Lee, Choi, and Oh (2006) concluded that speed monitoring displays have a positive impact on drivers' behaviour. They found a mean speed reduction of 8.2km/h at the location of a display in the short term, and 5.8km/h reduction 12 months later. Spiegel, Farahmand, Da Silva, Claassen, and Kalla (2012) also found positive results when they studied a device that displayed a child smiling with a green LED display reading "Thank You" beneath the picture or red letters stating "Slowly!" when speeding was detected. An increase in drivers adhering to the speed limit went up from 27.6% in the control condition to 41.1% in the experimental condition. However, this still leaves 58.9% of drivers exceeding the posted speed limit.

Gehlert, Schulze, and Schlag (2012) evaluated 3 different types of dynamic speed display signs (DSDS): 1) a standard DSDS with numeric values corresponding to the driver's speed, 2) a standard DSDS with numerical values highlighted in red or green depending on whether the car driver complied with or exceeded the local speed limit, and 3) a verbal coloured DSDS where the word THANK YOU in green letters or SLOW in red letters appeared based on whether the car driver complied with or exceeded the local speed limit. All 3 devices saw a reduction in speed when the device was installed but all speeds returned to baseline following their removal. Of the three devices, the verbal coloured DSDS saw the greatest reduction in speeds followed by the numeric coloured DSDS and lastly, the numeric DSDS.

Two of the studies examined the impact of visual displays on reminding drivers of a reduced speed limit following a trip interruption. Gregory, Irwin, Faulks, and Chekaluk (2014) found vehicles sped an average of 6.51km/h more after being interrupted by a stop sign or traffic light than uninterrupted vehicles. Adding a flashing "check speed" sign 70m after the traffic light saw the interruptive effect eliminated. Hawkins (2007) assessed the impact of a rear-facing beacon and an "End of School Zone" sign on vehicle speeds and found a slight reduction in speeds and 10% improved compliance. These findings can be used to provide a reminder when changing speed limits or where trip interruptions such as stop signs and traffic lights exist.

3E's Approach

Two studies evaluated a 3E's approach in residential areas and found minimal mean speed reductions; however, one of the studies included education and enforcement as supplements to a single "low cost engineering countermeasure (i.e. painting of a centre line)" (Islam & El-Basyouny, 2013, p. 85). The study by Blomberg and Cleven (2006) evaluated speed reductions on untreated streets with educational materials (yard signs, pamphlets)

and increased police enforcement patrols and ticketing, adjacent to streets that received traffic calming treatments. The study found a modest mean speed reduction, excellent increase in driver's compliance to the speed limit, and increased "knowledge of the program, awareness of enforcement efforts, and acceptance of the need to moderate speeds" (p. i).

Policy Scan

Three primary themes emerged from the policy scan within the realms of engineering and enforcement: physical traffic calming devices, speed limits less than 50km/h, and community safety zones.

Engineering

Physical Traffic Calming Devices

Physical traffic calming devices are designed to encourage motorists to slow down and adhere to the posted speed limit by restoring the road back to its intended function. Policies for physical traffic calming devices were identified in one county and five municipalities, primarily in land use planning documents such as Official Plans. Most of the statements are general in nature, indicating traffic calming measures will be "considered" if applicable. One municipal recommendation is specific for school zones while the others are applicable for any location. One community has a specific traffic calming document to help guide decisions on the best device for different scenarios; encouraging physical traffic calming devices only when passive or mitigating measures have been unsuccessful.

Enforcement

Speed Limits Less than 50km/h

Speed limits less than 50km/h aim to reduce vehicle speeds through posted speed limits below the current default urban limit of 50km/h. Several communities in the Thames Valley region have a reduced speed limit of 40km/h, including many near schools. Some speed limit reductions are paired with community safety zones or "school zone maximum speed when flashing" signs. The flashing signs remind motorists that the speed limit is reduced when the beacons are flashing during specific times of the day. In most cases, this is a reduction from 50km/h to 40km/h, but in one case, the sign is on a King's Highway and the reduction is from 80km/h to 60km/h when flashing. Only one community had a speed limit of 30km/h and documents identify that the traffic flow was already moving slowly in the area, increasing the likelihood of speed limit compliance.

Community Safety Zones

Community safety zones are double fine zones for drivers who exceed the posted speed limit and are primarily found in by-laws. The by-law impacting a school is based on which type of road it is located, as roads are owned and operated by the municipality, county, or province. Supportive by-laws were found at all levels of government within the Thames Valley region including one on a King's Highway, but the majority were found on county roads.

Discussion

Key Findings from the Literature

From the literature review, physical traffic calming measures, particularly vertical deflections, were found to be the most effective independent intervention at reducing traffic speeds. Physical traffic calming measures are also more sustainable at reducing traffic speeds because of the physical change to the road that encourages drivers to slow down and feel less comfortable travelling at higher speeds. The findings also suggest an increase in both objective and perceived safety related to traffic speed, as described by Leden et al. (2006), who found an increase of pedestrians, a decline of students being driven to school, and an increase in students cycling to school.

Two primary enforcement interventions were assessed through the literature: reduced speed limits and enforcement cameras. The studies found success with speed enforcement cameras but limited effectiveness of reduced speed limits, unless combined with additional strategies. Kattan et al. (2011) found 54.4% of drivers continued to travel over the newly posted 30km/h speed limit; however, compliance was higher in school zones compared to playground zones, on two lane roads compared to four, on roads with fencing, and at sites with speed display devices. Cairns et al. (2014) discussed more aesthetically pleasing and intensive street designs with accompanying health promotion and educational interventions around physical activity would do more for moving towards a wider cultural change. The most successful camera enforcement study also combined interventions with a 30 day "Safe Speed" education campaign and warning period prior to the program going live (Retting et al., 2008). It was clear from the literature that enforcement is most effective when combined with other strategies, particularly engineering and education. Awareness raising devices were least effective when used independently but often increased the success of engineering or enforcement interventions when combined. Studies identified devices that were most effective (verbal coloured DSDS); however, vehicle speeds returned to baseline when devices were removed.

Achieving Safety and Compliance

Nearly all the studies that evaluated one of the 3E's individually identified that using all three strategies would yield greater impacts and a move further towards cultural change. Unfortunately, it is difficult to confirm the effectiveness of the 3E's approach because in a study with multiple factors, it is difficult to determine which element led to the change. Using the 3E's approach is also more costly. The more effective interventions (i.e. physical traffic calming measures) are often already more costly, and adding educational and enforcement strategies to increase effectiveness and sustainability only further increases that cost. When choosing between different traffic calming options, it is important to consider those methods that have proven successful in other jurisdictions, as well as the long-term costs, risks, and benefits of each option.

For example, reducing speed limits are a popular approach by municipalities to broadly address speeding concerns; however, they may have unintended risks when used alone. The studies that looked at reduced speed limits found that the number of vehicles speeding remained high after implementation. The Office of the Chief Coroner for Ontario and the systematic review conducted by the NICE Centre for Public Health Excellence (2009) recommend the implementation of 30km/h speed limits on residential roads for the greatest reduction in child injuries. Roads are designed and built to accommodate vehicles at a specific speed, which in Ontario means they are built for the current urban speed limit or 50km/h. Reducing the speed limit from 50km/h to 30km/h is a 40% decrease that, without additional interventions, will lead to more motorists exceeding the speed limit. The greater the discrepancy between actual speed and the speed limit can create a false sense of security among pedestrians as they believe traffic is travelling slower than it actually is; potentially increasing risk of a collision instead of decreasing it. Therefore, the design and land use context of each road should be considered to customize potential solutions that will achieve the goal of speed reduction, balancing safety with compliance.

Additional measures can be implemented to increase compliance in reduced speed limit zones. For example, Gregory et al. (2014) found awareness raising devices such as "check speed" signs could be utilized to remind drivers of the decreased speed limit after trip interruptions such as stop signs or traffic signals. Several local communities combine enforcement and education through "school zone maximum speed when flashing" signs to raise awareness of the decreased speed limit through flashing beacons. Speed limits with corresponding flashing beacons increase compliance but are only in effect during specific times, days, and seasons, which unfortunately do not see the same speed reductions outside the restricted hours and weekends (Lazic, 2003). Community safety zones, consisting of double fine for drivers exceeding the posted speed limit, are another strategy employed locally but were not assessed through the literature resulting from this search. Their use however, could be considered as an enforcement measure when considering a comprehensive 3E's approach to targeting traffic speeds.

Physical traffic calming measures could negate the use of reduced speed limits as they change the design of the road to encourage drivers to slow down and feel less comfortable travelling at higher speeds. Building roads for a desired lower traffic speed is also more sustainable as it targets driver behaviour directly and requires less enforcement. Unfortunately, few local physical traffic calming policies were identified through the policy scan, and those that exist are quite general in nature. Municipalities could strengthen their traffic calming policies by making them more specific and ensure there is a budget for implementation. One specific local document does this by providing guidelines for investigating, selecting, and implementing appropriate traffic calming measures and putting a high priority on the safety of school travel (City of London, 2015). It is important to be specific and provide guidelines as environments and scenarios differ across communities.

Utilizing A Policy Approach

Strategies to combat a variety of barriers also differ greatly and need to be considered. For example, for the barrier of "my child lacks the cycling skills to bike to school", an educational Bike Rodeo or Festival could be implemented. However, barriers that arise consistently across multiple schools could benefit from a systemic approach. This can be accomplished by impacting policies at any of a variety of government levels or at school boards. Policies allow for impacts that are broader, more efficient, more sustainable, and create more upstream changes than approaching barriers on a school-by-school basis.

There are several ways to influence policy. For example, traffic speeds in school zones can be enhanced by advocating for increased funding for education or enforcement strategies. Changes to municipal policy could include land use planning policies within local Official Plans that support AST by influencing sidewalk and road infrastructure. By-laws are a type of legislation that addresses issues and concerns in the municipality that can result in legal action if not followed. Statements regarding speed limits and community safety zones are often found in local by-laws.

The ELMO ASRTS committee has an opportunity to impact local policy through the provision of local data obtained through STP data collection as well as by providing evidence, such as that found within this report. Members have the ability to advocate for local policies that decrease identified barriers and increase use of AST. Results of the initial STP school surveys identified perceived traffic speed as a top barrier from using AST among both parents and students. The results of this literature review identify that physical traffic calming measures are most effective and sustainable at reducing traffic speeds in school zones but that they should be used in combination with other enforcement and education strategies. While this approach is often more costly, utilizing a partnership approach can allow for a greater impact on a shared goal by combining organizational resources.

Conclusion

Fewer children are walking to school and one reason, as identified by ELMO ASRTS, is due to traffic related safety concerns. Both reality and perceptions of lack of safety result in fears that need to be addressed if families are to become more comfortable with AST. The purpose of the literature review was to look at the effectiveness of interventions for objectively decreasing speeds in order to affect both real and perceived dangers. The policy scan was conducted to determine what policies and interventions are currently being utilized to decrease vehicle speeds in local school communities.

From the review, physical traffic calming measures, particularly vertical deflections, were found to be the most effective individual strategy to decrease traffic speeds. Two enforcement interventions were evaluated: reduced speed limits and enforcement cameras. Speed enforcement cameras were relatively successful at decreasing speeds but reduced speed limits had limited success unless combined with other strategies. Awareness raising interventions were the least effective on their own but often increased success of other interventions when combined. Results of this literature review and policy scan can be used to advocate for policies that effectively decrease traffic speed in order to increase the use of AST among local families.

It is clear that change needs to happen to reverse the trend of fewer children using active modes of transport to and from school. For children and communities to experience the many benefits of AST, more work must be done to remove the barriers. Parental concerns around traffic speed and safety have been locally identified as a key barrier and working with local decision makers to develop supportive policies to decrease traffic speeds around schools is one way to help reverse the trend. This is one of many strategies that can be used to remove barriers and increase the use of AST in the Thames Valley region. The greatest action and strength of ELMO ASRTS is the partnership itself and the fact that by working together the common goal can be achieved sooner and with greater impact on the health and well-being of local children and society.

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Food Skills Pilot Program 2014: An Evaluation Report

MIDDLESEX-LONDON HEALTH UNIT

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Executive Summary

This evaluation report summarizes the results collected from the pre and post questionnaires completed by clients who participated in the Reproductive Health Team (RHT) Food Skills pilot program from June to December 2014. Results revealed that the Food Skills program positively influenced participants' knowledge, skills, attitudes, confidence and behavior related to healthy eating, cooking and nutrition.

The Food Skills pilot program, initiated by the Reproductive Health Team (RHT) at the Middlesex London Health Unit, centered on two main goals:

1. **Increasing knowledge related to food literacy.**
2. **Increasing access to and consumption of vegetables and fruit.**

Each program series consisted of 6-8 sessions of in-class healthy eating and cooking instruction with incentives being given in the form of cooking utensils and vouchers which clients could redeem for fresh vegetables and fruit. The vouchers provided to clients, Harvest Bucks and Veggie Vouchers, encouraged clients to access fresh produce and maximize integration of vegetables and fruit into their daily food intake. Key partnerships were developed with the Mutual Aid in Parenting Program (MAPP), the Carling-Thames Family Center, Childreach, Families First, and the London Food Bank.

The curriculum for the Food Skills program was initially developed by members of the RHT with input from participating clients through a needs assessment (Appendix A). The curriculum was composed of a combination of knowledge and skill components including purchasing, preparing, and cooking healthy family meals. All of the sessions were planned to meet the needs of the target population utilizing various strategies including health topic information, using local, in-season produce when available, and making low-cost simple meals and snacks. Various health topics were incorporated based on clients' requests (e.g., preconception health, choking, Triple P parenting, and personal health awareness).

Positive outcomes reported by participants as a result of participating in the program included: eating more vegetables and fruit; a higher level of knowledge about how to purchase quality produce most economically; an increased level of confidence about preparing and cooking healthy foods; an increased willingness to try new foods; increased ability to apply food safety principles; and an increased understanding of nutrition facts on food labels.

Background

Increased access to and consumption of vegetables and fruit was part of the 2012- 2014 strategic plan for the Middlesex-London Health Unit. The Food Skills pilot program was created as a key initiative to increase access to and consumption of vegetables and fruit among women living in low income households who are of reproductive age who were pregnant, or planning a pregnancy.

Women who are pregnant or planning a pregnancy have unique nutritional requirements, that, when met, have the potential to improve birth outcomes. Pre- pregnancy weight, maternal weight gain during pregnancy and infant birth weight all have significant influences on infant health and risk for the development of chronic disease longer term. Women need additional nutrients to support a healthy pregnancy and ensure the best possible birth outcomes. Vegetables and fruit contain many of the key nutrients needed to support optimal health both before and during pregnancy. Nutrient requirements before and during pregnancy can be met by following the recommendations on Canada's Food Guide and taking a prenatal multivitamin and mineral supplement.

Improved food literacy and consumption of vegetables and fruit has the potential to have a large impact on the health of this target group. It has been well documented that good nutrition during pregnancy is critical in supporting fetal development and protecting the mother from pregnancy-related risks such as gestational diabetes, excess weight gain, pregnancy-induced hypertension and iron-deficiency anemia (Black, Brimblecombe, Eyles, Morris, Vally, O'Dea, 2012). Women living in low income households are especially vulnerable and consume vegetables and fruit less often than those living in high income households reinforcing the need for programming with this population (Azagba and Sharaf, 2011).

Frequency of family meals and involvement in food preparation is associated with improved diet quality. Mothers are the primary role model for healthy eating for their children. The evidence suggests that women are mainly responsible for food preparation in the home and are the primary teachers of cooking and food preparation skills. Lack of appropriate role modeling for healthy food choices and changes in education curriculum in the schools has resulted in decreasing food literacy among upcoming generations. (Desjardins et al. 2013)

Program Goals

The overall goals of the program:

1. **Increasing knowledge related to food literacy.**

2. **Increasing access to and consumption of vegetables and fruit.**

Target Population

The target group for the Food Skills pilot program was women living in low income households who were of reproductive age, pregnant, or planning a pregnancy. During the pilot program phase, partnerships were developed with pre-existing groups in the community. Key partnerships included the Mutual Aid in Parenting Program (MAPP), the Carling-Thames Family Center, Childreach, Families First, and the London Food Bank.

Program Design and Delivery

Selection of Partnering Organizations and Program Delivery Sites

MLHU built on existing partnerships with the Mutual Aid in Parenting Program (MAPP), the Carling-Thames Family Centre, Childreach and Families First. The reason for choosing these partners as host organizations was based on the criteria outlined below:

- Ability to recruit participants from our target population (women of reproductive health age living below the low income cut-off)
- Pre-existing groups
- Perceived need for food literacy skills within their groups
- Availability of a kitchen suitable for group teaching
- Availability of a group facilitator
- Able to provide child minding

Along with the above criteria, host organizations were also responsible for identifying a list of participants to attend the program, providing the kitchen facilities, contributing to the snack, attending as a program facilitator and where necessary, arranging for child minding. One program did the majority of the grocery shopping.

The Food Skills Program

The RHT Food Skills program was co-facilitated by a Registered Dietitian and Public Health Nurse covering various aspects of food literacy, preconception health and parenting principles. This program required the direct involvement of a Registered Dietitian with Food Literacy programming experience to select the recipes and facilitate preparation used during sessions. Each session consisted of:

1. Hands-on food preparation,
2. Food tasting,
3. Group food skills and health teaching, and
4. Take-home incentives (fresh produce, left-over prepared food, Veggie Vouchers, Harvest Bucks and and/or kitchen utensils.)

Food skills included:

- Knowledge (i.e. about food, nutrition, label reading, food safety, ingredient substitution),
- Planning (i.e. organizing meals, food preparation on a budget, applying knowledge of the food guide when planning meals),
- Conceptualizing food (i.e. creative use of leftovers, adjusting recipes),
- Mechanical techniques (i.e. preparing meals, chopping/mixing, cooking, following recipes) and,
- Food perception (i.e. using your senses- texture, taste, when foods are cooked).

Health teaching included:

Preconception Health Topics

- Reproductive Health Team services
- Healthy Lifestyle
    - Eating a well-balanced diet, including fruits and vegetables
    - Folic Acid (discussion and distribution)
    - Physical activity guidelines
    - Mental Health- reducing stress levels
    - Identifying supportive relationships
    - Environmental exposures (Hand-washing, safe food handling, foods to avoid and safe alternatives)

Parenting

- Summertime, Hydration and the family- importance of water, milk options and limiting juice
- Triple P's Principle 'Take care of yourself as a parent' with the focus being on stress, food and mood

Phase 1 ran from June 2014 -September 2014. It consisted of a partnership with MAPP and involved 8 sessions at one London site, Carling Thames Family Centre, and one Strathroy site at the Children's Aid Society Office. Each session was 2 hours in length and occurred on a bi-weekly basis. . Small kitchen incentives directly related to the session topic were used to encourage food preparation at home and continued participation (e.g. fridge thermometers, Basic Shelf cookbooks, fresh local vegetables donated by the London Food Bank and prenatal vitamins to those interested).

Phase 2 ran from October 2014 to December 2014. It consisted of partnerships with Childreach Growing Together Program and Families First CAPC and was offered at two sites in London- the Carling Thames Family Centre and the South London Community Centre respectively. This phase involved 6 sessions per series with each session being 2 hours in length and occurring on a bi-weekly basis. Phase 2 Each session was planned and facilitated by 2-3 members of the RHT.

No clients were identified as having attended sessions during both phase 1 and phase 2 of the Food Skills program pilot.

Food Skills Curriculum

The Food Skills Core curriculum was developed by a team of Public Health Nurses and a Registered Dietitian. The core curriculum consisted of information and skill building techniques. The curriculum was adapted after an initial needs assessment with each group. The curriculum from Phase 1 was modified for Phase 2 by decreasing the number of sessions from eight to six due to scheduling and financial constraints.

Participants were also encouraged to share any recipes that they were familiar with and to discuss how recipes could be adapted by using heathier ingredients. Sessions were adjusted due to community needs and events that interrupted the scheduled sessions due to staff and facility availability

Curriculum Outline: Phase 1

Session 1: Hand Washing and Safe Food Storage

Session 2: Food Safety at Home

Session 3: Menu Planning

Session 4: Label reading

Session 5: Self Care and Parenting

Session 6: Fueling your brain with food – Healthy breakfasts and lunches

Session 7: Quick and Easy Dinners

Session 8: Physical Activity and Food Budgeting (canning)

Curriculum Outline: Phase 2

Session 1: Hand washing and Knife Safety

Session 2: Food Safety and Storage

Session 3: Menu Planning

Session 4: Preconception Nutrition

Session 5: Label reading and Toddler Nutrition

Session 6: Sweetened Beverages

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Program Cost

The total cost of the Food Skills pilot program from June-December of 2014 was $4471.89. This amounts to $18.60 per participant per session. Costs incurred were:

- $1039.65 for food used in the program,
- $952.30 for incentives (See Appendix)
- $2479.94 for *Veggie Vouchers and ^Harvest Bucks: at each session, participants were provided $$$ in either voucher

  *Veggie Vouchers are vouchers that had a set dollar amount and were created for this program. The vouchers were redeemed by participants for fresh produce at local participating grocery stores

  ^Harvest Bucks is a pre-existing program partnering the Middlesex London Health Unit with local farmer's markets provides vouchers to vulnerable families to purchase fresh produce.

Evaluation and Methodology

A pre-questionnaire was given to all participants to complete at the first session of each program and a post-questionnaire completed at the final session. The objectives were:

1. To assess whether there had been change in knowledge, skills, confidence or behavior over the program duration and;

2. To understand the impact of providing vouchers for purchasing of vegetables and fruit.

Not everyone completed the questionnaires or attended each session of the program so it was not possible to determine that the pre and post respondents were the same (Appendix B and C).

Participant Demographic Data

This evaluation report covers information gathered from individuals participating in **Phase 1** (June-September 2014) and **Phase 2** (October-December 2014).

Phase 1

In phase 1, all participants completed the pre-questionnaire and 79% of participants completed a post-questionnaire. In total 161 clients attended sessions during phase 1, with many attending multiple times for a total of 31 unique participants. Data from pre and post participant questionnaires indicate that:

• 83% were between the ages of 25-44, and 4% were aged 19-24.

• 83% of participants identified themselves as having children. None of the clients identified with having someone pregnant in their household at the time of the program with the average participant's household having two children.

• 37.5% lived outside of the city of London. This larger percentage was reflective of the program that was run at the Strathroy location primarily attended by rural residents of Middlesex County.

Phase 2

In phase 2, all participants completed the pre-questionnaire during the first session and 80% completed a post-questionnaire. In total, 79 participants attended sessions during Phase 2 with many attending multiple times for a total of 17 unique participants. Data from participant questionnaires demonstrated that:

- 100% were under the age of 25.
- 80% of participants had children; the average having 2 children per household. Two clients identified having a pregnant person living in their household.
- 6% lived outside of the city of London. No rural sites were offered during phase 2 resulting in a lower percentage of County participants who attended this phase.

The drop off rate between the respondents completing the pre and post questionnaires across Phase 1 and 2 was 20.5%. Not all participants attended every session.

Vegetable and Fruit Consumption

At the conclusion of the Food Skills pilot program:

- 68% of respondents agreed they were eating more vegetables and fruit than they did before participating in the pilot.
- 67% agreed that they had tried a new vegetable or fruit during the program
- 76% reported that as a result of attending the program, they were buying vegetables and fruit that they typically would not purchase
- 95% of participants reported that they learned new ways to incorporate vegetables into family meal preparation

Participants' Eating Behaviors, Knowledge and Skills

As a result of attendance at the program and teaching information sessions, participants in the program reported changes in their knowledge, skills and behaviors. Responses in the post questionnaire as compared to the pre questionnaire revealed:

- Increased confidence in planning meals for their families that include vegetables and fruit.
- Increased knowledge and ability to chop and prepare vegetables and fruit.
- Increased skills and ability in cooking vegetables and fruit by following a new recipe.
- Increased competence and confidence in using common kitchen utensils; especially a kitchen thermometer, apple corer and vegetable steamer.

Participants' Access to Vegetables and Fruit

One of the program goals was to increase access to vegetables and fruits for families. The results of the pre-questionnaire showed that 55% of participants reported that their family struggled to get enough food during the past year because of money. Activities that encouraged participants to reach this goal were to:

- Improved accessibility by introducing vegetables and fruits in the program
- Provided vouchers for participants to purchase vegetables and fruits
- Offered produce to take home either purchased by the program or donated by the food bank.
- Higher level of knowledge about how to purchase vegetables and fruit for a better quality and price.

At the end of the program when participants were asked what made it easy for them to eat vegetables and fruit, responses included:

- They liked the taste (58%)
- Being able to find sales or buy in bulk (58%)
- Trying to eat healthy (51%)
- Being able to walk to the food store (33%)

Part of increasing access to vegetables and fruit for participants was to offer Veggie Vouchers and Harvest Bucks. Partnering grocery stores for the Veggie Voucher program were chosen based on their proximity to the programming location.

In phase 1 of programming, $1565 in Veggie vouchers were distributed, with an 87% redemption rate. Of the 699 produce purchases that were made, 46% were vegetables and 54% were fruit. The most common vegetables purchased were lettuce, onions and potatoes with the most common fruit purchased apples, bananas and grapes.

A total of $356 in Harvest Bucks were given out during phase 1 of program with a 77% redemption rate. When surveyed, 89% of clients indicated they ate all of the vegetables and fruit that they purchased.

In phase 2 of programming, $490 in Veggie Vouchers were distributed, with a 43% redemption rate. Of the 92 purchases that were made, 42% were vegetables and 58% were fruit. The most common vegetables purchased were cucumber and lettuce with the most common fruit being apples, bananas and grapes.

A total of $312 Harvest Bucks coupons were given during phase 2 of program with an 89% redemption rate. When surveyed, 67% of clients indicated they ate all of the vegetables and fruit that they purchased

	Amount of Veggie Vouchers Distributed	**Percent of Veggie Vouchers Redeemed**	**Amount of Harvest Bucks Distributed**	**Percent of Harvest Bucks Redeemed**
Phase 1	$1565	87% ($1361)	$356	77% ($274)
Phase 2	$490	43% ($210)	$312	89% ($277)

Participants in the Food Skills Pilot

Themes that were identified from participant's comments included, increased:

- Confidence in planning meals for their families, mechanical skills (cutting, washing, measuring, cooking), use of leftovers, time management, use of common kitchen utensils.
- Skills in purchasing, preparing and properly storing vegetables and fruit.
- Knowledge about healthy and economic ways to purchase, plan and prepare nutritious meals for their families.
- Knowledge of food varieties, ingredients, nutritional label reading and food safety.
- Consumption of vegetables and fruit.

When asked what they learned from the program and how it was beneficial for them and their families, participants' responses reflected the desired outcomes. Some of their statements included:

- "Safer food storage- learning to keep raw meats in the very bottom of the fridge"
- "Make new recipes, be aware of nutrition labels"
- "Use food in a more useful way"
- "Importance of healthy eating, budgeting and meal planning"
- "Be a better cook, be a better parent"
- "Learn how to eat healthy"
- "Spend money more wisely on healthy choices"
- "To not get so stressed and learn how to communicate with children"
- "How to cook healthy, balanced meals and to shop for food in a better way"

Identified Barriers

The Food Skills pilot program provided participants with opportunities to try new healthy foods, introduce and share these foods with their families, and positively influence their healthy cooking and eating knowledge, skills, attitudes and behavior. Clients identified two major barriers to selecting and preparing healthy foods for themselves and their families:

- Perishability of vegetables and fruit (94%)
- Affordability of vegetables and fruit (75%)

Key Outcomes

Individual Level Outcomes

The Food Skills pilot led to the improvement of food literacy within the target population. Results indicated that at the end of the sessions, participants were:

- Eating more vegetables and fruit everyday
- More likely to meet the recommended 7-8 servings per day (Canada's Food Guide) than previously,
- More comfortable using basic kitchen utensils such as a meat thermometer, apple corer and vegetable steamer,
- Developing an increased level of confidence about healthy and economic ways to purchase the best quality vegetables and fruit for the least money,
- More comfortable in planning meals for their families that include vegetables and fruit

Unintended Positive Consequences

- The Food Skills pilot program unintentionally connected participants to and increased their awareness of other health related community resources. One of the sessions during Phase 1 had to be re-located to the Middlesex-London Health Unit on King Street. During this session, one of the participants identified that she did not currently have a healthcare provider but needed one and she was able to connect with the Sexual Health Clinic at MLHU to get an appointment. Another program participant was able to make contact with Oral Health Services and make an appointment for her children to obtain care when they previously had not.
- The Food Skills program also provided an indirect impact on the children of the participants who talked about how the knowledge, skills and access they acquired will influence the meals that they plan for their families. Participants noted that they were also encouraged to plan and prepare healthier options for their children while incorporating more vegetables and fruit in fun and interesting ways.

Future Goals and Considerations

Key Highlights

The evaluation results provided evidence that Food Skills is an effective program for fostering improved food literacy and increased consumption of and access to vegetables and fruit. The overall effectiveness of this client-centered program is related to the information sessions incorporating a hands-on skill building component.

Future Considerations

Recommendations for Future Programming:

- Build on the successes of this pilot.
- Develop best practices reflected in a core, evidence-based curriculum that can still be adapted to meet the needs of the target population.
- Expand partnerships with more community host organizations.
- Develop specific program guidelines.
- Continue to collect data (pre and post questionnaires) and build evidence of the impact of the Food Skills program on healthy eating and food security to inform key decision makers about future program and policy development.
- Consider collecting follow-up participant data to evaluate the longer term program impacts.
- Consider implications of including children and other family members in cooking
- Consider a train-the-trainer model to build community capacity and train peers or community members to facilitate program sessions

Conclusion

The RHT Food Skills pilot program was created as a key initiative to increase access to and consumption of vegetables and fruit among reproductive-aged women living in low income households because they have unique nutritional needs and significant challenges accessing healthy foods. Vegetables and fruit contain many of the key nutrients needed to support optimal health both before and during pregnancy. The RHT Food Skills program showed positive outcomes related to increased food skills and increased access and consumption of vegetables and fruit. It is recommended that the program continue with the implementation of the recommendations as listed above.

References

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Appendix A- Community Needs Assessment

Session:

Location:

I would like to learn more about:

	1-not at all	2	3	4	5- very much so!
Canada's Food Guide					
Reading labels					
Food Safety and storage					
Different types of foods					
Using new recipes					
Planning and preparing meals					
Budgeting-Couponing					
New cooking skills					
Cooking with my kids					
Gardening					
Canning					
Grocery store tour					
Berry picking					
Knife skills					
Apple picking					
Market tour					

Appendix B- Participant Pre-questionnaire

The Middlesex-London Health Unit wants to find out how much you and your family know about buying, preparing, cooking and eating vegetables and fruit. Thank-you for taking the time (about 5 minutes) to complete this survey; your answers will be used to help us improve our programs. You can stop this survey at any time.

1. How old are you?

Under 19 O	25-34 O	45-54 O
19-24 O	35-44 O	55+ O

2. Circle how many people live in your household *including yourself*?

Adults (18+)	1	2	3	4	5+
Children	1	2	3	4	5+

3. How many people in your house including yourself are pregnant *now*?

☐

4. Where do you live?
   - O City of London
   - O Outside London

5. Check how **many servings** of vegetables and fruit do you **usually eat per day**?

(Examples of 1 serving: ½ cup of fruit or vegetables, a small apple, 1 cup of salad, ½ cup juice)





	0	1-2 servings	3-4 servings	5-6 servings	7 or more
Fruit					
Vegetable					

6. *Circle* what type of vegetables and fruit do you eat **MOST** often?

Fresh Frozen Canned Not Applicable

7. Where do you buy your vegetables and fruit **MOST** often?
   - Grocery Store O
   - Farmer's Market O
   - Fruit and Vegetable Stand O
   - Other Location O

8. What are the things that make it **hard** for you to eat vegetables and fruit?

Please check all that apply:

- O They cost too much
- O They go bad before I can eat them
- O I get bored of eating them
- O I don't like vegetables
- O I don't like fruit
- O I don't like to try new types
- O My family doesn't want to eat them
- O I don't know how to cook or prepare them
- O I don't have time to cook or prepare them
- O I often eat out and they aren't available at restaurants
- O I choose to eat other things instead
- O I don't have transportation to the store/market
- O I don't have a way to cook them (microwave, stove, oven)
- O I don't have enough storage space (cupboards, fridge, freezer)
- O Nothing stops me from eating fruits and vegetables
- O Other: _____

9. Circle the number of daily servings of vegetables and fruit recommended for you by Canada's Food Guide?

1-2 3-4 5-6 7-8 More than 8 I don't know

10. What are the things that make it **easy** for you to eat vegetables and fruit?
Please check all that apply:

- O I find sales or buy things in bulk
- O I like the taste
- O I like to try new types of fruits and vegetables
- O My family is excited to try new types of fruits and vegetables
- O I enjoy cooking and preparing fruits and vegetables
- O The food store is close to my home/work/school
- O I can walk to the food store (grocery store/farmer's market)
- O I have storage space to keep the food that I prepare
- O I am trying to eat healthy
- O Other: _____

11. Why are vegetables and fruit good for you?

12. Please indicate your feelings about the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I know where to buy vegetables and fruit grown in Middlesex-London.					
I can plan a meal that includes vegetables and fruit.					
I can buy vegetables and fruit at a farmer's market.					
I can chop and prepare vegetables.					
I can cook vegetables.					

13. Circle which kitchen utensils you are comfortable using:









14. True or False: In the past year, I had difficulty buying food because food costs so much.

O True O False

15. True or False: In the past year, my family did not have enough vegetables and fruit to eat because they cost too much.

O True O False

Appendix C- Participant Post-questionnaire

1. How **many servings** of vegetables and fruit do you **usually eat per day**?

(Examples of 1 serving: ½ cup of fruit or vegetables, a small apple, 1 cup of salad, ½ cup juice)





	0	1-2	3-4	5-6	7 or more
Fruit					
Vegetable					

2. *Circle* what type of vegetables and fruit do you eat **MOST** often?

Fresh Frozen Canned Not Applicable

3. Where do you buy your vegetables and fruit **MOST** often?

Grocery Store O
Farmer's Market O
Fruit and Vegetable Stand O
Other Location O

4. How many servings of vegetables and fruit does Canada's Food Guide recommend that you eat per day?

1-2 3-4 5-6 7-8 More than 8 I don't know

5. True or False? I now eat more servings of vegetables and fruit than I did when I started this class:

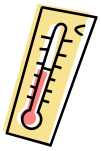
O True O False

6. Why are vegetables and fruit good for you?

7. Please indicate your feelings about the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I know where to buy vegetables and fruit grown in Middlesex-London.					
I can plan a meal that includes vegetables and fruit.					
I can buy vegetables and fruit at a farmer's market.					
I can chop and prepare vegetables and fruit.					
I can cook vegetables and fruit by following a new recipe.					

8. Circle which kitchen utensils you are comfortable using:









9. True or False: In the past year my family did not get enough to eat because of money.

O True O False

10. True or False: In the past year my family did not have enough vegetables and fruit to eat because of money.

O True O False

11. Please answer True or False for the following Questions:

a.	I tried a new vegetable or fruit during this class	T	F
b.	I can sneak 2 vegetables into meals with my kids	T	F
c.	I learned how to cook healthy food with my kids	T	F
d.	I am buying vegetables and fruit that I didn't before	T	F

12. What did you buy with your food vouchers?

13. If you didn't use all of the money, why do you think not?

14. Where did you use MOST of your vouchers?

Grocery Store ○
Farmer's Market ○

15. How much of the vegetables and fruit that you bought with your vouchers did your family eat?

○ All ○ Some ○ None

16. If you didn't eat it all, why do you think you didn't?

17. This program helped me to/taught me……

18. Was this your first time buying food at a farmer's market?

O Yes O No

19. Was this your first time using a voucher program?

O Yes O No

PROGRAM PLANNING & EVALUATION REPORT

FAMILY HEALTH SERVICES

PROGRAM/PROJECT

Food Skills 13 Week Post Program Evaluation

CONTACT(S)

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PURPOSE

- The purpose of this report is to provide the focus group and survey results conducted with the Westminster Families First Group.

BACKGROUND & METHODS

- A Food Skills course (RHT Food Skills Program) was completed with the Westminster Families First group in June-August of 2015.
- The course participants were asked to complete a short questionnaire at the beginning (pre-program) and conclusion of the program (post-program).
- 12 weeks after the conclusion of the program (12 weeks post-program) the RHT Food Skills Program return to complete one additional cooking session and to conduct a focus group and a follow-up questionnaire with the participants.
- A focus group guide and short questionnaire were developed for the evaluation 12 weeks post-program (see appendix). The survey complements questions asked previously on the pre- and post-program questionnaires.
- Two focus groups were conducted with a total of 12 participants, with 6 participants in each group (see appendix for a list of all reference themes).
- The focus group was recorded. All participants agreed to this and signed a consent form.
- The 12 week post-program questionnaire was completed by 10 of the 12 focus group participants.
- Participants were asked about their fruit and vegetable consumption at the beginning (pre-program), end of the program (post-program) and 12 weeks post-program.
- At the conclusion of program and 12 weeks post-program participants were also asked about topics covered in the RHT Food Skills Course.

RESULTS

KEY THEMES FROM BOTH FOCUS GROUPS

- Nine themes emerged from the discussions of both groups (see figure 1). The most frequently discussed themes were; “Information sharing: new and innovative ideas”, “Completed with another cooking program”, “Incentives”, “Barriers”, and “Unique cooking needs based on family structure”. These six themes best reflect the discussion across both focus groups.

INFORMATION SHARING: NEW AND INNOVATIVE IDEAS

- The women in both groups enjoyed sharing what they learned and/or adapted from the course. These included recipes, food preparation, food storage and safety tips. Their comments demonstrated the increased knowledge and awareness of topics presented in the RHT Food Skills Program.

“I’m always open to new recipes; I like the thing we are making today. I would have never made it on my own”

COMPLETED WITH ANOTHER COOKING PROGRAM

- The women in both focus groups referenced recipes and activities they completed with cooking programs other than the RHT Food Skills Program.
- The focus groups only referenced recipes completed with the RHT Food Skills Program 6 times. The syrups and granola recipes were the only two RHT Food Skills Program recipes identified. In total the groups referenced recipes completed with other cooking programs 16 times. The following recipes from other programs were referenced: Teriyaki chicken, chicken Alfredo, fudge, cheese balls, whipped topping cookie, Carmel-squash dessert and trail mix.
- In addition, a group member mentioned a memorable guest chef from a previous cooking course that also demonstrated food skills.

“Ryan the chef, he actually showed you proper techniques, it’s how you prepare, it is the way you cut the chicken and how you season it at the right time”

INCENTIVES

- Both focus groups identified incentives and the benefits of these incentives. The most frequently referenced incentive was the fruit and vegetable pickup one Thursday a month. A total of 8 women indicated they participated in the Thursday fruit and vegetable pick up. The harvest bucks were the second most common incentive referenced. The RHT Food Skills Program as well as other cooking program provided Harvest Bucks to this group. The groups also mentioned the planters and food prep incentives (e.g. grater, apple corer) that were unique to the RHT Food Skills Program.

“Oh we got incentives like graters, tools to work with, fridge thermometer, measuring cup, apple cutter I never had”

BARRIERS

- Women in both groups identified limited finances as a barrier for obtaining fruits and vegetables and cooking healthy meals. Other women in the group commented on the high cost of quality vegetables and fruit. The Harvest Bucks made buying quality fruits and vegetable a bit more affordable. While many enjoyed many of the recipes presented, they agreed that adding the required items to their grocery list was cost prohibitive. Other barriers specific to one focus groups were transportation to and from the program location as well as time constraints when it came to making healthy meals at home.

"I guess with the Harvest Bucks it made it easier to do those recipes and eat those veg and fruit"

"No, it's kind of a budget problem"

"It's an ingredient thing; you would have to go and get all those things and have them on hand"

UNIQUE COOKING NEEDS BASED ON FAMILY STRUCTURE

- Both groups expressed the need for recipes tailored to the needs of their family structure. While family structures across the groups varied, the key groups identified were families with young children and small or single person families. The young families desired kid-friendly meals and smaller families wanted simple one dish meals with minimal leftovers.

"Meals with meat for picky eaters"

"So because my sons gone now so it's just me and I'm finding and my family is finding that I'm not eating a whole lot anymore…they are worried…because I don't really want to just cook for me. I like you said, I'm not going to get veggies going, potatoes, I'm not going to get gravy going, I'm not going to get meat going when it's just me…not that it's anybody's fault"

LESS FREQUENTLY REFERENCED THEMES

The remaining themes discussed in both group were: "General positive feedback", "Concerns about food waste and minimizing food waste", "Sense of community" and "Making meals stretch". These themes were discussed in far less frequency but were consistent across both groups. While participants do not reference as many details from the RHT Food Skills Program they did provide general positive feedback about the course. Some women in both groups also expressed concerns around taking the time to make healthy meals that their families would not eat and then the food ends up going to waste.

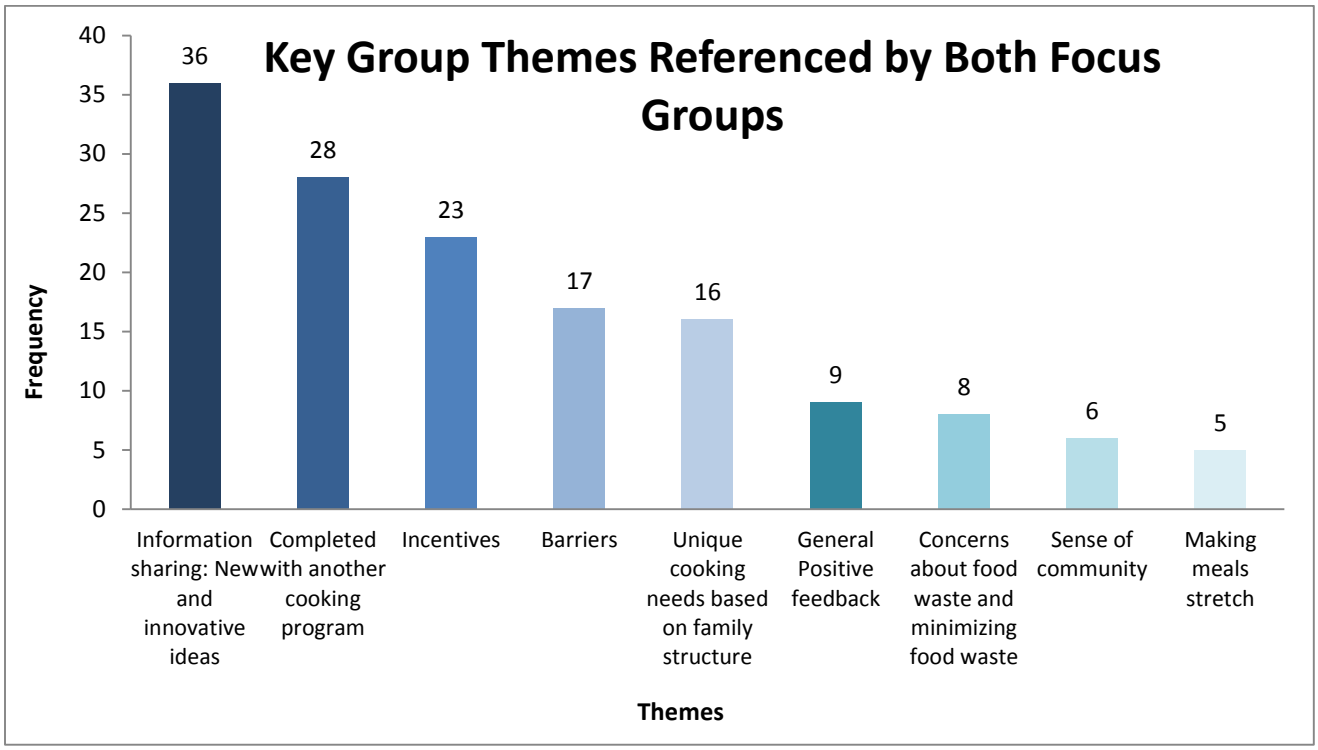
"…because when kids driving me nuts in the freakin' kitchen, under my feet and then they don't even eat it and then I'm stuck with all this clean up and stuff and then I get a bad case of….I don't waste my time on making something with 50 thousand step to make something healthy and then I'm stuck with it and then it just goes out to the animals"

Comments regarding food waste were often accompanied by comments regarding the unique cooking needs based on family structure and making meals stretch. Some of the women were interested in using a few core ingredients that can be used to make multiple recipes. By buying chicken, potatoes and broccoli in bulk and using this to create 3 different dinners for example. This suggestion builds upon budgeting tool of buying in bulk learned in the RHT Food Skills Course.

"…you could do one dinner and then like the next day you could beef it up somehow to make it a different meal to make it stretch….what can you do with that chicken to make it a different something the next day…"

"then take what's left over from that and make a stir fry the next day…or some wraps"

Members from both groups also shared that the cooking programs they participate in provide them with a sense of community, the Monday night Community Kitchen was mentioned specifically. Four women indicated that they attend the community kitchen.



THEMES FROM FOCUS GROUP ONE

A few themes emerged only in the discussions with the first focus group. These items were "Sharing personal recipes and experiences with food", "Interest in baking" and "Difficulty replicating recipes". The first group spent a great deal of time sharing their own recipes and experiences with food. One person mentioned how they improved upon a recipe learned in another cooking course. While the women in this group spoke generally about how much they enjoyed the RHT Food Skill Program no one could recall any of the recipes completed as part of the course. Another cooking program provided the group an opportunity to make bake goods. A few of the women expressed interest in baking because it is less expensive to make bake goods than to purchase.

"We have a lot of holidays and when you are buying that stuff it cost a lot to buy lots of kids Christmas desserts. My mom used to make a lot of this stuff and it's cheaper than buying a boxful and you can make all kinds of them. "

A couple of people in the group mentioned they had difficulty replicating the recipes once they were at home. It was unclear it these were recipes provided through the RHT Foods Skills Course or another cooking program.

THEMES FROM FOCUS GROUP TWO

In addition to the topics discussed in both groups, the second group's conversation was also largely dominated by their "Grocery store preferences" followed by "Simple dishes" and "Program longevity and consistency". Many of the women in the second group discussed the poor quality of Food Basics produce.

"Oh yea at Food Basics is the worst place to buy fruit in the world …I've tried it over and over again"

However, many continue to shop there because of the competitive prices and the vouchers they receive from the Families First group are only redeemable at Food Basics and/or Metro. The market was the preferred store for one person because of quality, but mentioned that it was quite expensive. It was discussed that Metro is too expensive and thus not an effective use of the card, leaving Food Basics as the only option if they would like to use the gift card. Some of the women preferred No Frills, indicating the produce quality exceeded Food Basics but were more reasonably priced than Metro. While the group agreed that Metro provides good quality they found shopping there cost prohibitive.

"I actually prefer No Frills to Food Basics but I get a card and that's why I go there…we get a gift voucher for Metro or Food Basics…Metro is too expensive so I never go there…"

One woman mentioned that while she enjoys shopping at No Frills, they will no longer price match items that are not in their flyer.

"That's helpful for me….price matching makes a huge difference for me…like going to one store with 5 flyers makes it some much easier than buying 5 things there, 2 things here…you know people don't have a car…"

Harvest bucks provided by the RHT Food Skills Program and other programs made choosing the market more affordable.

"Yea because I buy my fruit and vegetables down at the market, like if I buy fruit up at Food Basics I'm just throwing my money away because a) it's half rotten to begin with up there and it doesn't last, so I'm throwing it out…so for me making a couple of trips to the market, like one trip will easily cost me $12-14…just to make sure my kids have grapes, some bananas or carrots you know little bit size carrots….and I have to do that 2-3 times a week. So right there that's $20-$30… to get the quality anyway"

Many of the women in the second focus group expressed interested in learning more simple dishes. More specifically, group members were interested in simple dishes that were quick to prepare, only use a few ingredients and single dish meals.

A few members of group two expressed some concerns regarding the consistency of the program. The group stated a number of cooking programs have come through and it was unclear what the duration or frequency of each program would be. For example, while the frequency and duration of the initial

sessions of the RHT Food Skills Program were quite clear they were not told the Program would be returning at the time the focus groups were conducted. In addition, there are gaps in programming. They would have a group come in with programming for some time and then no programing for a period. Some of the women also receive a great deal of social support from these programs and become attached to the people who lead them.

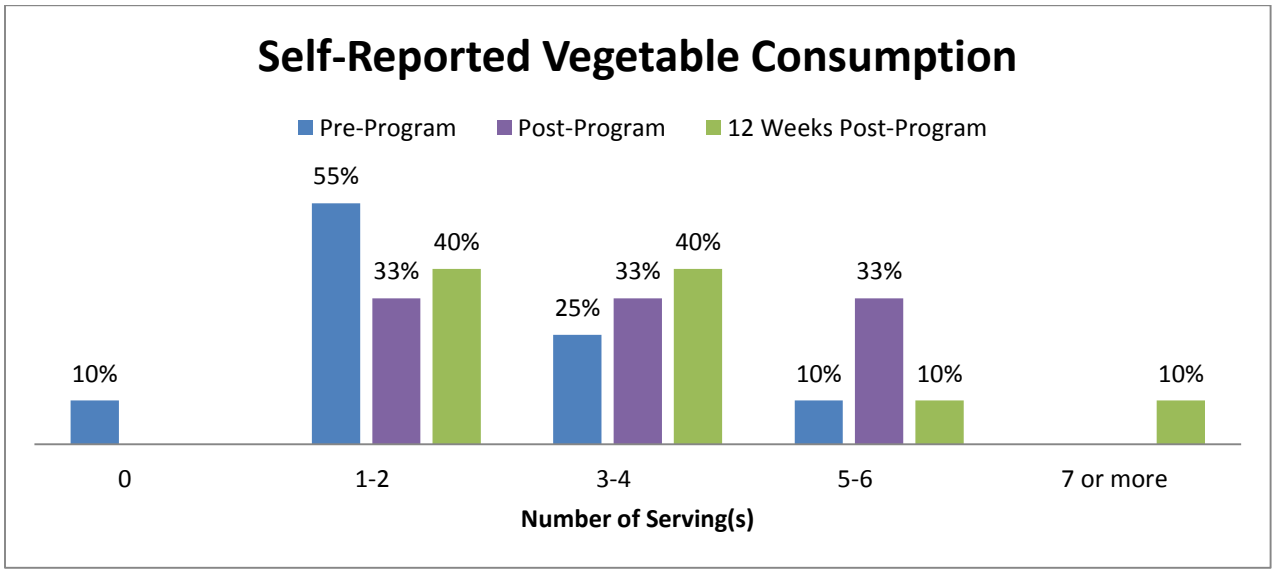
"Yea it's so important…I isolated myself for a while…so to have the group is awesome."

SURVEY RESULTS

SELF-REPORTED FRUIT AND VEGETABLE CONSUMPTION

- The results indicate that following the course (post-program) participants reported consuming a greater number of vegetables than at the beginning of the course. This trend appears to continue 12 weeks following the Food Skills Course (see figure 2).

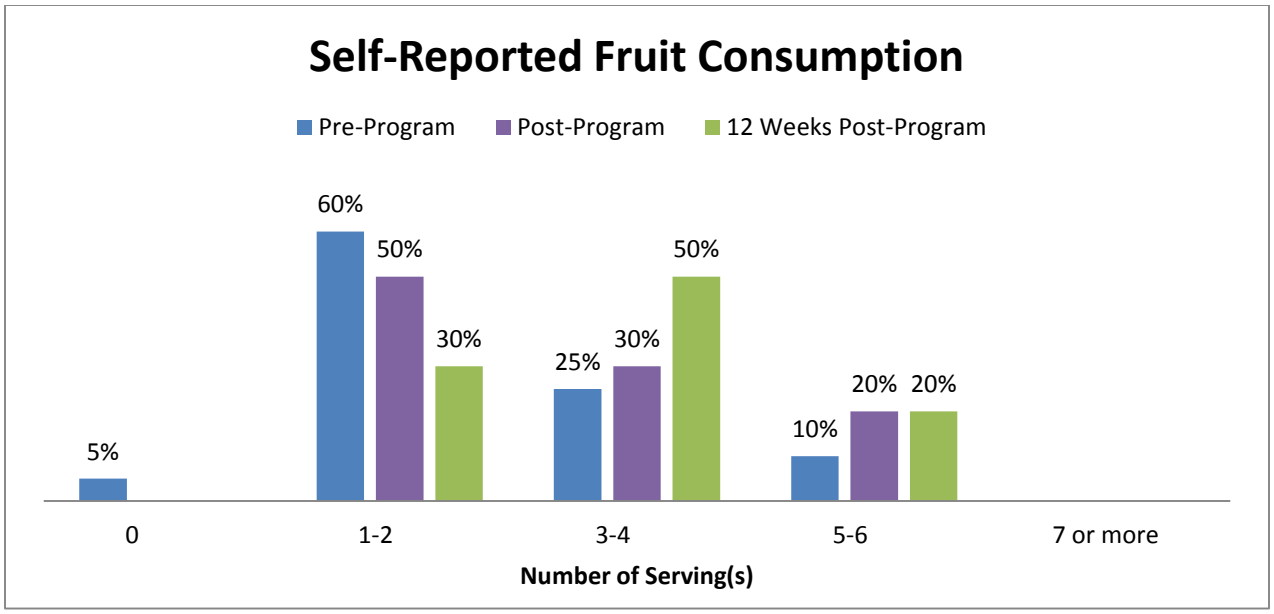
Figure 2. Self-Reported Vegetable Servings RHT Food Skills Participants



(Pre-program n=20, post-program n=9 and 12 weeks post-program n=10)

- The trend is similar for the self-reported fruit consumption. Participants reported eating more fruit at the conclusion of the program than at the beginning (see Figure 3). This trend also extends to the 12 week post-program survey.

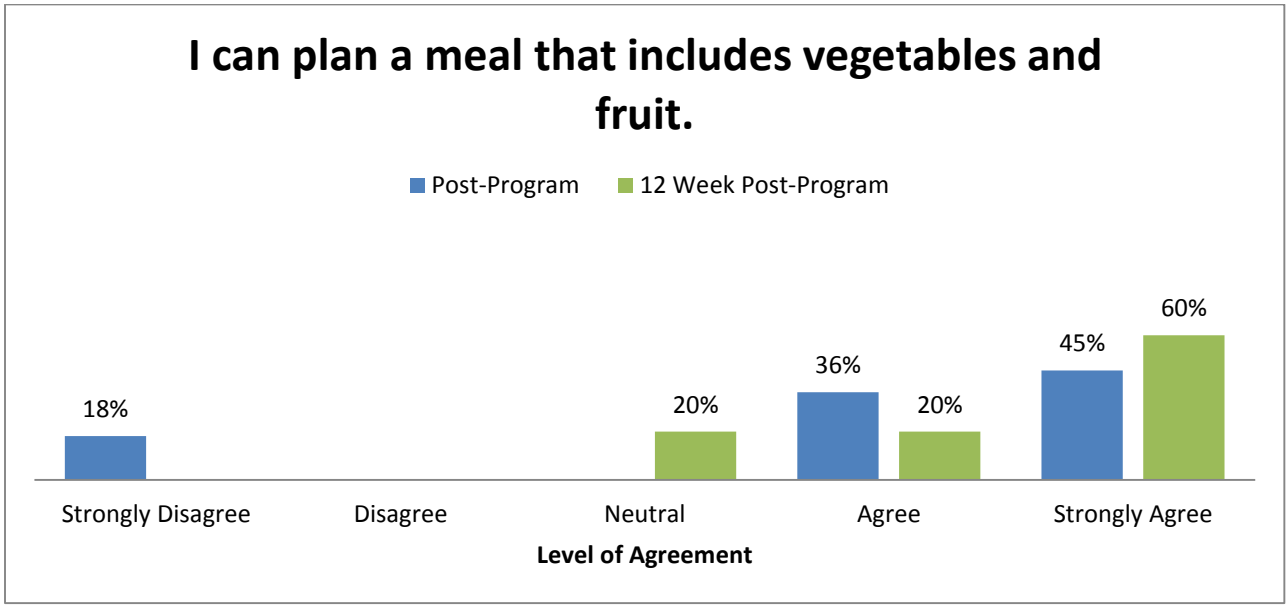
Figure 3. Self-Reported Fruit Servings RHT Food Skills Participants



(Pre-program n=20, post-program n=10 and 12 weeks post-program n=10)

- The majority of clients agreed or strongly agreed that they could plan a meal that included vegetables and fruit and at both time points (see figure 4).

Figure 4. Planning a Meal with Vegetable and Fruit

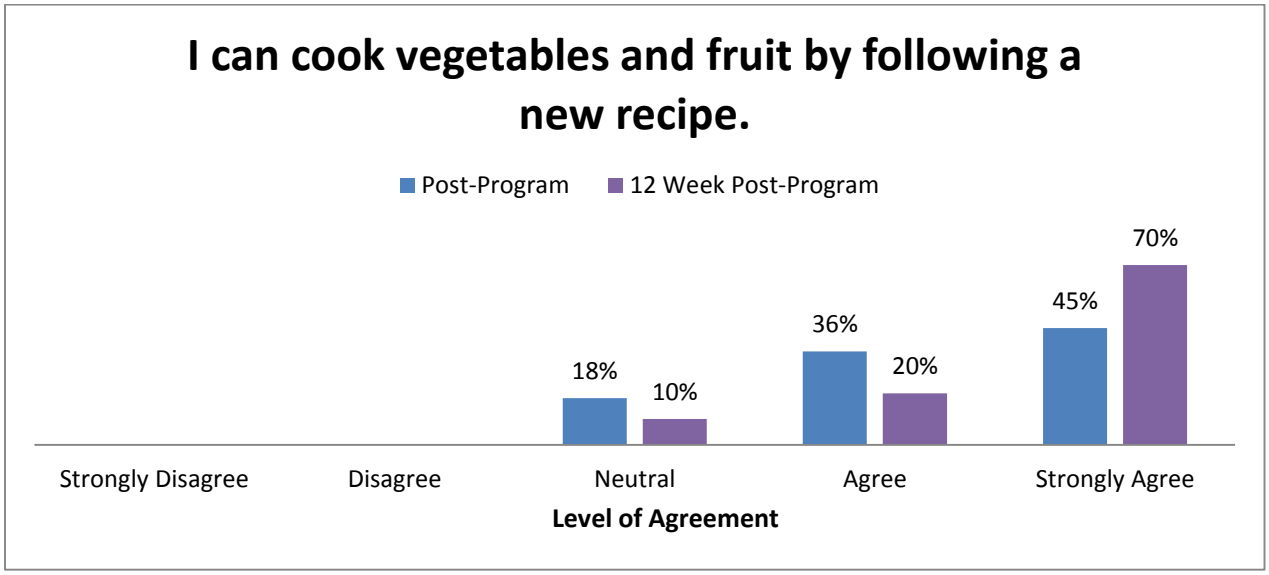


(Post-program n=11 and 12 weeks post-program n=10)

RHT FOOD SKILLS PROGRAM TOPICS AND FUTURE INTENTIONS

- Slightly more participants agreed that they could cook with vegetables and fruit using a new recipe 12 weeks post program than right after completing the program (see figure 5).

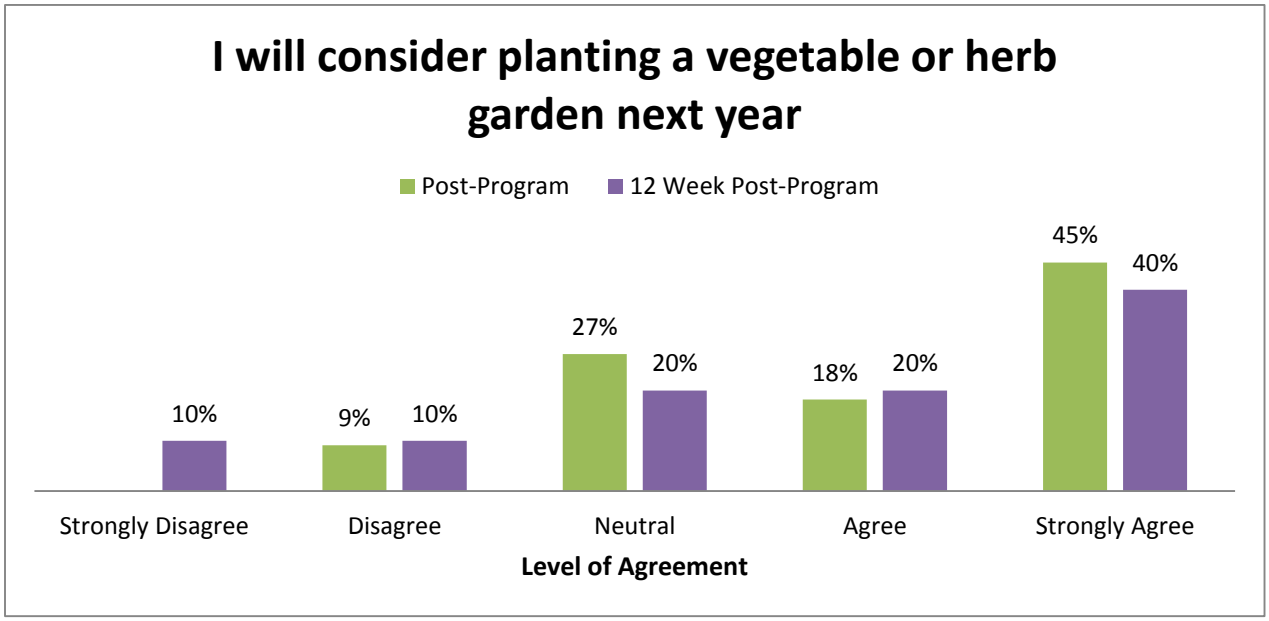
Figure 5. Cooking a New Recipe that Includes Vegetables and Fruit



(Post-program n=11 and 12 weeks post-program n=10)

- Slightly fewer people agreed they would consider planting a vegetable or herb garden in the coming year 12 weeks post-program than right after the completion of the program (see figure 6).

Figure 6. Planting a Vegeable or Herb Garden Next Year



- The results indicate that fewer participants tried I a new vegetable or fruit in the month 12 weeks post program than during the course.
- By the end of the program all respondents had learned new ways to save money at the grocery store and the majority were still using the money-saving tools they had learned 12 weeks post program.
- At the conclusion of the program the majority of participants planned to complete a receipe learned in the course and all participants said they planned to make a receipe from the course 12 weeks post program (see table 1).

Table 1. True and False Questions Post Program and 12 Weeks Post Program

	Questions	True	False	Total Responses
Post-Program	I tried a new vegetable or fruit during this class	10	0	10
	I learned new ideas to save money on grocery shopping	10	0	10
	I will prepare a recipe we made in the program	10	1	11
12 Week Post-Program	I tried a new vegetable or fruit this month.	6	4	10
	I saved money on grocery shopping this month using ideas from the Food Skills Course.	9	1	10
	I will prepare a recipe we made in the program this month.	10	0	10

DISCUSSION

As a result of the RHT Food Skill Program and other cooking programs it is apparent that the focus group members have an increased knowledge and awareness of food preparation, storage and safety. While in the context of the focus groups specific details related to the RHT Food Skill Program were rarely mentioned, the meal planning, food storage and safety information provided through the RHT Food Skills Program was viewed helpful and welcomed.

Since a number of cooking programs were recalled as part of this focus group, it is unclear if the increase in knowledge and skills can be solely attributed to the RHT Food Skills program. The survey data confirm that much of the knowledge around items taught in the course were retained 12 weeks following the program. While the findings of the survey support the changes in awareness, knowledge and behaviour, changes in behaviour were not supported by the focus group discussions. The vast majority of members indicated that they would try a recipe completed in the course post program; no one reported replicating a recipe and few could recall the one recipe made during the program. The survey results did indicate a trend of increased fruit and vegetable intake during the course and to some extent 12 weeks post program; however, none the women indicated increased fruit and vegetable consumption during the focus group discussions.

While the group enjoyed the programming provided by the RHT Food Skills course, they desired more customized solutions to address financial barriers they experience and to find recipes that meet the

need of their unique family structure. In addition, simple meals that make ingredients stretch are welcomed. The incentives provided through the RHT Food Skills Program and other venues seem to be somewhat helpful in dealing with financial barriers.

While only mentioned in a single focus group, the ability to share personal experiences with food and shopping at grocery stores with affordable and quality vegetables were paramount to the members of the respective groups.

LIMITATIONS

- While the focus group participants appear to be representative of the participants of the original RHT Food Skills Program, this was not confirmed. It is unclear whether focus group participants completed some or all of the original RHT Food Skills Program.
- The time points of the survey data are not linked it and may represent different individuals at each time point. No statistical analysis was completed on these data to determine if the change across time points was statistically significant.
- The sample sizes for the surveys were very small.

PREPARED BY: Christine Brignall
Date: January 11, 2016

APPENDIX

Food Skills Course Survey

1. In the last month, how many **servings** of vegetables and fruit did you **usually eat per day**?

(Examples of 1 serving: ½ cup of fruit or vegetables, a small apple, 1 cup of salad, ½ cup juice)





	0	1-2	3-4	5-6	7 or more
Fruit					
Vegetable					

2. Please indicate your feelings about the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I can plan a meal that includes vegetables and fruit.					
I can cook vegetables and fruit by following a new recipe.					
I will consider planting a vegetable or herb garden next year					

3. Please answer True or False for the following Questions:

I tried a new vegetable or fruit this month	T	F
I saved money on grocery shopping this month using ideas from the Food Skills Course	T	F
I will prepare a recipe we made in the program this month	T	F

Thank you for your feedback!

RHT Food Skills Program Focus Group

Welcome (2 Minutes)

Good morning, I am Christine Brignall and this is Tara Vyn. We would like to talk to you about the Food Skills Course you took with Erica and Ginette from May to August of this year. We are interested to know if you are still using the information and skills you learned in the program. Also, we want to know if you have made any changes as a result of the program. We need your input to make this program better for further groups. We want you to share your honest thoughts with us.

Before we begin has everyone read and signed the consent form? Does anyone have any questions? We have also given you a short survey. The questions are very similar to the questions you may have answered about the Food Skills Course before. This time we would like you to answer these questions based on the last few weeks. For example the first question asks about the number of fruits and vegetables you usually have in a day. Think about how many fruits and vegetables you have had recently before answering.

Ground Rules (5 Minutes)

Here are a few ground rules before we begin.

1. We want you to do the talking. We would like everyone to participate. I may call on you if I haven't heard from you in a while.
2. There are no right or wrong answers. Every person's experiences and thoughts are important. Speak up whether you agree or disagree. We want to hear a wide range of opinions.
3. What is said in this room stays here. We want you to feel comfortable sharing when sensitive issues come up.
4. We will be tape recording the group. We are doing this to make sure we do not miss anything you have to say. Tara will also be taking note just in case parts of the recording are hard to hear. You will not be identified in a report. You will remain anonymous. Once I have completed the report the recording will be destroyed. No one else will hear the recording but me.

If everyone understands, let's get started. ******START RECORDING******

Opening Questions (2 Minutes)

1. Icebreaker: What is your favourite food or meal? It can be healthy or unhealthy it doesn't matter. Dessert counts!
    a. *What are some foods your kids like to eat?*

    (If no one says anything start with your favourite meal).

Exploration Questions (30 Minutes)

2. What did you think of the recipes you made in the Food Skill Course? Do you still use the recipes? Why or why not?
    a. *What about the recipes in the "Basic Shelf Cookbook"*
    b. *Are there any issues related to having the ingredients are hand? Were there too many ingredients? Takes too long to prepare?*
    c. *Was there enough variety (e.g. too much breakfast lunch etc.)?*
    d. *Are there any issues with the preparation of the meals (e.g. too many cold or hot dishes)?*

3. When do you think you ate the most fruits and vegetables? Before the Food Skills Course? During? Or After the course?
4. Based on what you learned in the Food Skills Course have you made any changes to the way you eat or cook? Why or why not?
5. Since the Food Skills Course how confident do you feel about meal planning? Following a recipe? Making substitutions? Cooking? What about price matching? Buying in bulk?
    a. *Have you been able to apply any of these skills to dishes you made prior to the program?*
6. Based on what you learned in the Food Skills Course is it easier to buy or get more fruits and vegetables? Why or why not?
    a. *Have you used the fruit and vegetable distribution program here?*

<u>Exit Questions</u> (5 Minutes)

7. Is there anything else you would like to say about how the Food Skills course helped or did not help you?
    a. *What did you like being able to bring home leftovers? Harvest bucks? Fruits and vegetables? Multivitamins?*
    b. *What about the free produce every 2nd Thursday of the month?*
    c. *Is there anything else this program could offer to make it better?*
8. Aside from the course, do you think being a part of the Westminster/Families First Women's Group has helped you eat more fruits and vegetables? Plan and cook healthy meals?
    a. Do you think you would have participated in this program if it was just in the community and not tied to the Families First Women's Group?
    b. What about the cooking group some of you participate with Tayiba (community kitchen style group)?
    c. What about the course you took with Food Families (CYN program)?

Thank you for participating! This information will help us make the program even better! *(Provide group members with the incentive)*

****State which Focus Group, the date and time and **STOP** the **RECORDING******

Consent to Participate in Food Skill Program Focus Group

You have been asked to participate in a focus group sponsored by the Middlesex London Health Unit. The purpose of the group is to get your thoughts on the Food Skills Course you participated in June- August of 2015 and if you have made any change to your eating or cooking habits since then. The information learned in the focus groups will be used to improve the Food Skills Program.

You can choose whether or not to participate in the focus group and stop at any time. Although the focus group will be tape recorded, your responses will remain anonymous and no names will be mentioned in the report. The recording will be destroyed once information from the focus group is completed.

There are no right or wrong answers to the focus group questions. We want to hear many different viewpoints and would like to hear from everyone. We hope you can be honest even when your responses may not be in agreement with the rest of the group. In respect for each other, we ask that only one individual speak at a time in the group and that responses made by all participants be kept confidential.

I understand this information and agree to participate fully under the conditions stated above:

Name (*please print*): _____

Signed: _____

Date: _____

FOCUS GROUPS REFERENCED THEMES

The table below contains all of the themes coding in Focus Groups 1 and 2. The main or parent themes are bolded, the child or sub-themes are indented once and are not bolded. Themes subordinate to the child themes are intendent twice and are italicised. The parent references are the sum total of all their child theme references.

Name	Brief Description	Source	Number of References
Baking interest	Participant comment(s) related to an interest in learning baking techniques and recipes	Group 1	4
Barriers	Participant identified challenges to implementing food skills program knowledge	Group 1 & 2	17
Financial		Group 1 & 2	11
Obtaining fruit and vegetables		N/A	0
Time constraints		Group 2	3
Transportation		Group 2	2
Budgeting tools and grocery store preferences		Group 2	27
Budgeting tools	Budgeting tools identified or used by participants (e.g. price-matching)	Group 2	6
Grocery store preferences	Positive and/or negative comments related to the grocery store preferences for produce	Group 2	21
Food Basics		Group 2	9
Freshco		Group 2	1
Market		Group 2	1
Metro		Group 2	4
No Frills		Group 2	5
Completed with another cooking program	Recipes or events identified that pertain to a cooking program other than the RHT Food Skills Program	Group 1 & 2	28

Food Families Program		Group 1	3
Monday Community Kitchen	Comment(s) related to a local community kitchen some of the participants attend. The community kitchen operates a least one Monday each month.	Group 1	6
Concerns about food waste and minimizing food waste	Comment(s) related to wasting food and/or minimizing food waste. This theme included items related to preparing meals that would not be eaten by family members	Group 1 & 2	8
Difficulty replicating recipes	Comments indicating some difficulty remembering and/or replicating recipes presented in the RHT Food Skills Program or another cooking program. This also included participants desiring a copy of recipes learned in the RHT Food Skills Program or another cooking program	Group 1	2
General Positive feedback	Unspecific positive feedback about the RHT Food Skills Program or another cooking program	Group 1 & 2	9
Incentives		Group 1 & 2	23
Food prep incentives	Comment(s) related to the food preparation incentives provided by the RHT Food Skills Program (e.g. graters, apple slicer, etc.)	Group 2	1
Harvest bucks	Comment(s) related to the use of Harvest Bucks provide by the RHT Food Skills Program or another cooking program	Group 1 & 2	6
Planters	Comment(s) related to the planters provided by the RHT Food Skills Program	Group 2	3
Thursday fruit and vegetable pick up	Comment(s) related to a program that provides bags of fruit and vegetables related the second Thursday of every month to people who reside in the local housing complex.	Group 1 & 2	11

Vouchers	Comment(s) related to the $10 Food Basics/Metro gift card provided by the Food Families Program	Group 2	2
Information sharing: new and innovative ideas	Comment(s) presented by participants that demonstrate their knowledge and/or awareness of food storage and safety and/or meal planning and recipes learned in the RHT Food Skills Program or another cooking program	Group 1 & 2	36
Food storage and safety	This topic includes but was not limited to: handwashing, refrigerating prepared food, storing fruit and vegetables etc.	Group 2	8
Meal planning and recipes	This topic includes but was not limited to: identifying recipes learned in a cooking program, meal planning techniques etc.	Group 1 & 2	23
Recipes specific to Food Skills course	Comment(s) related to recipes presented in the RHT Food Skills Program	Group 2	5
Variety in the types of recipes	Participant comment(s) related to the desire to learn different types of recipes. This included but was not limited to recipes for various time meals (e.g. mains, casseroles, side dishes etc.)	Group 2	2
Making meals stretch	Participant comment(s) related to finding multiple uses for ingredients. This also includes creating a new meal from an existing meal or recipes	Group 1 & 2	5
Program longevity and consistency		Group 2	10
Communication	Participant comment(s) related to the communication of the frequency and duration of RHT Food Skills Program or another cooking program	Group 2	4
Feelings of abandonment	Participant comment(s) related feeling desertion when there are gaps in cooking programming	Group 2	2

Sense of community	Participants comments related to feeling of collectiveness as a result of the RHT Food Skill Program or another cooking program	Group 1 & 2	6
Sharing personal recipes and or experiences with food	Participant comment(s) related to personal recipes or experiences with food external to the RHT Food Skills Program or another cooking program.	Group 1	7
Simple dishes	Participant comments related to the desire to learn simple because they include few ingredients, prepared quickly or can be prepared in a single dish.	Group 2	5
Few ingredients		Group 2	1
Low cost	Referenced under "Barriers, financial."	N/A	0
Single dish meals		Group 2	4
Time efficient		Group 2	4
The application of food skills	Participant comment(s) that indicated they had applied the food storage, safety, recipes and /or food preparation techniques learned in the RHT Food Skills Program or another cooking program.	Group 2	1
Food storage and safety techniques	See Food storage and safety above.	N/A	0
Recipes and food preparation techniques	See Meal planning and recipes above.	Group 2	1
Unique cooking needs based on family structure	Participant comment(s) related to preparing meals for their unique family structure.	Group 1 & 2	16
Difficulties cooking for and with children		Group 1 & 2	8
Single person families		Group 2	1

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 068-16

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 November 17

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – NOVEMBER

Recommendation

It is recommended that Report No. 068-16 re: Medical Officer of Health Activity Report – November be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) for the period of October 10, 2016 to November 4, 2016.

On October 12th, the MOH was asked to lend his voice to the Poverty over London Campaign by taking the Quiz and encouraging others via social media to assist in making people aware of this important issue in our community and help end poverty within the next generation.

The fall Middlesex London Health Unit Town Hall was held on October 13th. The agenda was packed full of information and updates including: a presentation from Chris Callaghan and Pam Longworth from the School Health Team; a funding presentation from John Millson; a PBMA update from Jordan Banninga; an update on the Location Project from Amy Pavletic and Suzanne Vandervoort; an update on InMotion and the Be Well Website from Mary Lou Albanese; an update on the current HIV crisis in London from Dr. Hovhannisyan and Todd Coleman; an update from Shaya Dhinsa and Chris Blain on the Sexual Health Team; update on plans for new banners on the outside walls of 50 King St. from Dan Flaherty; an update on work being done by staff in regards to the issues of sugar-sweetened beverages and poverty from Dr. Mackie; a quiz on staff knowledge of Health Unit activities by Suzanne Vandervoort; and Ms. Kelly Ziegner, CEO at United Way about this year's campaign and the Health Unit's involvement.

On October 24th, the MOH welcomed Dr. Peter Donnelly, President and CEO of Public Health Ontario (PHO) and Kathryn Marsilio, PHO resident for a visit to the Health Unit. Dr. Donnelly met with leaders from the Middlesex and London community, and later with members of the Senior Leadership Team to discuss and learn more about public health initiatives, innovations, and challenges in the region.

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

October 11	Met with City Councillor Maureen Cassidy and Andrew Lockie, CEO at YMCA in regards to Poverty Panel work Presented a strategic update at the Middlesex County Council meeting
October 12	Poverty OVER London action/awareness campaign interview
October 13	Town Hall meeting Hosted a meeting of former Poverty Panel members Attended the London For All event at Goodwill Industries
October 14	Was interviewed by Craig Needles AM980 in regards to poverty Was interviewed by the Strathroy Gazette regarding strategic update presentation made at Middlesex County Council on October 11th

Attended the Shine the Light Launch at the London Abused Women's Centre
Was interviewed by Al Coombs, 1290 CJBK in regards to inMotion
Initial meeting with Adamm Liley, Professor Fanshawe College

October 17 Attended the Western University Humanitarian Award event

October 18 Met with Janette MacDonald, CEO and GM Downtown London to discuss the LiveWorkPlayLearn initiative

October 19 Gave a presentation to a grade 12 class at AB Lucas High School
Met with Matin Vatankhahi and Zack Zubilewich to discuss participating in a documentary (True Blue) about crystal meth in London

October 20 Participated in a media event with Peggy Sattler, MPP London West in regards to Bill 26 – providing paid leave for sexual, domestic violence survivors
Participated in the Provincial Public Health Unit teleconference

October 21 Provided keynote address at Dalla Lana School of Public Health Fall Conference - "Secure Income, Secure Health: Working Towards Equitable Solutions"

October 25 Met via a phone conversation with Dr. Jean Clinton, McMaster University in regards to Nurse Family Partnership
Participated in an interview with Al Coombs, 1290 CJBK regarding New Food Labelling in Canada
Had a Skype meeting with Mats Lyndon Junek, McMaster Resident in regards to sugary drinks

October 27 Attended the Banff Forum XV in Montebello Quebec

October 31 Participated in the filming of True Blue documentary about crystal meth
Interview with Mike Stubbs, AM980 in regards to the work in London to address poverty and a look ahead to the 2016 Conference on Ending Homelessness being held in London

November 2-4 Attended the 3 day 2016 National Conference on Ending Homelessness in London
Had a phone conversation with Roselle Martino, Ministry of Health and Long-Term Care to discuss sugar sweetened beverages
Introductory meeting with Reinhart Gauss, citizen activist

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