AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, September 20, 2018, 7:00 p.m.
399 RIDOUT STREET NORTH
SIDE ENTRANCE, (RECESSED DOOR)
Board of Health Boardroom

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

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

July 19, 2018 – Board of Health meeting
Receive: September 6, 2018 - Finance & Facilities Committee meeting

DELEGATIONS

7:05 – 7:15 p.m.	Ms. Trish Fulton, Chair, Finance & Facilities Committee, re: Item #1 September 6, 2018 Finance & Facilities Committee Meeting (Report No. 051-18)
7:15 – 7:25 p.m.	Mr. Trevor Hunter, Chair, Governance Committee re: Item #2 September 20, 2018 Governance Committee Meeting.
7:25 – 7:35 p.m.	Dr. Alex Summers and Ms. Ruth Sanderson re: Plan to update the online Community Health Status Resource
7:35 – 7:45 p.m.	Mr. Jordan Banninga, re: Item #6 Review of Public Health Services in Middlesex County

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Delegations & Committee Reports						
1	Finance & Facilities Committee Meeting (Report No. 051-18)	Revised Report: 037-18FFC-R 036-18-FFCR September 6, 2018 Agenda Minutes	x	x	x	To receive information and consider recommendations from the September 6, 2018 Finance & Facilities Committee meeting.
2	Governance Committee Meeting September 20, 2018	September 20, 2018 Agenda	x	x	x	To receive information and consider recommendations from the September 20, 2018 Governance Committee meeting.
Recommendation Reports						
3	Organizational Plan for Reconciliation (Report No. 052-18)	Appendix A		x		To provide an update and request direction on the organizational plan, which includes recommendations for relevant and effective actions to support reconciliation, which will result in decreased health inequities and improved health outcomes.
4	Nutritious Food Basket (Report No. 053-18)	Appendix A Appendix B Appendix C Appendix D Appendix E Appendix F Appendix G		x		To provide results from the 2018 Nutritious Food Basket Survey and a summary of highlights from the National Poverty Reduction Strategy.
5	Public Health Considerations for the 2018 Municipal Election (Report No. 059-18)	Appendix A		x		To provide a list of questions and public health considerations that candidates running in the 2018 municipal election may wish to ask themselves and direct the Medical Officer of Health to send the "Healthy People, Healthy Communities" Primer to all municipal candidates in Middlesex-

						London.
Information Reports						
6	Hepatitis A in Homeless/Under-Housed Population (Report No. 054-18)				x	To provide an update on the transmission of hepatitis A in the homeless and under-housed population and steps taken by MLHU to stop transmission of the virus.
7	Review of Public Health Services in Middlesex County - Findings (Report No. 055-18)	Appendix A Appendix B			x	To provide an update on the findings from the review of Public Health Services in Middlesex County.
8	2017-18 School-Based Dental Screening Results (Report No. 058-18)	Appendix A			x	To provide an update on the 2017-18 school-based dental screening results.
9	Summary Information Report for September (Report No. 056-18)	Appendix A			x	To provide an update on Health Unit programs and services for September.
10	Medical Officer of Health/Chief Executive Officer Activity Report for September (Report No. 057-18)	The Business Case for Supervised Consumption in London Ontario			x	To provide an update on the activities of the MOH/CEO for September.

OTHER BUSINESS

- Approve the draft 2019 Board of Health, Governance Committee and Finance & Facilities Committee meeting schedule
- Next Finance and Facilities Committee Meeting: October 4, 2018 @ 9:00 a.m.
- Next Board of Health Meeting: October 18, 2018 @ 7:00 p.m.
- Next Governance Committee Meeting: November 15, 2018 @ 6:00 p.m.

CORRESPONDENCE

CONFIDENTIAL

The Board of Health will move in-camera to discuss matters regarding potential litigation affecting the Middlesex-London Board of Health.

ADJOURNMENT

CORRESPONDENCE – SEPTEMBER 2018

a) Date: 2018 July 10
Topic: Public Health Approach to Drug Policy Reform
From: Simcoe Muskoka District Health Unit
To: The Honourable Ginette Petitpas Taylor, the Honourable Jody Wilson-Raybould

Background:
On July 10, 2018, the Board of Health for Simcoe Muskoka District Health Unit wrote to the Honourable Ginette Petitpas Taylor and the Honourable Jody Wilson-Raybould urging the federal government to consider the decriminalization of illicit psychoactive substances (IPS) and reform the necessary policies to more effectively address drug use and addiction as major societal problems. Simcoe Muskoka District Health Unit endorses the recommendations of the Canadian Public Health Association (CPHA) as stated in their 2017 Position Statement, which calls for s shift from addressing IPS as a criminal issue toward treating is as a public health issue.

Recommendation: Receive.

b) Date: 2018 July 12
Topic: Delay of *Smoke-Free Ontario Act, 2017*
From: Timiskaming Health Unit
To: The Honourable Christine Elliott

Background:
On July 11, 2018, at a special meeting of the Board of Health for Timiskaming Health Unit, a motion was passed to send a letter to the Honourable Christine Elliot expressing concern regarding the delay in implementing the *Smoke-Free Ontario Act, 2017* (SFOA 2017). A letter was issued to the Ontario Minister of Health on July 12, 2018, stating that Timiskaming Health Unit joins other public health units in Ontario in expressing concern over the government's decision to delay the SFOA 2017.

Recommendation: Receive.

c) Date: 2017 July 12
Topic: Speech from the Throne, titled "A Government for the People"
From: Association of Local Public Health Agencies (alPHa)
To: alPHa members

Background:
On July 12, 2018, a brief session of the legislature was held, and a Speech from the Throne was delivered by Premier Doug Ford titled "A Government for the People." The speech hinted at what the government's values and general priorities would be for the next four years.

Recommendation: Receive.

d) Date: 2018 July 16
Topic: Implementation of *Smoke-Free Ontario Act, 2017*
From: KFL&A Public Health
To: Minister Christine Elliott

Background:

On July 16, 2018, the Board of Health for KFL&A Public Health wrote to Minister Christine Elliott expressing concern over the delay in implementing the *Smoke-Free Ontario Act, 2017*. Refer to item b), above.

Recommendation: Receive.

e) Date: 2018 July 16
Topic: Mandatory Food Literacy Curricula in Ontario Schools
From: Peterborough Public Health
To: The Honourable Christine Elliott, the Honourable Lisa M. Thompson

Background:
On July 16, 2018, Peterborough Public Health wrote to Ministers Elliott and Thompson in support of KFL&A Public Health's call to examine current school curricula with regard to food literacy, and for the introduction of food literacy and food skills training as a mandatory component of school curricula. KFL&A Public Health's motion can be referenced in the Board of Health meeting agenda for May 17, 2018.

Recommendation: Receive.

f) Date: 2018 July 20
Topic: 2018 alPHa Conference Proceedings
From: Gordon Fleming, Manager, Public Health Issues, alPHa
To: Boards of Health

Background:
On July 20, 2018, the Association of Local Public Health Agencies (alPHa) released the proceedings of the association's 2018 conference, held June 10–12, 2018, on the theme of "The Changing Face of Public Health." Conference highlights included: a guided walking tour of the St. Lawrence neighbourhood, the combined annual business meeting and resolutions session, a panel session exploring key priorities for the public health sector and system sustainability, a discussion with the Chief Medical Officer of Health, a panel discussion convened to discuss local public health approaches to Indigenous engagement, a review of alPHa's Strategic Plan, a presentation about factoring values into government relations, and the presentation of the 2018 alPHa Distinguished Service Awards.

Recommendation: Receive.

g) Date: 2018 July 19
Topic: Pause in Implementation of *Smoke-Free Ontario Act*, 2017
From: Windsor-Essex County Health Unit
To: The Honourable Doug Ford

Background:
On July 19, 2018, Windsor and Essex County's Board of Health wrote to Premier Doug Ford expressing disappointment regarding the pause in implementing the *Smoke-Free Ontario Act, 2017*, and encouraging the provincial government to move forward with all aspects of the *Act* as soon as possible. The Board of Health for Windsor and Essex County advised Premier Ford that they are prepared to move forward with implementation of the regulations as they stand.

Recommendation: Receive.

h) Date: 2018 July 23
Topic: Pause in Implementation of *Smoke-Free Ontario Act, 2017*
From: Chatham-Kent Board of Health
To: The Honourable Doug Ford

Background:
On July 16, 2018, at a special meeting, the Chatham-Kent Board of Health received a staff presentation regarding the pause in implementing the *Smoke-Free Ontario Act, 2017* (SFOA 2017). The Board felt there was sufficient evidence to raise concern, and wrote to Premier Doug Ford on July 23, 2018, to urge the government to reconsider implementing SFOA 2017 without delay.

Recommendation: Receive.

i) Date: 2018 July 27
Topic: Implementation of *Smoke-Free Ontario Act*, 2017
From: Grey Bruce Health Unit
To: The Honourable Doug Ford

Background:
On July 27, 2018, the Board of Health for the Grey Bruce Health Unit wrote to Premier Doug Ford urgently requesting that the provincial government proceed with immediate implementation of the *Smoke-Free Ontario Act 2017*.

Recommendation: Receive.

j) Date: 2018 August 1
Topic: Ontario Basic Income Pilot
From: Simcoe Muskoka District Health Unit
To: The Honourable Lisa MacLeod

Background:
On August 2, 2018, the Simcoe Muskoka District Health Unit (SMDHU) Board of Health wrote to Minister Lisa MacLeod urging the provincial government to reconsider its intention to cancel the Ontario Basic Income Pilot. SMDHU has been a vocal proponent of the basic income concept since 2015, and is requesting that the provincial and federal governments jointly consider and investigate a basic income guarantee as a policy option for reducing poverty and income insecurity. SMDHU urges the government to maintain the pilot and its planned evaluation.

Recommendation: Receive.

k) Date: 2018 August 1
Topic: Toronto Overdose Action Plan: Status Report 2018
From: Toronto Public Health
To: Interested Parties

Background:
At its meeting on June 18, 2018, the Toronto Board of Health adopted the Toronto Overdose Action Plan: Status Report 2018, which, together with the provincial and federal governments, reinforced the urgency of the opioid poisoning emergency and the critical need to increase actions in response. The Toronto Board of Health urges the Ministry of Health and Long-Term Care to extend the term for overdose prevention sites from six months to twelve and to support the urgent implementation of

managed opioid programs. The Toronto Board of Health has requested that the Medical Officer of Health consider these items as next steps in developing the Toronto Drug Strategy. At its meeting on June 26–29, 2018, the Toronto City Council reaffirmed its support for a comprehensive, evidence-based response to the opioid overdose crisis and called on the Province of Ontario to continue its response by supporting and expanding existing provincially funded prevention, harm reduction, and treatment measures in the City of Toronto.

Recommendation: Receive.

l) Date: 2018 August 3
Topic: A Public Health Approach to Drug Policy
From: Toronto Public Health
To: Interested Parties

Background:
At its meeting on July 16, 2018, the Toronto Board of Health adopted the Public Health Approach to Drug Policy and directed that this report from the Medical Officer of Health be forwarded to Ontario Boards of Health and other key stakeholders for information and endorsement. The report calls for the federal government to decriminalize possession of all drugs for personal use and increase prevention, harm reduction, and treatment services.

Recommendation: Receive.

m) Date: 2018 August 3
Topic: Ontario Basic Income Pilot
From: Peterborough Public Health
To: The Honourable Lisa MacLeod

Background:
On August 3, 2018, the Board of Health for Peterborough Public Health wrote to Minister Lisa MacLeod urging her to reconsider the recent decision to cancel the Ontario Basic Income Pilot Project. Refer to correspondence item j), above.

Recommendation: Receive.

n) Date: 2018 August 3
Topic: Student Nutrition Program: Impact of Municipal Plan 2013–2018
From: Toronto Public Health
To: Interested Parties

Background:
At its meeting on July 16, 2018, the Toronto Board of Health adopted the Student Nutrition Program: Impact of Municipal Plan 2013–2018. The Toronto Board of Health requested that Ontario-based public health boards express their support and endorsement for a federal, universal, healthy school food program.

Recommendation: Receive.

o) Date: 2018 August 3
Topic: Ontario Basic Income Research Project and the Reduction in the Scheduled Social Assistance Rate Increase

From: Public Health Sudbury & Districts
To: The Honourable Doug Ford, the Honourable Lisa MacLeod, the Honourable Christine Elliott

Background:
On August 3, 2018, the Board of Health for Public Health Sudbury & Districts wrote to Premier Doug Ford and Ministers Christine Elliott and Lisa MacLeod to express concern regarding the announcement to terminate the Basic Income Research Project, as well as the reduction in the scheduled social assistance rate increase. The Board had previously called for the government to pursue a basic income guarantee policy and to increase social assistance rates.

Recommendation: Receive.

p) Date: 2018 August 8
Topic: Basic Income Research Project and Social Assistance Rate Reduction and Reform
From: Timiskaming Health Unit
To: The Honourable Doug Ford, the Honourable Lisa MacLeod, the Honourable Christine Elliott

Background:
On August 8, 2018, Board of Health for the Timiskaming Health Unit wrote to Premier Doug Ford and Ministers Christine Elliott and Lisa MacLeod expressing concern over the announcement to stop the Basic Income Research Project and the reduction in the scheduled social assistance rate increase. The Board of Health requests that the Ontario government reconsider the decision to cancel the pilot and maintain the planned increase to social assistance rates.

Recommendation: Receive.

q) Date: 2018 August 15
Topic: alPHa Municipal Election Policy Priorities
From: Association of Local Public Health Agencies (alPHa)
To: Board of Health Chairs

Background:
On August 15, 2018, the Association of Local Public Health Agencies (alPHa) issued a set of seven key policy priorities for consideration by electoral candidates in anticipation of the October 22 municipal election. These priorities include: alcohol, cannabis, food insecurity, mental health, opioids, oral health, and tobacco endgame. Much as before, alPHa requests that public health units and their boards of health reach out and share these priorities with local candidates. The customizable templates on the key priorities can be accessed on the alPHa website.

Recommendation: Receive.

r) Date: 2018 August 10
Topic: Basic Income Research Project Cancellation
From: KFL&A Public Health
To: The Honourable Lisa MacLeod

Background:
On August 3, 2018, the Board of Health for KFL&A Public Health wrote to Minister Lisa MacLeod to express disappointment with the decision to cancel Ontario's Basic Income Pilot and to ask the

Ontario government to reconsider its decision. KFL&A's Board of Health supports the position of the Association of Local Public Health Agencies (alPHa), as outlined in its August 2, 2018 letter to Minister McLeod.

Recommendation: Receive.

s) Date: 2018 August 17
Topic: Cancellation of Basic Income Pilot Project
From: Haliburton, Kawartha, Pine Ridge District Health Unit
To: The Honourable Lisa MacLeod

Background:
On August 17, 2018, the Board of Health for Haliburton, Kawartha, Pine Ridge District Health Unit wrote to Minister Lisa MacLeod urging the Ontario government to reconsider its decision to cancel the Ontario Basic Income Pilot and to ask that the Ontario government reconsider its decision. Refer to correspondence item r), above.

Recommendation: Receive.

t) Date: 2018 August 21
Topic: Ontario Basic Income Pilot Project
From: North Bay Parry Sound District Health Unit
To: The Honourable Doug Ford and the Honourable Lisa MacLeod

Background:
On August 16, 2018, the Board of Health for North Bay Parry Sound District Health Unit wrote to Premier Doug Ford and Minister Lisa MacLeod expressing concern over the decision to cancel the Ontario Basic Income Pilot and to reduce the scheduled increase to Ontario Works and the Ontario Disability Support Program rates. The Board of Health for North Bay Parry Sound District Health Unit urges the Ontario government to reinstate the Ontario Basic Income Pilot and follow through with the evaluation plan, proceed with the scheduled increase in social assistance rates, and refer to the report *Income Security: a Roadmap for Change* when formulating a plan for social assistance reform.

Recommendation: Receive.

u) Date: 2018 August 30
Topic: Ontario Basic Income Pilot Research Project
From: Leeds, Grenville and Lanark District Health Unit
To: The Honourable Doug Ford, the Honourable Lisa MacLeod, the Honourable Christine Elliott

Background:
On August 3, 2018, the Board of Health for Leeds, Grenville and Lanark District Health Unit wrote to Premier Doug Ford and Ministers Christine Elliott and Lisa MacLeod to express concern regarding the discontinuation of the Ontario Basic Income Pilot and to urge the Ontario government to reinstate the project.

Recommendation: Receive.

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

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, July 19, 2018, 7:00 p.m.

MEMBERS PRESENT:	**Ms. Joanne Vanderheyden, Chair** Mr. Michael Clarke Ms. Maureen Cassidy Mr. Jesse Helmer Mr. Trevor Hunter Mr. Ian Peer Mr. Marcel Meyer Mr. Kurtis Smith
REGRETS:	Ms. Trish Fulton Ms. Tino Kasi
MEDIA:	Ms. Megan Stacey, *London Free Press* Mr. Joel Merritt, CTV News London
OTHERS PRESENT:	Dr. Christopher Mackie, Secretary-Treasurer Dr. Alexander Summers, Associate Medical Officer of Health Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder) Ms. Marilyn Atkin, Program Lead, Community Outreach and Harm Reduction Ms. Cynthia Bos, Human Resources Partner Ms. Shaya Dhinsa, Manager, Sexual Health Ms. Melanie Elms, Public Health Nurse Mr. Brian Glasspoole, Manager, Finance Ms. Donna Kosmack, South West Tobacco Control Area Network Ms. Linda Stobo, Manager, Chronic Disease and Tobacco Control Ms. Maureen Rowlands, Director, Healthy Living Mr. Stephen Turner, Director, Environmental Health, and Infectious Diseases Mr. Alex Tyml, Online Communications Coordinator

Chair Vanderheyden called the meeting to order at 7:00 p.m. and welcomed Dr. Summers, Associate Medical Officer of Health.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Vanderheyden inquired if there were any disclosures of conflicts of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Clarke, seconded by Mr. Peer, *that the **AGENDA** for the July 19, 2018 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Cassidy, seconded by Mr. Helmer, *that the **MINUTES** of the June 21, 2018 Board of Health meeting be approved.*

Carried

DELEGATIONS AND COMMITTEE REPORTS

Dr. Ken Lee, Addictions Services Thames Valley (ADSTV) re: Item #2: Nurse Practitioner Secondment Follow-up (Report No. 045-18)

Dr. Lee provided additional information to the Board of Health, including background on why ASTV requested support from MLHU through the secondment of a Nurse Practitioner to provide interim support to Rapid Access to Addiction Medicine (RAAM) clinics in London and Chippewa of the Thames First Nation.

Discussion ensued on the following items:

- Services provided by the RAAM clinic and the clinic's interaction with medical schools, physicians, residents, and nurse practitioners.
- Treating with suboxone versus methodone, and the difference between patients who are administered these respective treatments.
- Whether or not decriminalization would make a difference in the RAAM clinic's current treatment practice.
- Linking new practitioners with other community supports to provide wraparound services to those being treated, and the current referral process for the RAAM clinic.
- How many people are currently being seen at the clinic, and if there are plans to expand or extend services.

It was moved by Mr. Helmer, seconded by Ms. Cassidy, *that the Board of Health receive Report No. 045-18 re: "Nurse Practitioner (NP) Secondment Follow-up" for information.*

Carried

Dr. Fatih Sekercioglu, Manager, Safe Water, Rabies, and Vector Borne Disease, Environmental Health and Infectious Diseases Division, re: Item #3: Small Non-Community Drinking Water Systems (Report No. 046-18)

Dr. Mackie introduced Dr. Sekercioglu and commended him for his work in completing his PhD while also working full-time as a manager at MLHU.

Dr. Sekercioglu gave a presentation and a summary of his dissertation to the Board of Health including background and history on Ontario's small drinking-water systems, why this research was needed, what his research goals were, his key findings, and how his work will be applicable to MLHU's efforts to safeguard rural small drinking-water systems in the Middlesex-London region.

Discussion ensued on the following items:

- Whether the training program developed through his dissertation is transferrable to other communities.
- How non-compliance is treated in areas that do not properly follow the regulations in place for small drinking-water systems.
- Whether Dr. Sekercioglu has had a chance to present his policy paper to the Ministry of Health and Long-Term Care.
- Whether or not there should be signage indicating when small drinking-water systems have last been inspected, or if they should be graded to advise the public before consuming.

It was moved by Mr. Hunter, seconded by Mr. Helmer, *that the Board of Health receive Report No. 045-18 re: "Dr. Fatih Sekercioglu's doctoral thesis: 'Ontario's Small, Non-Community Drinking Water Systems: How to Ensure Provision of Safe Drinking Water and Source Water Protection'" for information.*

Carried

Finance & Facilities Committee (FFC) Meeting – July 5, 2018 (Report No. 044-18)

Chair Vanderheyden introduced, provided context for, and summarized the following reports, which were considered at the July 5 FFC meeting:

Ministry of Children and Youth Services Program Funding (Report No. 029-18FFC)

It was moved by Ms. Cassidy, seconded by Mr. Helmer, *that the Board of Health:*

1. *Receive Report No. 029-18FFC re: "Ministry of Children and Youth Services Program Funding"; and*
2. *Direct staff to receive this funding.*

Carried

2019 PBMA Process, Criteria, and Weighting (Report No. 030-18FFC)

It was moved by Mr. Hunter, seconded by Mr. Clarke, *that the Board of Health approve the 2019 PBMA criteria and weighting proposed in Appendix A to Report No. 030-18FFC.*

Carried

Allocation of Additional 2018 Funding from the Ministry of Health and Long-Term Care (Report No. 031-18FFC)

Dr. Mackie provided context for this report, including additional information provided to the Board regarding the third point on the recommendation: a request to approve the over-hiring of permanent staff in limited circumstances. This additional information summarized the current recruitment issues faced across the divisions to further support the request to the Board of Health. Dr. Mackie reviewed the current issues, the implications associated with gapping nursing positions, and how the over-hiring of staff in limited circumstances would assist in addressing these issues.

It was moved by Mr. Helmer, seconded by Mr. Peer, *that the Board of Health:*

1. *Receive Report No. 031-18FFC re: "2018 Budget Funding Increases – Recommended Expenditures";*
2. *Approve Appendix A; and*
3. *Approve the judicious over-hiring of permanent staff in limited circumstances.*

Carried

The following reports were received by the Finance & Facilities Committee for information:

Chair Vanderheyden noted that the Finance & Facilities Committee reviewed the new policy G-205 Borrowing, which the Committee had revised and referred back to the Governance Committee.

It was moved by Ms. Cassidy, seconded by Mr. Helmer, *that the Board of Health receive the MINUTES of the July 5, 2018 Finance & Facilities Committee meeting as amended.*

Carried

RECOMMENDATION REPORTS

Smoking Strategy Developments re: *Smoke-Free Ontario Act, 2017* (Report No. 048-18)

Dr. Mackie introduced the report and provided context, recognizing that the new government's intention is to improve the legislation and that the Health Unit wishes to work with them to help inform tobacco control policy.

It was moved by Mr. Clarke, seconded by Mr. Peer, *that the Board of Health:*

1. *Receive Report No. 048-18 re: "Smoking Strategy Developments re:* Smoke-Free Ontario Act, 2017*" for information; and*
2. *Send a letter, attached as Appendix A, to the Ontario Government expressing MLHU's ongoing commitment to address the burden of tobacco and nicotine addiction, and to encourage continued engagement of the public health community in current and future reviews of tobacco control policy and provincial tobacco strategy development.*

Carried

Temporary Overdose Prevention Site Extension (Report No. 049-18)

Dr. Mackie introduced the report and provided context, outlining the current status and uptake of service at the Temporary Overdose Prevention Site (TOPS), the success of the program, and how the interventions provided by this service have saved lives since its inception. Dr. Mackie outlined the options for extending the service at TOPS, including both a federal and a provincial route.

Discussion ensued on the following items:

- Whether the TOPS would cease to operate once the permanent Supervised Consumption Facilities (SCFs) are approved and operating.
- That both the Regional HIV/AIDS Connection (RHAC) and MLHU are working with business owners and residents to address concerns about activities happening outside the TOPS facility, and that such activities outside or around the facility are not reflective of the success or conduct occurring inside the TOPS.
- Whether there is a need to extend the TOPS hours, and how this report addresses changes that may be made to the TOPS operations going forward.
- The contingency plan, if neither route for requesting an extension to TOPS services works out.

It was moved by Mr. Peer, seconded by Mr. Hunter, *that the Board of Health:*

1) *Receive Report No. 049-18 re: "Temporary Overdose Prevention Site Extension" for information;*
2) *Request that the Ministry of Health and Long-Term Care (MOHLTC) extend approval of the Temporary Overdose Prevention Site for an additional six-month period;*
3) *Support an Interim Supervised Consumption Facility with federal exemption approval until the permanent site opens; and*
4) *Direct the Chair to write to the Ontario Minister of Health and Long-Term Care inviting the Minister for a tour of Ontario's first Temporary Overdose Prevention Site.*

Carried

INFORMATION REPORTS

Summary Information Report for July (Report No. 050-18)

It was moved by Mr. Helmer, seconded by Mr. Meyer, *that the Board of Health receive Report No. 050-18 re: "Summary Information Report for July" for information.*

Carried

Medical Officer of Health/Chief Executive Officer Activity Report for July (Report No. 047-18)

It was moved by Ms. Cassidy, seconded by Mr. Helmer, *that the Board of Health receive Report No. 047-18 re: "Medical Officer of Health/Chief Executive Officer Activity Report for July" for information.*

Carried

CORRESPONDENCE

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

Carried

It was moved by Mr. Peer, seconded by Mr. Meyer, *that the Board of Health endorse item k).*

Carried

Chair Vanderheyden also made note of item n), and that this item would be referred to staff for purposes of developing a report to bring back to the Board of Health.

OTHER BUSINESS

It was moved by Ms. Cassidy, seconded by Mr. Hunter, *that the Board of Health cancel its planned August 16, 2018 meeting.*

Carried

Chair Vanderheyden reviewed the next meeting dates of the Finance & Facilities Committee, the Board of Health, and the Governance Committee:

- Next Finance & Facilities Committee meeting: September 6, 2018 @ 9:00 a.m.
- Next Board of Health meeting: September 20, 2018 @ 7:00 p.m.
- Next Governance Committee meeting: September 20, 2018 @ 6:00 p.m.

CONFIDENTIAL

It was moved by Ms. Cassidy, seconded by Mr. Hunter, *that the Board of Health approve the confidential minutes of the June 21, 2018 Board of Health meeting.*

Carried

ADJOURNMENT

At 7:57 p.m., it was moved by Mr. Meyer, seconded by Ms. Cassidy, *that the meeting be adjourned.*

Carried

JOANNE VANDERHEYDEN
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
50 King Street, London
Middlesex-London Health Unit
Thursday, September 6, 2018, 9:00 a.m.

MEMBERS PRESENT: Ms. Trish Fulton (Chair)
Ms. Tino Kasi
Mr. Marcel Meyer
Ms. Joanne Vanderheyden

REGRETS: Mr. Jesse Helmer

OTHERS PRESENT: Dr. Christopher Mackie, Secretary-Treasurer
Dr. Alexander Summers, Associate Medical Officer of Health
Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (Recorder)
Ms. Laura Di Cesare, Director, Healthy Organization
Mr. Brian Glasspoole, Manager, Finance
Mr. Joe Belancic, Manager, Procurement and Operations
Ms. Kendra Ramer, Manager, Strategic Projects
Mr. Stephen Turner, Director, Environmental Health and Infectious Diseases

Chair Fulton called the meeting to order at 9:01 a.m., and welcomed Dr. Summers to his first FFC meeting.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Fulton inquired if there were any disclosures of conflicts of interest. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden, *that the **AGENDA** for the September 6, 2018 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Kasi, seconded by Ms. Vanderheyden, *that the **MINUTES** of the July 5, 2017 Finance & Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 Q2 Financial Update and Factual Certificate (Report No. 033-18FFC)

Mr. Glasspoole introduced the report and provided context, noting the increase in one-time funding the Health Unit received from the Ministry (totalling $480,000 for 2018). Mr. Glasspoole noted that there are no significant variances, and advised that MLHU is tracking according to budget, with $476,000 of the expected gapping identified, compared with the $466,000 predicted for Q1 and Q2.

Discussion ensued on the following items:

- Fluctuating variances throughout the year, what factors contribute to gapping, and how to forecast and prepare for anticipated gapping in the future.
- How anticipated gapping is currently built into the forecast.
- That the source of gapping is often related to nursing positions, and that the strategy brought forward in June to consider the judicious over-hiring of Public Health Nurses would assist with addressing this issue.
- Whether a budget summary paragraph could be included with the budget, why gapping continues to occur, and what it means in terms of the budget.
- Reallocation of funds accrued through variance and gapping to other areas.
- That most public sector organizations reallocate through a quarterly variance process, and that MLHU will continue to find additional examples to support the process of reallocating variance funds.

Ms. Vanderheyden declared a potential perceived conflict of interest with regard to item 10 of the Factual Certificate, as she currently sits on the Western Fair board of directors. She abstained from the vote.

It was moved by Ms. Kasi, seconded by Mr. Meyer, *that the Finance & Facilities Committee receive and recommend that the Board of Health approve Report No. 033-18FFC re: "Q2 Financial Update and Factual Certificate."*

Carried

4.2 Middlesex-London Health Unit – March 31 Draft Financial Statements (Report No. 034-18FFC)

Mr. Glasspoole introduced the report and provided context, walking the Committee through the Consolidated Financial Statements (attached as Appendix A). On the audit report, Mr. Glasspoole flagged the note regarding tangible assets and how they are effectively capitalized, and noted that MLHU will conform to the auditor's recommendation on reporting of capitalized assets.

Discussion ensued on how large an item has to be in order to be considered a tangible capital asset, the equipment in question regarding the Health Unit's reporting of tangible capital assets, and how conforming to the auditor's recommendations for 2019 will also help with compliance in filing financial statements with the Ministry.

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee receive report No. 034-18FFC, and recommend that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31, 2018.*

Carried

4.3 Location Project – Status Update (Report No. 035-18FFC)

Ms. Ramer introduced the report and summarized the four main deliverables outlined in it.

Discussion ensued on the following items:

- That the build schedule will not be expedited, due to increased costs.
- The timeline for the move: currently about 14–15 months, based on the architectural projections.
- That the Health Unit's current landlord will be notified about timeline estimates throughout the process.

It was moved by Mr. Meyer, seconded by Ms. Kasi, *that the Finance & Facilities Committee receive Report 035-18FFC re: "Location Project – Status Update" be received for information.*

Carried

4.4 Location Project – Architectural Services (Report No. 036-18FFC)

Mr. Belancic introduced the report and provided background on the discussions that helped inform it, including negotiations with the architect regarding the cost of the contract, and ensuring that architectural work performed aligns with previously completed space needs assessments, budgets, and the scope of services required by MLHU.

Discussion ensued on the following items:

- The cost of retrofit versus new-build architectural services, and that MLHU was able to negotiate retrofit costs associated with this work to a favourable level.
- That, in requesting a single source for architectural services, MLHU is not in a position of conflict because the lease agreement specifically indicates the scope of work required for Citi Plaza; therefore, there is no overlapping work.
- The third-party review, which was completed to ensure that moving forward with a single-source contract was fiscally responsible.
- Clarification that the landlord has not asked MLHU to use their architect, but rather provided this as an option when MLHU was exploring opportunities to reduce costs and timelines.
- That this architect was selected to mitigate future financial risk should the Health Unit be required to vacate 50 King Street before the new location is ready for move-in.
- That the cost of the single-source contract is favourable given current market conditions and the third-party confirmed that the contract was lower than industry standards.
- That the single-source contract is in line with the Health Unit's non-competitive procurement policy, which indicates that if MLHU seeks specific expertise, a recommendation to single-source the work required may be made to the Board.
- That, given the architect's expertise and experience with the facility, it may be possible to commence and complete the work faster.
- The approximate overall cost of the build: about $5 million.
- That staff will include further information in a revised version of this report, before it is brought to the Board of Health on September 20.

It was moved by Ms. Vanderheyden, seconded by Ms. Kasi, *that the Finance & Facilities Committee:*

1) *Receive Report 036-18FFC re: "Location Project – Architectural Services" for information; and*
2) *Seek approval from the Board of Health to enter into a single-source contract with Endri Poletti Architect Inc. for the purpose of providing architectural services at Citi Plaza.*

Carried

4.5 Location Project – Project Management Services (Report No. 037-18FFC)

Mr. Belancic introduced the report and provided context, explaining the competitive process, and the justification for entering into a contract with BES Project Management.

Discussion ensued on the following item:

- How many quotes the Health Unit received for this work, and that the Committee would like to see additional information included in future reports (such as the fact that three tenders were issued before arriving at a recommendation to contract with BES Project Consulting).

It was noted that staff would revise this report to reflect the points raised by Mr. Meyer before it is brought to the Board for consideration on September 20.

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

1) *Receive Report No. 037-18FFC: "Location Project – Project Management Services" for information; and*
2) *Recommend that the Board of Health approve entering into a contract with BES Project Consulting for the purpose of providing construction project management services at Citi Plaza.*

Carried

OTHER BUSINESS

Dr. Mackie provided the Committee with a verbal update regarding workload distribution on Board of Health standing committees. He also advised that staff will be bringing forward, via the Governance Committee in September, a recommendation to develop an ad hoc Facilities Committee, which would see the location project through to completion and help to convey information appropriately to the Board of Health throughout the process.

The next Finance & Facilities Committee meeting will take place on October 4, at 9:00 a.m.

The Board of Health meeting will take place on September 20.

ADJOURNMENT

At 10:03 a.m., it was moved by Mr. Meyer, seconded by Ms. Kasi, *that the meeting be adjourned.*

Carried

At 10:03 a.m., Chair Fulton *adjourned the meeting*.

TRISH FULTON	**CHRISTOPHER MACKIE**
Chair	**Secretary-Treasurer**

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, June 21, 2018, 6:00 p.m.

Committee Members Present:	**Mr. Trevor Hunter (Chair)** Ms. Joanne Vanderheyden Ms. Trish Fulton Mr. Ian Peer Mr. Kurtis Smith
Others Present:	Mr. Michael Clarke (Board of Health member) Mr. Jesse Helmer (Board of Health member) Ms. Maureen Cassidy (Board of Health member, 6:56 p.m.) Dr. Christopher Mackie, Secretary-Treasurer Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder) Ms. Laura Di Cesare, Director, Healthy Organization Mr. Jordan Banninga, Manager, Program Planning and Evaluation

Dr. Mackie called the meeting to order at 6:00 p.m. He noted that this was the first Governance Committee meeting of 2018. Dr. Mackie then opened the floor to nominations for Chair of the Governance Committee for 2018.

Mr. Smith nominated Mr. Hunter for Chair of the Governance Committee for 2018.

It was moved by Mr. Smith, seconded by Mr. Peer, *that Mr. Trevor Hunter be nominated as Chair of the Governance Committee for 2018.*

Mr. Hunter accepted the nomination and agreed to let his name stand.

Dr. Mackie called for further nominations three more times. Hearing none, it was moved *that nominations be closed and that Mr. Hunter be named Chair of the Governance Committee for 2018.*

Carried

At 6:02 p.m., Mr. Hunter took the Chair.

DISCLOSURE OF CONFLICT(S) OF INTEREST

Chair Hunter inquired if there were any disclosures of conflicts of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Ms. Vanderheyden, *that the **AGENDA** for the June 21, 2018 Governance Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Smith, seconded by Mr. Peer, *that the **MINUTES** of the January 18, 2018 Governance Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 2018–20 Strategic Planning Update (Report No. 004-18GC)

Dr. Mackie introduced the report and outlined the approach used for the Balanced Scorecard.

Ms. Fulton noted a sentence missing on page 29, under "Measuring Progress," fourth bullet point. It was agreed that the sentence be adjusted to "Seek to hold ourselves accountable."

Discussion ensued on the following items:

- How often the Governance Committee and Board of Health are to be updated on the progress of the Balanced Scorecard.
- Why the administrative policy review is noted as being behind schedule on the Balanced Scorecard.
- Consideration of risk on location-related projects, and how to plan for loss of funding under the Risk Management Framework.
- The development of the Project Management Office (PMO), which has built a risk-mitigation schedule into all projects in order to mitigate risk in each case.
- The pilot project for activity-based workstations, along with a suggestion to use different acronyms for activity-based workstations (ABW) and alternative work arrangements (AWA), thereby highlighting the difference between the two activities.

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

1) *Recommend that the Board of Health receive Report No. 004-18GC re: "2018 Strategic Planning Update" for information; and*
2) *Approve the 2018–20 Middlesex-London Health Unit Balanced Scorecard.*

Carried

4.2 2018 Board of Health Self-Assessment Results (Report No. 005-18GC)

Discussion ensued on the results of the self-assessment, which included:

- The verbatim comments in the assessment.
- That elected officials bring a crucial element and perspective to the Board of Health.
- That this assessment will inform further discussion regarding the allocation of work between the two Board of Health standing committees, whereby some elements from each committee could be adjusted to even the workload.

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

1) *Recommend that the Board of Health receive Report No. 005-18GC re: "Board of Health Self-Assessment Results" for information; and*
2) *Consider the survey results and incorporate feedback into Board development planning for 2018.*

Carried

4.3 Organizational Structure Changes (Report No. 006-18GC)

It was moved by Mr. Peer, seconded by Ms. Fulton, *that the Governance Committee receive Report No. 006-18GC re: "Organizational Structure Changes" for information.*

Carried

4.4 Governance Policy Review (Report No. 007-18GC)

Discussion ensued on each of the following bylaws:

G-B30 Proceedings of the Board of Health
- Clarification of participation in meetings by electronic means, the parameters by which a Board member may participate electronically, and how this policy aligns with the *Municipal Act* (i.e., intent and interpretation of Section 19 of the *Act*).

G-150 Complaints
- The procedure for written complaints.
- Clarification as to which kinds of complaints are to be directed to the Secretary-Treasurer and which kinds to the Board Chair.
- Clarification of wording, in that a complaint should be directed to the Secretary-Treasurer's designate should the Secretary-Treasurer not be available to receive it.
- How the complaints policy aligns with the Whistleblower policy, and the difference between the two.
- The Health Unit's internal policies and procedures for dealing with complaints.

G-205 Borrowing
- The various types of borrowing.
- That the Finance & Facilities Committee should review this policy.
- Clarification that this policy only covers borrowing to acquire real property, not for other purposes.
- Discussion about formal agreements (which do not exist at this time) between band councils to provide Health Unit services on Reserve, and that this might be a future eventuality.

G-430 Informing of Financial Obligations
- No changes or discussion noted.

G-260 Governance Principles and Board Accountability
- Clarification of wording, in that the Health Unit is accountable both to the government and to the municipalities it serves, and whether lower-tier municipalities are included in this accountability statement.
- That acknowledging lower-tier municipalities is important, and will happen as part of the Health Unit's service review in Middlesex County. As staff gather information, there will be more clarity to inform this policy.

G-270 Roles and Responsibility of Individual Board Members
- The final page number was wrong. It will be corrected to read "4 of 4."
- The use of the word "outsiders" in the section on Board solidarity.
- How and to whom Board members are to refer media requests, and whether they speak on behalf of the Board or their particular constituency.

G-340 Whistleblowing
- Consistent use of terms throughout this policy in referring to "Board of Health" and "Health Unit."
- Responsibility of the Board Chair, under this policy, to follow up on and respond to complaints.
- The importance of ensuring that this policy works in practice.
- That this policy will be reviewed to ensure consistent use of terminology, and brought back to the Governance Committee for further review.

G-360 Removal and Resignation of Board Members
- No changes or discussion noted.

G-380 Conflicts of Interest and Declaration

- No changes or discussion noted.

I-120 Political Activities (Appendix C to Report No. 007-18GC)

- That the Committee commended the work done to complete this policy and noted that it has a good balance.
- That staff wrote this report in consultation with legal, and also in alignment with Western University's political activities policy, as suggested by Mr. Helmer.

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

1) Receive Report No. 007-18GC for information;
2) Recommend that the Board of Health approve the new and revised Governance Policies as outlined in Appendix A; and
3) Recommend that the Board of Health approve the new Administrative Policy on Political Activities (Appendix C).

Carried

A brief verbal discussion took place on item 4.5 (redistributing the work between standing committees). Dr. Mackie noted that staff are aware of the imbalance of workload between committees, and will complete a review of best practices in this area. They will bring a report back to the Governance Committee for consideration.

OTHER BUSINESS

Next meeting: Thursday, September 20, 2018.

ADJOURNMENT

At 6:22 p.m., it was moved by Ms. Vanderheyden, seconded by Mr. Smith, *that the meeting be adjourned.*

Carried

TREVOR HUNTER	**CHRISTOPHER MACKIE**
Chair	**Secretary-Treasurer**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 051-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 September 20

FINANCE & FACILITIES COMMITTEE MEETING – SEPTEMBER 6

The Finance & Facilities Committee met at 9:00 a.m. on Thursday, September 6, 2018. A summary of the discussion can be found in the draft minutes.

The following reports were considered, with two reports referred back to staff for additional information (Reports Nos. 036-18FFC and 037-18FFC-R).

Reports	Recommendations for Information and the Board of Health's Consideration
Q2 Financial Update and Factual Certificate (Report No. 033-18FFC)	It was moved by Ms. Kasi, seconded by Mr. Meyer, *that the Finance & Facilities Committee receive and recommend that the Board of Health approve Report No. 033-18FFC re: "Q2 Financial Update and Factual Certificate."* Carried
Middlesex-London Health Unit – March 31 Draft Financial Statements (Report No. 034-18FFC)	It was moved by Mr. Meyer, seconded by Ms. Vanderheyden, *that the Finance & Facilities Committee receive Report No. 034-18FFC and recommend that the Board of Health approve the audited Consolidated Financial Statements for the Middlesex-London Health Unit, March 31, 2018.* Carried
Location Project – Status Update (Report No. 035-18FFC)	It was moved by Mr. Meyer, seconded by Ms. Kasi, *that the Finance & Facilities Committee receive Report 035-18FFC re: "Location Project – Status Update" be received for information.* Carried
Location Project – Architectural Services (Report No. 036-18FFC)	It was moved by Ms. Vanderheyden, seconded by Ms. Kasi, *that the Finance & Facilities Committee:* *1) Receive Report 036-18FFC re: "Location Project – Architectural Services" for information; and* *2) Seek approval from the Board of Health to enter into a single-source contract with Endri Poletti Architect Inc. for the purpose of providing architectural services at Citi Plaza.* Carried

Location Project – Project Management Services (Report No. 037-18FFC-R)	It was moved by Mr. Meyer, seconded by Ms. Kasi, *that the Finance & Facilities Committee:* *1) Receive Report No. 037-18FFC re: "Location Project – Project Management Services" for information; and* *2) Recommend that the Board of Health approve entering into a contract with BES Project Consulting for the purpose of providing construction project management services at Citi Plaza.* Carried

The Committee's next meeting will be on Thursday, October 4, at 9:00 a.m., in Room 3A, 50 King Street.

This report was prepared by the Office of the Medical Officer of Health.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 036-18FFC-R

TO: Chair and Members of the Finance & Facilities Committee

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 September 20

REVISED

LOCATION PROJECT – ARCHITECTURAL SERVICES

It is recommended that the Board of Health:

1) ***Receive Report No. 036-18FFC-R: "Location Project – Architectural Services" for information; and***
2) ***Approve entering into a single source contract with Endri Poletti Architect Inc. for the purpose of providing Architectural Services at Citi Plaza.***

Key Points

- Tours of potential future tenants have begun at 50 King Street.
- Four major local architectural firms have been approached to provide quotes on the work to build out the MLHU space at Citi Plaza, including those involved in the location project to date. Only Endri Poletti Architect Inc has provided a quote on the full scope of work required.
- Endri Poletti Architect Inc is the firm that is used by the landlord, and is very familiar with the Citi Plaza facilities. They have provided an estimate of $468,000 to complete the work. At 9% of the overall budget, this is well below the industry standard rate (which is approximately 15.4%).
- The firm's intimate knowledge of the building and the integration with the landlord's architectural work will reduce the time required for architectural work, and reduce the overall timeline for the build.
- Single source is being recommended to provide efficiencies in cost and time as well as streamlined communications to both the landlord and the Health Unit.

Background

The Middlesex-London Health Unit (MLHU) has entered into a Lease Agreement with Avison Young to lease space at Citi Plaza that will consolidate the two London offices located at 50 King Street and 201 Queens Avenue to one central location. One of the first priorities is the selection of an architect to finalize designs and begin the construction process.

The Scope of Work for the Architect will include the following:

1) Pre-Design – Analysis of MLHU's project brief and update of the Space Needs Assessment.
2) Schematic Design – Preparation of the preliminary design concept and two design iterations.
3) Design Development – Preparation of the detailed design concept based on the preliminary design developed.
4) Construction Documents – Preparation of construction documents which include specifications based on the detailed design.
5) Bidding or Negotiations – Preparation and response to tender documents.
6) Construction Contract Administration – Coordination with the Project Management Consultant and attendance at Site Meetings.
7) One Year Warranty – Follow up on outstanding issues post construction.

The landlord has targeted Endri Poletti Architect Inc. as their architect of choice.

A single source contract will provide efficiencies in cost and time as well as streamlined communications to both the landlord and the Health Unit. A singular architect will also possess an improved understanding of the total project and implement checks and balances to ensure both sides are satisfied with the overall design and final outcome. The landlord has verified that their pricing is in line with industry standards. Furthermore, there may be an opportunity to review cost savings during the project to achieve further concessions.

Procurement protocols outlined in MLHU Policy G-230, Appendix A allow for non-competitive purchases. These circumstances include situations where one source of supply would be acceptable and cost effective as well as situations where there is an absence of competition for technical or other reasons. The goals of non-competitive purchases are to allow for procurement in an efficient and timely manner. This policy does require Board of Health approval for a contract of this value.

Time is an important consideration for the approval of this contract. The current lease agreement for 50 King Street provides a one-year exit clause for both parties. Contractors were contacted to investigate the option of expediting the build schedule to allow for an earlier move in date. The cost to expedite the build schedule for the first floor clinical spaces only is estimated at approximately $800,000. This would not include the office spaces on the second floor of the new location.

The cost received from Endri Polleti Architect Inc. (EPA) is $468,000 to provide professional Architectural, Electrical, Mechanical and Plumbing Engineering. Negotiations have progressed over the last 3 weeks to ensure MLHU received competitive pricing for the services rendered. These costs were also verified against comparative projects of this value with the Ontario Association of Architects and industry professionals (Appendix A). This fee represents 9% of the overall budget which is significantly less than the 15.4% industry average for a project of this scope and scale.

The landlord has a long history of using EPA to complete work at Citi Plaza, therefore they have an intimate knowledge of the building. If a different architect were to be selected, they would have a very steep learning curve at this site, and thus higher costs. The space that will be occupied by the Health Unit includes: the original building from the 1960's; renovations that were done to Galleria Mall in late 1980's; and subsequent renovations when Citi Bank Cards arrived in the early 2000's.

The partnership between Avison Young, MLHU and EPA will work efficiently and serve the collective best interests. EPA is a seasoned, professional organization with experience of small to very large jobs. They have experience designing the Elgin St Thomas Public Health building, the City of London's offices at Citi Plaza, the Springbank Medical Centre, and the Nixon Medical Centre. Furthermore, the Health Unit will also benefit from EPA's proximity, and ability to come to the site at a moment's notice. Additional benefits include an intimate knowledge of the contractors and a positive relationship with the City's building permits department.

Other Quotes

Following recommendations from the last FFC meetings, efforts were made to solicit additional proposals from architects familiar with this project. Three additional architects were contacted. Two of the architects declined the proposal request as they were already engaged in sufficient projects. One proposal was received which provided competitive pricing, but a significantly restricted scope of work. This proposal was also less attractive because it included pricing based on a percentage of the overall project costs, meaning there is a risk that costs for architectural services may increase during the life cycle of the project. In addition, this proposal has provided a tight timeline to finalize designs, limiting the ability to complete a robust consultation process with MLHU staff and clients. As a result, the recommendation is to proceed with EPA.

Next Steps

The Board of Health will continue to receive updates on the status of key deliverables with respect to the Location Project. Efforts are underway to finalize competitive quotations for a Construction Project Manager to compliment the Architectural Services.

This report was prepared by the Healthy Organization Division.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 037-18FFC-R

TO: Chair and Members of the Finance & Facilities Committee

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 September 20

REVISED

LOCATION PROJECT – PROJECT MANAGEMENT SERVICES

It is recommended that the Finance & Facilities Committee recommend that the Board of Health:

1) ***Receive Report No. 037-18FFC: "Location Project – Project Management Services" for information; and***
2) ***Approve entering into a contract with BES Project Consulting for the purpose of providing Construction Project Management Services at Citi Plaza.***

Key Points

- Three quotes were received from a mix of local and multinational organizations.
- The lowest quote that meet the scope of work request was selected.
- The value of the contract is estimated to be $143,643.

Background

The Middlesex-London Health Unit (MLHU) has entered into a Lease Agreement with Avison Young to lease space at Citi Plaza that will consolidate the two London offices located at 50 King Street and 201 Queens Avenue to one central location. It is imperative to hire the services of a Project Manager to finalize designs and manage the construction process.

Construction project managers control the time, cost and quality of construction projects, from residential, commercial and industrial buildings to roads, bridges and schools. They plan and coordinate all aspects of the construction process, including hiring contractors and working with engineers, architects and vendors. Managers might begin their jobs by determining the scheduling of different phases of a project based on established deadlines. They participate in contracting with vendors, contractors and other workers. As the project continues, construction managers typically confer with supervisors or other managers to monitor construction progress, including worker productivity and compliance with building and safety codes. Because they must ensure that a project is completed according to schedule, managers must resolve problems that arise due to inclement weather, emergencies or other issues that may cause delays.

The Scope of Work for the Project Manager will include the following:

1) Pre-Construction
2) Construction Phase
3) Project Budget Management
4) Liaison between Client and Architect
5) Record Keeping
6) Project Cost Spreadsheets to Cover the Total Project
7) Post Construction Phase and Warranty Period

A detailed Scope of Work is provided in Appendix A for further information.

Quote Process

A variety of organizations were contacted to quote on providing Construction Project Management services. To begin, an independent contractor whose core business is Project Management was contacted to discuss the overall scope of work and qualifications. This scope of work was shared with additional organizations which included the general contractor and a commercial real-estate services firm. The intent behind this bidding process was to attract a variety of organizations which could provide different perspectives to this project.

Vendor Selection

BES Project Consulting is the recommended vendor for this service. Their quote for $143,643 (plus applicable taxes) was the lowest acceptable bid received for the scope of work requested. The quotes received ranged between this low bid to a high of approximately $200,000. BES is a growing construction project management company which have been in business for 14 years and work throughout Southwestern Ontario, the Greater Toronto Area as well at Ottawa. They have extensive experience in the public sector. Their portfolio includes the Elgin St Thomas Health Unit, Brescia University College (New Residence and Dining Pavilion), Lambton College (Nova Health, Research and Athletic Fitness Centre), Goodwill Industries (Social Enterprise Abilities Center) and a number of projects with the London Health Sciences Centre.

Risk Mitigation

The selection of BES Project Consulting considers the potential risk of sufficient resource allocation during the course of the project. This consultant has provided details on the team which will be supporting this project and the workload required for success. This team coupled with regularly scheduled meetings with the architect and project management team will mitigate the resource risk.

Next Steps

The Finance and Facilities Committee will receive continual updates on the status of key deliverables with respect to the Location Project.

This report was prepared by the Healthy Organization Division.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 052-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 September 20

ORGANIZATIONAL PLAN FOR RECONCILIATION

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 052-18 re "Organizational Plan for Reconciliation" for information;***
2) ***Approve implementation of the organizational plan for reconciliation in principle; and***
3) ***Direct that the Senior Leadership Team consider these recommendations as well as the data from Our Health Counts, and bring any resource requirements forward through the PBMA process.***

Key Points

- The *Organizational Plan for Reconciliation* (see Appendix A) supports the requirements and outcomes outlined in the Health Equity Standard (2018), and Relationship with Indigenous Communities Guideline (2018), and positions the agency to move forward with actions to support reconciliation with Indigenous Peoples.
- Recommendations are theme-based and reflect the "Calls to Action" from the Truth and Reconciliation Commission of Canada, wise practices, and community conversations with local First Nations, urban Indigenous-led organizations, and Indigenous individuals.
- Our Health Counts is an Indigenous-led health status report due to be released September 14th.
- A dedicated position at management level would support successful implementation of this plan.

Background

According to the Truth and Reconciliation Commission(TRC), Reconciliation is an "…ongoing process of establishing and maintaining respectful relationships." All people have a role to play and a responsibility for understanding Canada's history, as well as ongoing impacts on Indigenous Peoples. The Truth and Reconciliation Commission of Canada's Calls to Action address health care and other sectors with which public health collaborates. There are significant disparities and inequities related to health outcomes for Indigenous populations; public health can contribute to improving health outcomes and decreasing inequities.

An organizational plan for reconciliation with Indigenous Peoples for Middlesex-London Health Unit (see Appendix A) serves to address the Health Equity Standard with the Ontario Public Health Standards (2018) which explicitly states that "…relationships between boards of health and Indigenous communities and organizations need to come from a place of trust, mutual respect, understanding, and reciprocity" (p. 21). The recommendations provide a foundation for relevant and effective short- and long-term actions.

Process to Date

The steps taken to develop an organizational plan included review of the "Calls to Action" from the Truth and Reconciliation Commission of Canada, wise practices and best practices identified by Indigenous scholars within peer-reviewed and grey literature. Significant and critical contributions to and direction for the recommendations came from conversations with the following local First Nations, urban Indigenous-led organizations, and Indigenous individuals:

- Liz Akiwenzie, Cultural Consultant, Traditional Facilitator, and Cultural Keeper
- Vanessa Ambtman-Smith, Indigenous Health Lead, South West LHIN
- Joe Antone, Urban resident, Member of Oneida Nation of the Thames
- Ida Cornelius, Health Administrator, Oneida Nation of the Thames
- Al Day, Executive Director, N'Amerind Friendship Centre
- Laurel Day, Life Long Care Support Worker, N'Amerind Friendship Centre
- Raymond Deleary, Executive Director, Atlohsa Native Family Healing Services
- Brian Dokis, Chief Executive Officer, Southwest Ontario Aboriginal Health Access Centre
- Kimberly Fisher, Health Director, Chippewas of the Thames First Nation
- Shauna Kechego-Nichols, Urban resident, Member of Chippewas of the Thames First Nation
- Diane Smylie, Provincial Director, Ontario Indigenous Cultural Safety Program

Now that the Our Health Counts report has been released, this Indigenous-led assessment of the health status of Indigenous people, including data from London and Middlesex, will be used to further enhance MLHU's reconciliation planning process, as outlined in one of the research recommendations.

Identified Themes

Based on the comprehensive development process, the resulting recommendations are clustered into the following themes:

- Awareness and education
- Supportive environments
- Relationships
- Research
- Workforce development
- Governance
- Equitable access and service delivery

Next Steps

This organizational plan demonstrates commitment to action for reconciliation with neighbouring First Nations and Indigenous-led organizations. It serves as a starting point for a fulsome collaborative approach to continue to build and strengthen engagement, relationships and trust with an overall goal of implementing actions to decrease health disparities and improve health outcomes for local Indigenous populations. The initial emphasis within the plan is on ongoing education, capacity-building, and supportive environments so that all staff are able to engage and work effectively and respectfully with Indigenous populations. Another area of emphasis is the building of trust and deepening of relationships with local organizations and communities that is necessary for any future collaborative efforts; this is a process that will take time and cannot be rushed. Serious consideration needs to be given to the development of a dedicated position at management level to advance the approved recommendations and activities of this plan.

This report was prepared by the Health Equity Core Team, Office of the Chief Nursing Officer.

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

Appendix A to Report No. 052-18

Taking Action for Reconciliation:

An Organizational Plan for Middlesex-London Health Unit

MIDDLESEX-LONDON HEALTH UNIT

June 2018

For information, please contact:

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Taking Action for Reconciliation: An Organizational Plan for Middlesex-London Health Unit
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Acknowledgement

We acknowledge that the Middlesex-London Health Unit, in which we operate, is on Indigenous land that has been inhabited by Indigenous peoples since time immemorial.

As settlers, we're grateful for the opportunity to be here and we thank all the generations of people who have taken care of this land - for thousands of years.

Long before today, there have been the first peoples of Turtle Island who have been the stewards of this place. In particular, we acknowledge the traditional territory of the Anishinaabeg, Haudenosaunee, Attawandaron (Neutral), and Wendat peoples. This area was originally governed by the Three Fires Confederacy consisting of the Odawa, Pottawatomi, and Ojibway. We recognize and deeply appreciate their historic connection to this place. This territory is covered by the Upper Canada Treaties.

It later became home to other nations who now call this place home. Considering this, we also recognize the contributions of Métis, Inuit, and other Indigenous peoples have made, both in shaping and strengthening this community in particular, and our province and country as a whole. As settlers, this recognition of the contributions and historic importance of Indigenous peoples must also be clearly and overtly connected to our collective commitment to make the promise and the challenge of Truth and Reconciliation real in our communities.

(adapted from Traditional Territory Acknowledgements in Ontario, Ontario Federation of Labour, 2017)

With respect and appreciation, we extend thanks to the following individuals who shared their expertise and perspective to support the development of this organizational plan for reconciliation.

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Executive Summary

The Truth and Reconciliation Commission of Canada provides 94 "calls to action" that lay the groundwork for how all sectors, including health, in what is now known as Canada can move forward in addressing systemic inequities and work towards reconciliation with Indigenous Peoples. In response to these calls to action, an organizational plan for Middlesex-London Health Unit (MLHU) for reconciliation requires a focus not only on health and public health issues, but an understanding and appreciation of the long-term impacts of colonization and racism that continue to exist today. As both an individual and collective process, reconciliation for public health necessitates a plan that looks beyond to the much larger societal context.

Within the current context, all MLHU staff are expected to be able to engage and work with Indigenous populations. Learning about Indigenous history, including colonialism and racism, is a necessary step to understand the current situation related to Indigenous health issues. Given that staff are almost exclusively settlers, topics of ongoing colonization, racism, power and privilege can be expected to be uncomfortable, and may result in resistance. Beyond learning, public health practitioners need a supportive internal environment to process, reflect, and increase their depth of understanding, so that they can move past resistance. As a result, the recommendations in this plan emphasize actions for awareness, reflection, education, and a supportive environment as precursors and an underlying base for further reconciliation actions.

Recommendations within this plan have been compiled from the literature, including a range of best practices and wise practices. Local context and perspective, from conversations and dialogue with representatives of local Indigenous-led organizations and individuals, was significant in the resulting recommendations for MLHU. It is essential that a fulsome collaborative approach with Indigenous organizations and neighbouring First Nations communities continues in order to build and strengthen existing relationships before implementation of actions. As such, the recommendations contained in this plan are to be considered preliminary and evolving.

The recommendations are on a continuum of simple to complex, and from those already in process to those that may be considered aspirational. They have been clustered into themes of:

- Awareness and Education
- Supportive Environments
- Relationships
- Research
- Workforce Development
- Governance
- Equitable Access and Service Delivery

Context

> "Achieving genuine reconciliation between Aboriginal and non-Aboriginal peoples in Canada is a responsibility we all share."
>
> *Jean-Paul Restoule, Associate Professor of Aboriginal Education at OISE/University of Toronto and a member of the Dokis First Nation (Anishinaabe)*

The *Two Row Wampum Belt* is representative of two distinct nations, Indigenous and European, who ventured by way of a Ship and a Canoe. These boats are journeying down the waterways alongside each other. It is an agreement that reminds all of us that we would peacefully share the land and respect each other's space, never infringing upon the others' way of life. Over time, the respect of traditions and formal agreements were breached. Now, the Wampum Belt reminds us that we are on a path to reconciliation and it is up to Indigenous and non-Indigenous allies to uphold these values and prior agreements to get to a place of active reconciliation.

In April 2016, a Two-Row Wampum Belt was given as a gift from The Chippewas of the Thames First Nation in the presence of the Oneida Nation of the Thames to the City of London Council. "It is on display in the Mayor's Office as a reminder of the deep and abiding friendship and of the mutual duty to respect the lasting principles of the pledge made long ago." (Pathways to Reconciliation, 2016). As such, we are all treaty people with rights, roles, and responsibilities regarding reconciliation.

An organizational plan for reconciliation with Indigenous Peoples for Middlesex-London Health Unit requires a focus not only on health and public health issues, but an understanding and appreciation of the long-term impacts of colonization and racism that continue to exist today. Reconciliation is an individual and collective process that is ongoing and will continue to be so for generations ahead. For those reasons, an organizational plan for reconciliation for a public health unit requires attention to the much larger context beyond health.

The need for reconciliation has been established for decades, but increased attention on the issue has resulted since the release of the United Nations Declaration on the Rights of Indigenous Peoples (2007), and in Canada, particularly since the establishment of the Truth and Reconciliation Commission of Canada (TRC) (2008) and the release of its "Calls to Action" (2015).

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) provides internationally recognized principles for the treatment of Indigenous peoples around the world. It is based on the principles of self-determination and participation, and respect for the rights and roles of Indigenous peoples within society. Canada supported UNDRIP in 2010 but without full endorsement and described it as an "aspirational" document. It is important to note that Canada did not become a full supporter without qualification until May 2016. This brings into sharp focus the political aspects and nuances related to reconciliation at the national level.

The Truth and Reconciliation Commission of Canada's Calls to Action outlines actions for reconciliation that are pertinent to all sectors within society. They aim to address the root causes of Indigenous health and social inequities, including societal attitudes and systemic racism. Many of the calls are directed at federal, provincial, territorial and Aboriginal governments, but the calls go beyond those governments to all sectors and individuals. Calls to Action #18-#24 are specific to health. Because the work of public health includes multi-sector collaboration along with the goal of achieving health equity for all, consideration of the calls beyond those that are health-specific is essential.

The provincial government is strongly committed to reconciliation with Indigenous Peoples, as evidenced by their report, *The Journey Together: Ontario's Commitment to Reconciliation with Indigenous Peoples* (2016). This report restates the government's "…commitment to continue the journey of reconciliation, through specific initiatives designed to bring meaningful change to the lives of Indigenous people and communities. We will continue to walk hand-in-hand with Indigenous partners, and build trusting, respectful and mutually beneficial relationships."

The Ontario Public Health Standards (2017) within the program outcomes and requirements of the Health Equity Standard explicitly state that "relationships between boards of health and Indigenous communities and organizations need to come from a place of trust, mutual respect, understanding, and reciprocity" (p. 21). This requires the establishment and building of meaningful relationships, engagement, and collaborative partnerships.

A support document for the Health Equity Standard, *Relationship with Indigenous Communities Guideline, 2018,* "…provides boards of health with the fundamentals to begin forming meaningful relationships with Indigenous communities…" (p. 3) and further emphasizes the importance of concepts outlined in the Health Equity standard. In addition to Ontario-specific information related to governing bodies, urban Indigenous organizations, and Aboriginal Health Access Centres, the guideline outlines principles that will underpin engagement approaches when applying the Standards to work with Indigenous populations.

The Middlesex-London Health Unit Strategic Plan 2015-2020 with its vision, mission and values provides an overarching framework to achieve improved health outcomes for all community members, including those of neighbouring First Nations and Indigenous individuals living in urban settings.

- Vision: People Reaching Their Potential
- Mission: To promote and protect the health of our community
- Values: collaboration, integrity, empowerment, striving for excellence, health equity

Additionally, the Health Unit has developed a plan for health equity staff capacity building (2017-2020) which includes the domain of “Indigenous Public Health Practice”. A Health Unit organizational plan for reconciliation will further demonstrate commitment to the ongoing process.

Ultimately the goal of public health is about the health of the community which includes recognition that Indigenous Peoples and Nations have the right to self-determination, including the right to the enjoyment of the highest attainable standard of wholistic health based on distinct political, social and cultural structures.

For that reason, it is imperative to recognize that colonialism is the over-riding determinant of health for Indigenous Peoples. The National Collaborating Centre for Aboriginal Health (NCCAH) “recognizes that colonization and colonialism cross-cut and influence all other social determinants of health of First Nations, Inuit and Métis individuals, families and communities. We also know that the health disparities and inequities experienced by Aboriginal peoples are rooted in racism and marginalization, dislocation, and social exclusion.” (NCCAH, n.d.). For public health to decrease existing health inequities, an understanding of the full context of Indigenous experiences of trauma and oppression over generations is needed.

Purpose

An organizational plan for reconciliation can support several purposes by outlining mechanisms that:

- demonstrate commitment to addressing the Truth and Reconciliation Commission of Canada's Calls to Action, particularly those related to health
- provide a supportive environment for reflection, increased knowledge and skill building
- serve to disrupt ongoing colonial practices related to health that are part of the organization
- enhance organizational capacity to address racially-based health inequities
- enhance ability to build relationships and meaningful engagement with Indigenous communities and organizations

Reconciliation is an "…ongoing process of establishing and maintaining respectful relationships" (Truth and Reconciliation Commission of Canada, 2015). It is also recognized that reconciliation can have different meanings for people and that it is important to respect these different understandings. Respecting different ways of understanding and living is a core tenet of reconciliation (Smylie, 2015).

Additionally, reconciliation has elements of truth, justice, forgiveness, healing, reparation, and love, but as a process, the end point of "reconciliation" cannot be guaranteed (Reconciliation Australia, 2017).

> "The river is the river and the sea is the sea. Salt water and fresh, two separate domains. Each has its own complex patterns, origins, stories. Even though they come together they will always exist in their own right. Our hope for Reconciliation is like that."
>
> *Patrick Dodson (Indigenous Australian Parliamentarian)*

One of the TRC's guiding principles is that reconciliation requires "…constructive action on addressing the ongoing legacies of colonialism that have had destructive impacts…". Embedding respect into relationships and actions in all that we do is extremely complex and that complexity should not be underestimated (Smylie, 2015).

Reconciliation cannot be addressed without acknowledging colonization and racism. Experiences of colonization and racism are closely intertwined. Colonial history includes actions of forced relocation of peoples from their traditional territories, the imposition of the Indian Act, Residential School System, Indian Hospitals, and the Sixties Scoop. The impacts of these experiences continue today as evidenced by health outcomes and intergenerational

trauma (Health Council of Canada, 2012). The "Millennium Scoop" can be interpreted as evidence that colonialism is an ongoing process; it refers to the fact that there are more First Nations children in care now than at the height of the residential school system (Canadian Press, 2011). Specifically, Aboriginal children account for 41%-56% of foster children, depending on the age group, yet they only represent about 7% of all children in each of the age groups (Statistics Canada, 2016). Despite such evidence, a common narrative about Indigenous people is that colonization is in the past and so 'they just need to move on'.

Within the current Health Unit context, all staff are expected to be able to engage and work with Indigenous populations. Given that staff are almost exclusively settlers, topics of ongoing colonization, racism, power and privilege can be expected to be uncomfortable. Not only will open and honest dialogue be uncomfortable, it may cause defensiveness, resistance, and even denial. Learning about Indigenous history, including colonialism and racism, is a necessary step to understand the current situation related to Indigenous health issues. Beyond learning, public health practitioners need a supportive internal environment to process, reflect, and increase their depth of understanding, so that they can move past denial and resistance. As a result, the recommendations in this plan emphasize actions for awareness, reflection, education, and creating a supportive environment as precursors and an underlying foundation for further reconciliation actions.

"Reconciliation is almost like a philosophy. In the indigenous worldview, it would be focused on building a relationship between people that doesn't have any differences attached to it. People would have a common vision of the world that they would want to live in. The first thing that we share as people is that we have a responsibility to make Creation a healthy, livable place. Then we would realize that we all have a responsibility for Creation. …Secondly, reconciliation is a human process. There are elements to that process of building relationship that reflects reconciliation such as the mutual acknowledgement that we are working together for the good of future generations. …Reconciliation is a human movement that is action oriented. Reconciliation is good for all people and for the country. It fulfills a worldview where all of us, regardless of our colour, our race or creed, can make a difference that affects the future. Our country would be a better place. Our world would be a better place."

Malcolm Saulis, Elder and university professor, quoted in The Ottawa Citizen, July 1, 2017, http://ottawacitizen.com/news/local-news/the-meaning-of-reconciliation

Recommendations

The following recommendations for inclusion within an organizational plan for reconciliation have been compiled from the literature, including a range of best practices and wise practices, and from perspective-sharing by representatives of local Indigenous-led organizations and individuals.

Health professionals are not expected to be cultural experts for all Indigenous Peoples. It is not possible for individuals to fully understand all the multi-faceted cultural components and nuances of multiple First Nations, Inuit and Metis communities. Rather it is important that professionals operate from the underlying principle of cultural humility which is a life-long learning journey that includes comfort with not knowing, openness to learning, and self-reflection.

Additionally, it is important to note that while the work and voice of health professionals (whether non-Indigenous or Indigenous) have value, it cannot be assumed that this perspective fully represents Indigenous people, families, and communities.

It needs to be emphasized that there is no homogenous Indigenous "community", but rather there are multiple unique Nations and communities (i.e., each with its own ancestral heritage, processes, protocols, culture, and language). During local conversations, that diversity was reflected in the perspectives and experiences that were shared.

An implementable action plan requires activities with timelines, outcomes and indicators. After review and approval of this initial plan, a sequence for implementation based on a logic model that includes timelines, outcomes and indicators can be developed.

Awareness and Education

The awareness and education activities are intended to develop individual skills for engagement and work with Indigenous populations, and also to support individual and organizational capacity building. In and of itself, participation in education does not lead to full competency for Indigenous-related public health practice, rather there is a need to understand and appreciate that knowledge as a precursor to any engagement activities. This requires ongoing education, reflection, and skill-building as part of a comprehensive plan, not one-time events. The basis of knowledge is truth, and the majority of Canadians have not been educated about the truth of colonial systems and structures, including the extensive impacts on Indigenous Peoples.

Activity
Ensure that staff development activities are based on the "wise practices" for Indigenous-specific cultural safety training. e.g. Practice #3: "Focus on power, privilege, & equity. Ground it in decolonizing & anti-racist pedagogy. Use principles of transformative education theory." (Churchill, et.al., 2017).
Provide learning opportunities for all levels of staff, including senior leadership, related to cultural competency, human rights, and anti-racism (TRC Calls to Action #23.iii. and #57). Additionally, offer education to members of the Board of Health.
Continue staff capacity building activities for Indigenous Public Health Practice as outlined in the approved Health Equity Staff Capacity Building Plan 2017-2020 (with ongoing adaptation as needed).
Provide learning opportunities for staff that extend beyond basic foundational learning, for example, the See Me Exhibit (an art installation related to Murdered and Missing Indigenous Women and Girls).
Include the principles of trauma and violence-informed care within learning opportunities.
Promote the use of culturally appropriate language and terminology (see Appendix A).
Promote public acknowledgement of traditional territories in a range of venues, e.g. at all HU-wide events, as part of email signatures, with a sign in Health Unit lobbies, on the home page of the MLHU website.
Encourage individual action to learn about Indigenous history broadly (e.g. reading of the TRC's Calls to Action) and locally (e.g. Mount Elgin Residential School, the three neighbouring First Nations). An example of individual action would be reading Indigenous authors as one way to expand perspective. A sample reading list is in Appendix B.

Promote ongoing reflection on Indigenous concepts of well-being and worldview, as well as self-reflection to further develop cultural humility as an approach to incorporate into practice.
Develop reciprocal training, orientation, and/or knowledge sharing activities with Indigenous organizations and/or neighbouring First Nations, as relevant.

Supportive Environments

Cultural safety training programs cannot work in isolation; system level support is required for accountability and organizational transformation (Churchill, et.al., 2017). To that end, leadership plays a key role in the development of supportive environments so that staff can work towards the reduction of health inequities within Indigenous populations. In addition, a supportive environment includes the provision of a welcoming atmosphere to all people entering the Health Unit buildings. This is primarily achieved through the development of skills and capacity in Health Unit staff (see above); one recommendation (as an example) related to creating a physical space which is "welcoming" is provided here.

Activity
Develop a MLHU vision that is specific to reconciliation.
Develop a framework and/or guiding principles as a basis for developing and practicing respect and understanding; acknowledge that each First Nation may have its own process and protocol for engaging and working with HU staff.
Develop explicit and intentional plans based on the above vision, framework and principles to guide staff in relationship-building and engagement activities. Include Indigenous worldview and knowledge through the support of local Elders, Healers, Knowledge Keepers, and Cultural Teachers. Identify key supporters for specific actions contained within the recommendations.
Develop an internal inventory to increase awareness and understanding of existing work with Indigenous populations and to promote connections between teams and divisions (see Appendix C).
Support the development of internal partnerships (when/as appropriate) to address identified prioritized issues and to improve program and service delivery.
Develop and maintain a repository of resources for posting on the HUB (see Appendix D as a sample).
Encourage and support attendance and/or participation at local Indigenous-led events (e.g. National Indigenous Peoples Day-June 21, Orange Shirt Day-September 30, Missing and Murdered Indigenous Women and Girls Memorial-February 14).
Ensure that opportunities for reflective practice related to Indigenous Public Health Practice are incorporated into regular supervision meetings and team meetings.
Develop and maintain a community of practice, such as a "white settler" community of practice. This would promote enhanced sharing and reflection related to racism, colonialism, power and privilege in a safe space.

Develop a “reconcili-ACTION” group, as referenced by the TRC. Such a group could act as a working group with a core function of building and maintaining momentum for reconciliation over time.
Continue to promote and provide client-centred care, which is inclusive of the principles of trauma and violence-informed care.
Continue to provide adequate funding and resources for the development and maintenance of activities to support cultural safety and cultural humility.
Establish and implement policies to sustain a supportive environment, as required, related to the identified recommendations.
Build cultural safety and cultural humility principles into all communications messages. This includes the use of culturally respectful, audience-identified terminology.
Include artwork/posters, produced by local Indigenous artists and photographers, within the lobbies and hallways of Health Unit sites.

Relationships

Establishing effective and respectful relationships is fundamental to reconciliation efforts and to improve health-related outcomes. Relationships are built on connections and the development of trust within First Nations communities and with Indigenous-led organizations working with individuals and communities. The importance of taking time, not rushing, and not jumping to premature action is frequently mentioned, both in the literature and by local community members.

Understanding Indigenous cultural protocols so that they can be put into action is a key principle of respectful relationships (Social Compass, 2016).

Activity
Work towards having an honest and authentic presence in a First Nation and/or Indigenous-led organization(s). This includes being upfront about intentions and getting to know a community or organization on a deeper level, moving past the barrier of "professionalism" that may impede relationship building.
Ensure that communication includes: an open and respectful style, time for listening and meaningful discussion, face-to-face dialogue, community visits, cultural protocol for meetings.
Incorporate strategies and recommendations from the *Relationship with Indigenous Communities Guideline, 2018* (Population and Public Health Division, Ministry of Health & Long-Term Care), as appropriate to MLHU context.
Develop guiding principles for ongoing and future engagement beyond what is contained in the *Relationship with Indigenous Communities Guideline, 2018* document to be specific to MLHU context, with direction from local Indigenous representatives.
When collaborating with and/or seeking direction from Indigenous communities or organizations, incorporate flexible timeframes with the recognition that there may be competing priorities and limited resources, and that consultations and approvals contained within internal processes may take time.
Develop and maintain a contact list of people, communities and organizations that are willing to collaborate with the Health Unit in the reconciliation process; this should be reciprocally- based and may require the strengthening and/or expansion of relationships.
Recognize and acknowledge resiliency and existing strengths within Indigenous communities.
Provide dedicated funding to respect and honour Indigenous protocols and traditions (e.g. Elder honoraria, gifts, traditional tobacco).

Use validation processes to ensure a more holistic view from multiple and diverse perspectives.
Strengthen and further develop relationships with the Local Health Integration Network, Indigenous Health Lead, to explore and/or deepen connections between public health and the LHIN and to avoid duplication (e.g. Indigenous roadmap for renewal and reconciliation, Indigenous Health Committee).
Explore the development of a community advisory board (e.g. Indigenous Health Advisory Circle (Toronto) which is a permanent, community-led health advisory circle). As the LHIN already has an Indigenous Health Committee, this requires further information in relation to purpose, potential overlap, and other factors.
Establish connections with the Indigenous Health Policy and Stakeholder Relations Lead (a position within the Indigenous Primary Health Care Council, a new Indigenous-governed, culture-based, and Indigenous-informed organization).
Consider the development of a Middlesex-London Indigenous Health Strategy. This would require participation with municipalities, First Nations, and other community partners. Multiple factors need to be considered including purpose, benefits, and whether the Health Unit should be positioned as a participant or lead.

Research

Indigenous Peoples have a history of being subjected to traumatizing and dehumanizing research practices throughout the colonization process. Existing Indigenous methodologies, knowledge, and protocols have not been considered "legitimate" based on the predominant Western perspective. The focus on Western-based research means that significant evidence has been and can be overlooked.

These recommendations are intended to change the focus of any Health Unit data collection and/or research to recognize the primacy of self-determination for Indigenous populations.

Activity
Respect principles of OCAP® (ownership, control, access, possession) regarding "how First Nations data should be collected, protected, used, or shared. They are the *de facto* standard for how to conduct research with First Nations." (First Nations Information Governance Centre).
Review the 15 recommendations from the Provincial "Three Ribbon" Expert Consensus Panel for consideration into MLHU evaluation activities.
Establish and monitor health indicators as identified by TRC Calls to Action #19 and #55iv, in order to determine progress in closing the gap between Indigenous and non-Indigenous communities (i.e., infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, availability of appropriate health services) as appropriate to public health and population health.
Respect Indigenous approaches to knowledge and learning. Identify potential opportunities for MLHU to participate in building on the existing evidence base, and ensure MLHU uses and supports approaches that work for improving health outcomes for Indigenous Peoples.
Develop communication protocols, based on direction from involved Indigenous partners, for ways of reporting to communities. Include how the community can access any Indigenous health data that the Health Unit may be holding.
Use and incorporate findings of the "Our Health Counts" project (specific to London site) as it becomes available.
Use a collaborative, rather than consultative, approach if/when decisions are made to conduct research; include acknowledgement of previous adverse research experiences, including history of "being done onto rather than done with".
Develop measures to assess cultural safety and humility across the Health Unit, as part of quality improvement. This can be an inclusive process that includes mixed method approaches to evaluation. A potential tool for further exploration is the Waawiyeyaa Evaluation Tool.

Workforce Development

Recommendations for workforce development relate to two aspects, those related to existing staff, and those that are focused on increasing the diversity of staff to a more proportionate representation of Indigenous populations.

Activity
Develop initiatives and establish policies to support the recruitment and retention of employees that identify as Indigenous at all levels, including administrative and senior levels within the organization (related to TRC Calls to Action #23i). For example, recruitment can make use of the "recruiting pipeline" through universities and colleges.
Include mandatory education as part of the orientation process for all new hires.
Incorporate completion of education components into performance management. Include cultural safety and humility indicators within performance appraisals.
Offer mentorship opportunities by Indigenous people with non-Indigenous staff to support culturally safe practices.
Consider having a dedicated position to advance the approved recommendations and activities of the organizational reconciliation plan. This would include consideration of the best placement of the role within the organizational structure, and the need for supporting infrastructure for the role.
When developing and reviewing internal policies, seek out Indigenous perspectives.
Develop an anti-racism and discrimination policy. Consider an accompanying "whistle-blower" policy. A "whistle-blower" policy can support those who are in the position of observing discriminatory and/or racist actions, but are not comfortable interrupting the situation. Such discomfort may be related to power differentials and the policy would serve a protective function.

Governance

The Government of Ontario and the Chiefs of Ontario signed a Political Accord in 2015 that affirms that First Nations have an inherent right to self-government. Related to health, the Minister of Health in February 2018 stated that the "…ultimate goal is a health-care system where these decisions are no longer made by the provincial government" and that this is expected to happen within a matter of years. The goal of self-determination and sovereignty may be defined differently by individual First Nations and Indigenous-led organizations. Formal models of working together, such as Memos of Understanding and Section 50 agreements, are possibilities for further exploration.

The recommendations provide options to support self-determination as much as possible while this shift is occurring.

Activity
Follow any formal protocols existing within First Nations and Indigenous-led organizations (e.g. when building relationship, when working in partnership).
Identify informal opportunities to support the principle of self-determination (i.e. partnerships to be beneficial to Indigenous organizations/communities and Indigenous-driven).
Develop mutual accountability agreements, as appropriate for any jointly planned and developed programs and services.
Develop a Health Unit position statement to publicly acknowledge support for the Truth Reconciliation Commission's Calls to Action, and the related resolutions by the Ontario Public Health Association (OPHA) and the Association of Local Public Health Agencies (alPHa).
Engage with Board of Health members to increase their understanding of the TRC's Calls to Action, including roles for public health (i.e. becoming allies).
Initiate process to explore interest in the development of Health Promotion and Protection Act Section 50 agreements.

Equitable Access and Service Delivery

There are multiple stories about experiences in the local health care system that illustrate negative assumptions, stereotyping, and racism directed towards Indigenous Peoples. Previous negative hospital experiences and historical trauma have contributed to mistrust of the health system. There is ongoing ambiguity around jurisdictional issues, and there can challenges related to jurisdiction between urban organizations and First Nations.

The funding structure for public health may not be clearly understood by local First Nations and Indigenous-led organizations, in that there can be perceived competition for money from the Indigenous "funding pot".

Activity
Develop Indigenous-specific programs and/or services, using a co-creation process, with Indigenous-led organizations and First Nations communities, if and when such programming is desired and deemed appropriate by these organizations and/or Nations.
Clarify all funding sources during the development process for collaborative Indigenous-related programs and/or services. Transparency about funding and operational expenses is important to the relationship-building process.
Take visible action, specifically the clear identification of an agency response through the use of policy, to engage and confront racism in demonstrable ways. Ensure that each instance of stereotyping, discrimination and racism within the organization receives an appropriate response.
Develop culturally-safe complaints processes.
Integrate processes related to complaints into quality improvement and accreditation processes.
Explore additional frameworks and approaches to address gaps in health disparities, e.g. "Indigenizing Psychology and Western Medicine", which uses working in a collaborative approach to provide services and resources for Indigenous people effectively and efficiently.

Community Conversations

Listening to the perspectives of local First Nations, Indigenous-led organizations, and individuals is an essential component to the development of any organizational plan for reconciliation. Throughout the course of unstructured one-to-one conversations with local individuals, extensive experiences and diverse thoughts were shared related to the Health Unit's intent to develop such a reconciliation plan.

Some larger contextual perspectives and questions which were shared included the following:

- a culture shift is needed first and it takes significant time to make such a shift
- there is a need to incorporate flexibility within timelines for both the overall plan development and any recommendations; "things" will emerge as the process develops and there needs to be the ability to respond and adjust the plan and recommendations to those changes
- there have been experiences of not being listened to during consultation processes; consultation should not be a "one-time thing"
- there is considerable value in the co-creation of an organizational plan, particularly in terms of any resulting actions to be developed
- using a collaborative model supports communities and organizations who expressed a need for allies, including those with institutional power
- how Indigenous health equity is framed is important. Step back and ask such questions as: "Why are we in such a position today with such great disparities in health between Indigenous and non-Indigenous peoples?" "Why has nothing changed given the amount of investment in resources?"
- continue to ask about unintended consequences when trying to change the system

Shared local perspectives were frequently aligned with the direction found within the TRC's Calls to Action, and findings in both research and grey literature. The above recommendations incorporate these shared perspectives. The diversity and depth of these local perspectives, as outlined below, expands further on the identified themes.

Awareness and Education

The acknowledgement of "truth" needs to come before anything else. Such truth includes education about what has happened and what continues to happen, not what has been taught in the provincial education system. Acknowledging truth requires a willingness to go deep into the reality of Canada and its founding. Education is foundational, and focusing on education first is considered an excellent approach so that individuals have a strong understanding as a basis for further learning. It was expressed that the on-line *Core Online Indigenous Cultural Safety Training* is considered to be an emerging best practice. Other modules and workshops from the Ontario Indigenous Cultural Safety Program, such as *Roots of Tolerance,* are available for consideration.

There were consistent comments that though on-line learning platforms are a positive starting point, learning by experiential learning and meaningful conversations is needed to deepen empathy, as well as understanding and appreciation of colonial structures and systems and their impact. It was noted that one-time education sessions are not enough, and since single sessions cannot be comprehensive, they may in fact contribute to resistance. Getting all of senior leadership and the Board of Health educated is a valuable first step to increase support and decrease any potential resistance at a staff level. Education is important before

approaching organizations and/or communities for engagement; otherwise the Indigenous person is put in the position of having to do that education before anything else can happen.

Even after individuals become more aware and educated, complacency can develop, so there is a need for ongoing work related to learning in order to achieve a true shift in support of reconciliation. Knowledge progression can occur from the completion of a core module (i.e., ICST) to then include local cultural knowledge and context. It was recommended to get to critical mass or a "tipping point" before moving beyond the core ICST module to other education interventions.

Throughout the conversations, specific suggestions were made as to what should be part of offered education, such as:

- extending the focus of understanding to beyond the impact of residential schools to include the resiliency and vibrancy that Indigenous communities offer
- providing content that leads to a full understanding of what happened at residential schools (e.g., nutrition experiments) and the ongoing impact of those experiences, including intergenerational pain and trauma
- including "real history" that is frank, open, and honest, and brings forward the underlying issues prior to the time of Confederation
- the understanding of protocols, such as protocols with elders and differing protocols of Nations
- deepening the understanding of the diversity between and within the several hundred First Nations that are part of what is now Canada. This is needed to move away from the stereotypical images and beliefs of the "pan-Canadian Indian".
- the value and importance of compassion, including that compassion may get lost due to Western teachings that emphasize professionalism
- the importance of "meeting a person's needs where they are at" when working with individuals and families
- the acknowledgement of the privilege that settlers have and have benefitted from
- how the colonial system, based on power and control, has created a system of dependency and co-dependency; change the focus to empowerment when working with individuals and consider "how are we going to empower?"
- the recognition that previous generations did not have a voice. Some Indigenous people have a voice now, but as a population, Indigenous Peoples continue to tend to be invisible.
- considering and including factors of why there is mistrust in the current health system
- include concepts about health, that health is mind, heart, spirit and body; food and ceremony are medicines. The Western system has strongly focused on the body and is resistant to the Indigenous health system.
- that disconnection from the earth, from themselves, and from each other all contribute to sickness, as does pain and trauma. Symptoms of disconnection are then passed along to the next generation.

Supportive Environments

The importance of visible leadership support at every level within the organization is necessary for the organization to make progress. Additionally, it must be recognized that the constraints of organizational structures can potentially impede the work of any staff who are practising and/or advancing culturally-safe practice; trying to work within the mainstream system to reverse colonial practices can present many challenges.

Identifying key supporters of specific activities and actions related to the recommendations can help to advance the process. The provision of time and removing barriers to completion of education and awareness-raising components in the plan is also key. Some concern was expressed that recommendations can end up "sitting on a shelf" with no resulting actions, and that it is important not to let this happen.

Relationships
Time is needed for relationship development and the process cannot be rushed; caution about moving too fast was expressed frequently. It is important to get to know the community first when wanting to approach it and its members (e.g., have current knowledge of who are the Chief and Council members). As part of getting to know the community, there should be the development of knowledge and understanding of existing working relationships between and among each other (First Nations and urban organizations).

Being open to talking, listening and learning from each other are all part of developing a comfort level and the building of trust. Colonial practice is normative so there can be assumptions that Indigenous Peoples don't know what they need. Whoever is involved with engagement activities needs to be well-versed (i.e., humble, respectful, a listener who is willing to spend time without pushing their own agenda). Rebuilding of relationship and taking action means taking responsibility for the systems and conditions that we create and perpetuate.

There needs to be a purpose for the relationship, not just because a relationship is mandated. True commitment to relationship-building requires an honest approach; the community knows who is real and who is without true and deep understanding. An approach without real commitment leads to loss of credibility at the time as well as going forward. A strong(er) relationship can be the by-product of a tangible meaningful project and/or proposal. Co-creation is an important element for the building of relationship.

Several examples of positive relationships and successful partnerships with the Health Unit were provided, such as the establishment of the dental clinic at the 50 King Street site; collaboration around the set-up of the Temporary Overdose Prevention Site (TOPS) and the proposed Supervised Consumption Facilities (SCF); responsiveness of the Health Unit when called upon related to communicable disease follow-up, Naloxone training, immunization, and presentations at health fairs. Interest was expressed in working together more, potentially in areas of chronic disease prevention; support for capacity-building around evaluation components; and support for knowledge and skills development, especially in relation to mental health. Sharing information about relevant in-services and resources available from the Health Unit can be supportive to relationship building and maintenance. There is openness to support from the Health Unit on the basis of "if and when" it is asked for.

Two resources of potential use for the reconciliation plan were suggested: i) the Chiefs of Ontario annual reports address work being done by them, including relationship with public health, and ii) a document currently in development about relationship and working with Aboriginal Access Health Centres for public health.

Three of the recommendations mention the South West Local Health Integration Network (SW LHIN) specifically. Conversation with the Indigenous Health Lead noted that the opportunities for collaboration are very strong. As the Indigenous Health Lead is in process of leaving the

SW LHIN, this requires further exploration when a new lead has been identified and established.

Research
Health and health care are strongly evidence-based. When the focus is on Western-based research, significant evidence can be missed, so it is important to consider "whose evidence is this?" Scholars are speaking now of Indigenous determinants of health, whereas what has previously been missing is the colonial context and the presence of anti-Indigenous racism in health care. There are almost no "best practices" from a Western perspective, but there are emerging practices.

The *Our Health Counts* project (London site) and the EQUIP study were mentioned as sources of data and evidence. It is anticipated that the *Our Health Counts* project will be releasing selected findings and data in the near future that will be helpful for planning and more accurate understanding of local populations.

Interest was expressed in mutual sharing (e.g., survey results) and learning from each other. The principles of OCAP (ownership, control, access, possession) are to be respected.

Workforce Development
Barriers to post-secondary education were noted as one area that impacts the potential number of Indigenous health professionals. For those who do pursue higher education in the health field, there can be resulting challenges related to maintaining Indigenous identity while working within the existing colonial teachings and structures of "health".

A practical strategy of using the "recruiting pipeline" within universities was suggested, as was the need for awareness and understanding of unconscious bias during the hiring process.

Overall workforce development needs to be addressed from a structural level. An organizational plan and resulting actions do not necessarily need to be solely Indigenous-led. The overarching goal is to deepen understanding and actions regardless of who is leading. A collaborative model for change recognizes an expressed need for allies, including those with institutional power.

As well as having the lead role appropriately placed within the organization structure, such a dedicated position requires supporting infrastructure. An example of a common mistake is the placement of an Indigenous person in a strategy lead role, but then placing that individual in a junior role without authority. That person can become caught between the community and organizational requirements and demands. Other staff may feel that they do not need to do anything themselves if actions are seen as the responsibility of the lead role. As well, staff may wait for the Indigenous person to always speak up first and to do most of the speaking. Even if this is coming from good intentions with a belief of being respectful, everyone has a responsibility to speak and act as an ally. Planning is needed to prevent such a lead role from devolving into one person being responsible for "all things Indigenous". "Burnout" can more easily happen when the lead is in a junior role. There are better results if such a role is a senior position; if the opportunity for the position to be at that level currently does not exist, serious consideration should be given to capacity building to achieve that end.
Two frameworks related to workforce development were suggested for review: the NUKA framework from Alaska, and one from the Centre for Addiction and Mental Health (CAMH).

Governance
High level political aspects cannot be overlooked when developing a reconciliation plan. The goal of self-determination and sovereignty may be defined differently by different First Nations. The following points were shared to illustrate further contextual aspects in relation to governance and potential impacts on thinking about reconciliation.

- Think about true self-determination in relation to traditional forms of government. The current on-reserve governance structure of elected Chief and Council have been imposed by the Indian Act
- A Nation-to Nation relationship is direct between Canada and the various First Nations with co-governance as a goal
- First Nations governments' goal is to reach complete autonomy and are not interested in devolving that authority to anyone else. This involves the unravelling of the current constitutional framework
- The lengthy oppression of South Africa and resulting governmental changes is an example of reconciliation that could be examined
- There are negative perceptions (i.e., seen as too much talking and not enough action) for some grassroots Indigenous community members around the Chiefs of Ontario as a political entity
- Models of working with public health can include formal Memos of Understanding between the health unit and an individual First Nation, as well as Section 50 (Health Promotion and Protection Act) agreements. A question was raised as to how existing Section 50 agreements at other Health Units have been operationalized and how well they are functioning.

Equitable Access and Service Delivery
The impacts of historical trauma, stereotyping, current negative experiences and racism within the healthcare system are major contributors to existing health disparities and inequities. Transportation and language barriers to accessing services continue to exist. It was noted that there can be confusion in primary care settings about supports available through the non-insured health benefit program which in turn can result in inconsistency in working with First Nation clients and/or health centres. There can also be confusion related to geographic boundaries as First Nations territories are not necessarily aligned with administrative boundaries of public health units. Both of these examples reinforce the need for increased knowledge and clarity when public health services are being offered.

Within First Nation communities, the building of wrap-around services for individuals can be limited by funding and human resources. Ideally, community members have options in terms of what health approach is best for them, whether a Western approach, a traditional healer and/or turning to a natural leader in the community for support. This can pose a challenge in trying to achieve balance between Western approaches and traditional approaches within a First Nation community.

It was noted that there is some ongoing ambiguity around jurisdictional issues which may include challenges within First Nations administration, as well as between urban organizations and First Nations. It was commented that the exercising of jurisdiction is of great importance as there can be too much deferral to white organizational authority.

The development of a palliative care team (work of the LHIN Indigenous Health Committee) was shared as an example of successful shift in the system from a service being LHIN-led to Indigenous-led (SOAHAC) that is already having visible impact.

There are examples of organizations, including health care, that have used approaches of Indigenizing Psychology and Western Medicine to address gaps in health disparities and to take a proactive approach to improving supports for Indigenous people who engage in the health system.

Appendix A – Glossary of Indigenous-Related Terminology

Glossary of Indigenous-Related Terms
June 2018

Language is a powerful tool. Public health staff are in a position of power and the language that we use can, and does, impact our clients, whether at an individual or community level.

The correct use of terminology when referring to Indigenous peoples in Canada demonstrates efforts to go beyond the misrepresentations and stereotypes that have been taught over the years by mainstream institutions that have upheld oppressive systems and isolated communities. Through use of appropriate language, we begin to engage in a process of solidarity with Indigenous communities and we educate ourselves on the hundreds of nations that live and walk beside us. Many Indigenous people prefer to be called by their specific nation. For example, "I am Ojibwe from Chippewas of the Thames or Mohawk from Six Nations or Algonquian from Pikwakanagan."

When referring to nations by their proper name, we begin to breakdown generalizations, labels, and overarching terminology that further leads to the false homogeneity that has led to the "one size fits all" approach. Indigenous communities across Canada are very diverse consisting of hundreds of nations with their own distinct dialects, languages, culture, customs and spiritual practices.

As language is continually evolving, it is helpful to stop and check yourself periodically. Some phrases or words that were used to refer to or label people in the past are now considered out-dated, insensitive and offensive.

There are various glossaries available from academia, Indigenous organizations, training centres, and so on related to Indigenous-related terms. This list has terminology selected primarily from the following:

- Indigenous Peoples: A Guide to Terminology. (2015). Indigenous Corporate Training https://www.ictinc.ca/aboriginal-peoples-a-guide-to-terminology
- University of Alberta Native Studies Glossary. (2015). https://www.ualberta.ca/admissions-programs/online-courses/indigenous-canada/glossary
- Terminology Guidelines. (June 2012). National Aboriginal Health Organization (NAHO)
- City of Saskatoon Communications Guide (May 2017) https://www.saskatoon.ca/sites/default/files/documents/community-services/planning-development/ayisinowak_a_communications_guide_web.pdf
- Relationship with Indigenous Communities Guideline. (2018). Ministry of Health and Long-Term Care

Each of these glossaries in their entirety are available via the provided links with the exception of NAHO. NAHO closed in 2012 related to funding, but as part of their closure the agreement was to keep the NAHO website in place for five years. NAHO materials are no longer available online as of December 2017.

This glossary will be reviewed and revised as needed. If you have terminology that you believe should be added, please contact the Indigenous Health Coordinator, Health Equity Core Team, Office of the Chief Nursing Officer.

Some general notes about terminology:

i. Whenever possible, try to use specific identities of Nations to more accurately capture the unique aspects of each Nation and their people.

ii. Indigenous Peoples are heterogeneous and there is not agreement by all Nations on all of the terms below. Differing options and rationale are included as much as possible within each term.

iii. Some of these terms are based within the legal and constitutional systems, such as the Indian Act of 1876.

iv. Use of the term "Indian". "The term Indian is considered outdated by many people, and there is much debate over whether to continue using this term. Use First Nation instead of Indian, except in the following cases:
- in direct quotations
- when citing titles of books, works of art, etc.
- in discussions of history where necessary for clarity and accuracy
- in discussions of some legal/constitutional matters requiring precision in terminology
- in discussions of rights and benefits provided on the basis of Indian status or
- in statistical information collected using these categories (e.g. the census)" *(Terminology Guidelines, NAHO)*

Local input has suggested an additional point to this list, which is that the use of "Indian" is also acceptable in discussions and research of treaty agreements.

v. If any of the sourced definitions included details about grammar, punctuation or usage, this info has been included with the definition.

vi. Multiple definitions are included with some terms so that you can see similarities and differences between them. You will also see some evolution of terminology over time. For example, in 2012, NAHO talks about "Aboriginal" as the preferred term and notes that Indigenous is not a term that is commonly used in Canada but is used more internationally. That has changed and Indigenous is the preferred term by many groups, including the federal government and the provincial government of Ontario.

vii. Regarding punctuation, the following perspective is from *Indigenous Peoples: A Guide to Terminology*. "Always capitalize Indigenous, Aboriginal, First Nation, Inuit, Métis as a sign of respect the same way that English, French and Spanish etc. are

capitalized. Avoid using possessive phrases like “Canada’s Indigenous Peoples” or “our Indigenous Peoples” as that has connotations of ownership. Perhaps go with “Indigenous Peoples of Canada”. We’re not sure why, but the plural possessive for First Nations, Indigenous Peoples, Aboriginal Peoples does not generally use the apostrophe so you won’t see, for example, “First Nations’ land”. Both Métis and Metis are in use. Go with what the people you are working with use. We harken back to our main terminology training tip here which is “always go with what people are calling themselves”. It requires some research but it will be worth the effort.”

viii. No culture remains static, but continually evolves over time. As Indigenous Peoples continue to decolonize their lives, they are free to choose what they would like to be called to reflect that evolving state of being. As time goes on, Indigenous Peoples are acquiring more knowledge and reclaiming their identities. Within the shifting of names, they are reinstating their freedom to choose.

Terminology

Aboriginal Peoples: " 'Aboriginal Peoples' is a collective name for all of the original Peoples of Canada and their descendants. The Canadian Constitution Act of 1982 specifies that the Aboriginal Peoples in Canada consist of three groups: Indians (First Nations), Inuit and Metis. The term 'Indigenous' is increasingly preferred in Canada over the term 'Aboriginal'. Ontario's current practice is to use the term Indigenous when referring to First Nations, Metis and Inuit Peoples as a group, and to refer to specific communities whenever possible. *(Relationship with Indigenous Communities Guideline)*

"Aboriginal Peoples" is a collective name for all of the original peoples of Canada and their descendants. Section 35 of the Constitution Act of 1982 specifies that the Aboriginal Peoples in Canada consist of three groups - Indian (First Nations), Inuit and Metis. It should not be used to describe only one or two of the groups." *(Terminology Guidelines, NAHO)*

"The collective noun used in the Constitution Act 1982 and includes the Indian (or First Nations), Inuit and Metis Peoples so legally it will always have a place at the terminology table.
Can:

- Use interchangeably with First Peoples
- Use interchangeably with First Nations
- Use interchangeably with Indigenous Peoples

Caution: If using interchangeably with First Nations note that some First Nations prefer not to be called Aboriginal Peoples. If using this term, it should always be Aboriginal Peoples together as opposed to Aboriginal or Aboriginals." *(Indigenous Peoples: A Guide to Terminology)*

"The descendants of the original inhabitants of North America. The Canadian Constitution recognizes three groups of Aboriginal Peoples: Indian, Metis and Inuit. These are three separate peoples with unique heritages, languages, cultural practices and spiritual beliefs." *(City of Saskatoon Communications Guide)*

Anishinaabe: "Anishinaabe (or the pluralized term Anishinaabeg) is the name of an Indigenous cultural group consisting of Odawa, Ojibway, Potawatomi, and Algonquin Indigenous peoples. Anishinaabeg peoples' traditional territories span the geographic area of the Northeast and sub-arctic regions of Canada and the United States." *(University of Alberta Native Studies)*
Please note that Algonquin is a language family.

Band: "A band is a community of Indians for whom lands have been set apart and for whom the Crown holds money. It is a body of Indians declared by the Governor-in-Council to be a band for the purposes of the Indian Act. Many bands today prefer to be called First Nations and have changed their name to incorporate First Nation…" *(Terminology Guidelines, NAHO)*
Locally, preferred terminology may include Settlement or First Nation.

"A group of First Nations peoples for whom lands have been set apart and money is held by the Crown…. the members of a band generally share common values, traditions and practices rooted in their ancestral heritage….many bands prefer to be known as First Nations." *(City of Saskatoon Communications Guide)*
Additional note: Language heritage can be considered as part of ancestral heritage or noted separately and specifically. Although the loss of language due to residential schools has been

significant, there are many initiatives and language revitalization efforts in place. Such revitalization needs to continue to be prioritized. The United Nations has deemed 2019 as the "Year of Indigenous Languages".

"The Indian Act defines 'Band', in part, as a body of Indians for whose use and benefit in common, lands have been set apart. Each Band has its own governing Band Council, usually consisting of a Chief and several councillors. The members of the Band usually share common values, traditions and practices rooted in their language and ancestral heritage. Today, many Bands prefer to be known as First Nations. Capitalize "Band" when it is part of a specific band, such as Osoyoos Indian Band, otherwise, use lowercase. *(Indigenous Peoples: A Guide to Terminology)*

Band Council: "This is the governing body for a band. It usually consists of a chief and councillors who are elected for two or three-year terms (under the Indian Act or band custom) to carry out band business, which may include education, health, water and sewer, fire services, community buildings, schools, roads, and other community businesses and services. Unless you are naming a specific band (e.g. the Bonaparte Indian Band), the word band should remain lowercase." *(Terminology Guidelines, NAHO)*

"The Band's governing body. Community members choose the Chief and councillors by election under section 74 of the Indian Act, or through traditional custom. The Band Council's powers vary with each band." *(Indigenous Peoples: A Guide to Terminology)*

Chief: "There are two classifications of Chief:

Band Chief: A person elected by Band members to govern for a specified term. Under the specifications of the Indian Act, First Nations must have an election every two years.

Hereditary Chief: A Hereditary Chief is a leader who has power passed down from one generation to the next along blood lines or other cultural protocols, similar to European royalty." *(Indigenous Peoples: A Guide to Terminology)*

Collective Rights: "Collective rights refers to the Constitutional recognition that Aboriginal peoples possess unique rights which are 'recognized and affirmed' under Section 35." *(University of Alberta Native Studies)*

Colonization: "The act or policy of colonizing; to bring settlers into a country; to make a country into a colony." *(City of Saskatoon Communications Guide)*

"Colonization is a process of establishing a colony in a foreign territory." *(University of Alberta Native Studies)*

Duties: "Aboriginal rights possess duties such as consultation, accommodations, honour of the crown, and fiduciary that help guide legal action." *(University of Alberta Native Studies)*

Elder: "Elders are recognized because they have earned the respect of their community through wisdom, harmony and balance of their actions in their teachings. Elders try to instill respect in their community members for the natural world and that the earth is their mother." *(Indigenous Peoples: A Guide to Terminology)*

"A person who has earned the right to be recognized as an Elder in his/her community and/or in other First Nations communities. Most have a variety of special gifts they have acquired and earned. These Elders have the ability to pass on traditional teachings and provide spiritual guidance." *(City of Saskatoon Communications Guide)*

Fiduciary obligation: "A legal duty described by the Supreme Court as the obligation of one party to look after the well-being of another. Canada has fiduciary obligations to Aboriginal people, meaning that Canada must consult and negotiate with Aboriginal people whenever their interests are concerned." *(Indigenous Peoples: A Guide to Terminology)*

First Nations: "This term generally applies to individuals both with or without Status under the federal Indian Act and therefore should be used carefully in order to avoid confusion. For example, when talking about a program that applies only to Status Indian youth, avoid using the term 'First Nation'. The term 'First Nation' should not be used as a synonym for Aboriginal or Indigenous people because it does not include Inuit or Metis. Some communities have adopted 'First Nation' to replace the term 'band'. Despite the widespread use, there is no legal definition for this term in Canada. There are 133 First Nation communities in Ontario, 127 of which are recognized by the federal Indian Act." *(Relationship with Indigenous Communities Guideline)*

"The term First Nations came into common usage in the early 1980s to replace band or Indian, which some people found offensive. Despite its widespread use, there is no legal definition for this term in Canada. Many people prefer to be called First Nations or First Nations People instead of Indians. The term should not be used as a synonym for Aboriginal Peoples because it doesn't include Inuit or Metis…" *(Terminology Guidelines, NAHO)*

"First Nation is a term used to identify Indigenous peoples of Canada who are neither Métis nor Inuit. This term came into common usage in the 1970s to replace the term "Indian" and "Indian band" which many find offensive. First Nations people includes both status and non-status Indians so there's a need to be careful with its usage, especially if in reference to programs that are specifically for status Indians. There is no legal definition for First Nation and it is acceptable as both a noun and a modifier.
Can:

- Use to refer to a single band or the plural First Nations for many bands
- Use "First Nation community" as a respectful alternative phrase
- Use instead of "Indian" when referring to an individual

Caution:

- If using interchangeably with Aboriginal Peoples as some First Nations people don't like the term Aboriginal Peoples.
- If using interchangeably with First Nations as some may have more preference for Indigenous Peoples, for example First Nation communities in Ontario have expressed publicly and politically that they prefer Indigenous Peoples" *(Indigenous Peoples: A Guide to Terminology)*

"…Although the term 'First Nation' is widely used, no legal definition of it exists. Among its uses, the term 'First Nations peoples' refers to the descendants of the original inhabitants of Canada. The term 'First Nation' has also been adopted to replace the word 'band' in the name of communities." *(City of Saskatoon Communications Guide)*

Friendship Centres: "First established in 1951, Friendship Centres work to address the needs of urban and recently urbanized First Nations, Metis and Inuit. Friendship Centres acts as hubs of Indigenous culture and provide information on employment and housing opportunities, spaces for ceremony and organize community-building activities." *(University of Alberta Native Studies)*

"Friendship Centres are community hubs where Indigenous people living in towns, cities, and urban centres can access culturally-based and culturally-appropriate programs and services every day. Today, Friendship Centres are dynamic hubs of economic and social convergence that create space for Indigenous communities to thrive. Friendship Centres are idea incubators for young Indigenous people attaining their education and employment goals, they are sites of cultural resurgence for Indigenous families who want to raise their children to be proud of who they are, and they are safe havens for Indigenous community members requiring supports… programs and initiatives that span justice, health, family support, long-term care, healing and wellness, employment and training, education, research, and more. Friendship Centres receive their mandate from their communities, and they are inclusive of all Indigenous people – First Nation, Status/Non-Status, Métis, Inuit, and those who self-identify as Indigenous." *(Ontario Federation of Indigenous Friendship Centres,* http://www.ofifc.org/)

"The N'Amerind (London) Friendship Centre is a non-profit organization committed to the promotion of physical, intellectual, emotional and spiritual well-being of Native people and in particular, Urban Native People. The commitment is realized through the implementation of culturally relevant programs aimed at social, recreational and educational needs, at developing leadership, at increasing awareness levels of native heritage, establishing resources for community development, and in promoting the development of urban aboriginal self-governing institutions." *(N'Amerind Friendship Centre,* http://www.namerind.on.ca/) N'Amerind Friendship Centre is located at 260 Colborne Street, London.

Indian: "…Indian Peoples are First Nation Peoples recognized as Aboriginal in the Canadian Constitution Act of 1982. In addition, three categories apply to Indians in Canada: Status Indians, Non-Status Indians, and Treaty Indians. The term "Indian" refers to the legal identity of a First Nations person who is registered under the federal Indian Act. The term 'Indian' should be used only when referring to a First Nations person with status under the Indian Act, and only within its legal context. Aside from this specific legal context, the term 'Indian' in Canada is consider outdated and maybe considered offensive due to it complex and often idiosyncratic colonial use in governing identity through this legislation and a myriad of other distinctions (i.e., 'treaty' and 'non-treaty', etc.)" *(Relationship with Indigenous Communities Guideline)*

"A person who is registered as an Indian or is entitled to be registered as an Indian under the *Indian Act*. A term that describes all the Aboriginal People in Canada who are not Inuit or Metis. Indian peoples are one of three groups of people recognized as Aboriginal in the *Constitution Act,* 1982. There are three definitions that apply to Indians in Canada: Status Indians, Non-Status Indians and Treaty Indians. The use of the term "Indian" has declined since the 1970s, when the term "First Nation" came into common usage." *(City of Saskatoon Communications Guide)*

"The term Indian collectively describes all the Indigenous People in Canada who are not Inuit or Metis. Indian Peoples are one of three peoples recognized as Aboriginal in the Constitution Act of 1982 along with Inuit and Metis. In addition, three categories apply to Indians in

Canada: Status Indians, Non-Status Indians and Treaty Indians…." *(Terminology Guidelines, NAHO)*

"'Indian' is the legal identity of an Indigenous person who is registered under the Indian Act.
Can:

- Use in direct quotations
- Use when citing titles of books, works of art, etc.
- Use in discussions of history where necessary for clarity and accuracy
- Use in discussions of some legal/constitutional matters requiring precision in terminology
- Use in discussions of rights and benefits provided on the basis of "Indian" status
- Use in statistical information collected using these categories (e.g., the Census)"

Caution: If using in front of individuals some may deem it as derogatory and outdated and call you out on it." *(Indigenous Peoples: A Guide to Terminology)*

Indian Act: "Canadian legislation first passed in 1876 and amended many times since then; defines an Indian in relation to federal obligation and sets out a series of regulations applying to Indians living on reserves." *(City of Saskatoon Communications Guide)*

Indigenous: "Indigenous means 'native to the area'. It is the preferred collective name for the original people of Canada and their descendants. This includes First Nations (status and non-status), Metis and Inuit. It is important to remember that each Indigenous nation in the larger category of 'Indigenous' has its own unique name for its community (e.g., Cree, Ojibway, Inuit)." *(Relationship with Indigenous Communities Guideline)*

"Indigenous means 'native to the area'. In this sense, Aboriginal Peoples are indeed indigenous to North America. Its meaning is similar to Aboriginal Peoples, Native Peoples or First Peoples. …As a proper name for a people, the term is capitalized; otherwise it is lower case." *(Terminology Guidelines, NAHO)*

Inuit: "Inuit homelands in Canada are found in the far north, including Nunavut, the Northwest Territories, the Yukon, northern Quebec and Labrador. There are no Inuit traditional territories in Ontario. Inuit live in the province in urban centres or other municipalities…and may be represented through distinct educational, social service and political organizations." *(Relationship with Indigenous Communities Guideline)*

"Inuit are a circumpolar people, inhabiting regions in Russia, Alaska, Canada and Greenland, united by a common culture and language. There are approximately 55,000 Inuit living in Canada.…the Indian Act does not cover Inuit. However, in 1939, the Supreme Court of Canada interpreted the federal government's power to make decisions affecting--Indians, and Lands reserved for the Indians—as extending to Inuit." *(Terminology Guidelines, NAHO)*

"Indigenous people in northern Canada, living mainly in Nunavut, Northwest Territories, northern Quebec and Labrador. Ontario has a very small Inuit population. Inuit are not covered by the Indian Act.
Can:

- Use Inuk when referring to an individual Inuit person
- Use Inuuk when referring to two people; for three or more people, it is Inuit

- Inuit People - in the Inuktitut language the term Inuit translates to "the people".

Caution:

- Eskimo as it is considered derogatory. Here's some more information on terminology related to Inuit Peoples of the World https://www.ictinc.ca/blog/inuit-people-of-the-world .
- Inuit are not the same as Innu as Innu are an Indigenous group that primarily live in northeastern Quebec and southern Labrador." *(Indigenous Peoples: A Guide to Terminology)*

Ottawa has the largest population of Inuit living in the south. Estimates place the population at least 3700 and up to 6000. http://www.cbc.ca/news/canada/ottawa/woefully-inaccurate-inuit-population-ottawa-1.4391742

Knowledge Keeper: "Knowledge keepers hold traditional knowledge and information passed down through oral history, customs and traditions which encompass beliefs, values, worldviews, language, and spiritual ways of life." *(Carleton University,* https://carleton.ca/indigenous/resources/guidelines-for-working-with-elders/)

League of Haudenosaunee: "The League of Haudenosaunee has several other names including: Haudenosaunee Confederacy, Iroquois League, League of the Five Nations, Six Nations. Specifically, the League of Haudenosaunee is made up of six nations, the Seneca, Cayuga, Oneida, Onondaga, Mohawk and Tuscarora. Together they are guided and governed by Kaianere'ko:wa, or the Great Law of Peace." *(University of Alberta Native Studies)*
An additional name is the Iroquois Confederacy.

Metis: "The Metis are a distinct people with mixed First Nations and European heritage with their own customs and recognizable group identity. Metis representative organizations may have differing criteria for who qualifies as Metis under their particular mandates." *(Relationship with Indigenous Communities Guideline)*

"The word Metis is French for "mixed blood". Section 35 of the Constitution Act of 1982 recognizes Metis as one of the three Aboriginal Peoples…..today, the term is used broadly to describe people with mixed First Nations and European ancestry who identify themselves as Metis. Note that Metis organizations have differing criteria about who qualifies as a Metis person." *(Terminology Guidelines, NAHO)*

"Many people and groups, particularly in the west and the North, have dropped the accent in Metis. In keeping with the Metis National Council, NAHO will use the accent. Nevertheless, it is best to check the names of individual Metis organizations before you publish them." *(Terminology Guidelines, NAHO)*

"The Metis are a post-contact Indigenous people of the Canadian west. The ethnogenesis of the Metis is situated in the fur trade as European men married into Indigenous (Cree, Ojibway, Saltueax) families. The offspring of these unions eventually spawned their own communities that nurtured their own unique language (Michif), culture, and a sense of nationalistic aspirations." *(University of Alberta Native Studies)*

"People of mixed Aboriginal and European ancestry. The Métis National Council adopted the following definition of "Métis" in 2002: "Métis" means a person who self-identifies as Métis, is

distinct from other Aboriginal peoples, is of historic Métis Nation Ancestry and who is accepted by the Métis Nation." *(Indigenous Peoples: A Guide to Terminology)*

"People born of, or descended from, both European and First Nations parents. A distinctive Metis Nation developed in what is now south Manitoba in the 1800s, and the descendants of these people later moved throughout the prairies. There are also many other groups of mixed ancestry people who consider themselves Metis." *(City of Saskatoon Communications Guide)*

Native: "Native is a word similar in meaning to Aboriginal. Native Peoples is a collective term to describe the descendants of the original peoples of North America. The term is increasingly seen as outdated (particularly when used as a noun) and is starting to lose acceptance." *(Terminology Guidelines, NAHO)*

"A becoming gradually outdated collective term referring to Indians (Status, Nonstatus, Treaty), Métis, and Inuit but has largely been replaced by Indigenous. While some First Nations individuals refer to themselves as "Native" that doesn't necessarily give non-Indigenous people license to do so.
Can:

- Use when working with organizations such as the Native Women's Association of Canada
- Use when an individual self-identifies using this term.

Caution:

- Use it sparingly as some see it as derogatory and outdated. The term was popular in the colonial and settler era. *(Indigenous Peoples: A Guide to Terminology)*

"A person born in a specified place; a local inhabitant; a member of an Indigenous people of a country, region, etc. as distinguished from settlers, immigrants and their descendants." *(City of Saskatoon Communications Guide)*

Non-Status Indian: "Non-Status Indians are people who consider themselves Indians or members of a First Nation but whom the Government of Canada does not recognize as Indians under the *Indian Act*, either because they are unable to prove their Indian status or have lost their status rights. Non-Status Indians are not entitled to the same rights and benefits available to Status Indians." *(Terminology Guidelines, NAHO)*

"An Indian person who is not registered as an Indian under the *Indian Act.* This may be because his or her ancestors were never registered or because he or she lost Indian status under former provisions of the *Indian Act.*" *(City of Saskatoon Communications Guide)*

It is important to note here how the Indian Act has affected status for Indigenous women. Many Indigenous women lost their right to pass on their Indian status if they married outside of their own Nation. If they married a non-First Nation person, they lost their own status and their ability to pass on treaty rights to their children and so on. Bill C3 was passed in 2011 which meant that after years of discrimination, many women, as well as their children, could finally regain their status. Years of systematic discrimination has led to Indigenous women experiencing some of the highest levels of violence and crime victimization. These factors have been linked to the numbers of under-reported and undocumented levels of hundreds of missing and murdered Indigenous women across Canada. The effort of the Canadian Government to dismantle matrilineal bloodlines has been known across nations and has had a detrimental effect on the strength and relevancy of Indigenous women in the value they held

pre-contact. In 2017, even more efforts to establish equality for Indigenous Women in Canada was introduced with the Gender Equality changes to the Indian Act. This is where the right of First Nation women to be able to pass on rights through their bloodline is re-established.

Numbered Treaties: "Treaties signed between 1871 and 1921, each numbered 1 to 11, through the North and West. All contained some rights conferred on Indians, such as reserves and annuities, and in return the First Nations agreed to share vast tracts of land." *(City of Saskatoon Communications Guide)*

Reserve: "A reserve is the land that is set aside by the Crown for the use and benefit of a band in Canada. Many First Nations now prefer the term First Nation community and no longer use reserve. Only capitalize reserve when used as part of a name, otherwise it should remain lowercase….Do not write "off-reserve Aboriginal people as neither the Metis nor Inuit live on reserves." *(Terminology Guidelines, NAHO)*

"Defined by the Indian Act as '… tract of land, the legal title to which is vested in Her Majesty, that has been set apart by Her Majesty for the use and benefit of a band.' A result of the definition of reserve land in the Indian Act is that reserve land cannot be privately owned by the Band or Band members. 'Reservation' is an American term." *(Indigenous Peoples: A Guide to Terminology)*

Self-determination: "A major objective of Aboriginal Peoples, country-wide, is to gain control over who can become members. Currently, bands are required to maintain a registry with many of the rules governing membership mandated by the Indian Act. As we move into the future, the desire is for communities to decide who their members are, and not be directed by a bureaucrat in Ottawa. Self-determination is the right to decide who your people are." *(Indigenous Peoples: A Guide to Terminology)*

"Self-determination refers to Indigenous peoples' right to freely determine their political status and pursue their economic, social and cultural development, unchallenged and away from state control." *(University of Alberta Native Studies)*

"The freedom of a people to decide their own allegiance or form of government." *(City of Saskatoon Communications Guide)*

Self-government: "Long before Europeans arrived in Canada, First Peoples were self-governing. In 1876, when the Indian Act went into effect, traditional governance systems were dismantled and alien regulations were imposed in their place. When we take a look at the day-to-day operations of a band we see that all the actions of the band are directed in accordance with the Indian Act. This is a huge problem for bands, and their politicians, because it means that while they are elected by their people they are accountable to the department of Aboriginal Affairs and Northern Development of Canada. Their preference would be to change to a system where the governing leaders are elected and accountable to their people. Such models do exist and the communities with self-government agreements have done well in terms of the nation building process." *(Indigenous Peoples: A Guide to Terminology)*

"The concept of self-government means that political bodies representing Indigenous peoples have the right to create and govern their own affairs. Aboriginal self-government in Canada refers to the state acknowledging and granting Aboriginal political organizations greater power in managing their own affairs." *(University of Alberta Native Studies)*

"Government by its own people; self-control." *(City of Saskatoon Communications Guide)*

Self-identification: "Self-identification refers to the voluntary, confidential, self-described declaration of Aboriginal identity." *(Indigenous Peoples: A Guide to Terminology)*

"Status Blindness": "Status blindness" refers to services and programs offered in urban centres being available to all Aboriginal people, no matter if they are status, non-status, Metis, Inuit, etc." *(University of Alberta Native Studies)*

Status Indians: "Status Indians are people who are entitled to have their names included on the Indian Register, an official list maintained by the federal government. Certain criteria determine who can be registered as a Status Indian. Only Status Indians are recognized as Indians under the *Indian Act* and are entitled to certain rights and benefits under the law." *(Terminology Guidelines, NAHO)*

Traditional Territory: "The geographic area identified by a First Nation to be the area of land which they and/or their ancestors traditionally occupied or used." *(Indigenous Peoples: A Guide to Terminology)*

Treaty: "An agreement between government and a First Nation that defines the rights of Aboriginal Peoples with respect to lands and resources over a specified area, and may also define the self government authority of a First Nation. Modern treaties, once ratified, become part of the law of the land." *(Indigenous Peoples: A Guide to Terminology)*

"Formally conducted, concluded and ratified agreement between states; an agreement between individuals or parties, especially for the purchase of property." *(City of Saskatoon Communications Guide)*

Treaty Indians: Treaty Indians are descendants of Indians who signed treaties with Canada and who have a contemporary connection with a treaty band…" *(Terminology Guidelines, NAHO)*

Tribe: "A tribe is a group of Native Americans sharing a common language and culture. The term is used frequently in the United States, but only in a few areas of Canada (e.g. the Blood Tribe in Alberta)." *(Terminology Guidelines, NAHO)*

Wendat (Wyandot/Huron) people: The Wendat (Wyandot/Huron) are Indigenous people of North America. Their traditional territory was located within the Saint Lawrence Valley, however, due to various wars and treaties they migrated and formed communities in the Great Lakes region." *(University of Alberta Native Studies)*

Upper Canada Treaties: Also known as the Upper Canada Land Surrenders, these agreements constitute an estimated number of 30 treaties covering much of what is now southwestern Ontario. Likely the first of these was Michilimackinac Island, No. 1, signed in 1781, and presumably the last was the Manitoulin Island Treaty, signed in 1862. www.thecanadianencyclopedia.ca/en/article/aboriginal-treaties/

Urban Indigenous Communities: "This term refers primarily to First Nation, Inuit and Metis individuals currently residing in urban areas. According to 2016 Census data, the urban

Indigenous population continues to be one of the fastest growing segments of Canadian society. It is important to note that there are indications that the Census may undercount urban Indigenous populations in some areas of Ontario. They are at risk of non-participation in the Census due to factors such as increased rates of mobility and its associated lack of living at a fixed address, historical distrust of government due to past and present colonial policies and migration between geographical locations." *Relationship with Indigenous Communities Guideline)*

2018-June-18

Appendix B – Sample Suggested Reading List

These books are just a small representation of works by (Canadian) Indigenous and settler authors; all are related to aspects of Indigenous cultures, lives, history, and experiences. They include fiction, non-fiction, memoirs, short stories, narratives and academic analyses.

Most are available from the London Public Library system and/or the Middlesex County Library system. A few are only available via the Western University Library system, which can be accessed via MLHU Library Services. If not available via the library system, they are available to purchase.

In the chart below, the library systems are identified in the "library availability" column as:
LPL: London Public Library
M: Middlesex County Library

Author	**Title**	**Publication Date**	**Category**	**Library Availability**
Barker, Adam J., Lowman, Emma Battell	Settler: Identity and Colonialism in the 21st Century	2015	Non-fiction	LPL
Bartleman, James	Raisin Wine: A Boyhood in a Different Muskoka	2008	Memoir	LPL; M
Benton-Banai, Edward	The Mishomis Book: the Voice of the Ojibway	2010	Traditional stories & teachings	Not available via the library system
Bourassa, Carrie; McKenna, Elder Betty; Juschka, Darlene (eds)	Listening to the Beat of Our Drum: Indigenous Parenting in Contemporary Society	2017	Non-fiction	Western University
**Boyden, Joseph (see note at end of this list)	Born with A Tooth	2001	Short stories	LPL; M
	The Orenda	2013	Fiction	LPL; M
	Three Day Road	2005	Fiction	LPL; M
	Through Black Spruce	2008	Fiction	LPL; M
	Wenjack	2016	Fiction	LPL; M
Campbell, Maria	Half-Breed	1983	Memoir	LPL
Campbell, Maria; Cardinal, Tantoo; Highway, Tomson;	Our Story: Aboriginal Voices on Canada's Past	2005	Narrative	LPL

Johnston, Basil; King, Thomas; Maracle, Brian; Maracle, Lee; Marchessault, Jovette; Qitsualik, Rachel; Taylor, Drew Hayden				
Caron, Maia	Song of Batoche	2017	Fiction	LPL
Daniels, Carol	Bearskin Diary	2015	Fiction	LPL
Daschuk, James	Clearing the Plains: Disease, Politics of Starvation and the Loss of Aboriginal Life	2013	Non-fiction	LPL; M
Dimaline, Cherie	The Marrow Thieves	2017	Young Adult	LPL; M
Dumont, Marilyn	A Really Good Brown Girl	2015	Poetry	LPL
Dupuis, Jenny Kay & Kacer, Kathy	I Am Not a Number	2016	Children	LPL; M
Florence, Melanie	He Who Dreams	2017	Fiction	LPL
Geddes, Gary	Medicine Unbundled: A Journey Through the Minefields of Indigenous Health Care	2017	Non-fiction	LPL
Gehl, Lynn	Claiming Anishnaabe: Decolonizing the Human Spirit	2017	Non-fiction	Western University
Gray Smith, Monique	Speaking Our Truth	2017	Young Adult	LPL; M
	You Hold Me Up	2017	Children	LPL; M
Greenwood, Margo; de Leuw, Sarah; Lindsay, Nicole Marie; Reading, Charlotte (eds)	Determinants of Indigenous Peoples' Health in Canada: Beyond the Social	2015	Non-fiction	MLHU library
Hargreaves, Allison	Violence Against Indigenous Women: Literature, Activism, Resistance	2017	Non-fiction	Western University
Hayes, Adrian	Pegahmagabow: Legendary Warrior, Forgotten Hero	2003	Non-fiction	Western University
Highway, Tomson	Kiss of the Fur Queen	1999	Fiction	LPL; M
Joseph, Bob	21 Things You May Not Know about the Indian Act: Helping Canadians Make Reconciliation with Indigenous Peoples a Reality	2018	Non-fiction	LPL
Kinew, Wab	The Reason You Walk: A Memoir	2015	Memoir	LPL; M

King, Thomas	An Inconvenient Indian: A Curious Account of Native People in North America	2012	Commentary	LPL; M
	Green Grass, Running Water	2010	Fiction	LPL; M
Lux, Maureen K.	Separate Beds: A History of Indian Hospitals, 1920s-1980s	2016	Non-fiction	Western University (e-book only so not available via inter-loan)
Maracle, Lee	Celia's Song	2014	Fiction	LPL
	I Am Woman: a native perspective on sociology and feminism	1996	Non-fiction	LPL: M
Marks, Don	They Call Me Chief: Warriors on Ice	2008	Memoir	Not available via the library system
McCall, Sophie; Reder, Deanna; Gaertner, David; L'Hirondelle Hill, Gabrielle (eds)	Read, Listen, Tell: Indigenous Stories from Turtle Island	2017	Narrative	Western University (e-book only so not available via inter-loan
McInnes, Brian D.	Sounding Thunder: the Stories of Francis Pegahmagabow	2016	Non-fiction	LPL
Merasty, Joseph Auguste	The Education of Augie Merasty: A Residential School Memoir	2015	Memoir	LPL; M
Metatawabin, Edmund	Up Ghost River: A Chief's Journey Through the Turbulent Waters of Native History	2015	Memoir	LPL; M
Metcalfe-Chenail, Danielle (ed)	In This Together: Fifteen Stories of Truth and Reconciliation	2016	Narrative	LPL
Monchalin, Lisa	The Colonial Problem: An Indigenous Perspective on Crime and Injustice in Canada	2016	Non-fiction	Western University
Porter, Tom	And Grandma said…	2008	Memoir	Not available via the library system

Regan, Paulette	Unsettling the Settler Within: Indian Residential Schools, Truth Telling, and Reconciliation in Canada	2011	Non-fiction	LPL; M
Robertson, David Alexander	Sugar Falls: A Residential School Story	2012	Graphic novel	LPL; M
	When We Were Alone	2016	Children	LPL
Robinson, Eden	Son of a Trickster	2017	Fiction	LPL; M
	Monkey Beach	2001	Fiction	LPL; M
Scofield, Gregory	Thunder Through My Veins: Memories of a Metis Childhood	1999	Memoir	LPL
Sellars, Bev	They Called Me Number One: Secrets and Survival at an Indian Residential School	2012	Memoir	LPL; M
Simpson, Leanne	Dancing On Our Turtle's Back: Stories of Nishannbeg Re-creation, Resurgence, and a New Emergence	2011	Narrative	Western University
Tait, Myra & Ladner, Kiera (eds)	Surviving Canada: Indigenous People Celebrate 150 Years of Betrayal	2017	Reflections	LPL
Talaga, Tanya	Seven Fallen Feathers: Racism, Death, and Hard Truths in a Northern City	2017	Non-fiction	LPL; M; MLHU
Taylor, Drew Hayden	The Best of Funny, You Don't Look Like One	2015	Short Stories	Not available. An earlier collection from 2002 available at Western University
	The Night Wanderer: A Native Gothic Novel	2007	Fiction, Young Adult	LPL; M
	Motorcycles and Sweetgrass	2010	Fiction	LPL; M
Van Camp, Richard	The Lesser Blessed (book)	1996	Fiction	M
	The Lesser Blessed (DVD)	2012	----------	LPL; M
Vermette, Katherena	The Break	2016	Fiction	LPL; M
Wagamese, Richard	Indian Horse	2012	Fiction	LPL; M
	Embers	2016	Meditations	LPL; M
	Medicine Walk	2014	Fiction	LPL; M

	Keeper'n Me	2006	Fiction	LPL
Wilson, Tom	Beautiful Scars: Steeltown Secrets, Mohawk Skywalkers and the Road Home	2017	Memoir	LPL; M

** Re: Joseph Boyden. Some of you may be familiar with the controversy around Joseph Boyden and his identification as Indigenous. It raised questions about who has the right to speak for the Indigenous community and stimulated dialogue within Indigenous and non-Indigenous communities. If interested in knowing more, check out: http://www.cbc.ca/radio/thecurrent/the-current-for-january-5-2017-1.3921340/indigenous-identity-and-the-case-of-joseph-boyden-1.3922327

June 2018

Appendix C – Internal Inventory

Working with Indigenous Populations
Middlesex-London Health Unit Internal Inventory (current as of February 2018)

Division	Team	Contact Name	Program/Broad "Topic"	Populations (specify which Nation and/or urban)	Activities
Healthy Start	Reproductive	Tracey Ashby, PHN, ext. 2270	FASD	All 3 Nations	i. Planning committee for FASD conference, collaborative effort of the 3 Nations. One conference was held in February 2018, and another one is being planned for September 2018
Healthy Start	Reproductive	Melissa Lonnee, PHN, ext. 2351	Prenatal	Urban: SOAHAC	i. Part of the "Wholistic Prenatal Program" offered by SOAHAC. Program is currently undergoing some reorganization (Jan 2018)
Healthy Start	Early Years	Catherine Winspear, PHN, ext. 2335	Aboriginal Book Bundles	Aboriginal Book Bundles are available at all 3 Nations, plus N'Amerind.	i. Supports the distribution of bundles by encouraging families to connect with the First Nation communities to receive the book bundles. ii. Participates in assembly of the book bundles.
Healthy Start	Early Years	Catherine Winspear, PHN, ext. 2335	Early years growth & development	Committee has representation from all 3 Nations plus	i. Joint committee that organizes the Prenatal Health Fairs at the 3 Nations. Shares

				N'Amerind, Merrymount, Atlohsa Native Family Healing Services, SOAHAC-Chippewa, Mnaasged	programming updates and provides a connecting link between the groups working with Indigenous families.
Healthy Start	Early Years	Catherine Winspear, PHN, ext. 2335	Parenting	All 3 Nations and N'Amerind	i. Will provide parenting education sessions on topics related to children less than 3 years upon request.
Healthy Start	Best Beginnings & Nurse Family Partnership (NFP)	Managers: Kathy Dowsett, ext. 2325; Isabel Resendes, ext. 2248; Jenn Proulx, ext. 2687	Prenatal and postnatal families with risk (identified via screening) as part of the HBHC and NFP programs that are available to all community members	Urban only	i. Home visits as per HBHC protocol and NFP protocol ii. Community Advisory Board for Nurse Family Partnership has representation from SOAHAC
Office of the Medical Officer of Health	Communications	Brooke Clark, PHN, ext. 2369	Health Care Provider Outreach	Health care centres in the 3 Nations, plus SOAHAC (as part of program to all health care providers within London & Middlesex)	i. Office visits to Health Care Providers in the community on an annual basis (provision of screening tools, info about resources). Includes provision of resources upon request. ii. Provision of a HCP binder on an annual basis

					(focused on info for patients) iii. Annual clinical day for physicians (Focus on 2-3 key topics at each event) iv. Monthly newsletter v. Is able to pull together focus groups of health care providers
Healthy Living	Oral Health	Misty Deming, Manager, ext. 2232 + Cindy Holden, dental hygienist, ext. 2553	Oral Health Screening as per Public Health Standards	3 Nations. Children residing outside of the Nations are screened as per the general population of their school/ daycare	i. Surveillance and oral screening within day cares and schools ii. Provision of the Healthy Smiles Ontario program
Healthy Living	Healthy Communities & Injury Prevention	Sandy Richardson, PHN, ext. 2412	Workplace Health and Wellness	Oneida Nation of the Thames (Ida Cornelius-health care administrator)	i. Presentations on workplace health-e.g. stress ii. Contact point for all HU resources/services related to workplace health
Healthy Living	Healthy Communities & Injury Prevention	Berthe Streef, PHN, ext. 2413	Physical Activity	All 3 Nations	i. Presentation at the Community Aboriginal Recreation Activator (CARA) Regional training (June 2018) (physical literacy for early years). There may be future opportunities.

Healthy Living	Healthy Communities & Injury Prevention	Meagan Melling, PHN, ext. 2223	Child Safety	Oneida Nation of the Thames	i. Promotion of child safety, particularly booster seats in relation to child passenger safety
Healthy Living	Child Health	Darrell Jutzi, Manager, ext. 2284	Growth & Development, Elementary School Curriculum	Antler River School (Chippewas of the Thames First Nation)	i. New opportunity as of January 2018 to provide curriculum support, in collaboration with the Sexual Health Team
Healthy Living	Chronic Disease Prevention & Tobacco Control	Ellen Lakusiak, Dietitian, ext. 2694	Middlesex-London Food Policy Council (MLFPC)	All 3 Nations + urban populations	i. There is a designated voting position on the Council for a person who is Indigenous. Current person is not local, but is a registered dietitian from Six Nations of the Grand River who does some work in the Middlesex London area. The Council aims to include consideration of an Indigenous perspective in any food policy discussions at MLFPC. ii. Hosting a food literacy networking event on March 2, 2018. Indigenous groups who do food skills programming have been invited to attend.
Healthy Living	Chronic Disease Prevention & Tobacco Control	Kim Loupos, Dietitian, ext. 2353	Harvest Bucks program (food access & food literacy)	3 Nations and Urban (via Indigenous community service providers). i.e.	i. Harvest Bucks is not specific to Indigenous populations-all organizations that provide food literacy programming

				Mnaasged: serves Chippewas of the Thames, Munsee-Munsee Delaware First Nation, Oneida Nation of the Thames, plus others; SOAHAC and other Urban recipients	in Middlesex-London are eligible to apply.
Healthy Living	Chronic Disease Prevention & Tobacco Control	Sarah Neil, PHN, ext. 2411; Janet Schaule, PHN, ext. 2679	Smoking Cessation	Urban	i. Smoking cessation services are focused on "priority populations" so may have clients from Indigenous population ii. Promote availability of options for nicotine replacement therapy (applicable to First Nations communities as well as urban populations)
Healthy Living	Chronic Disease Prevention & Tobacco Control	Sarah Neil, PHN, ext. 2411; Janet Schaule, PHN, ext. 2679	Smoking Cessation Community of Practice	Urban (SOAHAC); 2 Nations (Munsee-Delaware, Chippewas of the Thames)	i. Support for a community of practice to increase capacity for smoking cessation. Has members who are Indigenous.
Healthy Living	Young Adult	Anita Cramp, Manager, ext. 2242	Secondary School Services	Urban	i. During one-to-one sessions which are available to all students, there may be some contact with Indigenous students

Environmental Health & Infectious Diseases	Sexual Health and The Clinic	Leanne Powell, PHN, ext. 2353	Growth & Development, Elementary School Curriculum	Antler River School (Chippewas of the Thames)	i. Provision of presentations to grades 5-8 for healthy growth and development, i.e. healthy sexuality ii. Participate in health fairs at the 3 Nations (upon invitation) iii. Participate in health fairs at N'Amerind (upon invitation)
Environmental Health & Infectious Diseases	Safe Water, Rabies and Vector Borne Disease	Fatih Sekercioglu, Manager, ext. 2315	i. Safe Water ii. Rabies	3 Nations	i. Water bottle test kits for private well water (provided at community health centres) ii. Refer animal bite investigations to Health Canada PHIs (when notified by health care providers)
Environmental Health & Infectious Diseases	Infectious Diseases Control	Mary Lou Albanese, Manager, ext. 2538	Reportable diseases and outbreak investigations	Could be 3 Nations and urban-all of these are part of their work, not specifically targeted at Indigenous populations	i. Outbreak investigation at Oneida Nation of the Thames ii. Reportable disease follow-up iii. Inspections
Environmental Health & Infectious Diseases	Emergency Preparedness	Sean Bertleff, Manager, ext. 2371 and Lynn Vander Vloet, PA, ext. 2539	Fit-Testing Clinics	Chippewas of the Thames First Nation (could be available to others upon request)	i. Fit-testing for PSW students at Chippewas of the Thames First Nation

Appendix D– Sample Resource List

Resource List (February 2018)

The following list is not exhaustive. It includes selected links to other organizations, events and resources that can support ongoing learning about Indigenous populations. The list is not specific to health, but supports learning about other social determinants of health, including the impacts of ongoing colonialism and racism within Canada.

Organizations:

- National Collaborating Centre for Aboriginal Health (NCCAH), www.nccah.ca
- Reconciliation Canada, http://reconciliationcanada.ca/
- First Nations Health Authority, http://www.fnha.ca/
- First Nations Information Governance Centre, www.fnigc.ca
- National Centre for Truth and Reconciliation, www.nctr.ca
- Ministry of Indigenous Relations and Reconciliation, https://www.ontario.ca/page/ministry-indigenous-relations-and-reconciliation
- Indigenous Services Canada, https://www.canada.ca/en/indigenous-services-canada.html
- Crown-Indigenous Relations and Northern Affairs Canada, https://www.canada.ca/en/indigenous-northern-affairs.html
- Well Living House Action Research Centre for Indigenous Infant, Child, and Family Wellbeing, http://www.welllivinghouse.com/

Videos:

- "Finding Heart" video (about Dr. Peter Bryce, "whistle blower" from ~ 1907 about the terrible conditions in residential schools) ~ 14 minutes. https://www.youtube.com/watch?v=V1NQ_tgR_oA
- "Home Fire-Ending the Cycle of Family Violence" (2014), ~37 minutes. Restorative justice and family violence. Native Counselling Services of Alberta. http://www.ncsa.ca/programs/education/bearpaw-research-training-communication/home-fire-documentary/
- "8th Fire". (2011). CBC TV with host Wab Kinew. 4 episodes with each episode being about 45 minutes.
    - i. Indigenous in the city

  - ii. It's Time!
  - iii. Whose Land Is It Anyway?"
  - iv. At the Crossroads.

  The DVD is available at London Public Library. http://www.cbc.ca/8thfire/

- "We Were Children" (2012). National Film Board & Eagle Vision production. A Canadian documentary film about the experiences of First Nations children in the residential school system, ~85 minutes in length. Available from London Public Library.

- "Surviving the Survivor" (2010). CBC segment by Wab Kinew. ~ 8 minutes in length. https://www.youtube.com/watch?v=EPX9a5r6uAQ

Online/TV/Radio/Podcasts:

- "Indigenous Canada", (a massive open online course-MOOC), University of Alberta. https://www.coursera.org/learn/indigenous-canada

- mediaINDIGENA, a weekly Indigenous current affairs podcast. http://www.mediaindigena.com/

- Unreserved (host: Rosanna Deerchild), CBC Radio. http://www.cbc.ca/radio/podcasts/current-affairs-information/unreserved/

- APTN (Aboriginal Peoples Television Network). http://aptnnews.ca/

Provincial Government Documents

- The Journey Together: Ontario's Commitment to Reconciliation with Indigenous Peoples. (2016). https://www.ontario.ca/page/journey-together-ontarios-commitment-reconciliation-indigenous-peoples

- Walking Together: Ontario's Long-Term Strategy to End Violence Against Indigenous Women. (2016), and the One-Year Progress Report (2017). https://www.ontario.ca/page/walking-together-ontarios-long-term-strategy-end-violence-against-indigenous-women

Events:

- Orange Shirt Day, annually on September 30. "The annual Orange Shirt Day on September 30th opens the door to global conversation on all aspects of Residential Schools. It is an opportunity to create meaningful discussion about the effects of Residential Schools and the legacy they have left behind. A discussion all Canadians can tune into and create bridges with each other for reconciliation. A day for survivors to be reaffirmed that they matter, and so do those that have been affected. Every Child Matters, even if they are an adult, from now on…Orange Shirt Day is also an opportunity for First Nations, local governments, schools and communities to come together in the spirit of reconciliation and hope for generations of children to come." http://www.orangeshirtday.org/

Examples of local events: Promoted by SOAHAC in 2016. Mount Elgin Residential School Monument held an event in 2017. Atlohsa is holding an event at the Central Library on Sept. 27, 2018.

- National Indigenous Peoples Day (formerly known as National Aboriginal Day), annually on June 21. "In cooperation with national Indigenous organizations, the Government of Canada designated June 21 National Indigenous Peoples Day, a celebration of Indigenous culture and heritage. This date was chosen because it corresponds to the summer solstice, the longest day of the year, and because for generations, many Indigenous groups have celebrated their culture and heritage at this time of year." https://www.canada.ca/en/canadian-heritage/campaigns/celebrate-canada-days/aboriginal-day.html

- Memorial for Murdered and Missing Indigenous Women and Girls, annually on February 14. N'Amerind participates in this memorial event. Sample media coverage from 2018: http://thefirstnationscanada.com/2018/02/memorial-held-for-murdered-and-missing-indigenous-women-and-girls/

2018-February-20

Appendix E – Community Contributors

Liz Akiwenzie, Cultural Consultant, Traditional Facilitator, and Cultural Keeper

Vanessa Ambtman-Smith, Indigenous Health Lead, South West LHIN

Joe Antone, Urban resident, Member of Oneida Nation of the Thames

Ida Cornelius, Health Administrator, Oneida Nation of the Thames

Al Day, Executive Director, N'Amerind Friendship Centre

Laurel Day, Life Long Care Support Worker, N'Amerind Friendship Centre

Raymond Deleary, Executive Director, Atlohsa Native Family Healing Services

Brian Dokis, Chief Executive Officer, Southwest Ontario Aboriginal Health Access Centre

Kimberly Fisher, Health Director, Chippewas of the Thames First Nation

Shauna Kechego-Nichols, Urban resident, Member of Chippewas of the Thames First Nation

Diane Smylie, Provincial Director, Ontario Indigenous Cultural Safety Program

Appendix F – TRC Principles of Reconciliation (2015)

"The Truth and Reconciliation Commission of Canada believes that in order for Canada to flourish in the twenty-first century, reconciliation between Aboriginal and non-Aboriginal Canada must be based on the following principles.

1. The United Nations Declaration on the Rights of Indigenous Peoples is the framework for reconciliation at all levels and across all sectors of Canadian society.

2. First Nations, Inuit, and Métis peoples, as the original peoples of this country and as self-determining peoples, have Treaty, constitutional, and human rights that must be recognized and respected.

3. Reconciliation is a process of healing of relationships that requires public truth sharing, apology, and commemoration that acknowledge and redress past harms.

4. Reconciliation requires constructive action on addressing the ongoing legacies of colonialism that have had destructive impacts on Aboriginal peoples' education, cultures and languages, health, child welfare, the administration of justice, and economic opportunities and prosperity.

5. Reconciliation must create a more equitable and inclusive society by closing the gaps in social, health, and economic outcomes that exist between Aboriginal and non-Aboriginal Canadians.

6. All Canadians, as Treaty peoples, share responsibility for establishing and maintaining mutually respectful relationships.

7. The perspectives and understandings of Aboriginal Elders and Traditional Knowledge Keepers of the ethics, concepts, and practices of reconciliation are vital to long-term reconciliation.

8. Supporting Aboriginal peoples' cultural revitalization and integrating Indigenous knowledge systems, oral histories, laws, protocols, and connections to the land into the reconciliation process are essential.

9. Reconciliation requires political will, joint leadership, trust building, accountability, and transparency, as well as a substantial investment of resources.

10. Reconciliation requires sustained public education and dialogue, including youth engagement, about the history and legacy of residential schools, Treaties, and Aboriginal rights, as well as the historical and contemporary contributions of Aboriginal peoples to Canadian society."

References

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 053-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 September 20

2018 NUTRITIOUS FOOD BASKET SURVEY RESULTS AND IMPLICATIONS FOR GOVERNMENT PUBLIC POLICY AND ACTION

Recommendations

It is recommended that the Board of Health:

1) ***Request that the federal Minister of Families, Children and Social Development commit additional funding for poverty reduction in Budget 2019, and report the marginal food insecurity category separately from the food secure category within the Canadian Community Health Survey Household Food Security Survey Module;***
2) ***Request that the Ontario Minister of Children, Community and Social Services consider reinstating the Ontario Basic Income Pilot study to support completion of the evaluation, and to increase social assistance rates to reflect the cost of nutritious food and safe housing; and,***
3) ***Forward Report No. 053-18 re: "2018 Nutritious Food Basket Survey Results and Implications for Government Public Policy and Action" to Ontario boards of health, the City of London, Middlesex County, and appropriate community agencies***.

Key Points

- The Nutritious Food Basket survey results for 2018 demonstrate that incomes are not adequate for many Middlesex-London residents to afford basic needs.
- Food insecurity has a pervasive impact on health, and there is a need for income-based solutions.
- Action to address food insecurity and poverty is needed at all levels of government, including the implementation of Opportunity for All – Canada's First Poverty Reduction Strategy, Ontario's Basic Income Pilot, and announced social assistance reform and community programs, such as the Community Volunteer Income Tax Program.

Background and Survey Results

Food insecurity is the inadequate or insecure access to food due to financial constraints. It impacts one in eight households in Middlesex-London, with negative effects on physical and mental health. Adults who are severely food-insecure cost our healthcare system 2.5 times more than food-secure adults. Food insecurity disproportionately affects certain populations, including Indigenous peoples, lone-parent families, and low-income households.

This year, thirty-one Ontario public health units completed the Nutritious Food Basket survey to monitor food affordability as per the Population Health Assessment and Surveillance Protocol, 2018, comparing the local cost of food basket and rental costs in various income scenarios.

In May 2018, the estimated local monthly cost to feed a family of four was $851.80. Estimated food costs are a snapshot of prices at the time of data collection. Year-to-year changes may or may not be significant, especially in the context of 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 a median income

spends only about 11% of their after-tax income on food. Households with low incomes spend up to 35% of their income on food, not because food costs too much but because their incomes are too low.

Appendix A highlights scenarios for Middlesex-London residents using 2018 income rates, rental costs, and food costs, demonstrating that people with low incomes cannot afford to eat healthily after meeting other essential needs for basic living.

Although Middlesex-London residents are not participants in the Ontario Basic Income Pilot (OBIP), two OBIP scenarios were included to demonstrate the positive financial impact for participants. Anecdotally, OBIP participants in other jurisdictions reported many positive outcomes, including being able to afford basic needs, paying bills, finding work, improved mental health, planning for the future (e.g., saving money, further education), and contributing to the local community (Appendix B). Appendix C provides an overview of local food insecurity, income inadequacy, and opportunities for community action.

Opportunities for Action

While community food programs that address poor food skills, nutrition knowledge, or retail food access are important, they do not address the root cause of food insecurity, which is poverty. The Government of Canada recently released "Opportunity for All – Canada's First Poverty Reduction Strategy"; Appendix D provides a summary. The Strategy establishes an Official Poverty Line and includes annual measuring and reporting of targets and indicators, including food security, as measured by the Canadian Community Health Survey Household Food Security Survey Module. The Strategy also includes poverty reduction efforts announced in previous budgets. It is recommended that the Board of Health request the Government of Canada to commit to additional resources for poverty reduction in Budget 2019 (Appendix E).

Statistics Canada currently combines the categories of food security and marginal food insecurity (i.e., worrying about running out of food and/or limited food selection due to a lack of money for food). However, research shows that all individuals who experience some level of food insecurity are at greater risk of physical and mental health concerns. It is methodologically flawed to consider such individuals to be food secure.

The current income support system in Ontario is inadequate for households to cover basic needs. On July 31, 2018, the Ontario government announced they will develop and announce a sustainable social assistance program within one hundred days. The changes to income security programs proposed by the previous government have been replaced by an intermediate 1.5% increase to Ontario Works and the Ontario Disability Support Program. A wind-down of the OBIP was also announced. The Board of Health has a history of supporting social assistance reform and basic income (see reports 060-17, 007-17, 063-16, and 050-15). It is recommended that the Board of Health request that the Ontario government consider reinstatement of the OBIP study to support completion of the evaluation, and increase social assistance rates to reflect the cost of nutritious food and safe housing (Appendices F and G). The report Income Security: A Roadmap for Change includes valuable information to inform the government's review.

Millions of dollars of tax credits and benefits due to households go unclaimed each year. Lower-income households are less likely to file and claim such credits. Community organizations host free tax preparation clinics with support from Revenue Canada through the Community Volunteer Income Tax Program. In collaboration with community partners, Health Unit staff will explore options for increasing community capacity for such clinics.

This report was prepared by the Healthy Living Division.

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

Appendix A to Report No. 053-18

Monthly Income and Cost of Living Scenarios for 2018

	Income[1] (including Benefits & Credits)	**Rent**[2]	**Food**[3] (Nutritious Food Basket)	**What's Left?***
Single Man Ontario Works	$810	$655	$286.30	**-$131.30**
Single Man Ontario Disability Support Program	$1251	$840	$286.30	**$124.70**
Single Man Ontario Basic Income Pilot (previously receiving Ontario Works)	$1518	$655	$286.30	**$576.70**
Single Woman Old Age Security/Guaranteed Income Security	$1694	$840	$207.11	**$646.89**
Single Parent with 2 Children Ontario Works	$2363	$1041	$643.88	**$678.12**
Family of 4 Ontario Works	$2582	$1190	$851.80	**$540.20**
Family of 4 Ontario Basic Income Pilot (previously receiving Ontario Works)	$3334	$1190	$851.80	**$1292.20**
Family of 4 Minimum Wage Earner	$3603	$1190	$851.80	**$1561.20**
Family of 4 Median Income (after tax)	$7871	$1190	$851.80	**$5829.20**

*** People still need funds for utilities, Internet, phone, transportation, household operations and supplies, personal care items, clothing, school supplies, gifts, recreation and leisure, out of pocket medical and dental costs, education, savings and other costs.**

Data Sources

[1] Income Scenario Spreadsheet prepared by Ontario Dietitians in Public Health (2018)

[2] Canadian Mortgage and Housing Corporation Rental Market Statistics, Fall 2017 (utility costs may or may not be included in the rental estimates)

[3] Nutritious Food Basket Data Results for Middlesex-London Health Unit (2018)

Appendix B to Report No. 053-18

Ontario Basic Income Pilot Participant Quotes

““It's a great thing. It helps you feel like an *actual citizen*. There is more dignity attach to it than with (receiving) social assistance." [Alana Baltzer, 28 years old] … Baltzer, who is 28 and has mental health and arthritis challenges, said she is using her improved financial resources to *eat healthier* and lose weight, and to *finance an education* at Mohawk in social service work to start a career and get off social assistance entirely. *"I don't want to spend the rest of my life on social assistance. This is an opportunity to get out of poverty. I'm determined to not let it go to waste.""*

https://www.thespec.com/news-story/8317857-spotlight-shines-on-basic-income-poverty-pilot-project-in-hamilton/

"Mahood [53 years old] fell into deep poverty after a work-related back injury and the death of her husband two years ago. … "I figured I had a year and a half left before I would lose my apartment and have to rent a room. It was pretty frightening," she said. But with $1,200 in basic income every month on top of her disability benefits, Mahood has money for *rent and healthy food* – and has begun making regular payments to clear her *credit card debt*. "If I am careful, I should be debt-free when the program ends in three years," … "I feel *healthier* and I am not stressed all the time about money.""

"This has already been a huge life-change for me," she [Alana Baltzer, 28 years old] said. "I have a *full fridge*. I am eating more *healthy food*." And she says she can finally afford a mouth guard to help correct chronic teeth problems cause by years of poor eating. She has opened a tax-free *savings account* ...."

""My biggest focus is getting my *own place* and giving poor John his apartment back," says Hamilton resident Wendy Moore [60 years old], who has been sleeping on her friend's living room sofa for about a year. It is giving me back my *independence*," she said. "I don't feel so backed into a corner. If I want to eat, I can *afford to buy* something instead of going to a food bank or a soup kitchen."

https://www.thestar.com/news/gta/2018/02/24/from-barely-surviving-to-thriving-ontario-basic-income-recipients-report-less-stress-better-health.html

"Former security guard Tim Button ... says he has been unable to work because of a fall from a roof … Ontario's new "basic income" program has enabled him to ... *eat healthier*, schedule a long-postponed trip to the *dentist* and mull taking a *course* to help him get back to work."

"Dave Cherkewski [46 years old] …, says the extra $750 a month he is receiving has *eased the stress* of daily life and mental illness that has kept him out of work since 2002. … Cherkewski dreams of returning to *work* in a role where he can help people with mental health challenges. "With basic income I will be able to clarify my dream and actually make it a reality, because I can *focus all my effort* on that and not worry about, 'Well, I need to pay my 520-dollar rent, … I need to eat and do other things.'"

https://www.cnbc.com/2017/11/30/canada-tests-basic-income-effect-on-poverty-amid-lost-jobs.html

"Before it was a constant battle of what do I pay first and what do I let go. Sometimes I didn't have enough food, so I've had to use the food bank quite often," she [Barb Munro] says ... "I'm now able to *pay my rent and bills in full*, and on time." … "And when I shop for groceries, now I can buy *fresh produce* for the first time. I'm still cheap when I shop, but it's nice to have a few more options," she says. … "I'm very careful with the money now," she adds, and puts any *additional funds in the bank*. … Just recently she decided to get curtains for her windows – just two $10 panels, but that was an extra luxury

she wouldn't dare have chosen before getting basic income." … She *works part-time* at a local grocery store about 15 hours a week. She did that while she was on ODSP, too. "I prefer to work."

http://lindsayadvocate.ca/lindsay-woman-finds-mental-health-improving-basic-income/

"Dana Bowman, 56, expresses gratitude for *fresh produce* at least 10 times in the hour and a half we're having coffee … She feels *happier and healthier* – and, she says, so do many other people in her subsidized apartment building and around town. "I'm seeing people smiling and seeing people friendlier, saying hi more," she says. … In 2015, two years before the basic-income trial, Bowman asked a case worker if she could get help paying for transportation to a Fleming campus that offers classes in social work. The official said that would lead to cuts in other benefits Bowman relied on. The message Bowman says she got was: "You're unemployable. You're not worth investing in.""

https://www.technologyreview.com/s/611418/basic-income-could-work-if-you-do-it-canada-style/?utm_source=ISAC+Media+%26+Policy+News&utm_campaign=eaf8956727-Media+and+Policy+News+emails&utm_medium=email&utm_term=0_342c280cba-eaf8956727-81405749

"*Do people even realize just how much people who are on ODSP go without?* … have you ever had to plan out how many meals you could afford to eat that week? … Have you ever had to cancel a doctor's appointment because you don't have the money to take your family on the bus?"

"At perhaps the most desperate time in my life the Basic Income Pilot not only saved me, it also improved my life. The legally blind are prone to social isolation and reduced community involvement. While on the program I have been able to find some *seasonal work* – and I've begun *volunteering* in social services and the arts, to acquire new skills and experience, without worrying about food, clothing, and shelter. The Provincial Government has announced that the Basic Income Pilot is being cancelled because it is a disincentive to work. I am not lazy, I am not entitled, I am just disabled."

"The Ontario Basic Income Program gave me back my *Dignity*. I felt that my community was showing me, I was a valued member. By putting money where its mouth is, and equally important, where my mouth is. … Once I became paraplegic I was poor, full stop."

"When we were lucky enough to be accepted to the Basic Income Pilot our lives changed. We were able to start *eating healthier* which resulted in both of us *losing about forty pounds each*. We had gained that weight over years of having to eat carb heavy food because it is cheaper and it was all we could afford. My wife and I were able to start putting money into an *RRSP*/Mutual Fund to save for our retirement which is impossible on ODSP. … One of the biggest changes that Basic Income allowed was that I was starting to look for work. The problem I had doing this on disability was that my back most days is a 6 or 7 on the pain scale … . I don't know, however when I am going to wake up and that pain increases to a 10 which happens periodically. … The last time this happened to me it lasted a year and a half and I had to use a cane to walk and could barely move. *Basic Income was going to allow me to test the waters and see if I could work … . On disability I was terrified that if I did get a job and I was okay for a year, lets say, and I was removed from ODSP what would happen if after I was removed my pain increased and was unable to continue to work. The process of getting Disability is not easy and my wife does not make enough to support two adults while I go through this process.*"

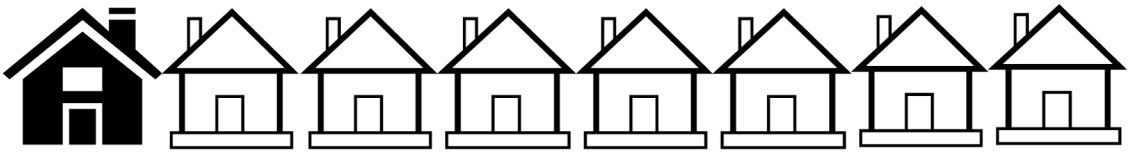
http://bivoices.hamiltonpoverty.ca/

Food Insecurity in Middlesex-London

2018

Appendix C to Report No. 053-18

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



About 1 in 8 Middlesex-London households struggle to put food on the table.

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 infections, chronic diseases and poor mental health.

Many Middlesex-London residents can't afford to make healthy choices.

Single people receiving social assistance cannot afford to pay for adequate housing and healthy food.

$ - - = **-$131**

3 out of 5 households who struggle to put food on the table have paid employment.

What can you do?

- Get involved during elections, your vote matters!
- Advocate for basic income, living wage, increased social assistance.
- Find out what type of community organizer you are at www.ifyouknew.ca.
- Get involved with "London for All: A Roadmap to End Poverty".
- Volunteer for the Community Volunteer Income Tax Program.
- Volunteer as an ally, child minder or meal provider at Bridges Out of Poverty / Circles. - sclarke@goodwillindustries.ca (London)
- Donate time, skills or money to support local organizations.

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

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

www.healthunit.com

Appendix D to Report No. 053-18

Highlights of Opportunity for All – Canada's First Poverty Reduction Strategy

"For the first time in Canada's history, the Strategy **sets an official measure of poverty: Canada's Official Poverty Line,** based on the cost of a basket of goods and services that individuals and families require to meet their basic needs and achieve a modest standard of living in communities across the country. ... Canada's Official Poverty Line will be used to measure progress toward two ambitious but realistic targets: by 2020, reducing the poverty rate by 20% from its 2015 level; and by 2030, reducing the poverty rate by 50% from its 2015 level." (Executive Summary, Chapter 1)

"… Opportunity for All will track, as part of a dashboard of indicators, four elements that all Canadians need, regardless of where they live: food, housing and shelter, health care, and a basic level of income." (Chapter 3) Although the Canadian Community Health Survey is conducted annually, the Household Food Security Survey Module is optional content. Options are being explored with Statistics Canada to collect food security data annually for all provinces and territories (Annex 1).

The Strategy includes poverty reduction efforts announced in recent federal budgets:

- Canada Child Benefit (Budget 2016)
- Restoring the age of eligibility from 67 to 65 for the Old Age Security pension and the Guaranteed Income Supplement (Budget 2016)
- Early Learning and Child Care (Budget 2016 and 2017)
- Public Transit Infrastructure (Budget 2016 and 2017)
- Pathways to Education (Budget 2017)
- National Housing Strategy (Budget 2017)
- Home Care and Mental Health (Budget 2017)
- Indigenous Housing (Budget 2017 and 2018)
- Canada Workers Benefit (Budget 2018)
- Indigenous Skills and Employment Training Program (Budget 2018)
- Advisory Council on the Implementation of National Pharmacare (Budget 2018)
- Additional funding for the Community Volunteer Income Tax Program (Budget 2018)

"… for many reasons, some groups of Canadians are more at risk of poverty. The Strategy aims to remove barriers that prevent these groups from moving up, so they can be at their best. In particular, these groups include Indigenous peoples, singles aged 45-64, Canadians with disabilities, single parents (most of whom are women), seniors, recent immigrants, Black Canadians and individuals from other racialized communities, LGBTQ2 (in particular transgender individuals) and Canadians with significant health issues." (Chapter 1)

"The Government of Canada is committed to reconciliation with Indigenous peoples and to a renewed relationship based on the recognition of rights, respect, cooperation, and partnership. No relationship is more important to the Government of Canada that its relationship with Indigenous peoples." (Chapter 2)

"To ensure accountability to Canadians, the Government is establishing a **National Advisory Council on Poverty** with a mandate to both advise the Government on poverty reduction and to report publicly to Parliament and Canadians on the progress it has made toward meeting the targets every year. As part of its role, the Advisory Council will also foster a national dialogue on poverty reduction." (Chapter 1)
"The Government also proposes to introduce the first ***Poverty Reduction Act*** in Parliament in Canada's history. This *Act* would entrench the targets, Canada's Official Poverty Line, and the Advisory Council into legislation." (Executive Summary)

Appendix E to Report No. 053-18

The Honourable Jean-Yves Duclos
Minister of Families, Children and Social Development
House of Commons
Ottawa, ON K1A 0A6

September 20, 2018

Re: Opportunity for All – Canada's First Poverty Reduction Strategy

Dear Minister Duclos:

The Middlesex-London Board of Health commends the Government of Canada for releasing *Opportunity for All – Canada's First Poverty Reduction Strategy* and setting strong poverty reduction targets so that all Canadians can reach their full potential for health and well-being. We request the Government of Canada to commit additional funding for poverty reduction in Budget 2019, and report the marginal food insecurity category separately from the food secure category within the Canadian Community Health Survey Household Food Security Survey Module.

Poverty and its negative impacts, must be addressed through systemic, targeted and sustainable approaches. Poverty is the root cause of food insecurity, which is inadequate or insecure access to food due to financial constraints. Food insecurity is a strong predictor of poorer physical and mental health, independent of other well-established social determinants of health such as income and education. The basic income guaranteed to seniors in Canada has been shown to reduce food insecurity risk by 50%. However, single working-age people with low incomes, post-secondary students, and low income families headed by working age parents with children over 18 years, among others, remain vulnerable to poverty.

The Canada Child Benefit is a financial support to families, but still leaves many families vulnerable to financial instability and poverty. Annually, the Health Unit monitors food affordability through the Nutritious Food Basket survey. Local food and rent costs are compared to low income scenarios. Our data shows that households receiving social assistance, and all eligible tax credits and entitlements, cannot afford basic needs including healthy food and safe, adequate housing. Most Ontario residents receiving social assistance and all eligible tax credits and entitlements live below the poverty line.

The Middlesex-London Board of Health commends the Government of Canada for committing to public tracking of a variety of indicators related to poverty, including food security. We strongly support your discussions with Statistics Canada about options for collecting the food security data annually for all provinces and territories. The Middlesex-London Board of Health, at its November 2017 meeting, recommended that the Household Food Security Survey Module (HFSSM) be made a core module of the Canadian Community Health Survey and sent a letter to Dr. Hassan Hutchison, Director General of the Office of Nutrition Policy and Promotion, dated February 1, 2018, expressing its support for regular and consistent monitoring of household food insecurity because it is fundamental to population health research and evidence-based policy decision-making at all levels of government.

When reporting the HFSSM results, Statistics Canada currently combines the categories of food secure and

…///1

marginal food insecurity (i.e., worrying about running out of food and/or limited food selection). However, research shows that all individuals who experience some level of food insecurity are at greater risk of physical and mental health concerns. Therefore, to accurately report food insecurity rates, we recommend the marginal food insecurity category be reported separate from the food secure category.

Thank you for consideration of our recommendations and your commitment to the health and well-being of all Canadians.

Sincerely,

Joanne Vanderheyden, Chair
Middlesex-London Board of Health

cc: The Right Honourable Justin Trudeau, Prime Minister of Canada
Hon. D. Ford, Premier of Ontario
The Honourable Patricia A. Hajdu, Minister of Employment, Workforce Development and Labour
Dr. Hassan Hutchison, Director General, Office of Nutrition Policy and Promotion, Health Canada
Dr. William Yan, Director of Nutritional Sciences, Food Directorate, Health Canada
Hon. L. MacLeod, Minister of Children, Community and Social Services
Hon. C. Elliot, Minister of Health and Long-Term Care
Ms. Lorelle Taylor, Associate Deputy Minister, Health System Information Management and CIO, Ontario Ministry of Health and Long-Term Care
Dr. Michael Hillmer, Executive Director, Information Management, Data and Analytics Office, Ontario Ministry of Health and Long-Term Care
Ms. Karen Vecchio, MP Elgin-Middlesex-London
Mr. Bev Shipley, MP Lambton-Kent-Middlesex
Mr. Peter Fragiskatos, MP London North Centre
Ms. Kate Young, MP London West
Ms. Irene Mathyssen, MP London-Fanshawe

Attachment – Report No. XXX-18, "2018 Nutritious Food Basket Survey Results and Implications for Government Public Policy and Action"

Appendix F to Report No. 053-18

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

September 20, 2018

Re: Ontario Basic Income Pilot Cancellation and Social Assistance Rates

Dear Minister MacLeod:

On behalf of the Board of Health of the Middlesex-London Health Unit, congratulations on your appointment as the Minister of Children, Community and Social Services. We have shared interests and we look forward to our continued partnership with the Ontario Government as we work together to tackle the economic and social conditions that influence individual and group differences in health status within our community.

The Middlesex-London Board of Health supports the Association of Local Public Health Agencies' (alPHa) position as outlined in its letter dated August 2, 2018 and asks that you consider reinstating the Ontario Basic Income Pilot (OBIP) study. The success of existing guaranteed income supplement programs (e.g., Old Age Security and Guaranteed Income Supplements for seniors) provides evidence of improved health status and quality of life for recipients. Continuation of the OBIP would allow researchers to fully assess the program's impact on labour participation, health, social engagement, food security, housing stability and educational activities to inform any future reforms to the social assistance program in Ontario.

We are concerned about the well-being of the over 4 000 Ontarians who were relying on these additional monthly funds for the full 3-year pilot length, who had made positive life changes they can't continue without the continuation of OBIP payments, like safer housing and pursuing higher education. OBIP participants report many positive outcomes including the ability to purchase nutritious food, improved housing, paying bills, improved mental health, finding paid employment, planning and building for the future (e.g., further education, saving money) and contributing to their local community. About 7 out of 10 OBIP participants are working, but struggling with precarious, low paid work. Many participants reported the additional monthly funds from OBIP were used for educational and training upgrades to support the attainment of more stable work.

The current income support system in Ontario is not adequate for households to cover basic needs. Annually, the Health Unit monitors food affordability through the Nutritious Food Basket survey. Local food and rent costs are compared to low income scenarios. Our data shows that households receiving social assistance cannot afford basic needs including healthy food and safe, adequate housing. Most Ontario residents receiving social assistance and all eligible tax credits and entitlements live below the poverty line, with the exception of single older adults receiving the Guaranteed Income Supplement and Old Age Security pension. A sustainable social assistance program should support recipients to transition off of social assistance, as they are able to, but also provide adequate funding to afford basic needs when receiving social assistance. The report Income Security: A Roadmap for Change includes valuable information to inform your social assistance review.

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We respectfully request you to consider the following recommendations in order to benefit the physical and mental health of many low income Ontarians:

- Reinstate the Ontario Basic Income Pilot study to support completion of the evaluation. The evidence obtained from the pilot would help determine whether the basic income model is an effective policy intervention to improve health and social outcomes in low income populations and help guide further refinements to the social assistance program to reduce poverty.
- Increase social assistance rates to reflect the cost of nutritious food and safe housing. The planned 1.5% increase to rates is a first step, but will still keep the rates below the poverty line.

Thank you for consideration of our recommendations and your commitment to the health and well-being of all Ontarians.

Sincerely,

Joanne Vanderheyden, Chair
Middlesex-London Board of Health

cc: Hon. Jeff Yurek, MPP Elgin-Middlesex-London
Hon. Monte McNaughton, MPP Lambton-Kent-Middlesex
Mr. Terence Kernaghan, MPP London North Centre
Ms. Peggy Sattler, MPP London West
Ms. Teresa Armstrong, MPP London-Fanshawe

Attachment – Report No. XXX-18, "2018 Nutritious Food Basket Survey Results and Implications for Government Public Policy and Action"

alPHa
Association of Local PUBLIC HEALTH Agencies

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August 2, 2018

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

Dear Minister MacLeod,

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

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing to express our disappointment with the decision to cancel Ontario's Basic Income Pilot (OBIP).

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

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

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

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

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

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

Sincerely,

Dr. Robert Kyle
alPHa President

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

ENCL.

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A15-4

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

SPONSOR: **Simcoe Muskoka District Health Unit**

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

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

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

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

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

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

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

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

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

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

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

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

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 059-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 September 20

PUBLIC HEALTH CONSIDERATIONS FOR THE 2018 MUNICIPAL ELECTION

Recommendation

It is recommended that the Board of Health:

1. ***Receive Report No. 059-18 "Public Health Considerations for the 2018 Municipal Election" for information; and,***
2. ***Direct the Medical Officer of Health to send the "Healthy People, Healthy Communities" primer, attached as Appendix A, to all municipal candidates in the Middlesex-London area in advance of the election to profile the role that municipal councils play in influencing individual and community health.***

Key Points

- Decisions made by municipal councils play an important role in influencing individual and community health.
- The *Healthy People, Healthy Communities* primer, attached as Appendix A, provides a list of questions and public health considerations that candidates running in the 2018 municipal election may wish to ask themselves when making decisions about the issues that our community is facing.

Background

Health is influenced by many factors, including genetics, individual lifestyles and behaviours, and the physical, social and economic environments in which we live. The social and physical factors that are beyond an individual's biology and control, are known as the social determinants of health. Under the Health Equity Standard of the *Ontario Public Health Standards*, public health units are mandated to address the social determinants of health and decrease health inequities such that "everyone has equal opportunities for optimal health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances". Health equity means that all individuals, groups, and communities have a fair chance to reach their full health potential without being disadvantaged by social, economic, and environmental conditions.

Public Health Considerations for Municipal Council Decision Making

The next Ontario municipal election will take place on October 22nd, 2018. Decisions made by municipal councils play an important role in impacting the health and well-being of individuals and entire communities. Policies and service delivery decisions made by municipal councils can influence the social determinants of health, including food access, income, housing, employment, education, social cohesion and the physical environment. To profile the role that municipal councils have in building healthy, vibrant and inclusive communities, the *Healthy People, Healthy Communities* primer was created. The primer provides a list of questions and public health considerations that candidates may wish to ask themselves when making decisions about the issues that our community is facing.

Elected officials play a very important role within our community and we depend upon them to make decisions that will improve the health of our community and its residents. The primer asks municipal candidates to think about the different factors that influence the social determinants of health, and the role that they may play as a member of a municipal council who is shaping the policies that may have an unintended or intended public health impact.

Next Steps

With Board of Health approval, Health Unit staff will send the *Healthy People, Healthy Communities* primer, attached as Appendix A, to every candidate in Middlesex County and the City of the London who is running in the 2018 municipal election. By sharing this information, the Health Unit has an opportunity to profile that health and health equity can be achieved through policy decisions that are made outside of the health sector.

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

Healthy People, Healthy Communities

Decisions made by municipal councils play an important role in influencing individual and community health and well-being.

The social determinants of health (e.g., income, housing, education, social inclusion) are impacted by policies and decisions made by municipal councils, who promote health equity by ensuring all have a fair chance to reach their full health potential without being disadvantaged by social, economic and environmental conditions beyond their control.

For municipal councils, the following questions can be used to ensure the impact on health is considered when making decisions about the issues our communities face.

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

Public Health Considerations During Decision-Making

Does the program or policy…

Natural Environment
• Protect parks, greenspace, and natural heritage systems while supporting biodiversity? • Promote an energy conscious culture? • Provide shade in urban play spaces, parks, yards and along streets?
Food Systems
• Reflect the vision and values described by the Middlesex-London Food Policy Council? • Increase accessibility to culturally-appropriate, healthy foods from local producers? • Promote collaboration between different sectors within the local food system?
Marginalized Populations
• Invest in public resources to support under-resourced families? • Engage with vulnerable individuals and families to address the root causes of health disparities? • Promote equity and diversity in economic and educational opportunities?
Community Services and Programs
• Improve access to culturally-appropriate, equitable, and evidence-informed social and health services? • Create opportunities for positive community involvement and participation in meaningful recreational activities? • Promote positive mental health and well-being?
Social Cohesion
• Promote community-wide arts and cultural events and recreational activities that bring people of all ages together? • Celebrate diversity and promote feelings of belonging and community well-being? • Create inclusive communities that welcome and support newcomers and marginalized populations?
Substance Use
• Promote equitable and barrier-free access to health and substance use services? • Use evidence and wise practices to prevent and reduce harms from tobacco, alcohol, cannabis, opioids and other drugs, using a four pillar approach? • Recognize and address stigma as a barrier to wellness?
Healthy Community Design and the Built Environment
• Support complete neighbourhood design where housing, employment, education, recreation, transportation options, healthy food, and public greenspaces are accessible to all? • Create streets that are safe and accessible for all ages, abilities, incomes and modes of travel? • Encourage walking, cycling and public transit use?
Communities for All Ages
• Provide support for early childhood development, including affordable and high-quality child care, early learning resources, supports for parents, and opportunities for play? • Consider the evidence and best practices to engage, attract and retain youth? • Support older adults through neighbourhood design, transportation options, and in-home health supports?

Adapted and revised for local use with permission from the Huron County and Grey Bruce Health Units.

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www.healthunit.com

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 054-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 September 20

HEPATITIS A IN HOMELESS / UNDER-HOUSED POPULATIONS

Recommendation

It is recommended that Report No. 054-18 re: "Hepatitis A in Homeless/Under-Housed Populations" be received for information.

Key Points

- Since 2017, Public Health Ontario has been investigating a cluster of hepatitis A cases. Individuals have reported illicit drug use as well as other risk factors, including sex with same sex (SWSS) among males, being homeless or under-housed, and incarceration.
- Internationally, there have been several large outbreaks of hepatitis A, specifically among homeless and under-housed populations, including in nearby jurisdictions like Michigan.
- In July 2018, MLHU received a report of a case of hepatitis A who was a client at a city shelter. This case was genotypically linked to the provincial outbreak.
- In an effort to stem transmission of the virus in homeless and under-housed populations, MLHU initiated post-exposure prophylaxis vaccination clinics in three city shelters, notified health care providers, and informed harm reduction and shelter workers.
- No additional cases of hepatitis A have been reported at this time.

Background

Hepatitis A is an infection of the liver caused by the hepatitis A virus. Symptoms include fever, loss of appetite, nausea, abdominal discomfort, and yellowing of the skin and eyes (jaundice). Recovery often takes four to six weeks, but can also take months. It is transmitted fecal-orally, and can be spread via contaminated food or drinking water, sharing of needles or drug-use equipment, or living in the same space as or having sex with an infected person. There is a vaccine for the hepatitis A virus that is very effective at preventing the disease. Additionally, if administered with expediency, this vaccine can decrease the probability of an individual developing the disease despite already having being exposed. This is called post-exposure prophylaxis.

In North America, cases of hepatitis A have typically been linked to travel to endemic countries or the ingestion of contaminated food products. However, in recent years, locally acquired outbreaks have been seen amongst men who have sex with men, people who use illicit drugs, and people who are homeless or under-housed. The United States Centers for Disease Control and Prevention (CDC) have been investigating hepatitis A outbreaks in multiple states among people with these risk factors. This has included nearby jurisdictions like Michigan, where an ongoing outbreak declared in 2016 has resulted in 808 cases, 709 hospitalizations, and 28 deaths.

In 2017, Public Health Ontario collaborated with Toronto Public Health and other health units in southern Ontario to investigate an increase of non-travel-associated hepatitis A cases. These cases were primarily observed amongst men who have sex with men, but other risk factors included homelessness and illicit drug use. These cases were centered in Toronto.

Many of the cases were linked to three distinct strains, or genotypes, of hepatitis A. Between June 1 and December 31, 2017, there were 25 cases with genotype 1A strain VRD_521_2016, 3 cases with genotype 1A strain RIVM HAV16-090, and 1 case with genotype 1A strain V16-25801. These three strains were closely related to circulating strains implicated in outbreaks occurring mostly among men who have sex with men (MSM) communities in the United Kingdom and Europe.

In 2018, genotypically linked cases were identified in two neighbouring health units beyond Toronto: Waterloo Region and Wellington-Dufferin-Guelph. Given these new cases, a provincial outbreak was declared. Among confirmed outbreak cases, the proportion of males that reported SWSS was lower in 2018 (13%) than in 2017 (56%). The proportion of cases who reported illicit drug use (i.e., any reported illicit drug use, including injection and/or non-injection drug use) was higher in 2018 (81%) than in 2017 (68%). The rate of hospitalization, too, was higher in 2018 (83%) than in 2017 (55%).

Middlesex-London Situation

On July 19, 2018, the Infectious Disease Control Team received a positive hepatitis A report in an individual with a history of injection drug use and homelessness. The individual was a recent client of a London shelter who had lived in the shelter during the period of infectivity.

Given the potential of an outbreak among people who use illicit drugs and people who are homeless or under-housed, MLHU rapidly organized and delivered post-exposure prophylaxis vaccination clinics. As the movement of the homeless population is highly transient, clinics were held at all three large city shelters.

The first clinic was offered on July 20, 2018, and 77 individuals were immunized. A second clinic was set up at the same shelter, followed by additional clinics at two other shelters and sites. In total, 162 individuals were vaccinated.

An alert was distributed to health care providers via email on July 24, 2018, to inform them about the risk of hepatitis A in the community. A letter was also distributed to shelter workers and harm reduction workers to emphasize appropriate hand hygiene, facilitate rapid recognition of hepatitis A cases, and encourage clients to receive the vaccine.

Next Steps

On August 8, 2018, the National Microbiology Lab confirmed that the July 19 case shared the same genotype as that identified in the provincial outbreak (1A VRD_521 HAV strain). At the time of this report, no additional cases of hepatitis A have been reported. The Infectious Disease Control Team will continue to monitor for additional hepatitis A cases.

This report was prepared by the Associate Medical Officer of Health and the Environmental Health and Infectious Disease Division.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 55-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 September 20

REVIEW OF PUBLIC HEALTH SERVICES IN MIDDLESEX COUNTY - FINDINGS

Recommendation

It is recommended that the Board of Health receive Report No. 055-18, re: "Review of Public Health Services in Middlesex County – Findings" for information.

Key Points

- The Middlesex-London Health Unit (MLHU) made a commitment to review its services in Middlesex County in order to ensure that they meet the needs of residents.
- MLHU conducted a multi-component service review that identified stakeholder priorities, current service delivery practices, best practices and potential action items.
- Staff are seeking Board of Health feedback on the findings to assist with the development of recommendations for service delivery improvement.

Background

The Middlesex-London Health Unit is preparing to renew its strategic plan by the end of 2019. A review of MLHU services provided in Middlesex County will ensure that appropriate services are matched to the public health needs identified in the County.

This service review process, conducted throughout the spring and summer of 2018, included:

- Presentations to all lower and upper tier municipalities;
- A survey of municipal council members;
- Key informant interviews;
- A literature review;
- An environmental scan;
- A community health status report; and
- The service delivery model for all public health programs.

Overview of the Findings

The information gathered in the service review was analyzed and collated into the following summaries for review:

- Organizational Practices;
- Accessibility;
- Community Engagement;
- Foundational Standards;
- Chronic Disease Prevention & Well-Being;
- Food Safety;
- Healthy Environments;
- Healthy Growth and Development;
- Immunization;
- Infectious and Communicable Diseases Prevention and Control;
- Safe Water;
- School Health; and
- Substance Misuse and Injury Prevention.

Each of these summaries provides an overview of stakeholder priorities, the current state of MLHU programs and practices, identified best practices and potential action items. The Middlesex County Public Health Service Review is attached as Appendix A and data sources for the review as Appendix B.

Next Steps

MLHU staff are seeking input from the Board of Health on the overall summary of organizational practices and program and service delivery in Middlesex County and potential considerations. These findings and considerations will also be shared with Middlesex County Council to seek their input.

Feedback from both the Board of Health and Middlesex County Council will be used to formulate recommendations to improve service delivery.

This report was prepared by the Healthy Organization Division.

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

Appendix A to Report No. 055-18

Review of Public Health Services in Middlesex County

September 2018

For information, please contact:

Jordan Banninga

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Cite reference as: Middlesex-London Health Unit (2018). *Review of Public Health Services in Middlesex County*. London, Ontario.

Editor:

Jordan Banninga
Manager, Program Planning & Evaluation

Table of Contents

Executive Summary

The Middlesex-London Health Unit (MLHU) is the largest autonomous health unit in Canada and has served the residents of both Middlesex County and the City of London since the merger of the Middlesex County Health Unit and London Public Health Department in 1971. During this time, MLHU has responded to many public health emergencies including the recent the opioid crisis (2017 – present), the H1N1 influenza pandemic (2009) and the SARS outbreak (2003). Additionally, MLHU has continuously provided high quality public health programs and services that impact the daily lives of our residents. There programs and services range from inspections in all food premises, the promotion of healthy active living, oversight of the vaccine supply, larviciding catch basins, to advocacy for safe roads. Our goal is to work upstream in our health system, preventing illness and disease before it happens.

The Review of Public Health Services in Middlesex County (RPHSMC) examines the programs and services delivered within the mandate outlined in the *Health Protection and Promotion Act* and the *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability*.

This review comes after a comprehensive community engagement process that sought the input of Middlesex-London residents on the potential consolidation of MLHU's London offices that began in 2015. Significant work was done to gather input from the residents of Middlesex County and the City of London through online and telephone surveys and additional consultation with Middlesex County through a partner consultation process.

Throughout these consultations the Board of Health reiterated its intention of maintaining an office in Strathroy, and the commitment to not reduce services to County of Middlesex residents.

In addition to gathering input from all areas of Middlesex and London to guide their decision making, the Board of Health also made a specific commitment to ensure that services in Middlesex County are reviewed and strengthened if needed.

Throughout the Spring and Summer of 2018, a service review process was conducted by staff at MLHU which included the completion of:

- Presentations to all lower and upper tier municipalities;
- A community health status report;
- A literature review;
- A survey of municipal council members;
- Key informant interviews;
- An environmental scan of Ontario public health units; and
- A description of county service delivery for each MLHU program.

The information gathered in the service review was analyzed and collated to describe an overview of MLHU programs and services, key stakeholder priorities, the current population health status, best practices identified from research and other Ontario public health units and consideration for future MLHU practice. The findings are organized as follows:

- Population Characteristics;
- Mortality;
- Social Determinants of Health;
- Organizational Practices;
- Accessibility;
- Community Engagement;
- Foundational Standards;

- Chronic Disease Prevention and Well-Being;
- Food Safety;
- Healthy Environments;
- Healthy Growth and Development;
- Immunization;
- Infectious and Communicable Diseases Prevention and Control;
- Safe Water;
- School Health; and
- Substance Misuse and Injury Prevention.

Overall, the health status of Middlesex County compares favorably to the rest of Ontario across a wide range of health indicators corresponding to the standards listed above. Nevertheless, there are always improvements to be made.

Important issues identified during the Middlesex County Public Health Service Review include the need to:

1. Establish regular communication channels (delegations, newsletters / correspondence) to all municipal councils (upper and lower tier);
2. Enhance staff and programming presence at the Strathroy office;
3. Explore a partnership with Middlesex County to utilize comprehensive libraries for program and service delivery;
4. Ensure MLHU's planning processes takes into consideration the public health needs of Middlesex residents and that staff seek input from Middlesex residents;
5. Develop data sharing agreements with local organizations;
6. Develop a community engagement strategy that includes stakeholders identified during asset mapping;
7. Increase opportunities to deliver services and connect with Middlesex County residents online, over the phone and through other non-physical means; and
8. Develop mechanisms for the public to provide feedback on how to improve service delivery.

The considerations identified in this service review and feedback from the Board of Health and Middlesex County Council will be used to develop formal recommendations for Board of Health endorsement and implementation by MLHU.

Mandate of the Middlesex-London Health Unit

The Middlesex-London Health Unit derives its mandate from the *Health Protection and Promotion Act* (HPPA). The Act is a provincial statute that gives the Board of Health its legal mandate to deliver public health programs and services, to prevent the spread of disease and to promote and protect the health of the residents of Middlesex-London.

The HPPA defines the structure, governance and functions of the board of health as well as the activities and authority of medical officers of health.

To operationalize the HPPA, the Ministry of Health and Long-Term Care publishes the *Ontario Public Health Standards (*OPHS*).* The OPHS sets out the requirements for programs, services and accountabilities to which boards of health are held.

The scope of the OPHS lays out specific requirements but these are not intended to limit the potential scope of a board of health's programming. This allows for boards of health to respond to community health needs with activities that can promote and protect the health of the population and reduce health inequities. The specific standards with requirements that the board of health must meet include:

The Foundational Standards:

- Population Health Assessment;
- Health Equity;
- Effective public health practice; and
- Emergency Management

And the Program Standards:

- Chronic Disease Prevention and Well-being;
- Food safety;
- Healthy Environments;
- Healthy Growth and Development;
- Immunization;
- Infectious and Communicable Disease Prevention and Control;
- Safe Water;
- School Health; and
- Substance Use and Injury Prevention

A board of health may deliver additional services beyond these requirements should there be a demonstrated health need and population health interventions can be delivered to address those needs.

Additionally, the OPHS outlines organizational requirements under the Public Health Accountability Framework. This framework is composed of four Domains:

- Delivery of Programs and Services;
- Fiduciary Requirements;
- Good Governance and Management Practices; and
- Public Health Practices

Data Sources and Methods

The RPHSMC utilized qualitative and quantitative data. These methods were used to inform the considerations articulated in this report. Triangulation is the term used to broadly describe the use of multiple data sources to cross-validate key themes, findings and concepts. The blending and integration of a variety of data sources and methods is seen to lead to more valid results.

The methods of the review and data sources used for triangulation included:

- Presentations to municipal councils;
- A community health status report;
- A literature scan;
- A survey of municipal council members;
- Key informant interviews;
- An environmental scan;
- A description of county service delivery for each MLHU program; and
- Asset mapping.

Presentations to Municipal Councils

To facilitate data gathering and to keep municipal representatives informed about the RPHSMC, visits were conducted to each of the lower-tier municipalities in Middlesex County throughout June and July 2018. MLHU staff provided an overview of the Health Unit's mandate, the services provided throughout the County and the methodology of the review. At each meeting, a municipal councillor survey was distributed in pre-addressed and stamped envelopes and mayors and deputy mayors were encouraged to volunteer for the key informant interview. Additionally, councillors had the opportunity to ask questions regarding the review or other public health issues.

Community Health Status Report

A Community Health Status report (CHSR) contains health status information on a range of topics relevant to public health and draws on the information to fully understand the health status of the population. The CHSR included in this service review was conducted by MLHU Population Health Assessment and Surveillance Team. This CHSR provides information regarding population characteristics, social determinants of health, deaths, illness and injuries, behavioral risk factors, reproductive health and child health specifically for Middlesex County.

The fulsome CHSR can be found in Appendix A.

Literature Scan

A literature scan was undertaken to determine effective service delivery models for public health services in rural settings. The scan was limited to service delivery frameworks, models, or plans by provincial, state, or federal public health agencies, both in Canada and abroad, as well as the websites of the health agencies in the same Statistics Canada health peer group (Group A) as Middlesex-London Health Unit.

The scan did not look at program specific strategies to improve service delivery to rural areas. This process of identifying program specific strategies is integrated into MLHU's ongoing program planning, implementation and evaluation process.

The findings of the literature scan can be found in Appendix B.

Survey of Municipal Council Members

To understand the community needs and identify strategies to enhance access to public health services, the MLHU commissioned an online survey of municipal councillors to assess their areas of public health priority, how the Health Unit can increase accessibility, and gather feedback on ways to improve services. The survey was conducted by Middlesex-London Health Unit staff during the period of June 4th, 2018 to August 31st, 2018. The overall completion rate was 26.9%, with a total of 14 surveys completed. Average completion time of the survey was 11 minutes and 20 seconds. Only completed surveys were included for analysis.

The findings of the survey can be found in Appendix C.

Key Informant Interviews

Following the survey of municipal council members, MLHU reached out to mayors and deputy mayors of municipalities in Middlesex County to understand their perspectives on public health services being provided to their residents and opportunities for improvement. The key informant interviews were conducted by Middlesex-London Health Unit staff during the period of July 19th, 2018 to September 6th, 2018. A total of three telephone interviews were completed. Average completion time of the survey was 30 minutes.

The findings of the key informant interviews can be found in Appendix D.

Environmental Scan

MLHU reached out to Ontario Public Health Units with similar demographics to understand their strategies for servicing rural populations. Specifically, in order to ensure that the Health Unit is considering all possible strategies and best practices, this environmental scan sought to identify potential service improvements for Middlesex County residents. The environmental scan was conducted by Middlesex-London Health Unit staff during the period of July 19th, 2018 to August 31st, 2018. The overall completion rate was 35.7%, with a total of 5 surveys completed. Average completion time of the survey was 7 minutes and 28 seconds. Only completed surveys were included for analysis.

The findings of the environmental scan can be found in Appendix E.

Description of County Service Delivery for each MLHU Program

An essential component of the RPHSMC was a summary of the services delivered in the county on a program-by-program basis. The community health status report identifies public health needs in the community and MLHU endeavors to ensure that the programs and services are planned and implemented in such a way so as to address those concerns.

The data was collected from each program manager at MLHU and is summarized in the sections in this report relevant to their programming.

Asset Mapping

Asset mapping is an exercise that provides information about the strengths and resources available in a community that can help address public health issues. While not included in this report, an inventory of over 850 assets has been compiled using data available from Middlesex County and other sources. This data will be used to inform future improvement strategies.

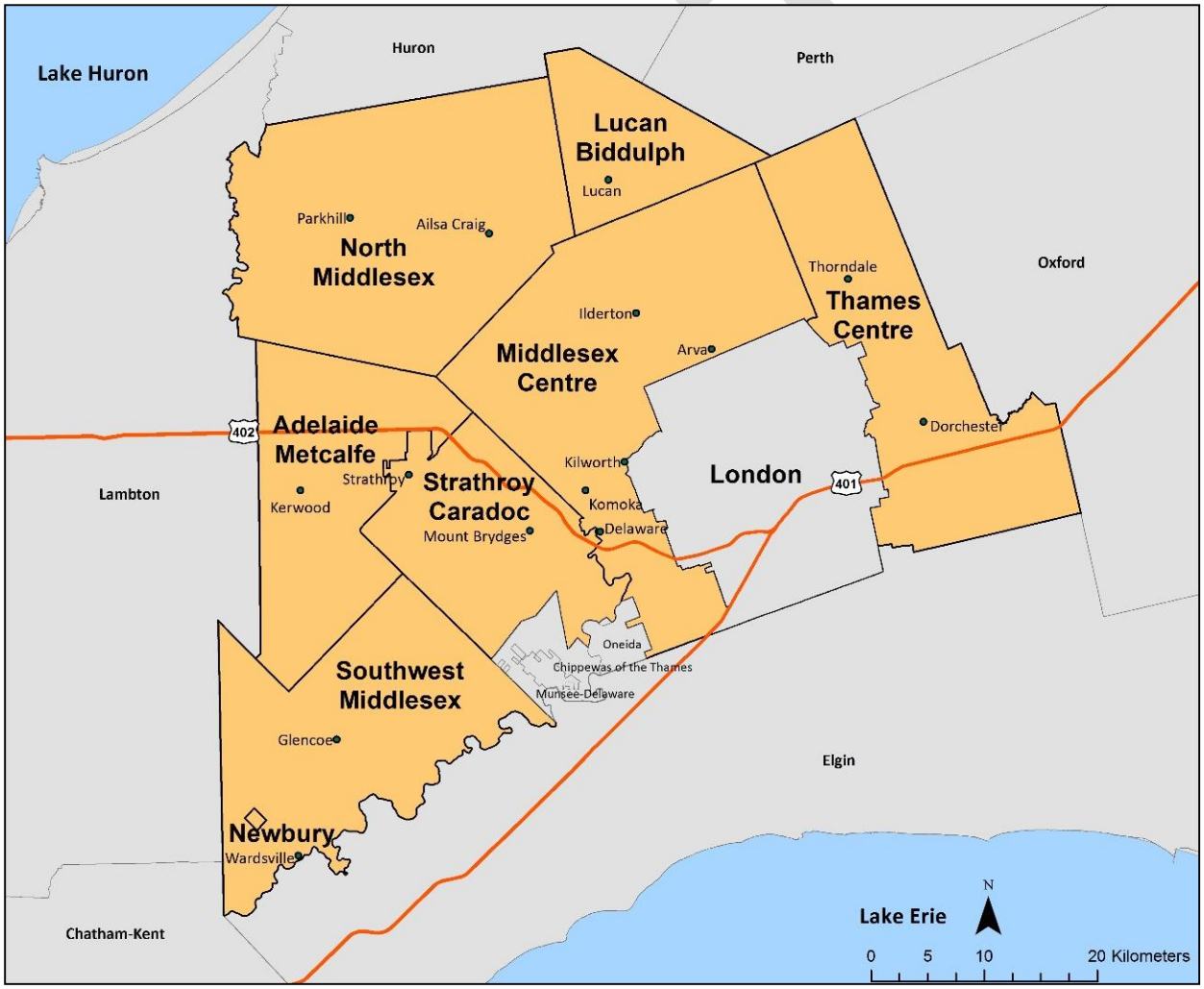
Findings

Population Characteristics

Middlesex County's population was 71,551 people according to the 2016 Census. The population of Middlesex County is concentrated in the three municipalities of: Strathroy-Caradoc, Middlesex Centre, and Thames Centre. These three municipalities account for nearly three quarters of Middlesex County's population and one in five of the residents of Middlesex County live in the town of Strathroy itself.

Middlesex County covers an area of 2,821 square kilometres in Southwestern Ontario and includes eight municipalities in order of geographic size (largest to smallest): North Middlesex, Middlesex Centre, Thames Centre, Southwest Middlesex, Adelaide Metcalfe, Strathroy-Caradoc, Lucan Biddulph and the Village of Newbury (Figure 1).

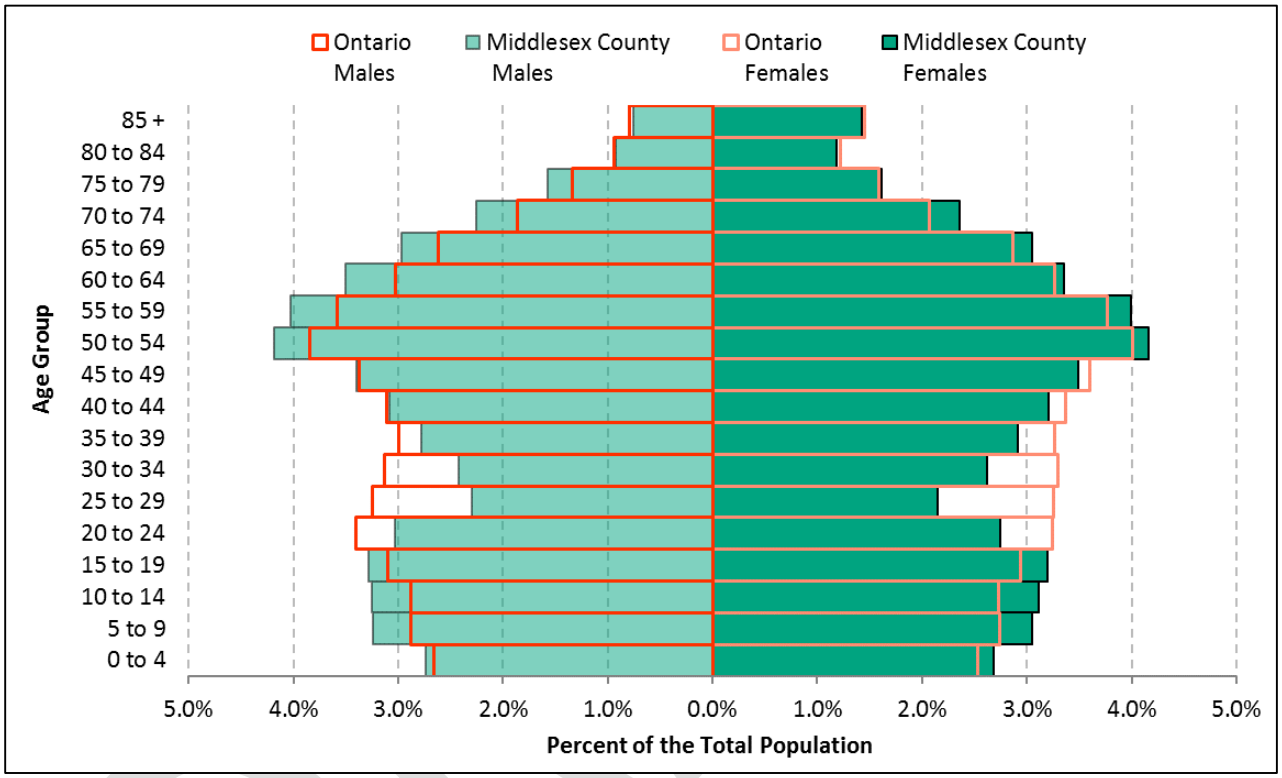
Figure 1. Middlesex County, municipalities and neighbouring areas, 2018.



Overall, there were similar numbers of males and females in Middlesex County in 2016. However, there were greater numbers of females than males in the oldest age group, 85 years and older (females 1025: males 545) which is consistent with the longer life expectancy for women in Middlesex County and may indicate that

public health could continue to work to close this gap by reducing risk factors for males. Generally, the age pyramid of Middlesex County was constricted in the young adult category (ages 20-39). This may be consistent with a general pattern seen in Ontario where youth and young adults migrate to more urban areas in search of education and employment opportunities (R.A. Malatest & Associates Ltd., 2002). Compared to the population of Ontario, the population of Middlesex County lacks younger adults aged 20-39 years and has a higher proportion of older children and older adults particularly older adult males.

Figure 2. Population Pyramid, percent of the population, by sex, by age group, Middlesex County and Ontario, 2016.



Data source: Statistics Canada. 2016 Census of Population (Unadjusted)

Middlesex County has had few immigrants in the past five years, with approximately 165 in total in 2016. They made up a much lower percent of the population (0.2%) than in Ontario overall (3.5%) Recent immigrants were concentrated in the three largest municipalities that surround the City of London. In general, the health of immigrants tends to be better than that of the overall population. This is largely due to the fact that immigrants must generally be healthy to immigrate and often have better diets and health behaviours initially than the Ontario population. However, resettlement may create vulnerabilities and require tailored public health services to reduce the health risks and promote well-being to stay healthy.

About 97% of the population of Middlesex County spoke English most often at home in 2016. Middlesex County had approximately 90 people who spoke French most often at home in 2016. The Middlesex-London Health Unit is a designated French language service area, and therefore endeavors to provide services in both official languages. However, 2.4% of the Middlesex County population spoke neither English nor French at home on a regular basis and may require public health services that meet their specific language needs. This proportion is much lower compared to the 14.4% in Ontario that do not regularly speak an official language at home.

For further details regarding population characteristics, refer to Appendix A.

Mortality

Death rates, also referred to as mortality rates, are frequently used as indicators of the overall health of a population. Trends in mortality can illustrate the health problems in our community that have the biggest impact on the population. Changes in mortality rates over time may be due to several different factors taking place in the community such as changes in the standard of living, the environment or other social determinants of health. Changes may also be due to access to quality health care, improved diagnosis and treatment of illness or the emergence of new health issues not seen before. Health protection and promotion efforts, such as those related to smoking prevention and cessation, may also have an important impact on mortality rates in populations.

The top eight leading causes of death between 2010 and 2012 in Middlesex County were chronic diseases (Table 1): ischemic heart disease, dementia and Alzheimer's disease, lung cancer, cerebrovascular diseases, lower respiratory diseases, colorectal cancer, diabetes and lymph and blood cancer. These accounted for 58.4% of all deaths. The ninth and tenth leading causes of death were influenza and pneumonia, and falls, respectively.

The top ten leading causes of death were the same for Middlesex County and Ontario, with the top eight causes following the same ranking order.

Ischemic heart disease, the leading cause of death in Middlesex County, accounted for 80% more deaths than lung cancer, the second leading cause of death.

Table 1. Number, percent and rank of the leading causes of death, Middlesex County and Ontario, 2010 to 2012 annual average.

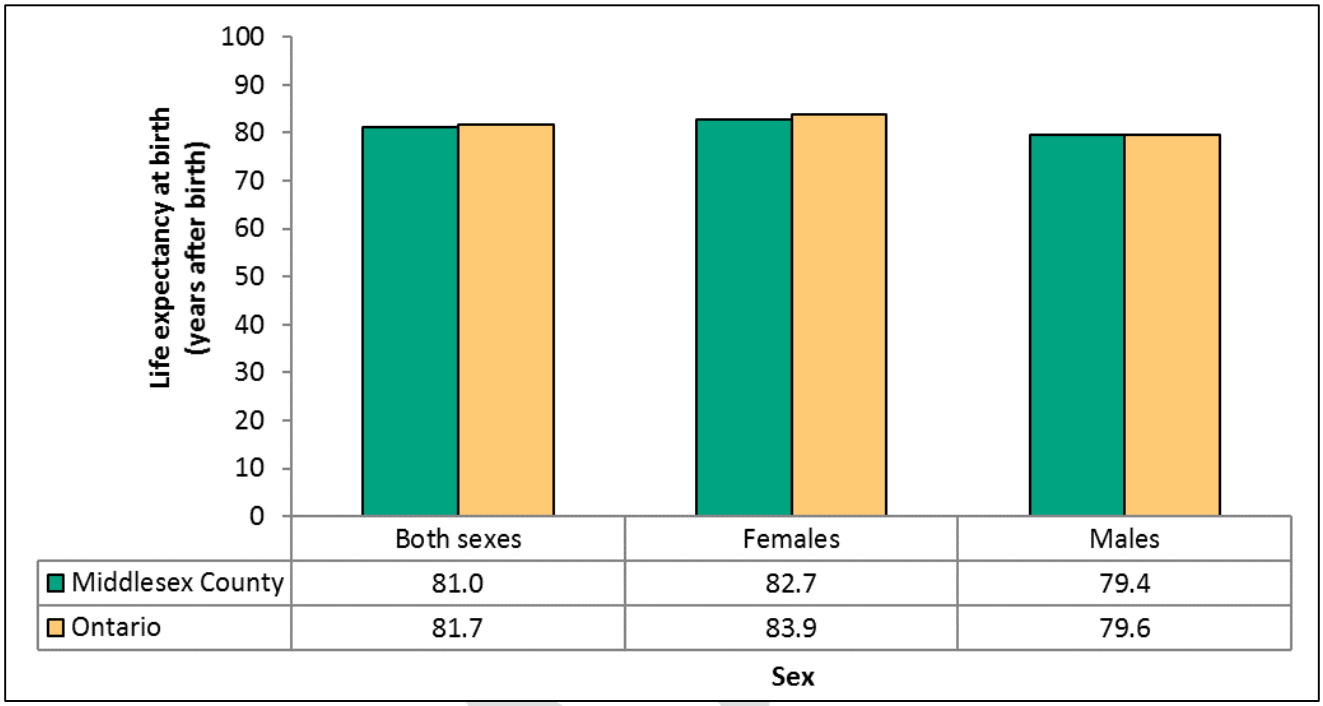
Leading Causes of Death	Average Annual Number of Deaths Middlesex County	Percent of All Deaths Middlesex County (%)	Ontario Rank
Ischemic Heart Disease	92	18.2	1
Dementia and Alzheimer's Disease	51	10.1	2
Lung Cancer	38	7.5	3
Cerebrovascular Diseases, incl. Stroke	31	6.2	4
Lower Respiratory Diseases	26	5.2	5
Colorectal Cancer	21	4.2	6
Diabetes	20	4.0	7
Lymph and Blood Cancer	14	2.9	8
Influenza and Pneumonia	14	2.7	10
Falls	13	2.7	9

Data source: Ontario Mortality Data, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 21, 2018.

Life expectancy is the average length of time that an individual will live if subjected to the mortality experience for the specified population and time period. Using data from 2010 to 2012, Middlesex County residents can expect to live on average 81.0 years at birth and 19.7 more years at age 65. The life expectancy for males was lower than females and the mortality rate for males was higher than for females.

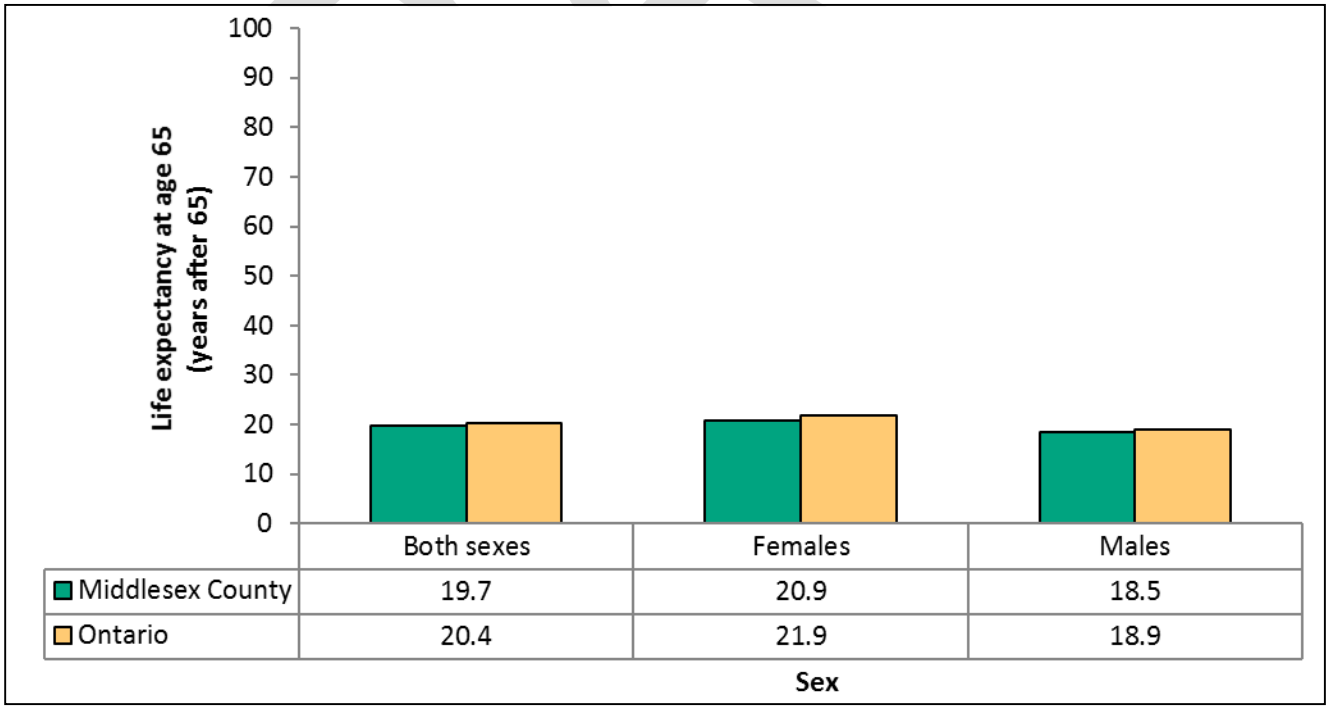
Males were much more likely to die prematurely than females in Middlesex County, generally reflecting higher rates of deaths in males at younger ages. Deaths due to breast cancer and lung cancer were the most common cause of premature death for females in Middlesex County; whereas for males it was ischemic heart disease.

Figure 3. Life expectancy at birth, by sex, Middlesex County and Ontario, 2008 to 2012 average.



Data source: Ontario Mortality Data, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 21, 2018.

Figure 4. Life expectancy at age 65, by sex, Middlesex County and Ontario, 2008 to 2012 average.



Data source: Ontario Mortality Data, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 21, 2018.

Potential years of lost life (PYLL) is an indicator of premature mortality. It measures the number of years lost from deaths before age 75. The younger a person is when they die, the greater the number of potential years of life that are lost.

As was the case in Ontario, males showed higher rates of PYLL than females in Middlesex County, generally reflecting higher rates of deaths in males at younger ages (Figure 5). Deaths due to breast cancer and lung cancer showed the highest PYLL rates for females in Middlesex County. The PYLL rates for both were slightly higher in Middlesex County females compared to Ontario females.

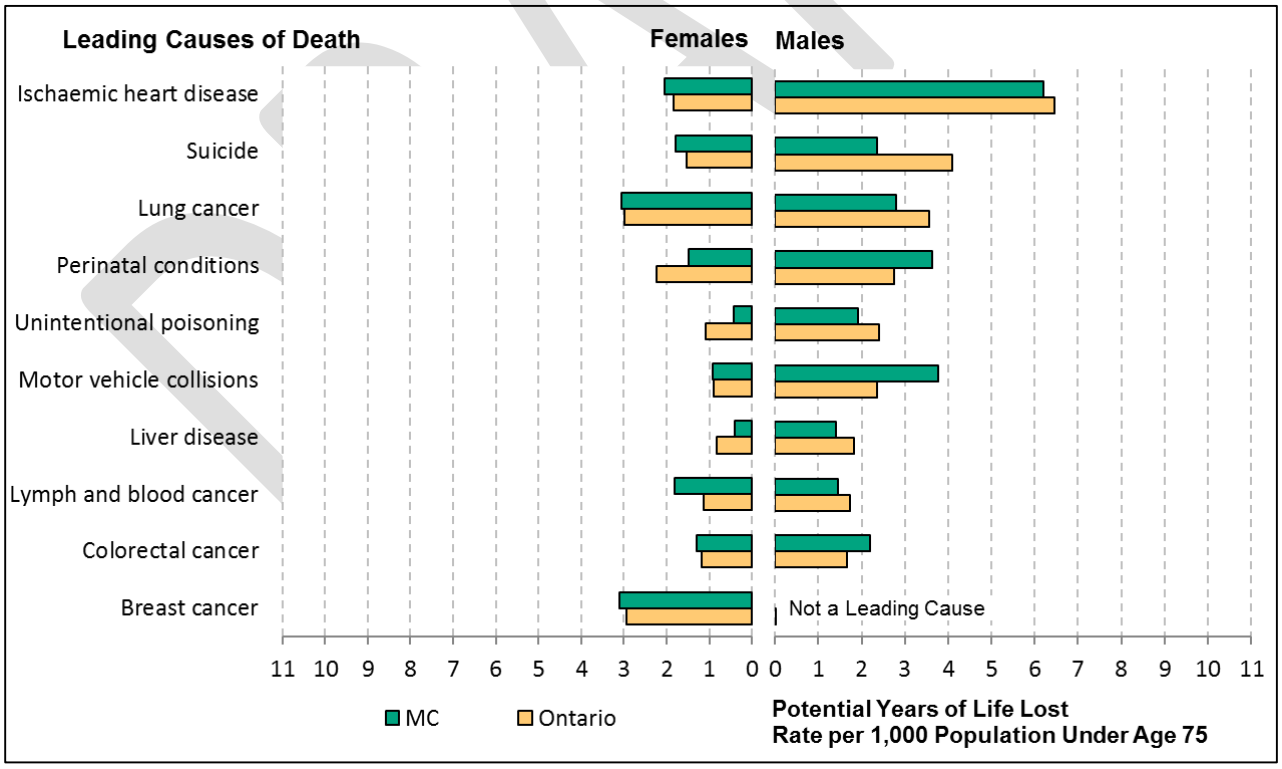
Ischaemic heart disease had the highest PYLL rate for males in both Middlesex County and Ontario. The PYLL rate for Middlesex County males was slightly lower than that for Ontario.

Deaths due motor vehicle collisions had the 2nd highest PYLL rate for males in Middlesex County; a rate higher than that for Ontario.

The presence of deaths due to perinatal conditions in this list of PYLL rates is largely reflective of the very young ages at which people die of these conditions. Compared to Ontario, the rate among women was lower for Middlesex County females, but higher for Middlesex County males.

For all cancers on the list (i.e., lung, lymph and blood, colorectal and breast), the PYLL rates for women were higher for Middlesex County than Ontario.

Figure 5. Potential years of life lost (PYLL) for leading causes of death, by sex, Middlesex County Ontario, 2010 to 2012 average.



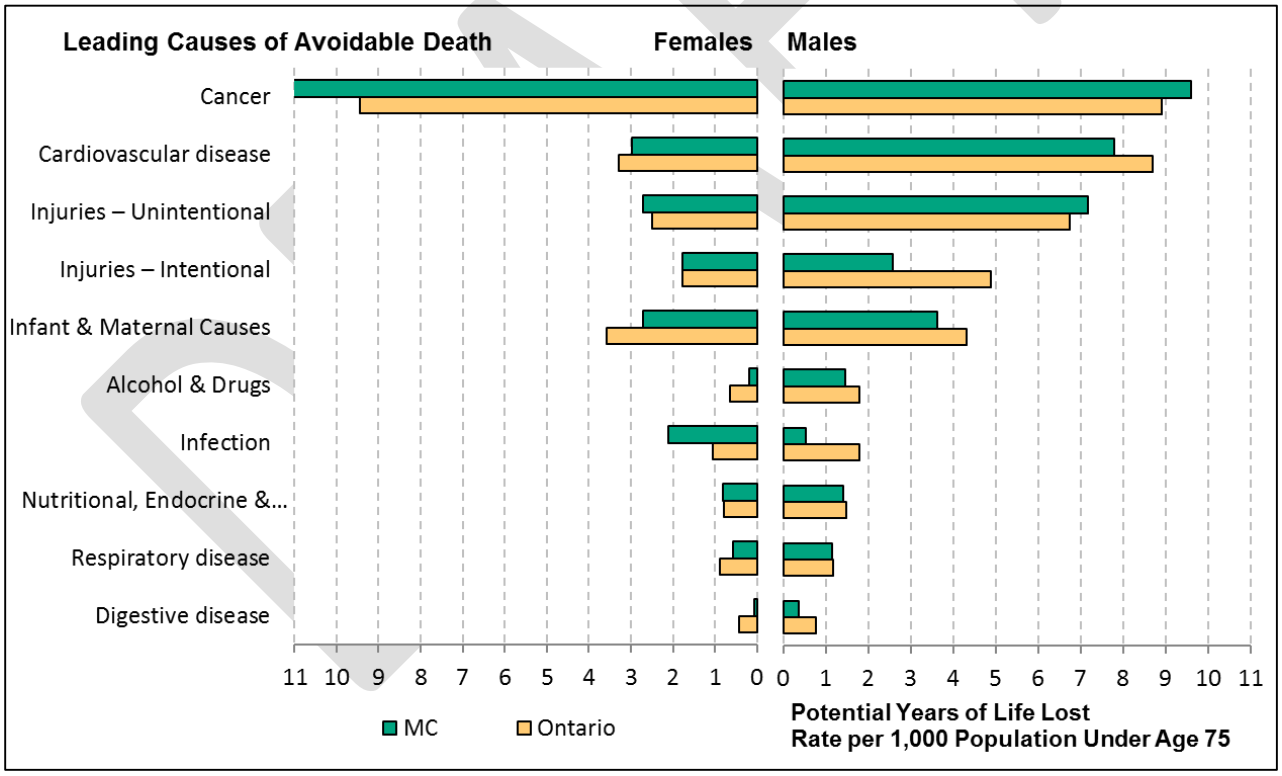
Data source: Ontario Mortality Data, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 21, 2018. Population Estimates, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario, Date Extracted: May 11, 2018.

Avoidable death refers to the number of deaths for every 1,000 people that could potentially have been avoided through effective health care, health promotion and disease prevention policies. The lower the number the better; it means that fewer individuals died prematurely from preventable or treatable causes. As was the case in Ontario, males showed higher rates of PYLL from avoidable causes than females in Middlesex County, generally reflecting higher rates of deaths in males at younger ages (Figure 6). For both sexes, cancer was the leading cause of avoidable death in both Middlesex County and Ontario. The PYLL rates for both sexes were higher for Middlesex County residents compared to Ontario.

Cardiovascular diseases, such as ischaemic heart disease, cerebrovascular disease, and rheumatic heart disease, were the second leading cause of avoidable death for both sexes in Middlesex County. PYLL rates for both females and males in Middlesex County were lower than Ontario.

Among females in Middlesex County, the third leading causes of avoidable death were due to unintentional injuries (e.g., falls, accidental poisoning, drowning) and infant and maternal causes (e.g., complications of perinatal period, congenital malformations, chromosomal anomalies). Among males in Middlesex County, the third leading cause of avoidable death was unintentional injuries and the PYLL rate was higher than Ontario.

Figure 6. Potential years of life lost from leading causes of avoidable death, by sex, Middlesex County and Ontario, 2010 to 2012 average.



Data source: Ontario Mortality Data, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 21, 2018. Population Estimates, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario, Date Extracted: May 11, 2018.

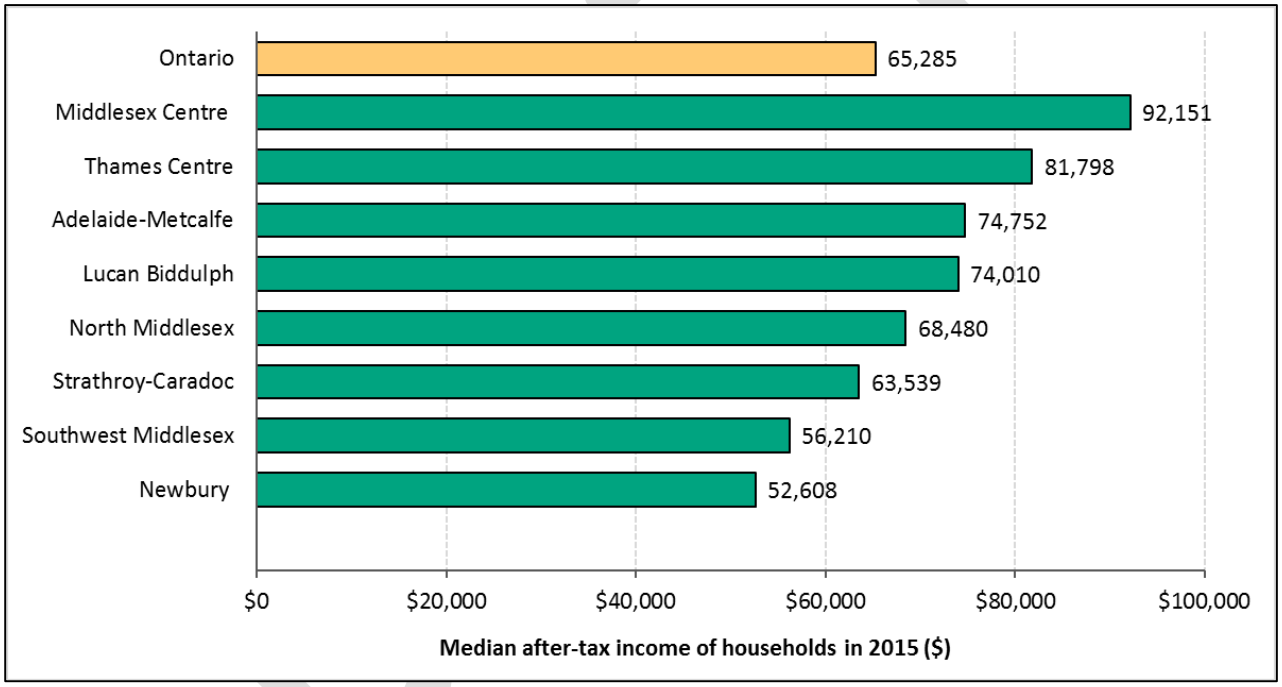
For further details regarding deaths in Middlesex County, refer to Appendix A.

Social Determinants of Health

Understanding the conditions in which people are born, grow up, live, work and play are known as the social determinants of health and contribute to the population health needs of communities. The programs and services delivered by the Middlesex-London Health Unit aim to reduce the negative impact of social determinants that contribute to avoidable differences in the health status of populations (i.e., health inequities) (Ontario Ministry of Health and Long-Term Care, 2018). Better health is associated with better socio-economic status (Williams, 2018). Generally, Middlesex County is better off than the province in terms of three key determinants of health: income, employment and education. However, within Middlesex County some disparities persist.

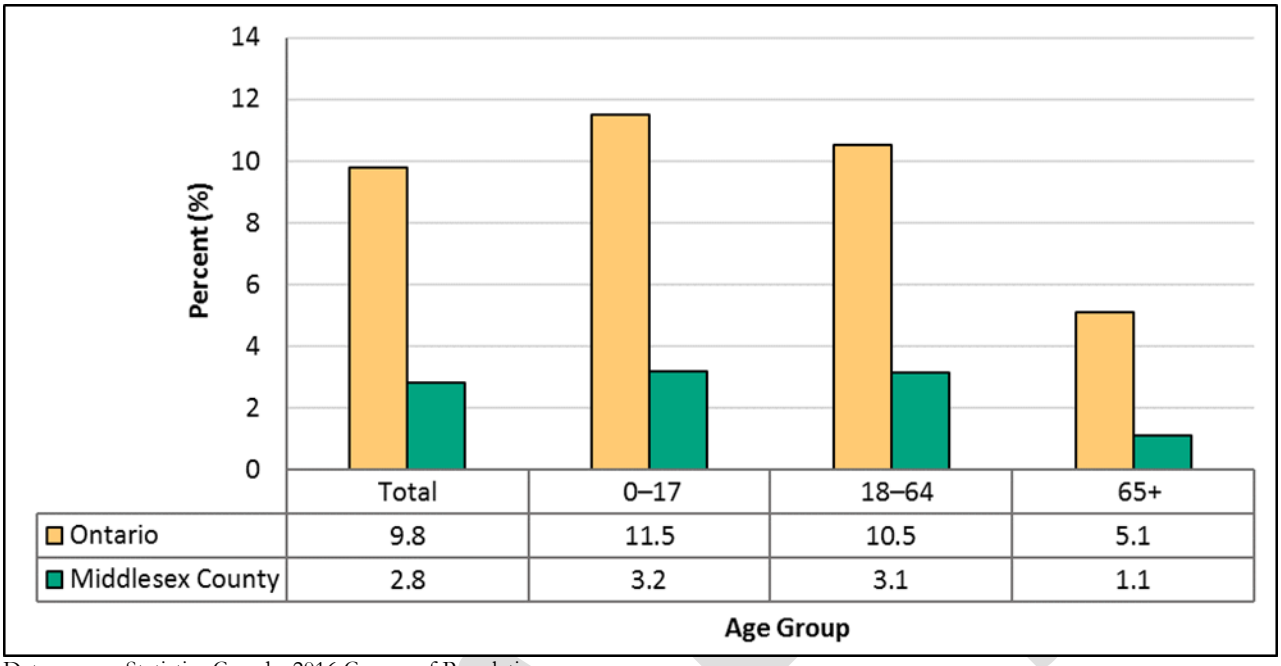
Median household income was higher than the Ontario median household income in five out of the eight municipalities and Middlesex County had a much lower percent of the population that was relatively worse-off financially living in low-income after tax in 2015 (2.8%) compared with Ontario (9.8%). However, children are disproportionately affected by low income within Middlesex County compared with seniors aged 65 and older.

Figure 7. Median after-tax income of households, Middlesex County by lower tier municipality and Ontario, 2015.



Data source: Statistics Canada. 2016 Census of Population

Figure 8. Percent of the population below the low income cut-off after tax, by age group, Middlesex County and Ontario, 2015.



Data source: Statistics Canada. 2016 Census of Population.

Unemployment rates in Middlesex County were generally better than the province and seven out of eight of the municipalities (all but the Village of Newbury) had rates lower than the province.

Table 2. Unemployment count and rate for population aged 15+, Middlesex County lower tier municipalities and Ontario, 2015.

Region	Number Unemployed	Number Participating in Labour Force	Unemployment Rate (%)
Newbury	35	190	18.4
Lucan Biddulph	130	2,730	7.4
Strathroy-Caradoc	545	11,235	4.9
Southwest Middlesex	135	3,000	4.5
Thames Centre	345	7,680	4.5
Middlesex Centre	425	9,690	4.4
North Middlesex	155	3,535	4.4
Adelaide-Metcalfe	65	1,715	3.8
Middlesex County	1,835	39,775	4.6
Ontario	529,525	7,141,675	7.4

Data source: Statistics Canada - 2016 Census, 25% Sample Data. Catalogue Number 98-400-X2016365.

Post-secondary education levels in Middlesex County have increased over time from 58.6% in 2006 to 64.1% in 2016 and became similar to the province in 2016 (65.1%). However, the type of postsecondary education differed. The residents of Middlesex County were more likely to have a college, apprenticeship or trades certificate and less likely to have a university degree than Ontarians as a whole.

Table 3. Percent of the population (age 25–64) by highest educational attainment, Middlesex County and Ontario, 2016.

Highest Level of Educational Attainment	Middlesex County (%)	Ontario (%)
No certificate, diploma or degree	9.9	10.4
High school certificate or equivalent	26.1	24.5
Postsecondary certificate, diploma or degree	64.1	65.1
Apprenticeship or trades certificate or diploma	9.2	6.2
College, CEGEP or other non-university certificate or diploma	33.7	24.7
University certificate or diploma below the bachelor level	2.2	2.4
University certificate, diploma or degree	19.0	31.9

Data source: Statistics Canada, 2016 Census of the Population.

For further details regarding social determinants of health, refer to Appendix A.

Organizational Practices

Overview

The Middlesex-London Health Unit takes great effort to deliver the best possible public health programs and services for the residents of Middlesex County and to meet the organizational requirements of the Ministry of Health and Long-Term Care. To meet these requirements, boards must:

- Deliver public health programs and services in accordance with the Foundational and Program Standards and incorporated protocols and guidelines
- Be accountable for using public health funding efficiently and for its intended purpose
- Use recommended best practices in governance and organizational processes
- Foster a culture of excellence in professional practice and a culture of quality and continuous organizational self-improvement.

Stakeholder Perspectives

There was no specific reference to organizational practices in the municipal councillor survey or the key informant interviews.

Current State

Considerable efforts have been undertaken to ensure that MLHU organizational practices optimize program and service delivery and ensure accountability for Middlesex County residents. Activities that support Ministry requirements include the annual service plan submission and reporting on accountability agreement indicators. The Annual Service Plan and Budget Submission is prepared by boards of health to communicate their program plans and budgeted expenditures for a given year. Information provided in the Annual Service Plan describes the programs and services boards of health deliver in accordance with the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, based on local needs and budgets at the program level. The Annual Service Plan includes board of health generated objectives and measures for monitoring achievements and reflects the requirements in the Standards.

From a fiduciary perspective, MLHU has adopted robust financial processes and controls including Program Budgeting Marginal Analysis (PBMA), quarterly variance reporting, and the factual certificate.

PBMA is a criteria-based budgeting process that facilitates reallocation of resources based on maximizing services. This is done through the transparent application of pre-defined criteria and decision-making processes to prioritize where proposed funding investments and disinvestments are made.

Health Unit management completes a factual certificate to increase oversight in key areas of financial and risk management. The certificate process ensures that the Finance and Facilities Committee has done its due diligence. The certificate is reviewed on a quarterly basis alongside financial updates. Management also provides financial analysis for each quarter and reports the actual and projected budget variance as well as any budget adjustments. Included are noteworthy items that have arisen since the previous financial update that could impact the Middlesex-London Health Unit budget.

From a governance perspective, MLHU has implemented a comprehensive governance program including board of health nomination, recruitment, orientation, development, annual attestations, risk management, strategic planning, Medical Officer of Health / Chief Executive Officer performance appraisal and bylaw, policy, and procedures review and development.

Regarding a culture of excellence, quality and continue improvement, MLHU has a chief nursing officer, nursing practice council, and a research advisory chair. MLHU has also implemented a detailed program planning and evaluation framework and is in the process of implementing a project management office.

Best Practices

Literature Scan

In other settings, it is public health professionals educating and supporting others to deliver the services rather than delivering services themselves. Some examples are family doctors or pharmacists providing immunizations, health screening, and health promotion messaging and schools implementing healthy policy and delivering public-health related curricula. Similarly, public health professionals can incorporate already existing facilities and infrastructure within the community into their public health services, such as referring clients to physical activity facilities or encouraging the use of walking trails; this reduces the amount of travel and potential costs to individuals while also not incurring operational costs for the public health system. Several results advocate for conducting community resource inventories or gap analyses to determine what services are being delivered and by whom to reduce redundancies in service provision.

While having public health issues addressed by others within the community has many benefits to improving access to services and reducing costs to the public health system, it can make it potentially challenging for community members to become aware of, and navigate to, all the different services. This emphasizes the importance of co-ordinating services. Developing formal partnerships with community stakeholders can improve co-ordination of effort, reduce duplication, incorporate non-health sector contributors to health and wellbeing, and provide consistent messaging; however, they also require planned communication to the community to raise awareness and inform how to access services. Some jurisdictions also incorporate the role of a wellness or system navigator who connects clients to the various services in their community depending upon their health needs.

Staffing mix also has an impact on maximizing service delivery and available resources. While mainly discussed within the context of primary health care teams whose services addressed public health issues, a prevalent model is multidisciplinary teams working together to provide services. The composition of these teams is dependent upon the needs of the specific community but can include not just physicians and nurses, but also allied health professionals, community health workers, and social service providers. Having multiple disciplines on the same team can improve the quality of care and reduce the need to travel as different disciplines are available together to provide their expertise. It can also improve the timeliness and cost-effectiveness of care as clients can receive service from the most appropriate professional, not necessarily the most expensive, for example receiving an immunization from a nurse practitioner or pharmacist rather than waiting to see the physician, who is then available to provide services outside of other professions' scopes. Success of this model necessitates that professionals practice at the full scope of their profession and with clear role delineation, thereby increasing the variety of services that are available in the community, often at reduced costs. Along those lines, several results also advocate for the increased use of generalist, as opposed to specialist professionals, as they can provide a greater breadth of services. This can be important in rural areas which may have difficulty recruiting or affording health care professionals or not have the volume of requests to support a specialist. Increasing the use of lay health educators or community health workers is also promoted as a more cost effective means of providing education and outreach, connecting clients to community resources, and possibly performing direct services such as screening and rapid tests.

For further details, see Appendix B

Environmental Scan

Other health units commented on the difficulty of obtaining data for rural areas but that it is important that feedback opportunities be built into program planning and evaluation.

Strategies to more effectively delivery services to rural populations included:

- Communication planning and resource coordination
- Educating municipal candidates about public health issues as a helpful way of ensuring key stakeholders understand the work of health units
- Development of a community engagement strategy to guide working with rural residents and municipalities
- Using community development approaches
- Ensuring that the board is representative of the community.

For further details, see Appendix E

Accessibility

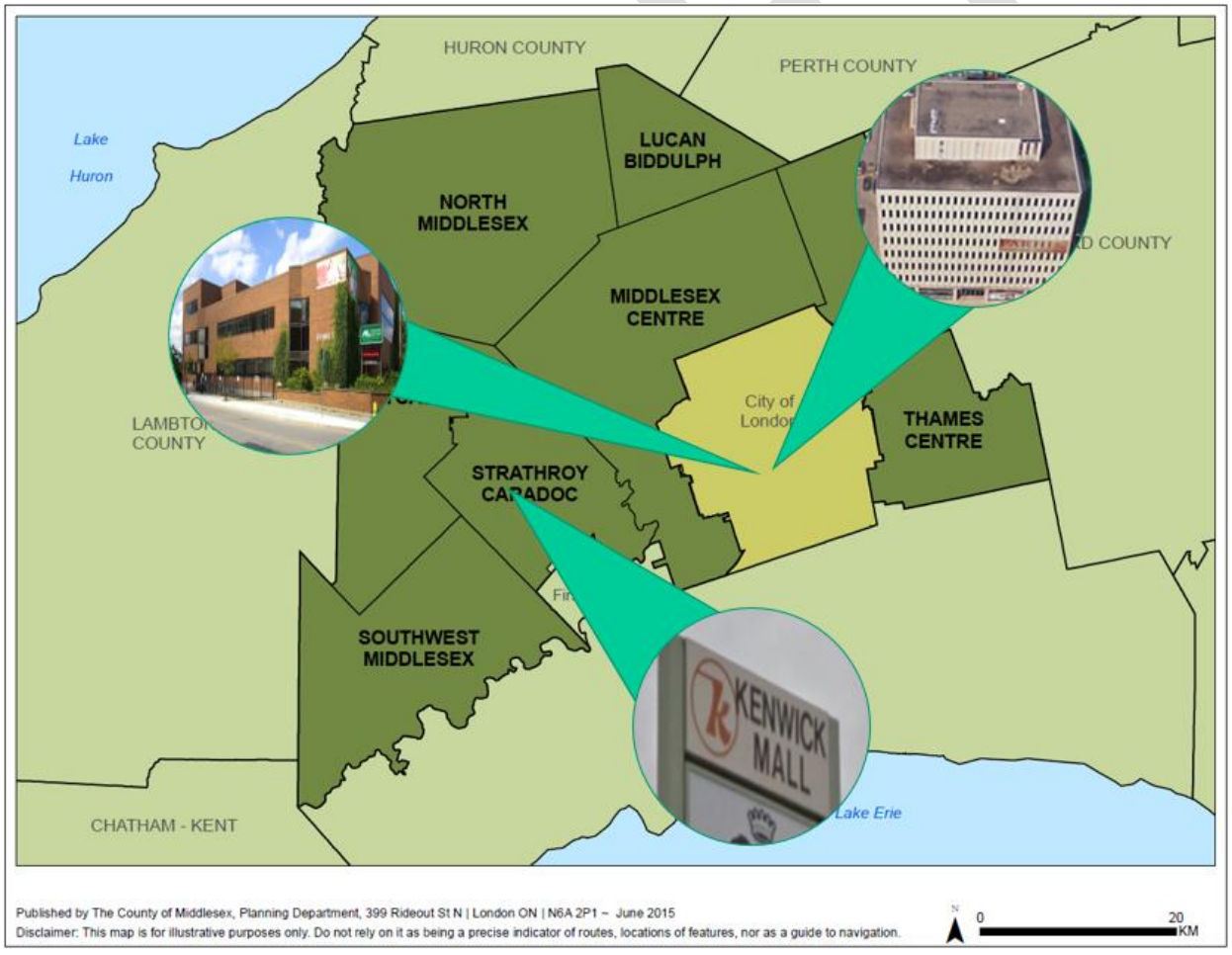
Overview

Low population densities can make it difficult to have health care offices and providers available in every community due to a lack of critical mass and economies of scale. This results in rural populations often needing to travel greater distances to access services or having trouble navigating the health system as some services are available locally while others are not.

Current State

The Middlesex-London Health Unit operates three different physical facilities, one of them being in Middlesex County at the Kenwick Mall in Strathroy. While MLHU does direct service delivery to clients in these offices, the majority of work is conducted as outreach in homes, schools, restaurants, long-term care homes and other spaces throughout Middlesex County as well as through numerous forms of print, electronic and social media. Online channels are increasingly important and MLHU has established a strong virtual presence, including online with its website, social media, online learning modules, over the phone, and through smart phone apps.

Figure 9. Middlesex-London Health Unit office locations, 2018.



Data source: The County of Middlesex, Planning Department. 399 Ridout St. N. | London ON | N6A 2P1 - July 2015

Stakeholder Perspectives

Of the respondents to the municipal councillor survey, 77% indicated that MLHU programs and services are very accessible or somewhat accessible to residents of Middlesex County.

Comments from the councillor survey indicated the Strathroy office services those in Strathroy or around it but not other parts of the county. Additionally, it was felt that there had been staffing cuts and fewer services are offered in Strathroy.

In the key informant interviews, all respondents noted that transportation is a significant challenge for their residents, particularly the most vulnerable residents. There is a lack of public transportation options for county residents and many residents are not familiar with MLHU locations and how to access them. It was also noted that it can be difficult for residents to get to downtown London for services.

All key informants also mentioned that libraries are becoming the hub of many communities and provide spaces for information to be shared and services to be delivered in a way that people would not be stigmatized for accessing MLHU services.

Lastly, all respondents touched upon the need to collaborate with community partners to share information and to use spaces that are already existing in the community. Some of the places to share information include schools, hospitals, primary care providers, town halls, municipality-specific web pages, local media, etc. Some of the physical spaces to use include schools, community rooms, grocery stores, libraries, town halls, social housing, etc.

Suggestions from the councillor survey to increase accessibility included:

- Providing programming in each community
- Offering more programming in Strathroy
- Participating in the regional transportation initiative
- Utilizing municipal/county spaces
- Offering rotating / mobile clinics around the county
- Improving the efficiency of responding to questions online or over the phone
- Offering programming through other health care providers / private sector

For further details, see Appendix C and D.

Best Practices

Literature Scan

Strategies to improve access to services in rural communities revolve around leveraging already-existing community assets. One approach is to collaborate with community organizations and other health service providers to deliver public health services. This can consist of public health employees delivering the services, but using other organizations' facilities, which reduces operational costs, increases the number of locations through which services can be delivered, and further encourages community development. It can also consist of already existing community organizations and health care providers addressing public health issues and providing public health services themselves, which expands potential hours and locations through which individuals can receive public health information and services, as well as reduces costs by requiring less public health-specific infrastructure and reducing duplication of efforts. In some settings, this is a component of the health care system as there are no specific public health agencies or organizations addressing specific issues.

In settings where primary care has responsibility for population and public health outcomes, the most prevalent model proposed is that of a "health hub", although the model goes by many different names. In

essence, a health hub is a model whereby many different health care providers and services are integrated, usually with multi-disciplinary teams, and co-located or networked with other social services such as housing, education, child services, and social assistance. Even in settings where separate public health entities exist, such as Ontario, the health hub model is promoted for rural settings with the vision that public health will collaborate with the health hubs. The health hub model helps to address several of the challenges rural communities face. Having multiple health and social services co-located or networked together can decrease operating costs such as physical and technological infrastructure. It can also decrease the amount of travelling rural residents are required to do to access various services. Having health and social services integrated to various degrees can also help to address the social determinants of health by improving access to, and collaboration among, the various services and supports such as housing, education, and social assistance and streamline referrals. Increased collaboration and integration of multiple services can also improve role clarity among providers, thereby reducing duplication of services which can free up capacity and resources.

Another theme which emerged was the need for expanding access to services in order to meet the diverse population needs within a community. In rural communities, populations are more dispersed, most services require driving to access, and unemployment and seasonal work are more prevalent, which can make accessing services from fixed sites during regular business hours more difficult. As such, different service delivery models are usually required; however, determining the appropriate service delivery model to implement depends upon the unique needs of each community and its residents, meeting people where they are and providing services in manners that are acceptable for them. Suggested methods for expanding access to services include, as mentioned above, providing services through other community organizations, facilities, or service providers, thereby increasing the number of locations and potential hours. Outreach, mobile, and home visiting services are also mentioned frequently, especially in the delivery of substance misuse, sexual health, and harm reduction services, but also to deliver maternal and child health services such as breastfeeding support. Developing formal service agreements between health authorities is another approach proposed from New South Wales in Australia to enable residents who live close to the border to access services from a neighbouring health authority should those services be closer. Finally, technology is advocated as being a manner through which to deliver both direct services through telehealth, as well as health education and information through web-based resources. Live telemedicine alleviates the challenge of having a full range of professionals located in the community, while pre-recorded telemedicine or web content and web-based tools address the challenge of accessing set locations during set hours. Examples of using technology to improve service delivery include using web-based tools to support self-care for chronic disease prevention and management, migrating vaccination reporting online, supplying information about community services online, telehealth for direct patient-provider consultations using either rooms equipped with required equipment or mobile smartphone applications, and telehealth to better connect community stakeholders and health care providers for collaboration, support, and professional development.

For further details, see Appendix B

Environmental Scan

Two of the five health units surveyed had more than one satellite office to service their populations and noted that these locations provided the same services as their main site.

All health units use community spaces for the delivery of their programs and services and described a wide range of locations including:

- Libraries
- Community centres
- Social housing common areas
- Recreation centres
- Municipal offices
- School spaces
- Community health centres
- Community hubs
- Early years centres
- Hospitals
- Faith-based organization spaces

They also outlined numerous other methods that they use to increase accessibility for their residents:

- Website, social media and other internet applications
- Phone service
- Information at municipal offices
- Drop off sites for water testing in rural communities
- Mobilizing and building capacity with community groups and partners to deliver services (health care providers, other social services, volunteers, etc.)
- Board meetings rotated between municipal and First Nation sites
- Partnerships with neighbouring health units when residents may have closer options
- Having staff working in schools across rural areas
- Staff attendance at community events
- Rotating the location of classes and courses
- Offering taxi vouchers

For further details, see Appendix E

Community Engagement

Overview

The Ontario Public Health Standards and the programs and services delivered by the Middlesex-London Health Unit are based on the principles of partnership, collaboration and engagement. This means engaging with multiple sectors, partners, communities, priority populations and citizens.

MLHU incorporates community engagement into all aspects of program planning, implementation and evaluation; however, there are always opportunities to improve engagement.

As part of this review, MLHU sought feedback from stakeholders on how to best engage the community using the International Association for Public Participation (IAP2) Spectrum.

Figure. 10 – IAP2 Spectrum of Public Participation

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PUBLIC PARTICIPATION GOAL	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives and/or solutions.	To obtain public feedback on analysis, alternatives and/or decision.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision-making in the hands of the public.
PROMISE TO THE PUBLIC	We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Data source: International Association for Public Participation. https://iap2canada.ca/Resources/Documents/0702-Foundations-Spectrum-MW-rev2%20(1).pdf accessed May 2019.

Stakeholder Perspectives

Councillors and key informants identified potential opportunities for engaging with Middlesex County stakeholders across the spectrum including:

- Social media
- Sharing information at other locations (libraries, schools, town halls, doctors' offices, etc.)
- Online newsletters
- Regular delegations to municipal councils
- Developing good relationships with municipal decision makers
- Information sessions in the community and to service organizations
- Information in tax notices
- Digital media
- Print media
- Service clubs
- Billboards and portable signage

- Formal feedback mechanisms for the public to utilize on an ongoing basis
- Ensuring that mandates for decision-making are clear

Community assets that councillors and key informants felt MLHU should keep in mind during community engagement included:

- Local service clubs
- Existing health providers
- School boards and education providers
- Public transit providers
- Municipal councils and administrators
- Social service agencies and not-for-profits
- Faith-based organizations
- Community centres
- Private businesses
- Libraries
- Local media outlets
- Municipal offices
- Parks
- Arenas
- Sports clubs

For further details, see Appendix C and D.

Current State

The Middlesex-London Health Unit engages a wide-range of community partners on all public health issues. Community and stakeholder engagement is a core public health principle that is integrated into all of the programs and services delivered by MLHU.

A planning and evaluation framework that MLHU has implemented explicitly describes the importance of engaging with stakeholder and the process for effective engagement at the programmatic level.

At the organizational level, MLHU has partnership agreements with stakeholders across Middlesex County which formalize relationships and clarify mandates.

A major engagement initiative that MLHU also conducts is healthcare provider outreach. There is a dedicated team that provides a direct link between the programs and services that MLHU provides and the healthcare providers across Middlesex County. The team conducts annual visits to each healthcare provider in addition to sending out monthly communications regarding important public health issues.

Best Practices

Literature Scan

Consistent across the included papers was the idea that each rural community is unique with its own specific combination of challenges and assets. As such, there is no one-size-fits-all service delivery model that will work for rural communities. As a result, the importance of engaging with community members, community organizations, municipal government agencies, and other local health care providers to assess local needs and assets and to develop local strategies was prominent among the results.

For further details, see Appendix B

Environmental Scan

In regards to community engagement, Ontario public health units surveyed noted the following considerations:

- Surveys
- Community meetings
- Feedback is built into program delivery and evaluation
- Ensuring that residents and municipalities are involved in the planning process
- A community engagement strategy to guide work
- Residents and municipalities are involved in all aspects of planning, implementation and evaluation
- Staff that act as liaisons between stakeholder groups
- Use a community development approach
- Ensuring board representation of the community
- Build and use coalitions
- Public health units can provide advice to municipalities when they make decisions regarding public health matters

For further details, see Appendix E.

Foundational Standards

Overview

The Ontario Public Health Standards outline that public health programs and services are to be informed by evidence, responsive to the needs and emerging issues of the health unit's population and use the best available evidence to address them. This is done through:

- Population health assessment;
- A focus on health equity to support people to reach their full health potential;
- The application of evidence-informed decision-making, research, knowledge exchange, program planning and evaluation, and communication;
- A focus on quality and transparency; and
- Emergency management to ensure that programs and services have the capacity to respond to new and emerging events and cope with a range of disruptions.

Stakeholder Perspectives

In the municipal councillor survey, when asked how important is it for MLHU to focus on the following standards for public health practice:

- 91% of respondents indicated that Health Equity is very important or extremely important
- 93% indicated that Effective Public Health Practice is very important or extremely important
- 69% indicated that Emergency Preparedness is very important or extremely important
- 77% indicated that Population Health Assessment is very important or extremely important

For further details, see Appendix C and D.

Current State

The Middlesex-London Health Unit has staff dedicated to supporting the Foundational Standards and the work of all of the public health programs and services delivered in Middlesex-London. The teams that provide this support include the Population Health Assessment Team, the Health Equity Core Team, the Program Planning & Evaluation Team and the Emergency Management Team. These staff are based out of the London offices of MLHU.

Best Practices

Literature Scan

To further understand local community needs and the ability to monitor progress on desired health outcomes, another prevalent theme was having systems in place to collect, monitor, analyze, and share local data. Strategies included conducting regular community health assessments, having data sharing agreements with other community organizations, and having standard Electronic Medical Records in order to aggregate local data from multiple providers.

For further details, see Appendix B

Program Standard / Health Topics

Chronic Disease Prevention and Well-Being

Overview

The goal of these public health services is to reduce the burden of chronic diseases of public health importance including, but not limited to, obesity, cardiovascular diseases, respiratory disease, cancer, diabetes, intermediate health states (such as metabolic syndrome and prediabetes), hypertension, dementia, mental illness, and addictions and improve well-being.

The top eight leading causes of death between 2010 and 2012 in Middlesex County were chronic diseases (Table 1 – page 9): ischemic heart disease, dementia and Alzheimer's disease, lung cancer, cerebrovascular diseases, lower respiratory diseases, colorectal cancer, diabetes and lymph and blood cancer. These accounted for 58.4% of all deaths.

The top ten leading causes of death were the same for Middlesex County and Ontario, with the top eight causes following the same ranking order.

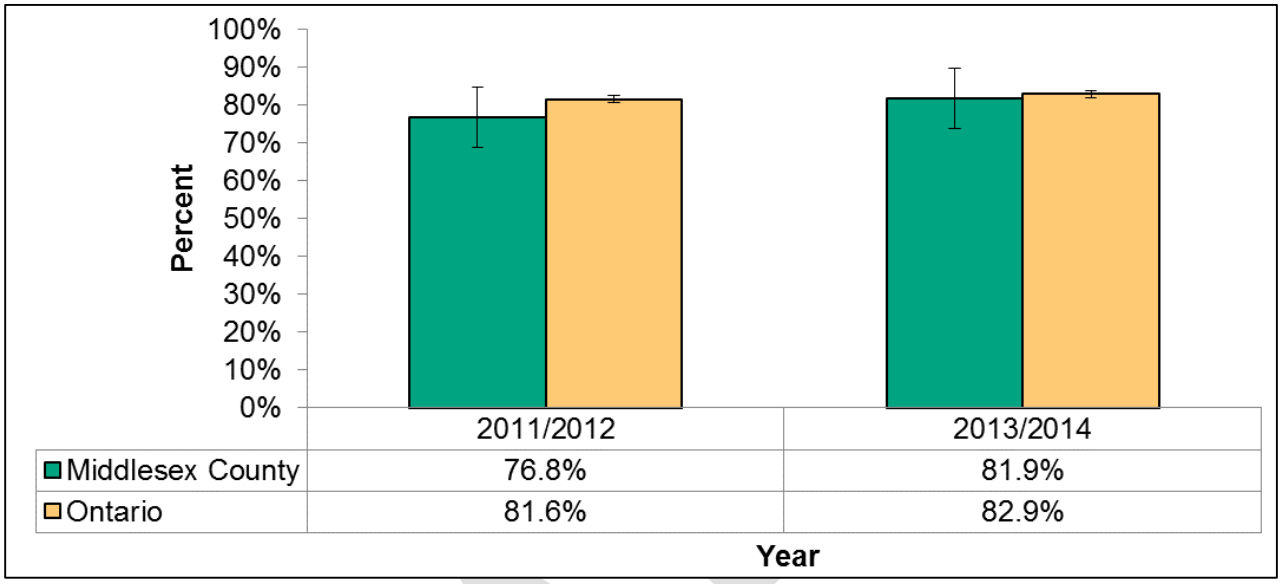
Ischemic heart disease, the leading cause of death in Middlesex County, accounted for 80% more deaths as lung cancer, the second leading cause of death.

Healthy weight has been measured by body mass index (BMI). This is ratio of weight to height (kg/m^2). Normal weight is classified as a BMI of 18.5–24.9, overweight is a BMI of 25.0–29.9 and obese is a BMI 30.0 and above. It is an important predictor of many chronic conditions including several of the leading preventable causes of death in Middlesex County. Over 60% the population was considered overweight or obese in Middlesex County in 2013/14. This represents an area of population health risk. Diabetes is a chronic condition for which BMI is a predictor. Looking at the rates of diabetes in the population there is a fairly steady rate over time between the years of 2004 to 2017. In general, the Middlesex County rate is lower than that of the province and males are disproportionately affected with higher rates.

Chronic diseases are linked to behavioural risk factors such as alcohol consumption, physical inactivity and smoking. In data from community health surveys from the years 2011 to 2014, a substantial portion of the population of Middlesex County reported behaviours that put them at risk for chronic diseases and injuries. For instance, only about half the population reported being active or moderately active during their leisure time, averaging 1.5 or more kcal/kg/day of energy expenditure from leisure-time physical activity. This is approximately the amount of exercise that is required to experience some health benefits. In the same time frame, only about half did not exceed the low risk alcohol drinking guidelines. Current smoking continues in about 20% of the adult population.

In 2013/2014, 81.9% of adults aged 19 years and over in Middlesex County reported that they were non-smokers (Figure 11). Compared to the province, Middlesex County had a similar proportion of non-smokers.

Figure 11. Percent of non-smokers among adults age 19 years or older, Middlesex County and Ontario, 2011/2012 and 2013/2014.

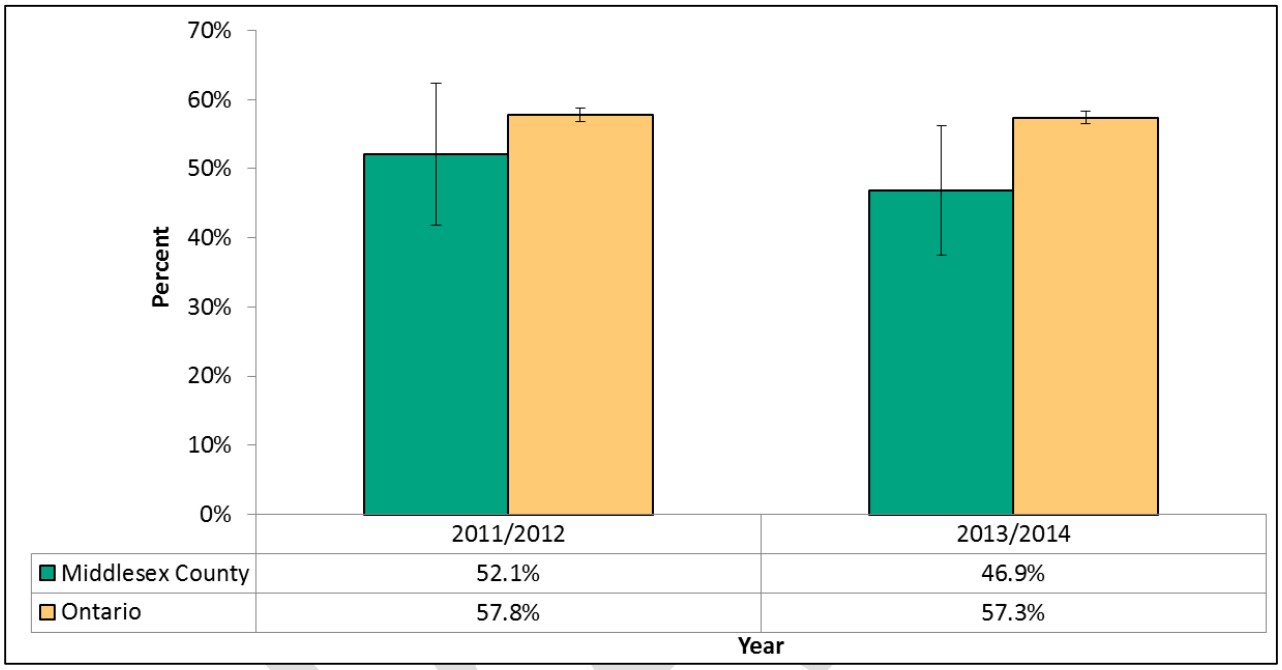


Data source: Canadian Community Health Survey, Statistics Canada, Share File, Ontario Ministry of Health and Long-Term Care.

The proportion of those aged 19 and older, in Middlesex County, who did not exceed the low risk drinking guidelines in 2013/2014 was 46.9% (Figure 12).

The rate in Middlesex County was significantly lower than that of Ontario (57.3%) in 2013/2014, however only approximately half did not exceed the drinking guideline in both 2011/2012 and 2013/2014 (Figure 12).

Figure 12. Percent of population (age 19 years and older) who did not exceed the Low Risk Drinking Guidelines, Middlesex County and Ontario, 2011/2012 and 2013/2014.

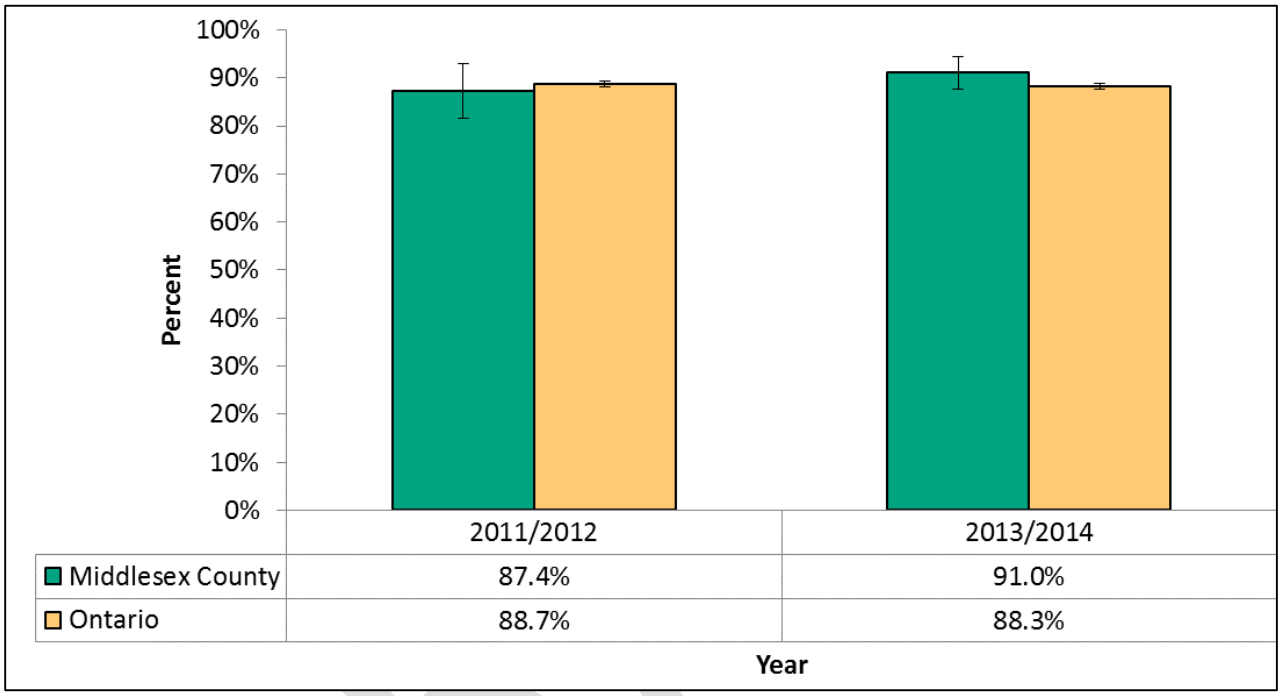


Data source: Canadian Community Health Survey, Statistics Canada, Share File, Ontario Ministry of Health and Long-Term Care.

Data indicates that Middlesex County patterns of behavioural risk factors are not different from Ontario. This could be due, partly, to a small number of people responding to the survey in Middlesex County. However, it likely indicates that lifestyle behaviour rates in Middlesex County are similar to the province.

Self-rated health is a self-assessment of an individual's current health status that encompasses both experiences and understanding of the causes and impacts of disease. It has been shown to be predictive of the development of chronic conditions and mortality. Over 90% of people rated their overall health as good, very good or excellent after taking physical, mental and social well-being into consideration. Respondents are asked to consider health, not just from the perspective of absence of disease and injury, but also to consider social, mental and physical aspects of their well-being.

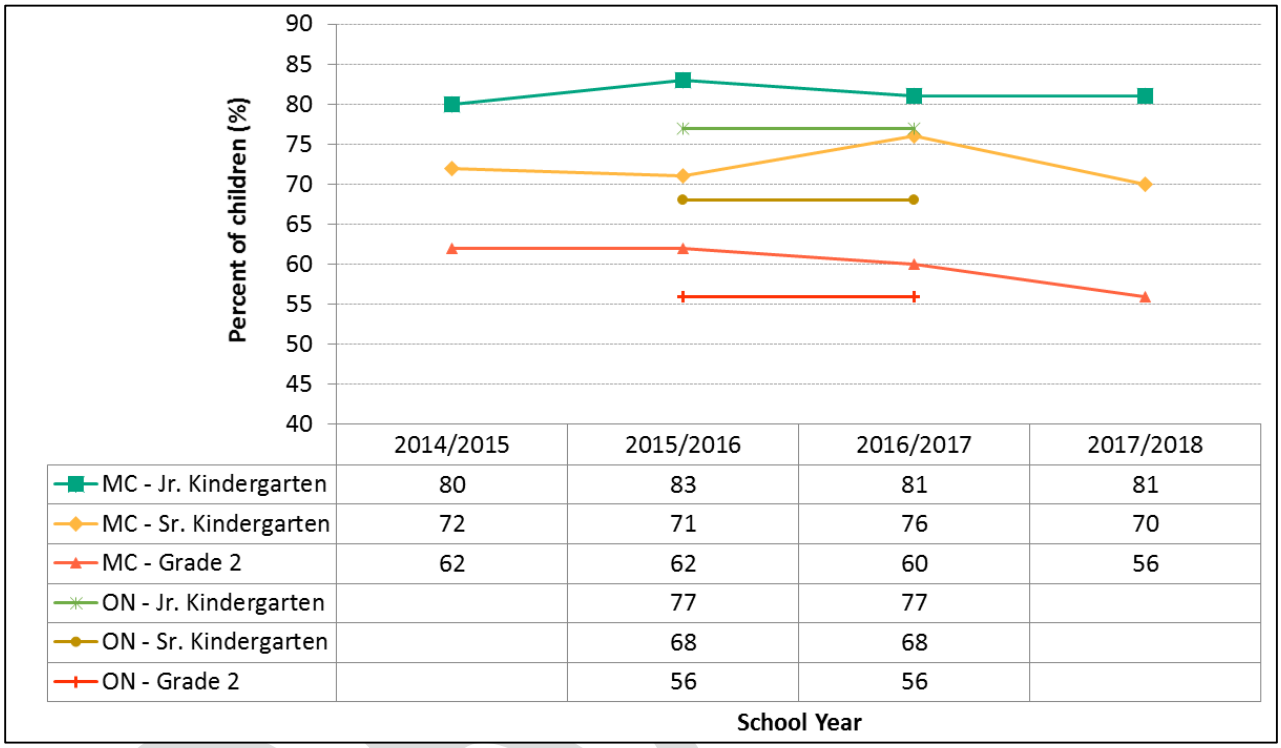
Figure 13. Percent of the population (age 12 years or older) who reported "excellent", "very good" or "good health", Middlesex County and Ontario, 2011/2012 and 2013/2014.



Data source: Canadian Community Health Survey, Statistics Canada, Share File, Ontario Ministry of Health and Long-Term Care.

Understanding tooth decay in the school aged children population is important because of its implications for quality of life. In Middlesex County, where some drinking water is not fluoridated, tooth decay increases as children age from junior kindergarten until grade 2. The percentage of children with no cavities or decay goes down and the number of teeth affected in those with decay increases as grade level goes up. In comparison to a sample of health units making up approximately half on the Ontario population, Middlesex County rates of decay were lower in the 2015/2016 and 2016/2017 school years.

Figure 14. Percent of children who had no visible tooth decay (caries free) in Middlesex County and Ontario.



	2014/2015	2015/2016	2016/2017	2017/2018
MC - Jr. Kindergarten	80	83	81	81
MC - Sr. Kindergarten	72	71	76	70
MC - Grade 2	62	62	60	56
ON - Jr. Kindergarten		77	77	
ON - Sr. Kindergarten		68	68	
ON - Grade 2		56	56	

Data source: Oral Health Information Surveillance System (OHISS), Ministry of Health and Long-Term Care. Extracted date: July 17, 2018 & Oakley, D. 2018. Summary of 2015-2017 Oral Health Screening: Results from Participating Ontario Health Units: For the Ontario Association of Public Health Dentistry.

For further details, see Appendix A.

Stakeholder Perspectives

In the councillor survey, 84% of respondents indicated that it is important for MLHU to focus on Chronic Disease Prevention and Well-being.

Mental health was also noted in both the survey and key informant interviews. Specifically, key informants felt that it is an issue that requires the involvement of many different community organizations to solve and not just the Health Unit. With limited resources, the response will depend on communication and awareness about where people can access services, and partnerships between those who have resources in the county.

For further details, see Appendix C and D.

Current Program and Service Delivery

Programming to meet Middlesex County needs for chronic disease prevention and well-being includes:

Sun Safety and Ultraviolet Radiation Exposure

Intervention/Service	Location of Delivery	Frequency of Delivery
Provide health education on Sun Safety	Anywhere in the community that is requesting education or information on Sun Safety	Upon request
Increase public awareness of skin cancer and sun protective behaviours through social media	Social media platforms such as Facebook, Instagram, Twitter and the Carrot app	Weekly in the summer months
Advocate and collaborate with the Ontario Sun Safety Working Group to raise awareness and provide province wide recommendations on skin cancer prevention	Meet with working group to provide province wide messaging on Sun protective behaviours	Meet 3-4 times a year
Collaborate with the school health team to raise awareness and provide education on skin cancer prevention	Middlesex County schools	Upon request
Provide supportive environments by providing sun hats to high risk families within the Healthy Babies Healthy Children program	Healthy Baby Healthy Children home visits	Frequency of visits would vary for each family
Promote the Skin Cancer Prevention Act to reduce youth access to artificial tanning services	Artificial tanning operators – 7 in Middlesex County	Annual inspection to provide vendor education and ensure that signage is posted. Additional inspections would occur after a complaint has been received.
Environmental Support/Policy Development/Advocacy	Municipalities, workplaces, childcare facilities and programs and schools	Ongoing – frequency and location of service is dependent upon uptake

Food Literacy

Intervention/Service	Location of Delivery	Frequency of Delivery
Ailsa Craig and Area Food Bank food literacy program– a group of community members interested in cooking healthy, seasonal, low-cost recipes meet to prepare and enjoy a full meal together. Food literacy skills are developed and enhanced (including food and nutrition knowledge; food skills; self-efficacy and confidence) to improve dietary behaviours.	Community space (e.g., recreation facility kitchen space, faith-based organization's kitchen; typically in Ailsa Craig and/or Parkhill)	Pilot project initially conducted in April 2018. Will offer programming as requested, likely 2-4 times annually (seasonally).
Increase public awareness of healthy eating behaviours and increased community service capacity for the provision of food literacy programs and services through partnerships and social media platforms	Social media platforms such as Facebook, Instagram, and Twitter and promotion of UnlockFood.ca	Ongoing
Group Home and Youth Opportunities Unlimited Food Literacy Programming and Group Home Client Consultations	Strathroy (YOU), Ailsa Craig (Craigwood Youth Services) and Parkhill (Anago-Parkhill Therapeutic Care Residence)	Approximately 3 – 4 times annually per site

Food Insecurity

Intervention/Service	Location of Delivery	Frequency of Delivery
Collection of Nutritious Food Basket costing data	Grocery stores (costing)	Once per year
Advocating for provincial and federal policies to reduce the rate of household food insecurity (e.g., increased social assistance rates, basic income, affordable housing, annual monitoring of food insecurity)	N/A	Ongoing
Distribution of Harvest Bucks (vouchers redeemable for fresh vegetables and fruit at participating locations)	Community organizations (e.g., in 2018 – Oneida Nation of the Thames, SOAHAC Muncey)	Ongoing – community organizations distribute Bucks through their programming throughout the year based on program schedules
Increase public awareness of impact of food insecurity and the	Social media platforms such as Facebook, Instagram, and Twitter	Ongoing – capitalizing on "opportunities" when they present themselves

need for income-based solutions through social media		

Food Systems and Food Environment

Intervention/Service	Location of Delivery	Frequency of Delivery
Partnerships and Capacity Building- Work with Healthy Kids Community Challenge (HKCC) Middlesex County	Komoka Community Centre	2015-2017 (3 meetings of steering committee per year)
Partnerships and Capacity Building- Participation in 2018 Middlesex County Agriculture Forum	Coldstream Community Centre	April 18, 2018
Public Awareness and Education, Policy; Partnerships and Capacity Building- Improve food environments in Middlesex-London re: sugar sweetened beverages/ Marketing to Kids	Social media platforms such as Facebook, Instagram, and Twitter, and mass media channels as resources permit	1/year campaign for sports teams Ongoing through website/social media
Advocacy and Policy, Public Awareness and Education, Partnerships and Capacity Building- Middlesex-London Food Policy Council	Social media and website, meetings held at Middlesex County Building Ridout St. London, events across City and County	Established Nov. 2016; 9 meetings/year Action Groups; 5 meetings/year Events; 2 in 2017, 4 in 2018
Public Awareness and Education, Partnerships and Capacity Building- Development of Get Fresh... Eat Local Guide with Middlesex County Federation of Agriculture	Office work; provided nutrition content for guide	1/year
Public Awareness and Education, Policy; Partnerships and Capacity Building- Supporting workplaces wanting to make policy and culture change that would encourage healthy eating for employees (e.g., policy related to food and drink offered at meetings and events)	Workplaces	Upon request

Prevention of Tobacco Use and Emerging Products

Intervention/Service	Location of Delivery	Frequency of Delivery
Creation of a comprehensive substance use toolkit for high schools to provide support and resources related to tobacco, e-cigarettes and cannabis	Online Print	Upon request / as required
Education and awareness sessions related to emerging products such as e-cigarettes	In-person / onsite at requested location	Upon request
Support the development of comprehensive high school policies that create supportive environments and provide protection from second-hand smoke, tobacco and emerging products	Phone Email Dissemination of information / materials via mail or in-person on site	Upon request and / or in response to complaints
Host Smoke-Free Movie events to increase public awareness about the causal link between child and youth exposures to tobacco impressions in movies and tobacco use initiation	Municipality of Strathroy-Caradoc – Strathroy Fairgrounds	1 time per year
Implement Smoke-Free Movie activities that garner support for legislative changes to the movie rating system, including collection of signatures on petitions and engaging with local MPPs	Community spaces (e.g. parks) Social media/mass media MPP offices	Events to gather petition signatures happen over the course of the year Typically visits to MPP offices occur once/year
Host grassroots events in parks and playgrounds to promote tobacco- and vape-free restrictions	Community spaces (e.g. parks and playgrounds) Social media/mass media	3-4 times per year
Support and promote the That's Risky campaign to profile the risk between second-hand smoke exposure and breast cancer with young adults	Community spaces Social media/mass media	Campaign will occur once per year, with grassroots activities happening 1-2 times per year, as opportunities present themselves for appropriate community engagement
Promote and implement the Know What's in Your Mouth campaign to increase awareness about the dangers of smokeless tobacco use to young athletes and their parents	Community spaces (e.g. parks and playgrounds) High schools	1-2 times per year

Promote and disseminate WouldURather campaign materials with an emphasis on the "Don't Start and Win" category	Community spaces Social media/mass media	1 time per year
Participate and support SWTCAN's development of the Young Adult Male campaign to increase lifetime smoking abstinence rates among young adult males working in sales, service, and blue collar trades and to prevent young adult males who smoke occasionally from progressing to regular smoking	(in development)	(in development)

Tobacco Cessation

Intervention/Service	Location of Delivery	Frequency of Delivery
Tobacco Cessation Services through the Quit Clinic (one on one counselling and provision of nicotine replacement therapy at no cost)	MLHU Strathroy Office - Kenwick Mall Home visits Phone call and medication drop-offs	1 x month on site at Kenwick (depending on number of clients) Home visits based on needs of individual clients
Healthcare provider capacity building and partnerships Maintain Middlesex-London Tobacco Cessation Community of Practice (CoP) - sharing and dissemination of training opportunities and updated tobacco cessation resources; knowledge exchange among CoP members via online discussion board Dissemination of You Can Make It Happen Materials Training related to brief cessation interventions	Online (CoP) Discussion Board Email In-person / onsite Mail	Training related to brief cessation interventions upon request CoP updated monthly on CoP discussion board and via e-newsletter Knowledge exchange among CoP members as required by members Distribution of YCMIH materials upon request
Promotion of mass media campaigns related to smoking cessation to increase quit attempts	Dissemination of materials and messaging through mail Social media and online Media release	Mail out of resources happens 1 - 2 x/year or more frequent if requested Social media monthly (6-8 x / month) Media release 1-2 x / year
Support the development of policies that promote and support cessation for clients and employees within workplaces	Onsite / in-person meetings Phone and email communication MLHU website	Upon request

Protection from Second-hand Smoke and Emerging Products

Intervention/Service	Location of Delivery	Frequency of Delivery
Smoke-Free Housing Respond to complaints/ inquiries related to drifting second-hand tobacco and cannabis smoke in multi-unit housing Promotion of and advocacy for comprehensive smoke-free policies to landlords, property managers and tenants	Phone, mail and email (inquiries / complaints) Social media and online Mail for dissemination of resources In-person / onsite at buildings	Upon request Social media Oct / November and throughout the year as opportunities arise
Support the development of comprehensive policies that create supportive environments and provide protection from second-hand smoke and emerging products	Phone Email Dissemination of information / materials via mail or in-person on site	Upon request and / or in response to complaints
Promotion of campaigns related to the law and protection from second-hand smoke and emerging products Workplace campaigns Smoke-Free Parks Changes in legislation or bylaws Smoke is Smoke	Social media and online Paid advertising (print) Radio On-site in parks, workplaces etc. Email	1-2 x / year and / or dependent on changes to the legislation Oct during healthy workplace month
Work towards reducing retail density related to tobacco and e-cigarette retailers by the implementation of retail zoning and licencing measures	In-person Reports Email Phone	Dependant upon implementation plan and uptake by municipalities Licensing inspections for tobacco and e-cigarette retailers occur as new applications are received by municipalities

Tobacco Enforcement – Smoke-Free Ontario Act, Electronic Cigarettes Act, 2015 and municipal bylaws

Intervention/Service	Location of Delivery	Frequency of Delivery
Enforcement of the Smoke-Free Ontario Act – youth access provisions and display, promotion and marketing restrictions	Tobacco Retailers – approx. 45 in the County	Youth Access - at least three times per year Display Promotion and Handling Inspection – at least once per year New Retailer Onsite Education Visit – as needed Complaints generate additional inspections
Public Disclosure of tobacco retailer convictions and respond to request for property inquiries	Health Unit website	Ongoing
Enforcement of the Smoke-Free Ontario Act – public places and enclosed workplaces	Public places, workplaces, Middlesex Hospital Alliance (Strathroy General and Four Counties), common areas of multi-unit housing complexes, and schools (private, secondary and elementary)	Mandated to respond to all complaints received. In addition to complaint-based inspections, proactive inspections occur to support and promote compliance (as resources and capacity permit). 100% of all secondary schools are inspected and a meeting with school administration occurs at least once annually. Total Workplace, Schools, Hospitals, Vendors, Public Place Inspections for SFOA for 2017: Total Inspections: 4,764 County Inspections: 795 (16.7%) London Inspections: 3,969 (83.3%)
Enforcement of the Electronic Cigarettes Act, 2015	E-Cigarette Retailers – approx. 20 in the County	Youth Access - at least once per year Display Promotion and Handling Inspection – at least once per year New Retailer Onsite Education Visit – as needed Complaints generate additional inspections
Promotion and enforcement of the Strathroy-Caradoc Bylaw to Regulate and Prohibit Smoking Near Municipally-Owned Buildings	Arenas, community centres, municipal administration building, outdoor special events	Consultation with Municipal staff as requested/required. Complaint-based and proactive inspections, and the provision of signage scheduled on an ongoing and as-needed basis.

Promotion and enforcement of the Lucan Biddulph Smoke-free Municipal Spaces Bylaw	Arenas, trails, municipal administration buildings, public works offices, community centres, playgrounds, parks and sports fields, outdoor special events	Consultation with Municipal staff as requested/required. Complaint-based and proactive inspections, and the provision of signage scheduled on an ongoing and as-needed basis.
Environmental Support/Policy Development/Advocacy	Property that is under the management and oversight of municipal council, including land/property/spaces that fall under the Municipal Act.	Ongoing – uptake is dependant upon Municipal staff and Council support for policy change

Cannabis

Intervention/Service	Location of Delivery	Frequency of Delivery
Smoke-Free Housing Respond to complaints/ inquiries related to drifting second-hand cannabis smoke in multi-unit housing Promotion of and advocacy for comprehensive smoke-free policies to landlords, property managers and tenants to address cannabis use and the growth of cannabis in rental housing	Phone, mail and email (inquiries / complaints) Social media and online Mail for dissemination of resources In-person / onsite at buildings	Upon request Social media throughout the year as opportunities arise
Support the development of comprehensive policies that create supportive environments and provide protection from second-hand cannabis smoke	Phone Email Dissemination of information / materials via mail or in-person on site Email List Serv	Upon request and / or in response to complaints
Promotion of campaigns and provision of information related to the legalization of cannabis and promotion of the lower risk cannabis use guidelines to minimize harm from use of cannabis Workplace campaigns / workshops/mail-outs/inquiries Changes in legislation or bylaws Smoke is Smoke Local implementation of provincial/federal campaigns	Social media and online Paid advertising (print) Radio On-site in workplaces or through community events, etc. Email Healthcare Provider Outreach Email List Serv	1-2 x / year and / or dependent on changes to the legislation Oct during healthy workplace month

Creation of targeted messaging / materials for priority populations		
Provide advice and information regarding the public health approach to cannabis legalization, and sharing lessons learned from comprehensive tobacco control and alcohol, including retail density and zoning	In-person Reports Email Phone Email List Serv	Dependant upon implementation plan set out by the Provincial Government and decisions made by local municipalities regarding policies and bylaws to control the retail sale of cannabis
Creation of a comprehensive substance use toolkit for high schools to provide support and resources related to tobacco, e-cigarettes and cannabis	Online Print	Upon request / as required

Active Living/Physical Activity

Intervention/Service	Location of Delivery	Frequency of Delivery
Knowledge Transfer (Education/Awareness /Skill Building/consultation support) based on request from community partners ---------- Recent example: Move, Sleep, Sit – Raising Active Children – promotion of the 24-Hour Movement Guidelines for the Early Years (0-4 Years) and connection with theme 4 of HKCC Power Off and Play via Ilderton EarlyON Programs in Middlesex County	From office via email/phone, at community spaces ---------- Ilderton EarlyON Programs (Ilderton, Thorndale, Lucan, Komoka, Dorchester)	On request ---------- Attended 9 Groups (month of July and 1st week of August 2018) during all Ilderton EarlyON Programs held in the county
Provide support, encouragement and skill building for daycare staff to encourage implementation of physical literacy and physical activity practices and policies in child care centres	Daycare centres in Middlesex	On request
2013- 2017 inMotion Challenge campaign to promote physical activity *large campaign completed 2017.	Across Middlesex	Month of October and year round

Healthy Communities/Healthy Community Design

Intervention/Service	Location of Delivery	Frequency of Delivery
Healthy Communities / Healthy Community Design - Consultation	Meetings with consultants and Planners (various locations within Middlesex County) From office via email/phone	Upon request – ad hoc, e.g. Middlesex County Trails Guide, Middlesex Centre Trails Master Plan
Active Transportation - Consultation	Meetings with consultants and Planners (various locations within Middlesex County) From office via email/phone	Upon request – ad hoc
Public Health recommendations for official plans, master plans, etc.	Reports & presentations (various locations within Middlesex County) From office	When municipal processes are undertaken
Campaigns	Various locations within Middlesex County, e.g. Share The Road Signage Project (2014) - presentations to municipal Councils, road signage, radio ads, social media, hard copy promotional materials at various MC outlets)	As per partnership opportunities

Active & Safe School Travel

Intervention/Service	Location of Delivery	Frequency of Delivery
As part of a partnership, create supportive environments for active school travel by providing schools opportunity to submit expressions of interest for bike racks, and "wayfinding" signs with education packages	Elementary Schools	One time 2018-2019
Consultation with school staff, school community, or PHN's assigned to schools for the facilitation of School Travel Planning (STP) in order to remove barriers and promote active school travel	MLHU office via email/phone Data collection activities, events, and STP meetings and/or presentations at the school level occur at schools. Since 2010- Schools committed to School Travel Planning (STP) process: LDSCB = London 4, Middlesex 1 TVDSB = London 17, Middlesex 2 *note higher proportion of county schools have majority of students bussed.	Dependent on a particular school's involvement and commitment to the program. Average weekly consultations in an STP program school.
Policy input: As part of ASRTS partnership, provides input with data and evidence into policy decisions affecting safe active travel to school	Meetings, site visits (various locations).	When municipal processes are undertaken & Upon request – ad hoc
Through ASRTS, Student transportation services is hoping to implement a pilot project for Walking School Bus for schools that consent	School neighbourhoods and school property	Undetermined. New project.

Healthy Workplace Program

Intervention/Service	Location of Delivery	Frequency of Delivery
Biweekly and seasonal electronic newsletter	Email to workplace contacts	Bi weekly
Resources – guides and displays	Physical copies are available for drop off or pick up at MLHU offices by workplace representatives and arrangements made according convenience for both parties	Intermittent through year as requested
Annual workplace workshop. Topic changes by year e.g. physical activity in the workplace, healthy aging in the workplace, Sept 2018: Cannabis and the Workplace	Workshop typically held at a central location in London	Annually
Consultation for workplaces	From office via email/phone On location at workplaces	As requested throughout year

Oral Health

Intervention/Service	Location of Delivery	Frequency of Delivery
Follow Up	Follow up for all children screened in the clinic or at school	As required
Client Navigation	Assist families in finding a dentist / establishing a dental home	As required
Healthy Smiles Ontario (HSO) Program Promotion	HSO program is promoted throughout Middlesex County.	Ongoing

Food Safety

Overview

The goal of these public health services is to reduce the burden of food-borne illnesses.

Stakeholder Perspectives

In the councillor survey, 93% of respondents indicated that it is important for MLHU to focus on Food Safety. There were no comments or feedback regarding MLHU food safety programming in the key informant interviews.

For further details, see Appendix C and D.

Current Program and Service Delivery

Programming to meet Middlesex County needs for food safety includes:

Food Safety Inspections

Intervention/Service	Location of Delivery	Frequency of Delivery
Food Premises Inspections	All food premises in Middlesex County	1 – 3 compliance inspections per year, or more if required including re-inspections.
Bylaw Enforcement	All food premises in Middlesex County	1 – 3 checks per year, or more if required during re-inspections.
Special Events Inspections	Throughout Middlesex County	1 vendor inspection, depending on level of risk, per special event. Not all events are inspected, but assessed to determine if inspections are necessary.
Farmers Markets	Throughout Middlesex County	1 – 2 assessments per year at each Farmers Market, follow ups on a complaint basis and as required.

Food Handler Training

Intervention/Service	Location of Delivery	Frequency of Delivery
Food Handler Training Exams	MLHU Strathroy Office	1 per month
Food Hander Training Course Instruction	Offsite at various locations throughout the County (churches, service clubs etc.)	This varies depending on demonstrated need (roughly 5 -10 per year)

DineSafe – Disclosure Program / Mandatory Food Handler Certification

Intervention/Service	Location of Delivery	Frequency of Delivery
DineSafe Website	Online	Ongoing
DineSafe on-site posting	All food premises in Middlesex County	Ongoing, checked during food premises inspections, 1 – 3 times per year
Mandatory Food Handler Certification	All food premises in Middlesex County	Ongoing, checked during food premises inspections, 1 – 3 times per year

Complaints and Service Requests (Food Safety, Health Hazards)

Intervention/Service	Location of Delivery	Frequency of Delivery
Food Safety Complaints (food handling, suspected and confirmed foodborne illness follow-ups, outbreak management work)	All food premises in Middlesex County	Several per week

Healthy Environments

Overview

The goal of these public health services is to reduce exposure to health hazards and promote the development of healthy natural environments that support health and mitigate existing and emerging risks, including the impact of a changing climate.

Stakeholder Priorities

In the councillor survey, 77% of respondents indicated that it is important for MLHU to focus on healthy environments. There were no comments or feedback regarding MLHU healthy environments programming in the key informant interviews.

For further details, see Appendix C and D.

Current Program and Service Delivery

Programming to meet Middlesex County needs for healthy environments includes:

Inspections of Facilities

Intervention/Service	Location of Delivery	Frequency of Delivery
Seasonal Farm Housing Surveillance and Inspections Management and Response Awareness and Education	Farms throughout Middlesex County	Inspections occur 2 times per year Ongoing surveillance, awareness and education
Recreational Camps Surveillance and Inspections Management and Response Awareness and Education	Recreational Camps throughout Middlesex County	Inspections occur 1 time per year, and more depending of food safety risk assessment Ongoing surveillance, awareness and education
Health Hazard Complaints (bed bugs, mould, indoor air quality, hoarding, special risk and vulnerable occupancies)	Private residences and various locations throughout the County	Several per week
Extreme temperature Warnings / Alerts	Through media releases with a focus on vulnerable residents (schools, retirement homes, shelters etc.)	Approximately 10 – 15 alerts are issued per year

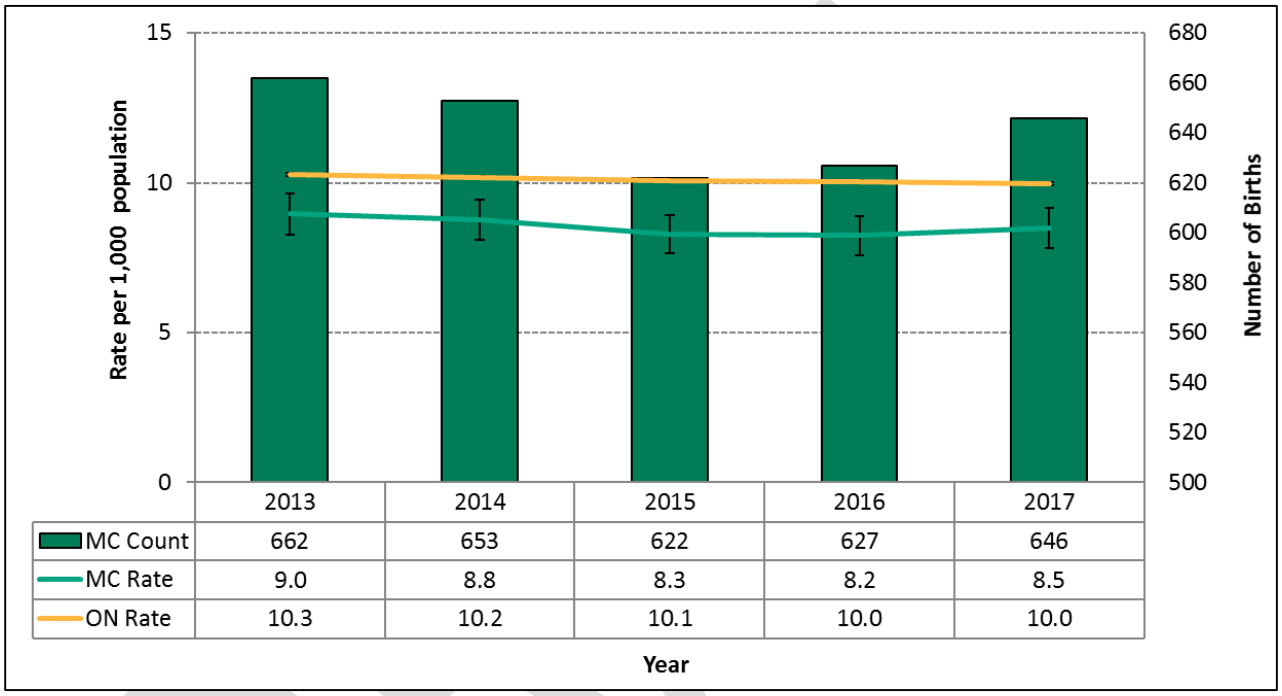
Healthy Growth and Development

Overview

The goal of these public health services is to achieve optimal preconception, pregnancy, newborn, child, youth, parental and family health.

Pregnancy rates in Middlesex County have remained relatively stable at a rate of approximately 8 births per 1,000 population. While stable, pregnancy rates in Middlesex County are consistently lower than those for Ontario.

Figure 15. Count and crude birth rates per 1,000 population, Middlesex County and Ontario, 2013 to 2017.

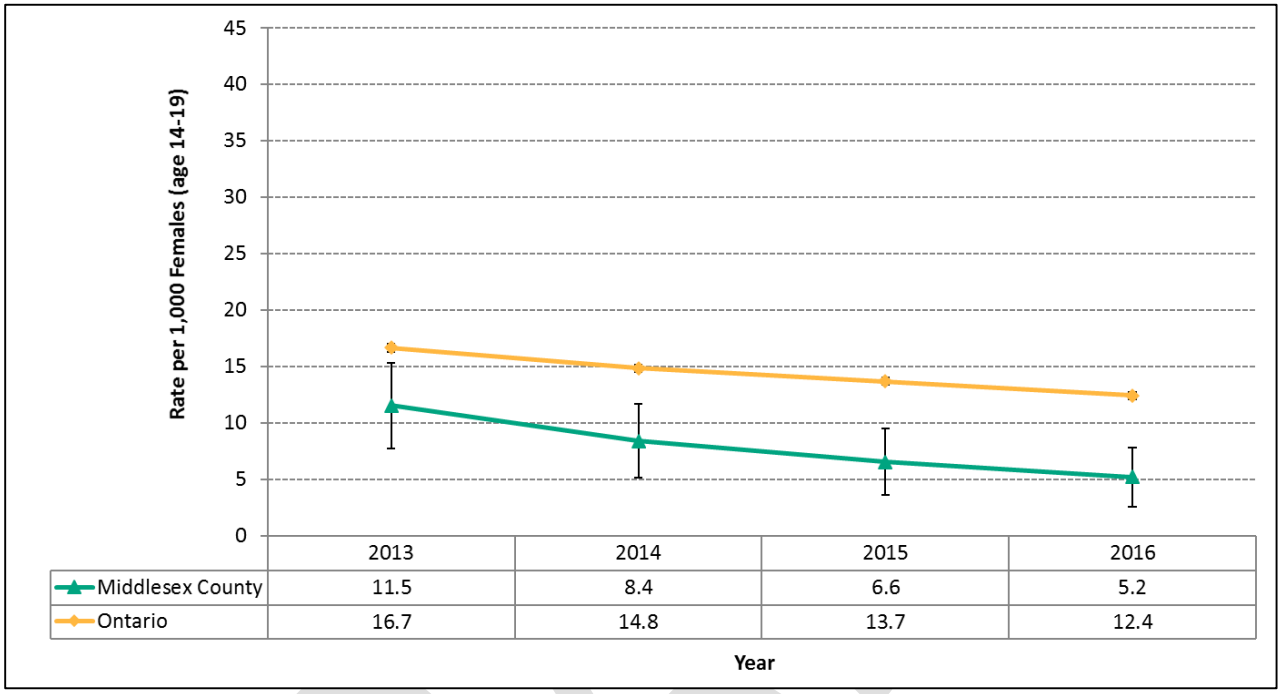


	2013	2014	2015	2016	2017
MC Count	662	653	622	627	646
MC Rate	9.0	8.8	8.3	8.2	8.5
ON Rate	10.3	10.2	10.1	10.0	10.0

Data source: BORN Information System, BORN Ontario. Information accessed on: July 7, 2018; Therapeutic abortions, Date Extracted: June 19, 2018 & Population Estimates, Date Extracted: May 11, 2018, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario.

In recent years, teen pregnancy (ages 14 to 19) rates in Middlesex County have been significantly lower than that for Ontario. The rates have declined each year from 2013 to 2016 which is a downward trend also observed in the province.

Figure 16. Teen pregnancy rate per 1,000 (age 14–19), Middlesex County and Ontario, 2013 to 2016.



	2013	2014	2015	2016
Middlesex County	11.5	8.4	6.6	5.2
Ontario	16.7	14.8	13.7	12.4

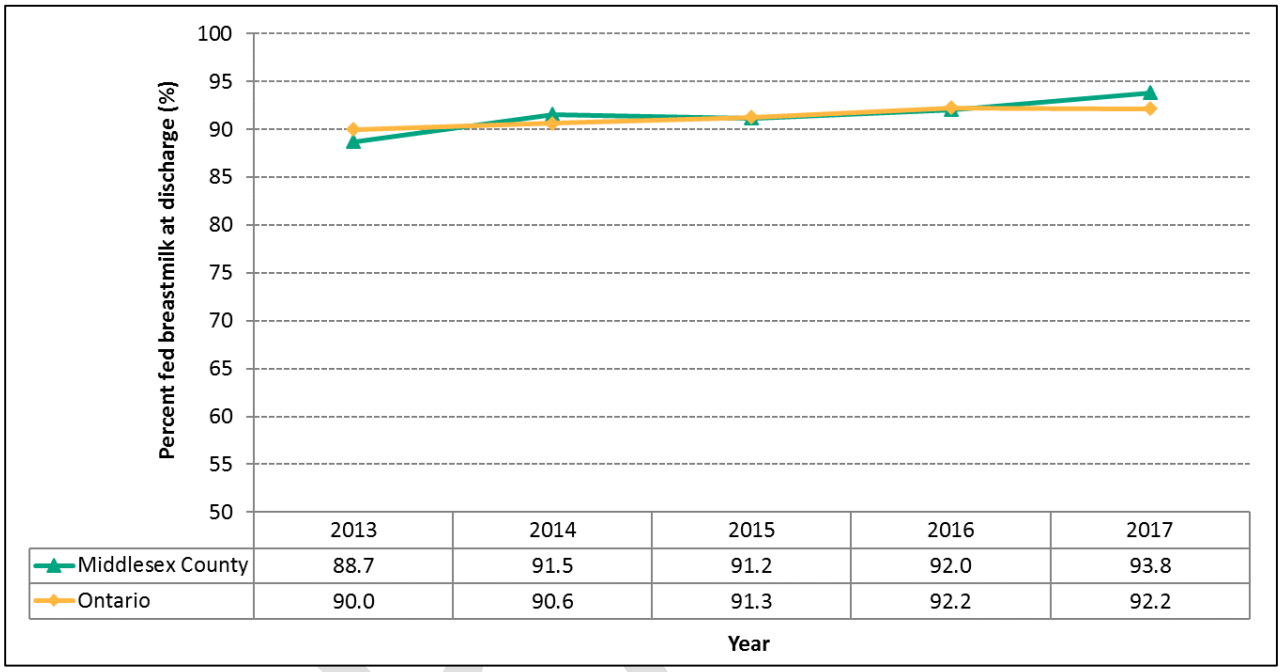
Data source: BORN Information System, BORN Ontario. Information accessed on: July 7, 2018; Therapeutic abortions, Date Extracted: June 19, 2018 & Population Estimates, Date Extracted: May 11, 2018, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario.

In Middlesex County and Ontario, the highest pregnancy rates are among women aged 30 to 34, followed by those aged 25 to 29. Compared to Ontario, females in Middlesex County tend to give birth at slightly younger ages: the third highest pregnancy rate is among women age 25 to 29, and pregnancy rates are significantly lower among women 35 years and older.

Pregnant women who are particularly young (i.e., teenagers) or old (i.e., ages 35 and older) tend to experience more problems delivering the baby and with various birth outcomes such as prematurity, low birth weight, and neonatal death. These mothers may therefore require more supports before and after birth than mothers in their twenties and early thirties.

Breastfeeding is the biologically natural way to provide infants with the nutrition they need for healthy growth and development. Health Canada recommends breastfeeding exclusively for the first six months, with continued breastfeeding for up to two years and beyond (Canadian Institute for Health Information, 2012). In 2017, over 93% of infants in Middlesex County were fed breastmilk at discharge from the hospital or midwifery practice group; a proportion slightly higher than the province and which has increased gradually over time since 2013.

Figure 17. Proportion of infants fed breastmilk (exclusively or in combination) at discharge from hospital or Midwifery Practice Group (MPG) per the number of live births discharged home and home births, Middlesex County and Ontario, 2013 to 2017.



	2013	2014	2015	2016	2017
Middlesex County	88.7	91.5	91.2	92.0	93.8
Ontario	90.0	90.6	91.3	92.2	92.2

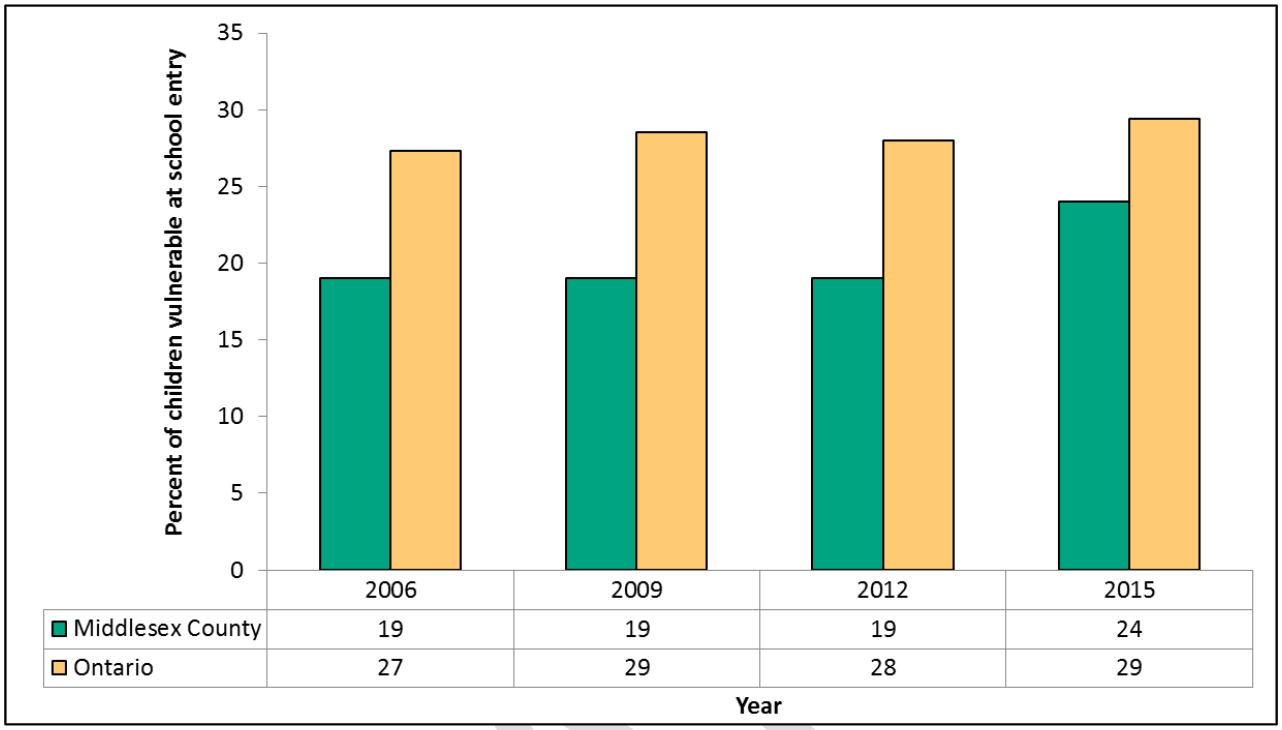
Data sources: (1) PHU – Newborn Clinical Report. BORN Information System, BORN Ontario. Information accessed on July 7, 2018. (2) Public Health Unit Analytic Reporting Tool (Cube), BORN Information System, BORN Ontario. Date Extracted: July 31, 2018.

The percent of children entering school that were vulnerable on at least one domain of the Early Development Instrument has been lower than the province since the inception of the measurement tool in 2006 (Figure 18). Recently, the Middlesex County rate has increased but continues to be lower than the province.

The physical health and well-being domain has the highest proportion of vulnerable children in Middlesex County (15.9%), followed by the emotional maturity domain (Table 4). These are also the top two areas for Ontario.

In all municipalities in Middlesex County results showed the percentage of children vulnerable from nearly all domains across all years tested to be lower than Ontario rates (data not shown).

Figure 18. Percentage of children vulnerable in one or more EDI domains, Middlesex County and Ontario, 2006, 2009, 2012, 2015.



Data source: Middlesex County Municipalities Child & Family Community Profile: Appendix 2: Early Development Instrument (EDI), 2012. (2013). Middlesex Children's Services Network. Available at https://www.middlesex.ca/sites/default/files/Appendix%202_Middlesex%20EDI%202012.pdf & Middlesex County community profile. (ca. 2016). [Unpublished report for the Middlesex Children's Service Network]. Middlesex Children's Service Network.

Table 4. Percentage of children at school entry vulnerable by EDI domain, 2015.

Early Development Instrument Domain	% of children vulnerable at school entry	
	Middlesex County	Ontario
Physical health and well-being	15.9	16.1
Emotional maturity	10.5	12.3
Social competence	7.3	10.7
Communication skills and general knowledge	7.2	10.2
Language and cognitive development	4.1	6.7
One or more EDI domains	24.0	29.4

Data source: Middlesex County Municipalities Child & Family Community Profile: Appendix 2: Early Development Instrument (EDI), 2012. (2013). Middlesex Children's Services Network. Available at https://www.middlesex.ca/sites/default/files/Appendix%202_Middlesex%20EDI%202012.pdf & Middlesex County community profile. (ca. 2016). [Unpublished report for the Middlesex Children's Service Network]. Middlesex Children's Service Network.

Stakeholder Priorities

In the councillor survey, 67% of respondents indicated that it is important for MLHU to focus on healthy growth and development. Key informants also commented on the challenges of mothers and families today who typically have to balance pregnancy and parenting with working and other priorities.

Mental health was also noted in both the survey and key informant interviews. Specifically, key informants felt that it is an issue that requires the involvement of many different community organizations to solve and not just the Health Unit. With limited resources, the response will depend on communication and awareness about where people can access services, and partnerships between those who have resources in the county.

For further details, see Appendix C and D.

Current Program and Service Delivery

Programming to meet Middlesex County needs for healthy growth and development includes:

Health Babies Health Children Home Visiting and Nurse Family Partnership

Intervention/Service	Location of Delivery	Frequency of Delivery
Home Visiting For families (pregnant women and families with children up to transition to school) that score with risk according to the HBHC Program Protocol 2018	Homes throughout Middlesex County	Offered continuously to all eligible families
Home Visiting – Nurse Family Partnership For first pregnancy or first time parenting; <21 years of age; enrolled prior to 28 weeks gestation; experiencing socioeconomic disadvantage	Homes throughout Middlesex County	Offered continuously to all eligible families

Shelter Work

Intervention/Service	Location of Delivery	Frequency of Delivery
Work in Shelters Public Health Nurses complete assessments, provide health teaching, and make referrals to other service providers and community agencies	Women's Rural Resource Centre (WRRC)	WRRC staff call PHN if there are appropriate referrals.

Healthy Start Infant Drop-ins

Intervention/Service	Location of Delivery	Frequency of Delivery
Assessment, education and support/counselling for a variety of topics including, but not limited to: Breastfeeding, infant feeding and nutrition, growth and early childhood development, safety, sleep, car seat safety, physical literacy, physical well being, attachment, perinatal and infant mental health, parenting, suggestions/referrals for community supports and interventions. Referrals are also made to other MLHU services	Glencoe Early ON Centre at Glencoe Presbyterian Church – biweekly Strathroy MLHU – biweekly Strathroy Early ON Centre – biweekly Ilderton (Library) Early ON Centre – every 4 weeks Komoka Wellness (Early ON) Centre – every 4 weeks Lucan (Library) Early ON Centre – biweekly Dochester (Library) Early ON Centre – biweekly Parkhill (Library) Early On Centre – biweekly	On a regular basis throughout Middlesex County

Breastfeeding Home Visiting

Intervention/Service	Location of Delivery	Frequency of Delivery
Breastfeeding Home Visits (screening, assessment and visits)	Homes throughout Middlesex County	Offered continuously to all eligible families

Preconception Health

Intervention/Service	Location of Delivery	Frequency of Delivery
Presentations through London Family Court Clinic	Community spaces in Ailsa Craig and Parkhill	As requested
Awareness and education	Social media Webpages Print material	Ongoing

Prenatal Health

Intervention/Service	Location of Delivery	Frequency of Delivery
Universal prenatal education sessions	Strathroy MLHU office	Groups run one night per week for 6 weeks; We offer 5 series per year in Strathroy. Other County locations (Ilderton, Dorchester, Lucan) have had low enrolment and are not currently offered
Online prenatal education modules	Online	Ongoing
Smart Start for Babies Prenatal and Postpartum Program	Strathroy MLHU office	If 3 clients are registered, the class would be once per week for 2 hours. If less than 3 clients, the program is offered in the client's home.

Preparation for Parenthood

Intervention/Service	Location of Delivery	Frequency of Delivery
Preparation for Parenthood Class	Ontario Early Years Centres /Family Centres	Several are scheduled throughout the year but are occasionally cancelled due to low registration

Baby-Friendly Initiative

Intervention/Service	Location of Delivery	Frequency of Delivery
Infant Feeding Surveillance System	Client's are contacted by telephone	Parents of newborns are phoned or emailed and asked to complete a survey – at 6 months, 12 months, and 18 months postpartum
Baby-Friendly Initiative (BFI) 20-Hour Breastfeeding Course for Health Care Providers	As requested	As requested
Printed information about infant feeding	Prenatal Classes in Strathroy; In hospital before discharge; home visits	Ongoing
MLHU website information about infant feeding	MLHU website	Ongoing
National Breastfeeding Week Awareness Campaign	MLHU website & social media	Annually

Food Skills

Intervention/Service	Location of Delivery	Frequency of Delivery
Awareness and education about healthy eating and food literacy	MLHU website	Ongoing
Food Skills Program	Family Centres, Community Centres (with approved commercial kitchen)	When a partnership is formed with a community partner, 8 sessions monthly or bi-monthly

Immunization

Overview

The goal of these public health services is to eliminate the burden of vaccine preventable disease through immunization.

The *Immunization of School Pupils Act* identifies a number of diseases against which students need to be vaccinated. Each year, the Middlesex-London Health Unit reviews the immunization records of students attending schools in the region to ensure that their immunizations are up to date (Ontario Ministry of Health and Long-Term Care, 2016). In the 2017–2018 school year, greater than 95% of immunization records of 7-year old students in Middlesex County schools were up-to-date for seven key diseases.

Table 5. Proportion of immunization records forecast up-to-date* for childhood vaccines among 7-year olds†, Middlesex County§, 2017–2018 school year.

Vaccine component	Up-to-date status	
	Middlesex County schools estimate (%)	Middlesex County schools range (%)
Diphtheria	96.9	80.0–100
Measles	97.4	80.0–100
Mumps	97.5	80.0–100
Pertussis	96.9	80.0–100
Polio	97.1	80.0–100
Rubella	98.8	80.0–100
Tetanus	96.9	80.0–100

Data source: Middlesex-London Health Unit Panorama Enhanced Analytics and Reporting (PEAR): Forecaster Compliance for Disease by Age or School – Aggregate – STD – PR2001. Toronto ON: Ontario Ministry of Health and Long-Term Care; 2018 August 14 [cited 2018 August 14].

* Records were considered to be up to date when the immunization forecast was classified as up to date, and not eligible, due or overdue for the identified immunization based on the Publicly Funded Immunization Schedule for Ontario (Ministry of Health and Long-Term Care, 2016).

† Birth year is 2010 for the 2017-18 school year.

§ Middlesex County estimate based on enrollment of children born in 2010 in elementary schools (public and private) located in Middlesex County for which the Middlesex-London Health Unit screened immunization records in the 2017-18 school year.

Stakeholder Priorities

In the councillor survey, 83% of respondents indicated that it is important for MLHU to focus on immunization. It was described as an issue of primary public health concern by three of the councillors responding to the survey and one councillor noted regarding adverse effects. There were no comments or feedback regarding MLHU immunization in the key informant interviews.

For further details, see Appendix C and D.

Current Program and Service Delivery

Programming to meet Middlesex County needs for immunization includes:

Immunization Program

Intervention/Service	Location of Delivery	Frequency of Delivery
Immunization clinic (walk-in and appointment based)	Strathroy office	First Wednesday of every month
School immunization clinics for grade 7 students and high school students (including private schools)	All schools in Middlesex County	Elementary schools are visited twice every school year High schools are visited once every school year
Immunization phone line, fax and email service (for immunization record submissions and contact with staff member)	Virtual - over the phone, email or fax machine	Available as needed
Immunization screening and follow up of select grades of students in elementary and high schools (and child care centres as of fall 2018)	Work is done within the London health unit office and information flow and suspension orders filter through school and child care offices	Once per year for each school /child care centre
Cold chain inspections of all fridges holding Ontario publicly funded vaccine	Every healthcare provider office in Middlesex County that holds publicly funded vaccine is inspected	Once per year

Infectious and Communicable Diseases Prevention and Control

Overview

The goal of these public health services is to reduce the burden of communicable diseases and other infectious diseases of public health significance.

There are approximately 70 diseases of public health significance that are reported to the local Medical Officer of Health under the *Health Protection and Promotion Act*. Among these, HIV/AIDS*, hepatitis C†, and active tuberculosis§ are all infections that can have long-term impacts on effected individuals and, once diagnosed, require follow up with a health care provider.

Between 2005 and 2017, the average reported incidence rates of HIV/AIDS, hepatitis C, and active tuberculosis cases were lower among Middlesex County residents compared to the provincial rate (Table 6).

Table 6. Reported incidence rate of HIV/AIDS, hepatitis C, and active tuberculosis, Middlesex County and Ontario, 2005–2017 average.

Infectious disease	Rate per 100,000 population	
	Middlesex County	Ontario
HIV/AIDS*	1.5	6.5
Hepatitis C†	16.9	33.3
Tuberculosis (active)§	<1.0	4.8

Data source: Middlesex County data: Middlesex London Health Unit integrated Public Health Information System (iPHIS) Cognos Report Net: custom report. Ontario Ministry of Health and Long-Term Care; Extracted August 13, 2018. Ontario data: Public Health Ontario. Infectious Diseases Query: Ontario: Case counts and crude rates of reportable diseases by public health unit and year. Ontario Agency for Health Protection and Promotion; Extracted August 15, 2018.

* HIV/AIDS cases are reported by encounter date, which is the date that public health was first notified of the case.

† Hepatitis C cases are reported by episode date, which is the earliest available of symptom onset date, specimen collection date, laboratory test date, or date reported to public health. Hepatitis C cases include all cases with a positive antibody test, and therefore includes people with acute infections, spontaneously resolved acute infections, chronic infections, and those who have received effective anti-viral therapy (cured).

§ Active tuberculosis cases are reported by the date the individual was diagnosed with active tuberculosis.

Stakeholder Priorities

In the councillor survey, 92% of respondents indicated that it is important for MLHU to focus on infectious and communicable disease prevention and control. Respondents to both the councillor survey and the key informant interviews indicated that vector-borne disease is a public health issue of primary concern particularly due to reports of West Nile Virus being present in North Middlesex. Respondents felt that the larviciding program is important to county residents.

For further details, see Appendix C and D.

Current Program and Service Delivery

Programming to meet Middlesex County needs for infectious and communicable disease prevention and control includes:

Rabies Prevention and Control

Intervention/Service	Location of Delivery	Frequency of Delivery
Investigating human exposures to animals suspected of having rabies	Based on the location of the animal owner and/or victim	Referral-based
Confirming the rabies vaccination status of the animals (suspected of having rabies)	Veterinary clinics	Referral-based
Rabies prevention awareness activities	Municipal offices, library locations, MLHU-Strathroy office	Regularly
Partnering with veterinary clinics to organize low-cost rabies clinic	Veterinary clinics	Once a year

Vector-Borne Disease

Intervention/Service	Location of Delivery	Frequency of Delivery
Assessing standing water sites in Middlesex-London on public property and develop local vector-borne disease control strategies based on this data	Bodies of standing water located on public property	May to September
Surveillance of ticks and mosquitos	Across the county	April to November
Responding to complaints and inquiries from residents regarding Vector Borne Diseases	Complaint-based	Year around
Assessing private properties when standing water concerns are reported and oversee remedial actions	Referral-based	May to September
Educating and engaging residents in practices and activities at local community events in order to reduce exposure to Vector Borne Diseases	Across the Middlesex County	May to September

Reportable Disease Follow up and Case Management

Intervention/Service	Location of Delivery	Frequency of Delivery
Investigation and management of cases of reportable enteric illnesses (e.g., salmonella, *E. coli*), vaccine preventable diseases (e.g., pertussis, mumps), and individuals with vector-borne diseases (e.g., West Nile virus, Lyme disease) Interview all reported suspect and confirmed cases. Ensure clients have been notified of their diagnosis, have completed appropriate testing, and receive counselling about their illness and how to prevent transmission to others	Over the phone	Year round
Support and education for facilities managing communicable disease cases (e.g., disease exposures in child care centres, long-term care homes with residents with communicable diseases)	By email, over the phone, or at the location of the centre/home	Year round
Follow up of active TB cases Coordinate the provision of publicly funded tuberculosis treatment medications and provide direct observed therapy (DOT)	In the client's home	Year round DOT can range from a daily to monthly visit to the client's home until the course of treatment is completed, usually six months to one year.
Follow up of suspect tuberculosis (TB) cases Ensure that appropriate testing has been completed, and that clients receive counselling about how to prevent transmission to others	Over the phone or in the client's home	Year round
TB assessment and treatment clinic – physician led Provide clinical assessment and treatment plan for high risk government assisted refugees and immigration surveillance clients who may have latent TB infection, and contacts of active TB cases who do not have a primary health care provider	MLHU 50 King Street site	Every two months

TB assessment and treatment clinic – public health nurse led Provide follow up, clinical assessment, and medication for clients of the physician led clinic who receive latent TB treatment	MLHU 50 King Street site	Every month

Outbreak Management

Intervention/Service	Location of Delivery	Frequency of Delivery
Follow up respiratory and gastroenteritis outbreaks in licensed long-term care homes, retirement homes, and hospitals Provide public health recommendations for outbreak management, and participate on outbreak management meetings as required.	By email, over the phone, or at the location of the home/hospital	Year round
Follow up gastroenteritis outbreaks in licensed child care centres Provide public health recommendations for outbreak management	By email, over the phone, or at the location of the centre	Year round

Inspections

Intervention/Service	Location of Delivery	Frequency of Delivery
Food Premises Inspections of licensed long-term care homes and retirement homes	At the location of the long-term care/retirement home	1 – 3 compliance inspections per year, or more if required including re-inspections.
Food Premises Inspections of licensed child care centres and extended day programs (before and after school programs)	At the location of the child care centre/extended day program	1 – 3 compliance inspections per year, or more if required including re-inspections.
Infection prevention and control (IPAC) inspections of personal service settings (e.g., tattoo and piercing shops, spas, nail salons)	At the location of the business	1 compliance inspection per year, or more if required including re-inspections
IPAC inspections of funeral homes	At the location of the business	1 compliance inspection every other year, or more if required including re-inspections
IPAC inspections of licensed child care centres and extended day programs (before and after school programs)	At the location of the child care centre/extended day program	1 compliance inspection per year, or more if required including re-inspections

Infection Prevention and Control (IPAC) Management and Investigations

Intervention/Service	Location of Delivery	Frequency of Delivery
Complaints and Service Requests (CSR) from members of the public related to IPAC practices in health care settings (e.g., medical and dental clinics) and personal service settings (e.g., tattoo shops, salons). Assess adherence to IPAC practices and determine if a lapse in practice has occurred. Assess risk of infectious disease transmission to clients of the service	At the location of the clinic/business	As reported. There are usually several CSR to investigate each month.
Participation in Professional Advisory Committee (PAC) meetings at licensed long-term care homes Provide support and recommendations regarding IPAC issues	At the location of the long-term care home	Quarterly
Licensing consultation for retirement homes Provide support and recommendations regarding IPAC issues	At the location of the retirement home	Annually
Licensing consultation for new personal service settings Provide support and recommendations regarding IPAC issues	At the location of the business	Year round, as new businesses open

Sexual Health Clinics

Intervention/Service	Location of Delivery	Frequency of Delivery
Sexually Transmitted Infection Clinic and Family Planning Clinic led by Public Health Nurse under Medical Directives	MLHU Strathroy location	Once a week on Thursdays three times per month
Sexually Transmitted Infection Clinic and Family Planning Clinic led by Physician	MLHU Strathroy location	Once a month

Needle Exchange

Intervention/Service	Location of Delivery	Frequency of Delivery
Access to harm reduction supplies and disposal of used equipment Referral to addiction services, housing etc. Access naloxone kits to prevent overdoses	MLHU Strathroy office Shopper's Drug Mart 78 Front Street	Once a week at MLHU Strathroy office and one evening a month Daily at the Shopper's Drug Mart

TI and Blood-Borne Infection Case Management

Intervention/Service	Location of Delivery	Frequency of Delivery
Case management for reportable infectious diseases i.e. Chlamydia, Gonorrhea, Syphilis, HIV, and Hepatitis B and C Ensure clients have been notified of their disease, treated according to Guidelines, and notification of for testing	Management of cases is conducted over the phone Clients in the county who need treatment can access the Strathroy office	Once a week on Thursdays three times per month for Public Health Nurse Care Once a month for Physician care

Sexual Health Promotion

Intervention/Service	Location of Delivery	Frequency of Delivery
Campaigns to target populations at risk. Campaigns include presentations, posters and social media.	Presentations are targeted to the priority populations of Middlesex-London. There are presentations in the county as requested.	Ongoing and as requested

Safe Water

Overview

The goal of these public health services is to prevent or reduce the burden of water-borne illnesses related to drinking water and to prevent or reduce the burden of water-borne illnesses and injuries related to recreational water use.

Stakeholder Priorities

In the councillor survey, 100% of respondents indicated that it is important for MLHU to focus on safe water. Key informants noted that the well water drop-off sites are a valuable service to Middlesex residents.

For further details, see Appendix C and D.

Current Program and Service Delivery

Programming to meet Middlesex County needs for safe water includes:

Drinking Water

Intervention/Service	Location of Delivery	Frequency of Delivery
Responding to Adverse Water Quality Incidents in municipal systems	Over the phone	N/A
Responding to Adverse Water Quality Incidents in Small Drinking Water Systems	Over the phone	N/A
Risk assessment of Small Drinking Water Systems	Location of the SDWS	Once every three years
Monitoring the test results of Small Drinking Water Systems regularly	Results reviewed at MLHU office	Bi-monthly
Issuing Drinking/Boil Water Advisories as needed	Advisories issued through media, online, etc.	N/A
Conducting water haulage vehicle inspections	Location of the business	Once a year
Delivering resources (test kits and information) and offering guidance to private well owners	Municipal offices, library locations, MLHU-Strathroy office	Every day
Fluoride Monitoring	Monitor fluoride levels on all municipal water systems	Monthly

Recreational Water

Intervention/Service	Location of Delivery	Frequency of Delivery
Inspection of public pools	All public pools in Middlesex County	4 times per year
Inspection of public spas	All public spas in Middlesex County	4 times per year
Inspection of wading pools and splash pads	All wading pools and splash pads in Middlesex County	2 times per year
Investigating complaints related to recreational water facilities	All public pools, spas, wading pools, splash pads in Middlesex County	Complaint-based

Beach Water Management Program

Intervention/Service	Location of Delivery	Frequency of Delivery
Testing and monitoring beaches	All public beaches in Middlesex County	Once per week, June to September

School Health

Overview

The goal of these public health services is to achieve optimal health of school-aged children and youth through partnership and collaboration with school board and schools.

Understanding tooth decay in the school aged children population is important because of its implications for quality of life. In Middlesex County, where some drinking water is not fluoridated, tooth decay increases as children age from junior kindergarten until grade 2. The percentage of children with no cavities or decay goes down and the number of teeth affected in those with decay increases as grade level goes up. In comparison to a sample of health units making up approximately half on the Ontario population, Middlesex County rates of decay were lower in the 2015/2016 and 2016/2017 school years.

The *Immunization of School Pupils Act* identifies a number of diseases against which students need to be vaccinated. Each year, the Middlesex-London Health Unit reviews the immunization records of students attending schools in the region to ensure that their immunizations are up to date (Ontario Ministry of Health and Long-Term Care, 2016). In the 2017–2018 school year, greater than 95% of immunization records of 7-year old students in Middlesex County schools were up-to-date for seven key diseases.

Stakeholder Priorities

In the councillor survey, 85% of respondents indicated that it is important for MLHU to focus on school health. There was also considerable feedback that highlighted schools as a primary location where MLHU should be delivering public health services.

Mental health was also noted in both the survey and key informant interviews. Specifically, key informants felt that it is an issue that requires the involvement of many different community organizations to solve and not just the Health Unit. With limited resources, the response will depend on communication and awareness about where people can access services, and partnerships between those who have resources in the county.

For further details, see Appendix C and D.

Current Program and Service Delivery

Programming to meet Middlesex County needs for school includes:

Healthy Schools

Intervention/Service	Location of Delivery	Frequency of Delivery
Increasing Vegetable and Fruit Consumption Toolkit	All elementary and secondary schools in Middlesex County	Ongoing / as needed
Reducing Sedentary Behaviour Toolkit	All elementary and secondary schools in Middlesex County	Ongoing / as needed
Improving School Connectedness Toolkit	All elementary and secondary schools in Middlesex County	Ongoing / as needed
Promoting Healthy Growth and Development Toolkit	All elementary and secondary schools in Middlesex County	Ongoing / as needed
Reducing Substance Use Toolkit	All elementary and secondary schools in Middlesex County	Ongoing / as needed
Let's Get Cookin'	Elementary Schools	N/A
Social Media Promotion	N/A	Ongoing / as needed
Healthy School Recognition Program	All elementary and secondary schools in Middlesex County	Ongoing / as needed
Active and Safe Routes to School	All elementary schools in Middlesex County	N/A

Situational Supports

Intervention/Service	Location of Delivery	Frequency of Delivery
One-on-one situation supports with students in secondary schools	All secondary schools in Middlesex County	As needed
Principal and school staff consultation	All elementary and secondary schools in Middlesex County	As needed
Parent consultations	All elementary and secondary schools in Middlesex County	As needed

Parenting

Intervention/Service	Location of Delivery	Frequency of Delivery
School Enterers packages	All elementary schools in Middlesex County	Once per year
Parenting presentations/workshops	All elementary and secondary schools in Middlesex County	As requested

Curriculum Supports

Intervention/Service	Location of Delivery	Frequency of Delivery
Fact Sheets	All elementary schools in Middlesex County	As needed
Presentations and Lesson Plans	All elementary schools in Middlesex County	As needed
Classroom Support – Reach and Teach Kits	All elementary schools in Middlesex County	As needed

Oral Health

Intervention/Service	Location of Delivery	Frequency of Delivery
Dental Screening in Schools	All elementary schools in Middlesex County	Once per year
Dental Screening + Fluoride Varnish Application in Daycare Settings	Dental screening and fluoride varnish are offered to daycares in the county.	Three times per year
Fluoride Varnish Application in Elementary Schools	Fluoride varnish is offered at schools in the county.	Three times per year

Substance Misuse and Injury Prevention

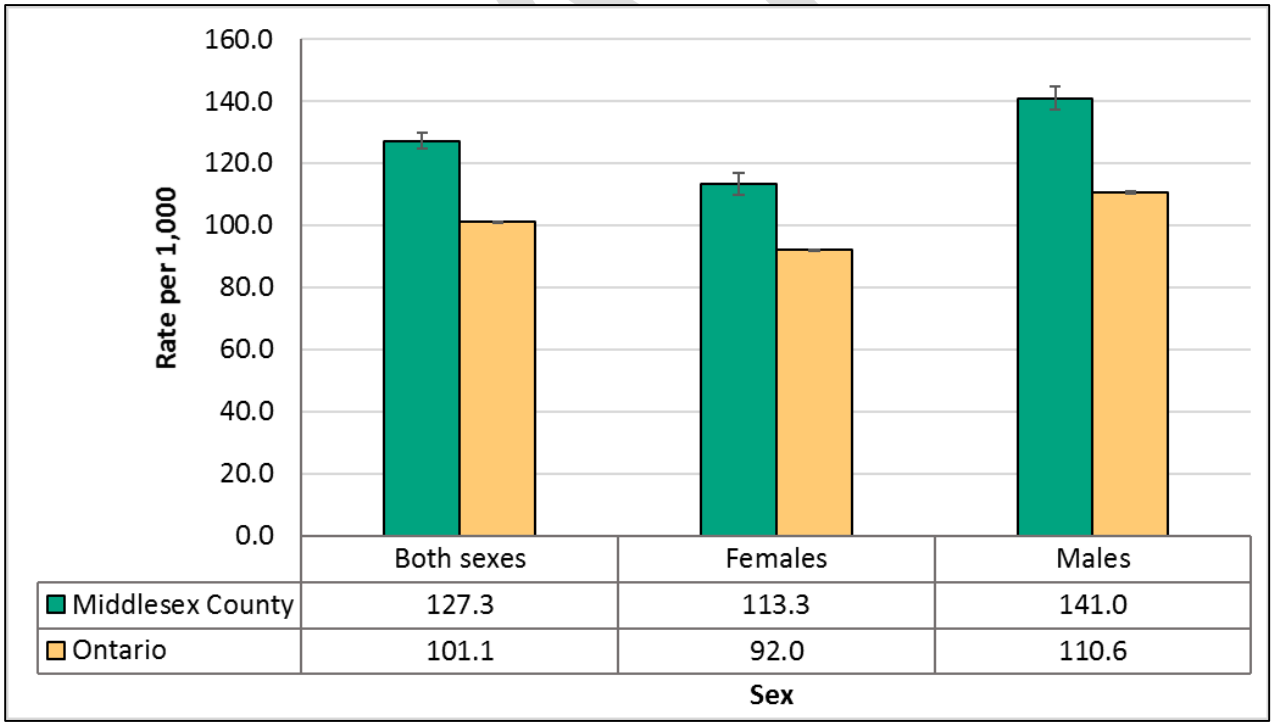
Overview

The goal of these public health services is to reduce the burden of preventable injuries and substance use.

While less impactful than chronic disease, injuries are also within the top causes of death and are a large burden in potential years of life lost. Injuries commonly bring people to the emergency department for care and Middlesex County is no exception. In fact, between 2015 and 2017 rates of emergency department (ED) visits for injury were significantly higher in Middlesex County (127.3 per 1,000 people) compared to Ontario (101.1 per 1,000 people). The rate of deaths from injuries, however, was not higher than Ontario. This indicates that residents of Middlesex County experienced more non-fatal injuries than those in the province overall. The most common reason for an injury-related visit to the ED was falls, which was higher in females than males. Being struck against or cut by objects and overexertion were the next most common causes for both sexes. Motor vehicle crashes were the fifth most common injury for females and sixth most common for males. Off-road vehicle collision rates were higher than the provincial rate; whereas, pedestrian-related injury visits are lower. There is no difference with cycling collisions.

Intentional injuries such as the ED visit rate for self-harm in Middlesex County was similar to the Ontario rate. The rate of assault-related ED visits was significantly lower than the province.

Figure 19. Emergency department visits for all injuries, unadjusted rates per 1,000 population, by sex, Middlesex County and Ontario, 2015 to 2017 annual average.



Data source: National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Health and Long-term Care, IntelliHEALTH ONTARIO, Extracted: August 16, 2017.

Table 7. Emergency department visit counts and unadjusted rates per 100,000 population, by sex, Middlesex County, 2015 to 2017 annual average.

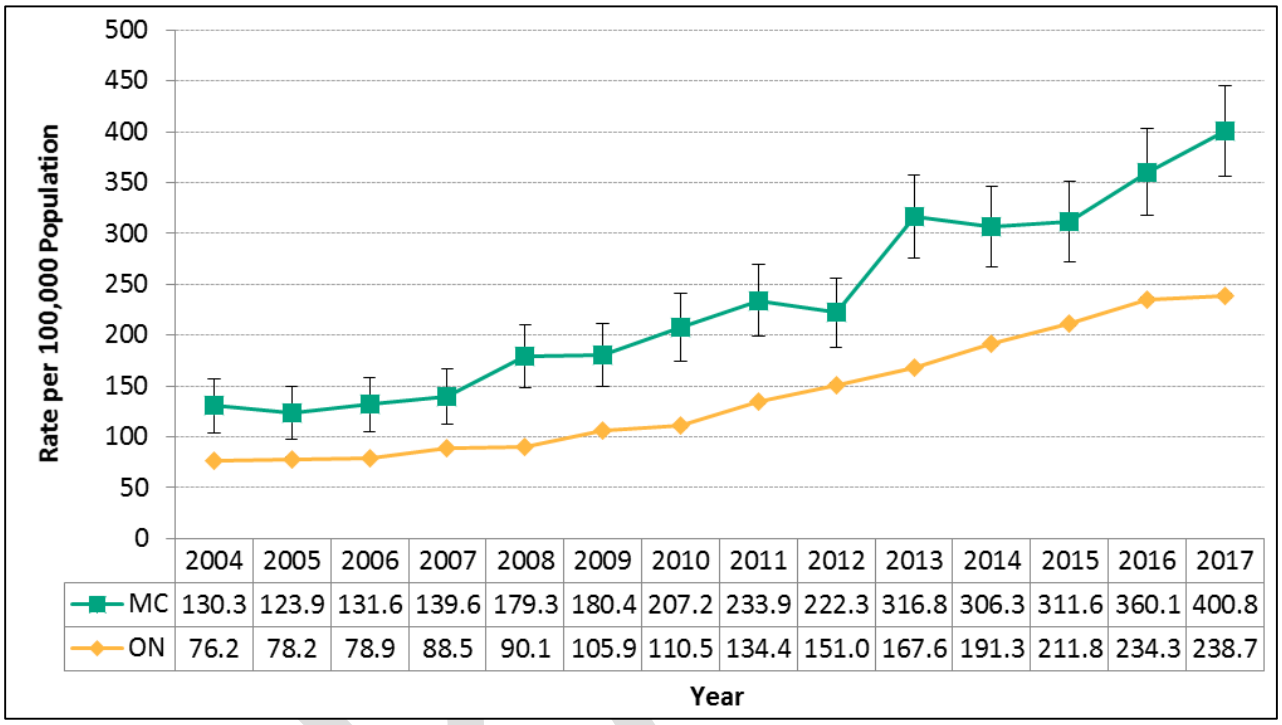
Middlesex County rank	Cause Unadjusted rate per 100,000 ± 95% Confidence Interval (Count)	
	Females	Males
1	Falls* 4,049.6 ± 203.1 (1527)	Falls* 3,377.3 ± 184.7 (1285)
2	Struck by/against object* 1,708.4 ± 131.9 (644)	Struck by/against object* 2,812 ± 168.5 (1,070)
3	Overexertion* 1,004.0 ± 101.1 (379)	Cut/pierced by object* 1,687.3 ± 130.5 (642)
4	Cut/pierced by object* 742.4 ± 87 (280)	Overexertion* 1,063.6 ± 103.6 (405)
5	Motor vehicle collision 637.2 ± 81 (240)	Foreign body in eye/orifice* 1,049.5 ± 102.9 (399)
6	Bite by Dog or other Mammal* 332.3 ± 58.2 (125)	Motor vehicle collision* 807.7 ± 90.3 (307)
7	Caught/crushed between objects* 295.2 ± 54.8 (111)	Caught/crushed between objects* 437.2 ± 66.4 (166)
8	Foreign body in eye/orifice 281.0 ± 53.5 (106)	Bite by dog or other mammal* 261.9 ± 51.4 (100)
9	Insect bite 198.9 ± 45.0 (75)	Other land transport collisions 223.4 ± 47.5 (85)
10	Other land transport collisions* 197.1 ± 44.8 (74)	Poisoning 184.9 ± 43.2 (70)
All unintentional injuries*	11,008.6 ± 334.9 (4,152)	13810.5 ± 373.4 (5,254)

Data source: National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Health and Long-term Care, IntelliHEALTH ONTARIO, Extracted: August 16, 2017.

Note: * indicates the MC sex-specific rate is statistically significantly higher than the ON sex-specific rate.

Concussion-related ED visits have also been on the rise in recent years and Middlesex County experienced a substantially higher rate than in the province overall. Local research indicates children in rural populations who experience concussions are much more likely to have sustained the injury in a motor vehicle crash compared to their urban counterparts (Stewart, Gilliland & Fraser, 2014).

Figure 20. Unadjusted rates of emergency department visits for concussions per 100,000 population, Middlesex County and Ontario, 2004 to 2017.

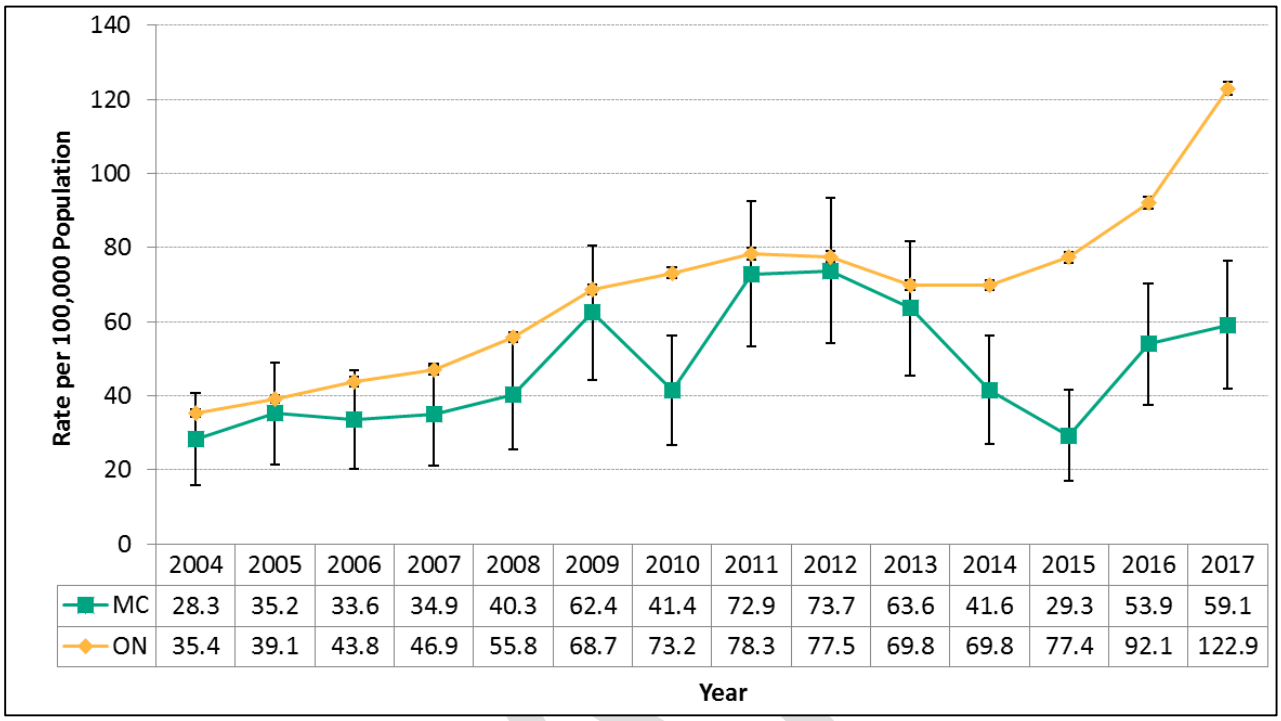


	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
MC	130.3	123.9	131.6	139.6	179.3	180.4	207.2	233.9	222.3	316.8	306.3	311.6	360.1	400.8
ON	76.2	78.2	78.9	88.5	90.1	105.9	110.5	134.4	151.0	167.6	191.3	211.8	234.3	238.7

Data source: National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Health and Long-term Care, IntelliHEALTH ONTARIO, Extracted: August 9, 2018.

The harms associated with drug use are important to consider in light of the public health crisis related to opioids and cannabis legalization in Canada. In Ontario there has been an increase over time in emergency department visits associated with each of these substances both for poisonings and related mental or behavioural disorders. It is worth noting that rates of ED visits in Middlesex County are lower than Ontario and the difference is statistically significant for both cannabis and opioids. Cannabis visit rates have increased significantly since 2004. However, opioid ED visits have not shown a statistically significant increase between 2004 and 2017 in Middlesex County. This is a marked difference from the trend seen in Ontario and surrounding communities.

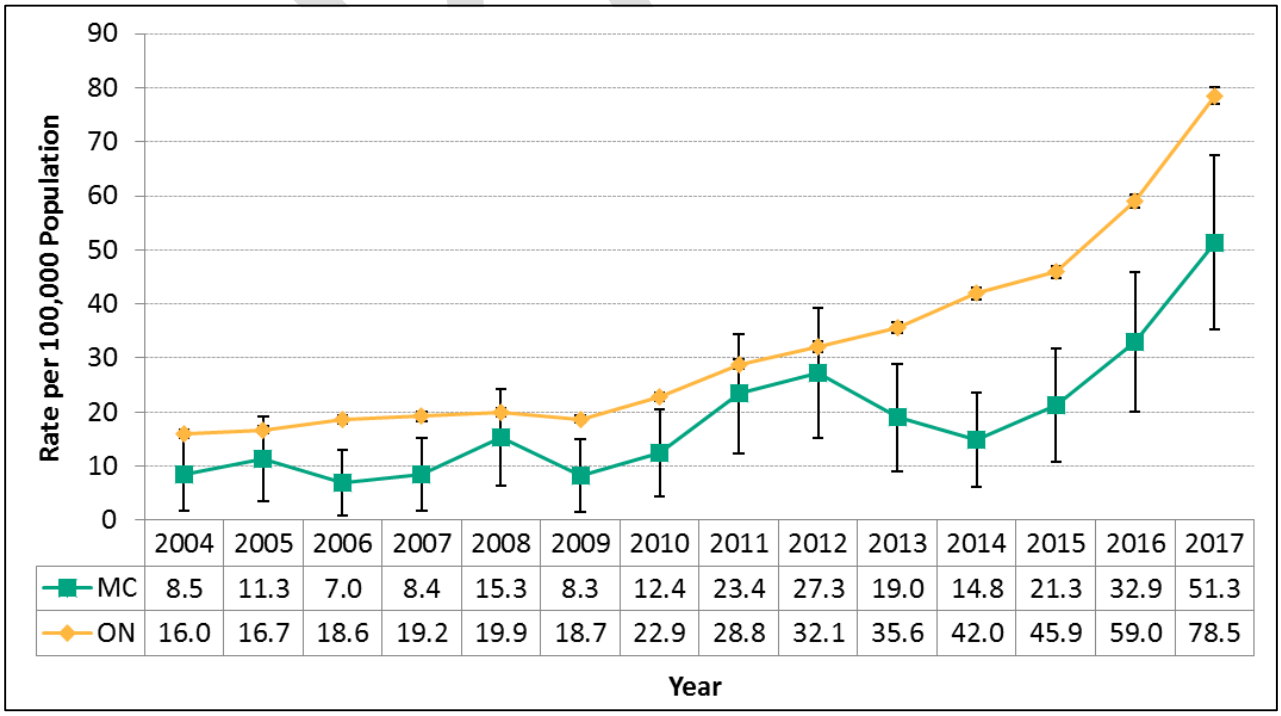
Figure 21. Opioid-related emergency department visits, counts and unadjusted rates per 100,000 population, Middlesex County and Ontario, 2004 to 2017.



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
MC	28.3	35.2	33.6	34.9	40.3	62.4	41.4	72.9	73.7	63.6	41.6	29.3	53.9	59.1
ON	35.4	39.1	43.8	46.9	55.8	68.7	73.2	78.3	77.5	69.8	69.8	77.4	92.1	122.9

Data source: National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Health and Long-term Care, IntelliHEALTH ONTARIO, Extracted: August 23, 2018.

Figure 22. Cannabis-related emergency department visits, counts and unadjusted rates per 100,000 population, Middlesex County and Ontario, 2004 to 2017.



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
MC	8.5	11.3	7.0	8.4	15.3	8.3	12.4	23.4	27.3	19.0	14.8	21.3	32.9	51.3
ON	16.0	16.7	18.6	19.2	19.9	18.7	22.9	28.8	32.1	35.6	42.0	45.9	59.0	78.5

Data source: National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Health and Long-term Care, IntelliHEALTH ONTARIO, Extracted: August 23, 2018.

Stakeholder Priorities

In the councillor survey, 77% of respondents indicated that it is important for MLHU to focus on substance use and injury prevention. Opioids were the public health issue of primary concern for councillors who responded to the survey. This was reiterated in the key informant interviews where respondents noted the intersections between opioids, drug addiction, housing and mental health.

Mental health was also noted in both the survey and key informant interviews. Specifically, key informants felt that it is an issue that requires the involvement of many different community organizations to solve and not just the Health Unit. With limited resources, the response will depend on communication and awareness about where people can access services, and partnerships between those who have resources in the county.

For further details, see Appendix C and D.

Current Program and Service Delivery

Programming to meet Middlesex County needs for substance use and injury prevention includes:

Healthy Aging & Falls Prevention

Intervention/Service	Location of Delivery	Frequency of Delivery
Education/Awareness /Skill Building and consultation support related to Healthy Aging / Fall Prevention	Website, social media, availability of paper resources ---------- Office by phone email, presentations at various locations	Ongoing ---------- On request

Substance Misuse Prevention (Alcohol and Other Drugs)

Intervention/Service	Location of Delivery	Frequency of Delivery
Municipal Alcohol Policy Review/Consultation	Done via email and/or in-person visit to municipal office	Every second year (review/consultation)
Provision of Health Promotion Information	Done via email/mail outs predominantly	As needed/requested/available
Public Inquiries regarding alcohol concerns	Via telephone or email	As requested
Middlesex-London Community Drug and Alcohol Strategy: 1)Environmental scan and survey of organizations and service providers to identify needs ---------- 2) community consultations as part of developing final strategy	Email and phone Online In person	Ongoing

Road Safety

Intervention/Service	Location of Delivery	Frequency of Delivery
2017-2018 Pedestrian cross over (PXO campaign)	Social media, Youtube, Note: no PXOs in Middlesex County however MLHU You Tube, Facebook and Twitter channels and the MTO - LMRSC Facebook channel cover city and county, for county-city commuters.	One time campaign (April 16, 2018 – May 18, 2018), ongoing information sharing
National Teen Driver Safety Week promotion of messaging and event	2018 event to be held at a county secondary school, exact location TBA	Yearly campaign
Not By Accident (NBA) fall forum (project of South West Injury Prevention Network). Focus changes annually e.g. Cannabis and road safety, vision zero etc. --- 2018 no NBA planned related to limited resources. Alternately a planned Vision Zero forum "Primer" for smaller number of participants (project of South West Injury Prevention Network)	Held in London – central location to surrounding municipalities --- to be held at MTO office, Exeter Road	Previous annual forum for >10 years
Winter driving campaign. --- 2018 Snow How Winter Driving campaign – LMRSC & Ontario Good Roads Association	Social media --- Social Media	Annual with MTO

Child Safety

Intervention/Service	Location of Delivery	Frequency of Delivery
Farm Safety day	Elementary schools	Annually at different schools
Drowning Prevention campaign messaging	Radio, Billboards, social media	Annually, usually June-September
Helmets on Kids campaign helmet distribution	Elementary schools & at request of community partners/organizations	Annually in June
Safety Never Hurts newsletter	Emailed newsletter	Seasonal
Kids Need a Boost program – Education to all populations and distribution of booster seats to families in need when requested	Various Community spaces, elementary schools, home visits, reserves, social media	Throughout the year as requested
Various presentations, resources and/or materials related to Child Safety as requested	Various community spaces, elementary schools, family centres, reserves	As requested throughout the year

Next Steps

The findings and considerations outlined in this report are intended to highlight tangible opportunities for MLHU and assist with the identification of recommendations that merit endorsement by the board of health.

These findings and considerations will be shared with Middlesex County Council to seek their input on the review findings and to identify recommendations they feel should be considered.

Additionally, these findings will be disseminated to all program teams at MLHU for inclusion in their ongoing planning processes.

Appendix B to Report No. 055-18

Review of Public Health Services in Middlesex County

Report Appendices

MIDDLESEX-LONDON HEALTH UNIT

September 2018

Appendix A

Community Health Status Report

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Contents

Executive Summary

An understanding of the overall health and wellbeing of the residents of Middlesex County[1] is key to effectively plan where to focus public health efforts. This information helps to assess where Middlesex County is doing well and understand where improvements can be made.

This report uses a collection of social and health indicators to create a picture of the health status of the Middlesex County population. It begins with an overview of population and geographic structure characteristics of the Middlesex County population, as well as the social factors, "social determinants" that influence people's health, including income, employment and education. It then looks specifically at health indicators based on local data available to public health related to deaths, illness and injury, behavioural risk factors, reproductive health and child health. Comparisons are provided, where the data permits, with Ontario and by sex and age group. This helps to identify priority groups in the population experiencing or at increased risk of poor health outcomes which may require special attention. Trends over time were also examined to indicate whether the health status in the Middlesex County community is improving or getting worse.

This report tells us that overall the population of Middlesex County is experiencing good health on a number of measures. Middlesex County residents are generally better off than the province in terms of three key determinants of health: income, education and employment. It is also worth noting that some issues of public health importance are lower in Middlesex County than the province including teen pregnancies, as well as opioid and cannabis-related emergency department visits. In addition, Middlesex County's average life expectancy at birth is similar to Ontario's overall at 81.0 years and residents that reach age 65 can expect to live 19.7 more years on average. A long life-expectancy is an indicator that a population is overall doing well on many factors that collectively influence our health.

While overall, Middlesex County is doing very well, there are some areas that warrant our attention. Chronic diseases (including cancers and cardiovascular diseases) and unintentional injuries continue to be the leading causes of avoidable death. Behavioural risk factors that contribute to the development of chronic disease and injury (e.g., alcohol consumption, physical inactivity and smoking), while not different than Ontario, continue to be higher in the population than is ideal for health and wellbeing. For instance, only about half of the population reported being active or moderately active during their leisure time. Preventable injuries of particular concern in the County include: falls, being struck or cut by objects, overexertion, motor vehicle crashes, off-road collisions and concussions. Concussion related emergency department visits have been on the rise in recent years in Middlesex County and are substantially higher than in the province overall.

In addition, some residents within Middlesex County are not as healthy as others or are at higher risk for poor health outcomes. For example, almost a quarter of children entering school in Middlesex County in

[1] In this report, "Middlesex County" refers to the eight lower tier municipalities (i.e., North Middlesex, Southwest Middlesex, Thames Centre, Strathroy-Caradoc, Middlesex Centre, Adelaide Metcalfe, Lucan Biddulph and the Village of Newbury) but excludes the City of London and the three First Nations communities (i.e., Chippewas of the Thames First Nation (Anishinaabeg of the territory of Deshkan Ziibiing), Munsee-Delaware Nation (Lenni Lenape) and Oneida (iOnyota'a:ka)) which are politically independent of the County. In addition, to honour the First Nations Ownership, Control, Access and Possession (OCAP) principles, data from the First Nations communities are not included in some of our public health data sources (e.g., BORN).

2015 were vulnerable on a least one area of the Early Development Instrument, and physical health and wellbeing was the single area with the greatest proportion of vulnerable children in Middlesex County.

In summary, this health status report provides a picture to understand and act on health gaps in Middlesex County. While continuing to provide programs and services that support and maintain the population's high levels of health, Middlesex County may benefit from additional efforts in chronic disease prevention including behavior risk factor reduction as well as injury prevention and targeted investments in children's early development.

1. Population characteristics

1.1. Summary

Meeting the public health needs of a population involves understanding the size and demographic characteristics of the population. For example, knowing that there is a high proportion of young children in a population might focus public health services on preventing childhood illnesses and injuries, while supporting families, and orienting communities, to ensure that children get the very best start in life as possible.

Middlesex County's population was 71,551 people according to the 2016 Census. The population of Middlesex County is concentrated in the three municipalities of: Strathroy-Caradoc, Middlesex Centre, Thames Centre. These three municipalities account for nearly three quarters of Middlesex County's population and one in five of the residents of Middlesex County live in the town of Strathroy itself.

Overall, there were similar numbers of males and females in Middlesex County in 2016. However, there were greater numbers of females than males in the oldest age group, 85 years and older (females 1025: males 545) which is consistent with the longer life expectancy for women in Middlesex County and may indicate that public health could continue to work to close this gap by reducing risk factors for males. Generally, the age pyramid of Middlesex County was constricted in the young adult category (ages 20-39). This may be consistent with a general pattern seen in Ontario where youth and young adults migrate to more urban areas in search of education and employment opportunities (R.A. Malatest & Associates Ltd., 2002). Compared to the population of Ontario, the population of Middlesex County lacks younger adults aged 20-39 years and has a higher proportion of older children and older adults particularly older adult males. This can become a health concern in places that are facing an aging population, as it may become more difficult for the working population to provide for those that may be more vulnerable in the non-working population (i.e., dependents generally considered aged 15 or younger or those 65 and older that are not typically working) (Williams, 2005) (United Nations, "n.d.").

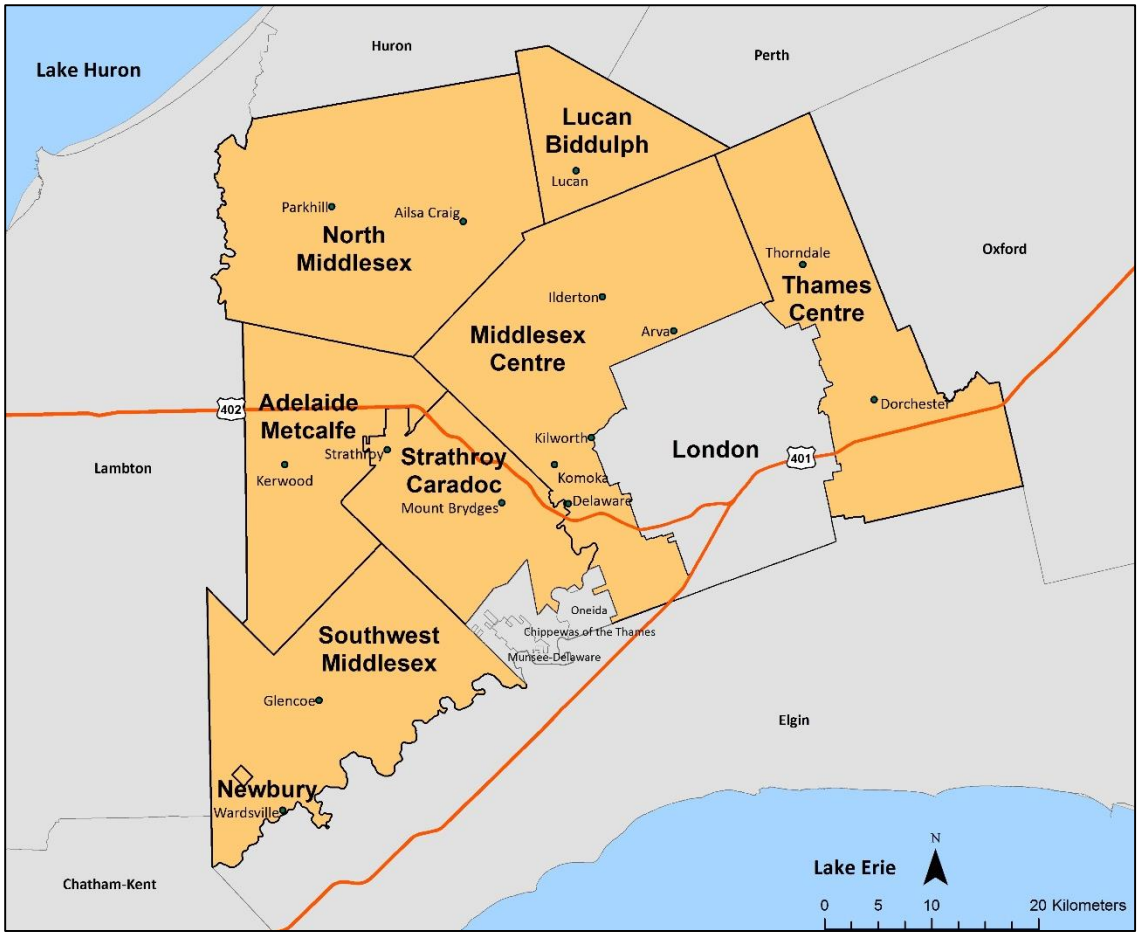
Middlesex County had few immigrants in the past five years, approximately 165 people in total in 2016. They made up a much lower percent of the population (0.2%) than in Ontario overall (3.5%) Recent immigrants were concentrated in the three largest municipalities that surround the City of London. In general, the health of immigrants tends to be better than that of the overall population. This is largely due to the fact that immigrants must generally be healthy to immigrate and often have better diets and health behaviours initially than the Ontario population. However, resettlement may create vulnerabilities and require tailored public health services to reduce the health risks and promote well-being to stay healthy.

About 97% of the population of Middlesex County spoke English most often at home in 2016. Middlesex County had approximately 90 people who spoke French most often at home in 2016. The Middlesex-London Health Unit is a designated French language service area, and therefore endeavors to provide services in both official languages. However, 2.4% of the Middlesex County population spoke neither English nor French at home on a regular basis and may require public health services that meet their specific language needs. This proportion is much lower compared to the 14.4% in Ontario that do not regularly speak an official language at home.

1.2. Geography

- Middlesex County covers an area of 2,821 square kilometres in Southwestern Ontario.
- It includes eight municipalities in order of geographic size: North Middlesex, Middlesex Centre, Thames Centre, Southwest Middlesex, Adelaide Metcalfe, Strathroy-Caradoc, Lucan Biddulph and the Village of Newbury (Figure 1).

Figure 1. Middlesex County, municipalities and neighbouring areas, 2018.



1.3. Total population and distribution

- The population of Middlesex County in 2016 was 71,551 (Table 1).
- Middlesex County was home to approximately 16% of the total population living in the Middlesex-London Health Unit's catchment area (MLHU's population was 455,526 including the City of London and the First Nations communities that participated in 2016 census).
- Strathroy-Caradoc had the largest population in Middlesex County (29.2%), followed by Middlesex Centre (24.1%) and Thames Centre (18.4%) (Table 1).
- The population of the town of Strathroy (14,401) accounted for 20.1% of Middlesex County's population.

- While the 2016 Census provides the most recent and comprehensive picture of the population, some people were missed during the count. Adjusted population figures will be released by Statistics Canada to more precisely account for this undercount, however until these are released the population in 2016 can generally be adjusted upward by 3.5% to 74,059 (Poirier & Vanderwerff, 2018). Population estimates for 2016 indicate that the count may be higher, closer to 76,093. For the purposes of calculating health indicators for this report, population estimates have been used to estimate the population denominators.

Table 1. Population of Middlesex County and the lower tier municipalities, 2016.

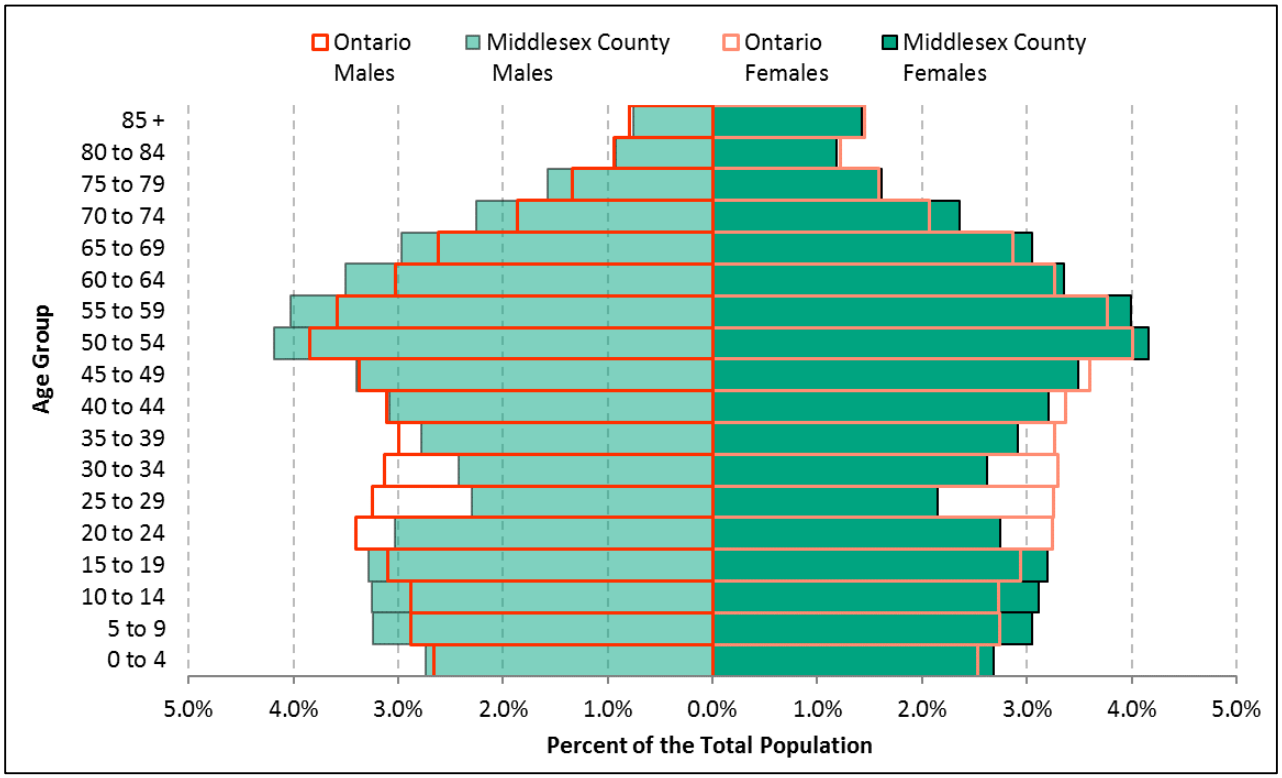
Region	Population	
	Count	Percent (%)
Strathroy-Caradoc	20,867	29.2
Middlesex Centre	17,262	24.1
Thames Centre	13,191	18.4
North Middlesex	6,352	8.9
Southwest Middlesex	5,723	8.0
Lucan Biddulph	4,700	6.6
Adelaide-Metcalfe	2,990	4.2
Newbury	466	0.7
Middlesex County	71,551	100

Source: Statistics Canada. 2016 Census of Population (Unadjusted)

1.4. Sex and age distribution

- There were similar numbers of males (35,640) and females (36,075) in Middlesex County. Much of this difference can be accounted for by the greater number of females than males in the oldest age group of 85 years and older (females 1025: males 545).
- Generally, the age pyramid was constricted in the young adult category (ages 20-39).
- Compared to the population of Ontario, Middlesex County had a greater proportion of children (both males and females) between the ages of 5 and 19 years. Middlesex County also had a greater proportion of older adults 50-79 years, particularly older adult males compared to Ontario (Figure 2).
- Middlesex County had a lower proportion of younger adults (both males and females) aged 20-39 (Figure 2). This finding was particularly interesting given the higher proportion of young children that might have parents in this age group.

Figure 2. Population Pyramid, percent of the population, by sex, by age group, Middlesex County and Ontario, 2016.



Data source: Statistics Canada. 2016 Census of Population (Unadjusted)

1.5. Recent immigrants

- In Middlesex County in 2016, approximately 165 people (0.2% of the population) were newcomers having recently immigrated to Canada (between 2011–2016; the five years prior to the 2016 Census). This is much lower than Ontario overall (3.5%) (Table 2). This is the most recent comprehensive information available, however it may not fully capture recent immigration waves, e.g., immigrants from Syria.
- Recent immigrants in Middlesex County were concentrated in the three largest municipalities adjacent to the City of London, specifically: Middlesex Centre, Thames Centre and Strathroy-Caradoc (Table 2 2).

Table 2. Number and percent of recent immigrants (immigrated between 2011–2016), Middlesex County and Ontario, 2016.

Region	Recent Immigrants	
	Number	Percent (%)
Adelaide-Metcalfe	10	0.3
Lucan Biddulph	15	0.3
Middlesex Centre	50	0.3
Newbury	0	0.0
North Middlesex	0	0.0
Southwest Middlesex	10	0.2
Strathroy-Caradoc	30	0.1
Thames Centre	50	0.4
Middlesex County	165	0.2
Ontario	472,170	3.5

Data source: Statistics Canada. 2016 Census of Population (Unadjusted)

1.6. Language

- 1,505 people (2.4%) of the population of Middlesex County spoke one of the non-official languages at home on a regular basis compared to 14.4% in Ontario (Table 3).
- 90 people in Middlesex County (0.02%) were estimated to speak French at home on a regular basis compared to 2.1% in Ontario in 2016 (Table 3).
- For those people in Middlesex County that spoke a non-official language at home, over half spoke Portuguese (505) or German (310). This is followed by Dutch, Polish and Spanish in the top five non-official languages spoken at home in Middlesex County (Table 4).

Table 3. Number and percent of the population, by language spoken most often at home, Middlesex County, lower tier municipalities and Ontario, 2016.

Region	English		French		Non-official language	
	Number	Percent (%)	Number	Percent (%)	Number	Percent (%)
Adelaide-Metcalfe	2,890	96.8	0	0.0	65	2.2
Lucan Biddulph	4,575	98.6	0	0.0	30	0.6
Middlesex Centre	16,480	97.0	25	0.1	295	1.7
Newbury	460	97.9	0	0.0	5	1.1
North Middlesex	6,045	98.3	0	0.0	55	0.9
Southwest Middlesex	5,625	98.3	0	0.0	45	0.8
Strathroy-Caradoc	19,615	95.4	35	0.2	600	2.9
Thames Centre	12,655	95.9	20	0.2	405	3.1
Middlesex County	**68,500**	**96.7**	**90**	**0.02**	**1,505**	**2.4**
Ontario	10,328,680	77.6	277,045	2.1	1,916,315	14.4

Data source: Statistics Canada. 2016 Census of Population (Unadjusted)

Table 4. Number of the population speaking non-official languages, by top five languages spoken at home in Middlesex County, Middlesex County, lower tier municipalities and Ontario, 2016.

Region	Portuguese	German	Dutch	Polish	Spanish	Other
Adelaide-Metcalfe	25	15	15	0	0	10
Lucan Biddulph	0	10	10	5	0	20
Middlesex Centre	15	20	20	50	30	140
Newbury	0	0	0	0	0	0
North Middlesex	5	5	15	5	0	15
Southwest Middlesex	10	15	10	0	0	5
Strathroy-Caradoc	430	5	20	5	10	115
Thames Centre	20	240	15	25	10	95
Middlesex County	**505**	**310**	**100**	**85**	**60**	**470**
Ontario	67,415	37,255	4,450	52,555	104,820	1,636,025

Data source: Statistics Canada. 2016 Census of Population (Unadjusted)

2. Social determinants of health

2.1. Summary

Understanding the conditions in which people are born, grow up, live, work and play—are known as the social determinants of health and contribute to the population health needs of communities. Public health aims to reduce the negative impact of social determinants that contribute to avoidable differences in the health status of populations (i.e., health inequities) (Ontario Ministry of Health and Long-Term Care, 2018). Better health is associated with better socio-economic status (Williams, 2018). Generally, Middlesex County is better off than the province in terms of three key determinants of health: income, employment and education. However, within Middlesex County some disparities persist.

Median household income was higher in five out of the eight municipalities and Middlesex County had a much lower percent of the population that was relatively worse-off financially living in low-income after tax in 2015 (2.8%) compared with Ontario (9.8%). However, children are disproportionally affected by low income within Middlesex County compared with seniors aged 65 and older.

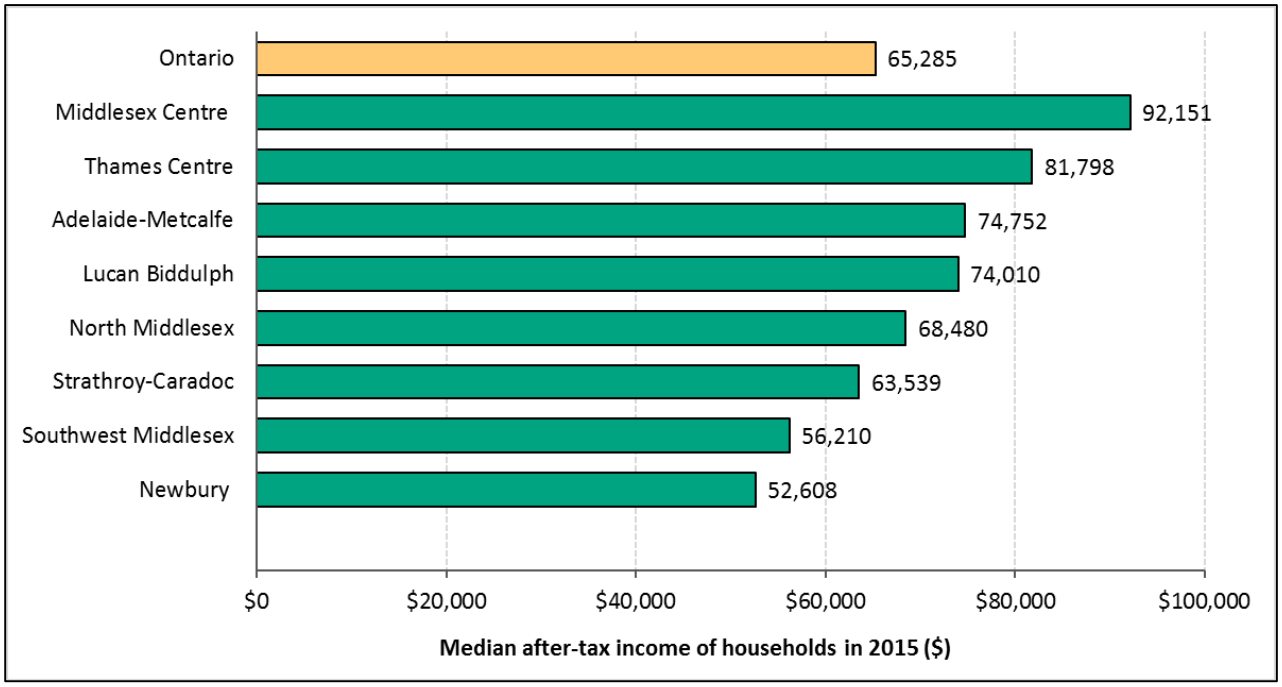
Unemployment rates in Middlesex County were generally better than the province and seven out of eight of the municipalities (all but the Village of Newbury) had rates lower than the province.

Post-secondary education levels in Middlesex County have increased over time from 58.6% in 2006 to 64.1% in 2016 and became similar to the province in 2016 (65.1%). However, the type of postsecondary education differed. The residents of Middlesex County were more likely to have a college, apprenticeship or trades certificate and less likely to have a university degree than Ontarians as a whole.

2.2. Income

- The 2015 median after-tax income for households was higher in five of the eight municipalities in Middlesex County compared with Ontario, specifically: Middlesex Centre, Thames Centre, Adelaide-Metcalfe, Lucan Biddulph and North Middlesex (Figure 3).
- Middlesex Centre households had a notably higher median income at $92,151.

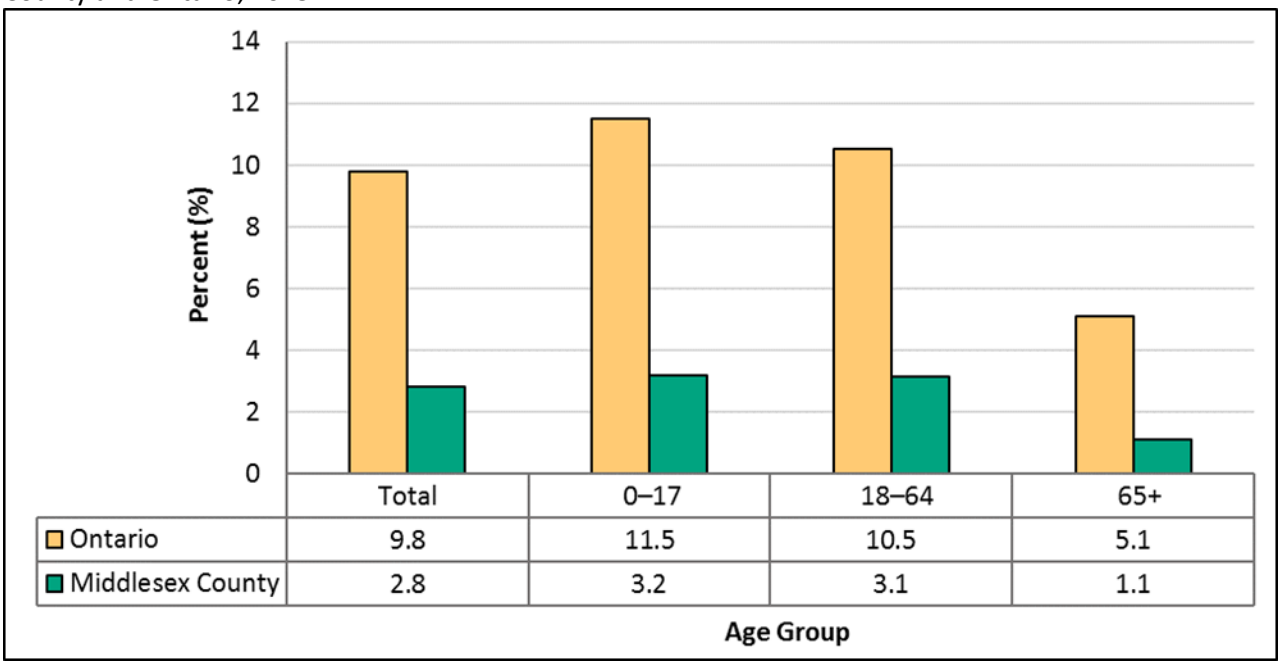
Figure 3. Median after-tax income of households, Middlesex County by lower tier municipality and Ontario, 2015.



Data source: Statistics Canada. 2016 Census of Population

- Overall, approximately 1,975 (2.8 %) of the population lived below the low-income cut-off (LICO) after-tax in 2015 in Middlesex County (Figure 4). Low-income cut-offs are used as a measure of those who are relatively worse-off financially, and not as an absolute measure of poverty. This measure reports the income level at which a family may be in financial difficulty because they will have to spend a greater proportion of their household income on food, clothing and shelter than the average family of a similar size. The cut-offs vary by family size and by size of community ("Table 4.3," 2017).
- The proportion of people living in low-income in Middlesex County was better (i.e., lower) than Ontario (9.8%).
- A greater percent of young people (less than 18 years of age) lived below the LICO in 2015 (3.2%) compared to seniors (aged 65+) (1.1%) in Middlesex County.

Figure 4. Percent of the population below the low income cut-off after tax, by age group, Middlesex County and Ontario, 2015.



Data source: Statistics Canada. 2016 Census of Population.

2.3. Employment

- In Middlesex County in 2015, approximately 1,835 or 4.6% were unemployed of those participating in the labour force aged 15 years and older (Table 5).
- Overall, the unemployment rate of Middlesex County was lower than the Ontario rate (7.4%). The 2015 unemployment rate by County municipality was lower than or the same as the Ontario rate for seven of the eight municipalities. The unemployment rate was higher in the Village of Newbury (18.4%) (Table 5).
- More recent information and time trends are not available for Middlesex County, however in general the employment rates in Ontario peaked in 2009 at 9.2% and have since improved.

Table 5. Unemployment count and rate for population aged 15+, Middlesex County lower tier municipalities and Ontario, 2015.

Region	Number Unemployed	Number Participating in Labour Force	Unemployment Rate (%)
Newbury	35	190	18.4
Lucan Biddulph	130	2,730	7.4
Strathroy-Caradoc	545	11,235	4.9
Southwest Middlesex	135	3,000	4.5
Thames Centre	345	7,680	4.5
Middlesex Centre	425	9,690	4.4
North Middlesex	155	3,535	4.4
Adelaide-Metcalfe	65	1,715	3.8
Middlesex County	1,835	39,775	4.6
Ontario	529,525	7,141,675	7.4

Data source: Statistics Canada - 2016 Census, 25% Sample Data. Catalogue Number 98-400-X2016365.

2.4. Education

- In 2016, in Middlesex County, 9.9% of adults aged 25-64 had not completed high school; 26.1% had a high school certificate or equivalent and 64.1% had a postsecondary certificate, diploma or degree (Table 6).

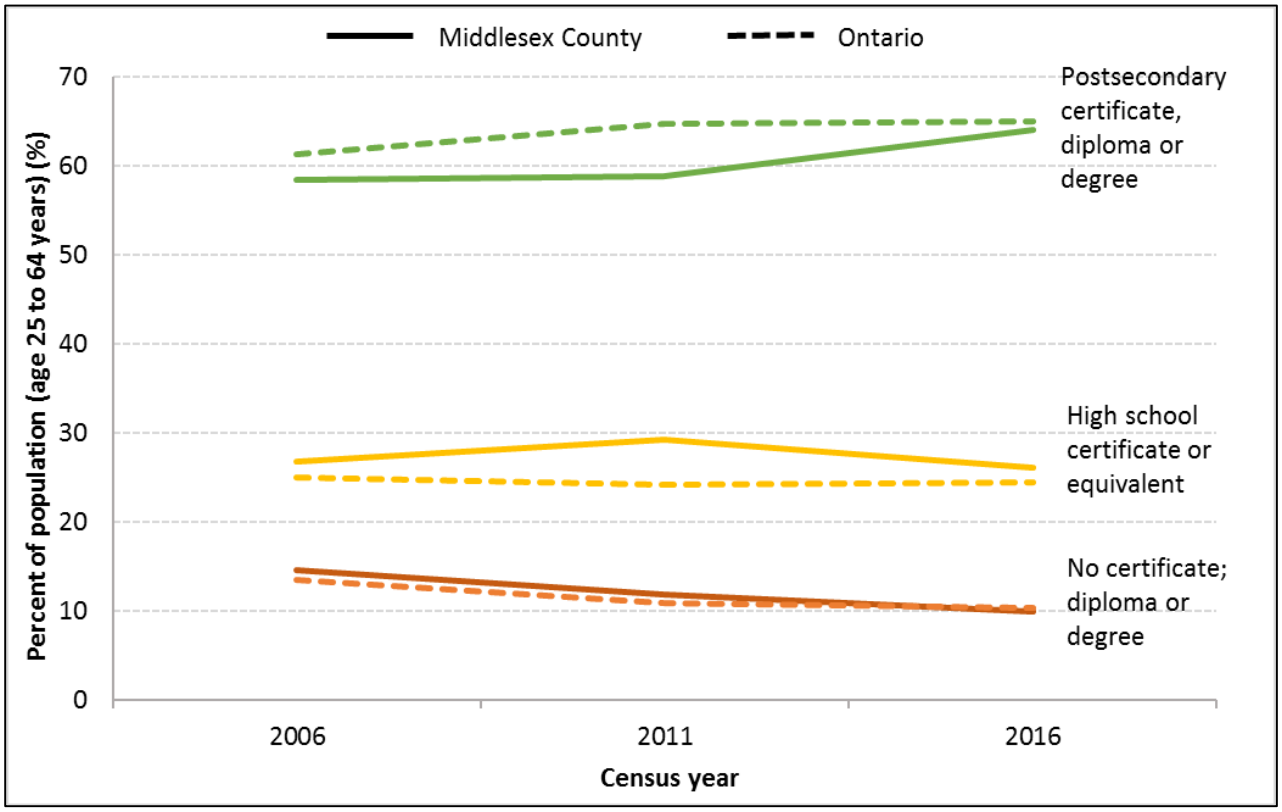
Table 6. Percent of the population (age 25–64) by highest educational attainment, Middlesex County and Ontario, 2016.

Highest Level of Educational Attainment	Middlesex County (%)	Ontario (%)
No certificate, diploma or degree	9.9	10.4
High school certificate or equivalent	26.1	24.5
Postsecondary certificate, diploma or degree	64.1	65.1
Apprenticeship or trades certificate or diploma	9.2	6.2
College, CEGEP or other non-university certificate or diploma	33.7	24.7
University certificate or diploma below the bachelor level	2.2	2.4
University certificate, diploma or degree	19.0	31.9

Data source: Statistics Canada, 2016 Census of the Population.

- The percent of the population aged 25–64 with postsecondary education in Middlesex County increased over time from 58.5% in 2006 to 64.1% and is now similar to Ontario (65.1%) (Figure 5)
- The type of postsecondary educational certificate obtained by the population in Middlesex County differs from Ontario. The residents of Middlesex County were more likely to have a college diploma (County 33.7%; Ontario 24.7%) or certificate in the apprenticeship or trades (County 9.2%; Ontario 6.2%) and less likely to have a university diploma (County 19.0%; Ontario 31.9%) (Figure 5).

Figure 5. Trends over time in highest level of educational attainment, percent of the population (25–64 years), Middlesex County and Ontario, 2006–2016.



Data source: Statistics Canada, 2006 Census, 2011 NHS, 2016 Census.

3. Deaths

3.1. Summary

Death rates, also referred to as mortality rates, are frequently used as indicators of the overall health of a population. Trends in mortality can illustrate the health problems in our community that have the biggest impact on the population. Changes in mortality rates over time may be due to several different factors taking place in the community such as changes in the standard of living, the environment or other social determinants of health. Changes may also be due to access to quality health care, improved diagnosis and treatment of illness or the emergence of new health issues not seen before. Health protection and promotion efforts, such as those related to smoking prevention and cessation, may also have an important impact on mortality rates in populations. Rates of leading causes of death indicate which diseases affect a community in the biggest way. Looking at the age and sex of people who die from each disease gives an idea of who is affected most by each cause of death.

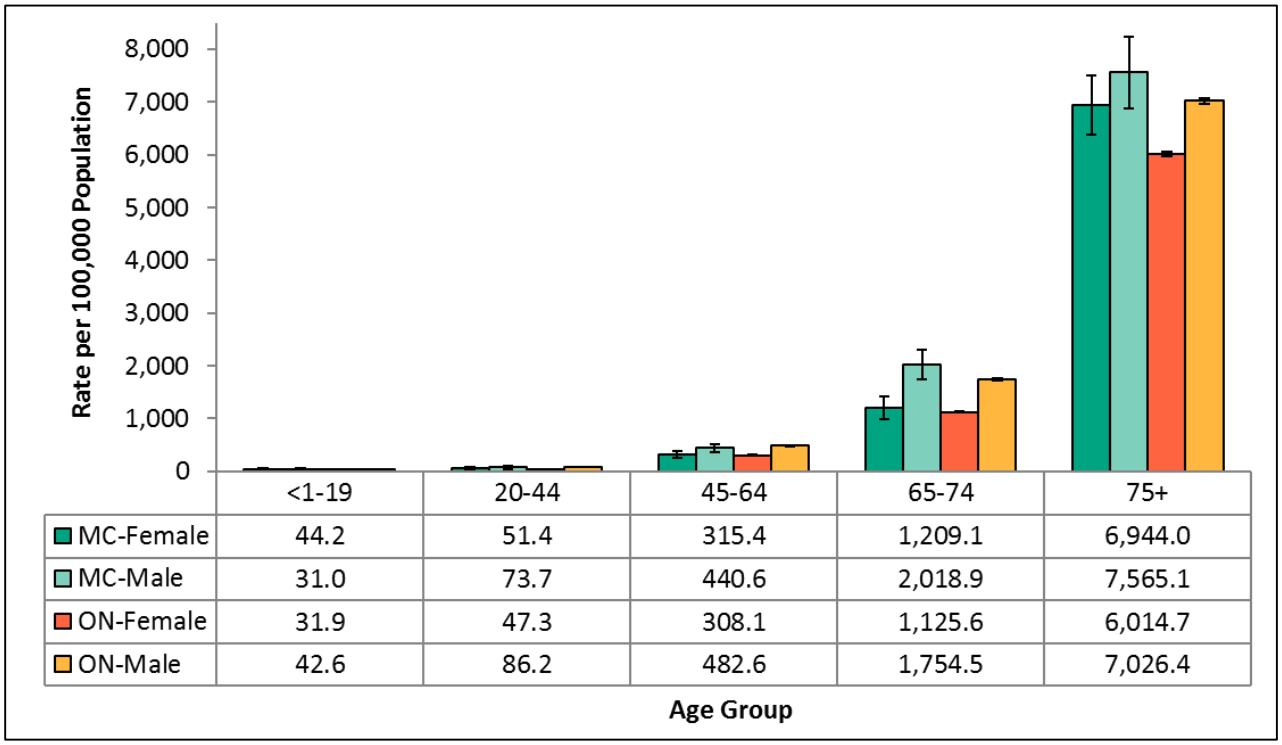
Life expectancy is the average length of time that an individual will live if subjected to the mortality experience for the specified population and time period. Using data from 2010 to 2012, Middlesex County residents can expect to live on average 81.0 years at birth and 19.7 more years at age 65. The life expectancy for males was lower than females and the mortality rate for males was higher than for females.

Males were much more likely to die prematurely than females in Middlesex County, generally reflecting higher rates of deaths in males at younger ages. Deaths due to breast cancer and lung cancer were the most common cause of premature death for females in Middlesex County; whereas for males it was ischemic heart disease.

3.2. Deaths by age group

- Death rates in Middlesex County and Ontario show an expected large rise in older age groups, particularly among those aged 75 years and older (Figure 6). For both sexes, mortality rates among those 75 years and older were higher for Middlesex County than Ontario, however the rates were only significantly different for females.
- For all groups above 20 years of age, age-specific mortality rates in Middlesex County were higher for males than for females. In Ontario, age-specific mortality rates were higher for males in age all groups.

Figure 6. All cause mortality rates per 100,000 population, by sex, by age group, Middlesex County and Ontario, 2010 to 2012 average.



	<1-19	20-44	45-64	65-74	75+
MC-Female	44.2	51.4	315.4	1,209.1	6,944.0
MC-Male	31.0	73.7	440.6	2,018.9	7,565.1
ON-Female	31.9	47.3	308.1	1,125.6	6,014.7
ON-Male	42.6	86.2	482.6	1,754.5	7,026.4

Data source: Ontario Mortality Data, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 21, 2018; Population Estimates, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario, Date Extracted: May 11, 2018.

3.3. Leading causes of death

- The top eight leading causes of death between 2010 and 2012 in Middlesex County were chronic diseases (Table 7): ischemic heart disease, dementia and Alzheimer's disease, lung cancer, cerebrovascular diseases, lower respiratory diseases, colorectal cancer, diabetes and lymph and blood cancer. These accounted for 58.4% of all deaths. The ninth and tenth leading causes of death were influenza and pneumonia, and falls, respectively.
- The top ten leading causes of death were the same for Middlesex County and Ontario, with the top eight causes following the same ranking order.
- Ischemic heart disease, the leading cause of death in Middlesex County, accounted for 80% more deaths as lung cancer, the second leading cause of death.
- The categories used for leading causes of death are based on a standard list derived by Becker *et al*. (2006) using the International Statistical Classification of Diseases and Related Health Problems tenth revision (ICD-10). They are ranked to demonstrate and compare the most frequently occurring causes out of the total number of deaths in a population. The number of deaths presented is the average number per year during this time period.

Table 7. Number, percent and rank of the leading causes of death, Middlesex County and Ontario, 2010 to 2012 annual average.

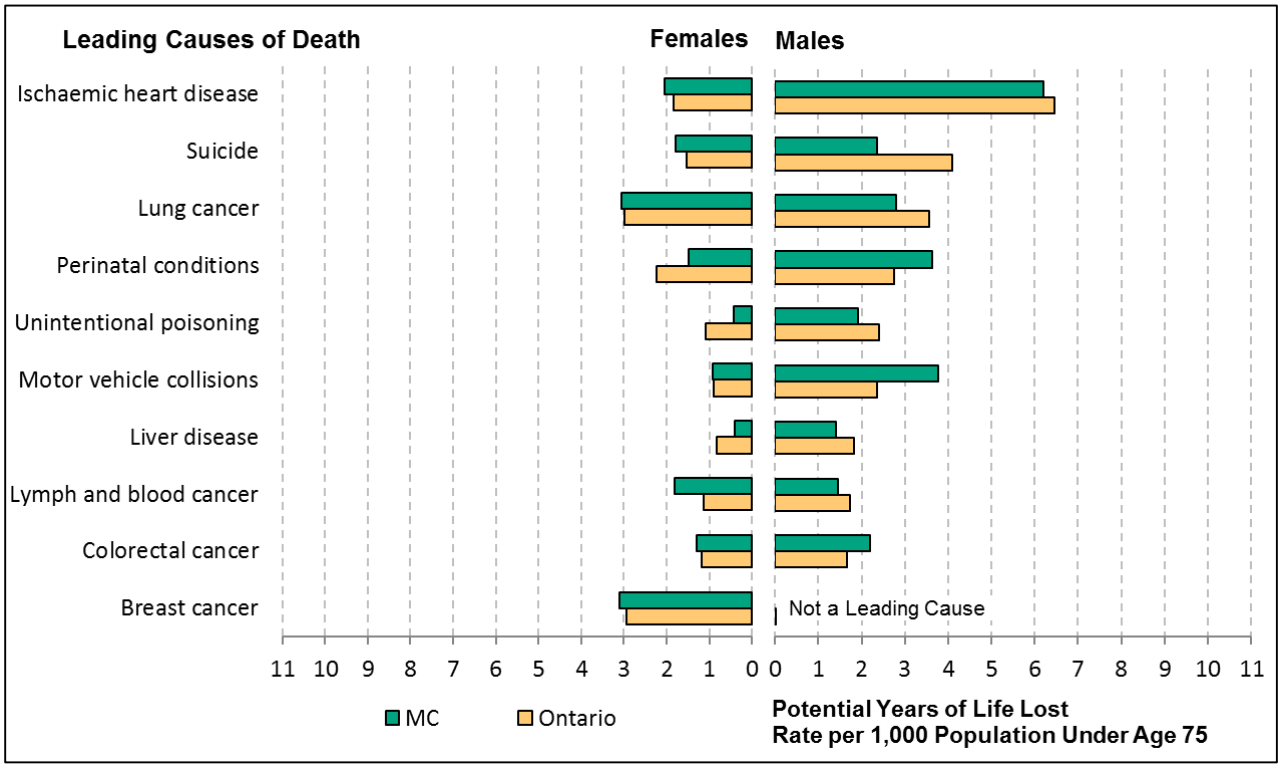
Leading Causes of Death	Average Annual Number of Deaths Middlesex County	Percent of All Deaths Middlesex County (%)	Ontario Rank
Ischemic Heart Disease	92	18.2	1
Dementia and Alzheimer's Disease	51	10.1	2
Lung Cancer	38	7.5	3
Cerebrovascular Diseases, incl. Stroke	31	6.2	4
Lower Respiratory Diseases	26	5.2	5
Colorectal Cancer	21	4.2	6
Diabetes	20	4.0	7
Lymph and Blood Cancer	14	2.9	8
Influenza and Pneumonia	14	2.7	10
Falls	13	2.7	9

Data source: Ontario Mortality Data, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 21, 2018.

3.4. Potential years of life lost (PYLL)

- PYLL is an indicator of premature mortality. It measures the number of years lost from deaths before age 75. The younger a person is when they die, the greater the number of potential years of life that are lost.
- As was the case in Ontario, males showed higher rates of PYLL than females in Middlesex County, generally reflecting higher rates of deaths in males at younger ages (Figure 7).
- Deaths due to breast cancer and lung cancer showed the highest PYLL rates for females in Middlesex County. The PYLL rates for both were slightly higher in Middlesex County females compared to Ontario females.
- Ischaemic heart disease had the highest PYLL rate for males in both Middlesex County and Ontario. The PYLL rate for Middlesex County males was slightly lower than that for Ontario.
- Deaths due motor vehicle collisions had the 2nd highest PYLL rate for males in Middlesex County; a rate higher than that for Ontario.
- The presence of deaths due to perinatal conditions in this list of PYLL rates is largely reflective of the very young ages at which people die of these conditions. Compared to Ontario, the rate among women was lower for Middlesex County females, but higher for Middlesex County males.
- For all cancers on the list (i.e., lung, lymph and blood, colorectal and breast), the PYLL rates for women were higher for Middlesex County than Ontario.

Figure 7. Potential years of life lost (PYLL) for leading causes of death, by sex, Middlesex County Ontario, 2010 to 2012 average.



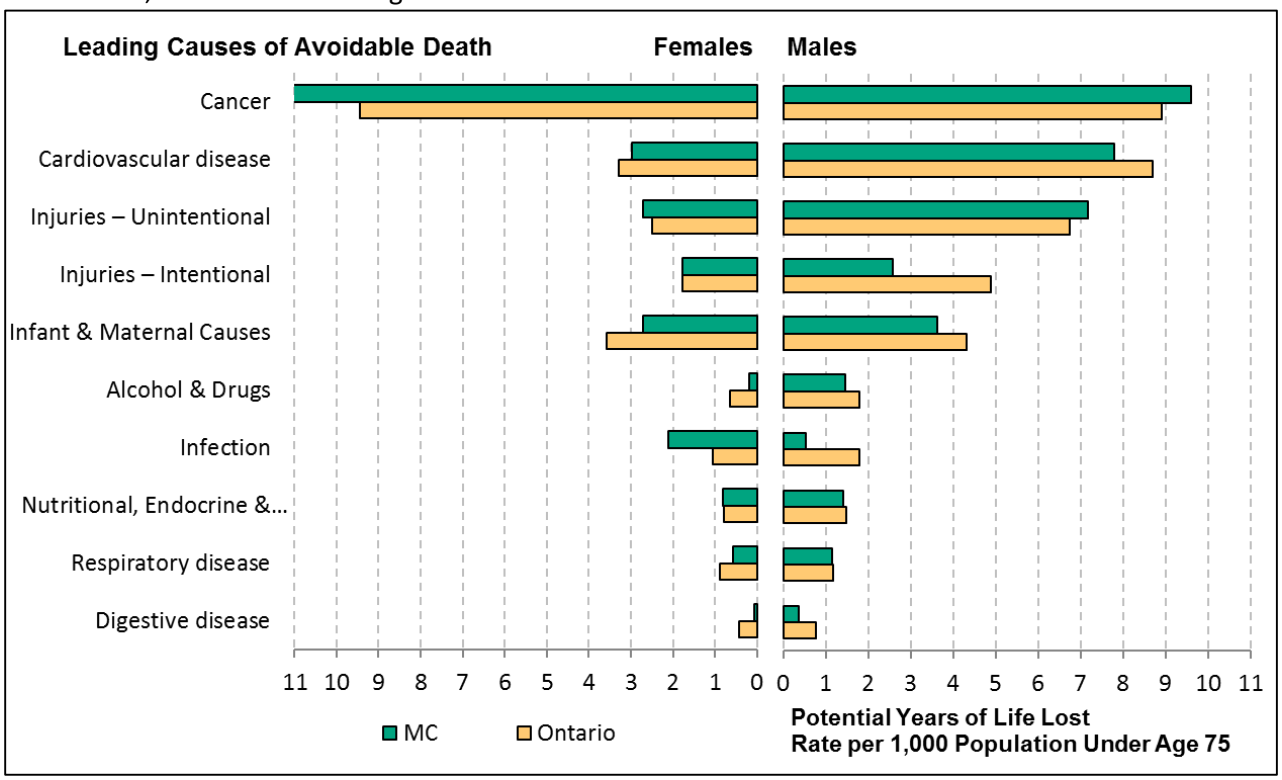
Data source: Ontario Mortality Data, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 21, 2018. Population Estimates, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario, Date Extracted: May 11, 2018.

3.5. Avoidable death

- Avoidable death refers to the number of deaths for every 1,000 people that could potentially have been avoided through effective health care, health promotion and disease prevention policies (CIHI, 2012).
- The lower the number the better; it means that fewer individuals died prematurely from preventable or treatable causes.
- As was the case in Ontario, males showed higher rates of PYLL from avoidable causes than females in Middlesex County, generally reflecting higher rates of deaths in males at younger ages (Figure 8).
- For both sexes, cancer was the leading cause of avoidable death in both Middlesex County and Ontario. The PYLL rates for both sexes were higher for Middlesex County residents compared to Ontario.
- Cardiovascular diseases, such as ischaemic heart disease, cerebrovascular disease, and rheumatic heart disease, were the second leading cause of avoidable death for both sexes in Middlesex County. PYLL rates for both females and males in Middlesex County were lower than Ontario.
- Among females in Middlesex County, the third leading causes of avoidable death were due to unintentional injuries (e.g., falls, accidental poisoning, drowning) and infant and maternal causes (e.g., complications of perinatal period, congenital malformations, chromosomal anomalies).

- Among males in Middlesex County, the third leading cause of avoidable death was unintentional injuries and the PYLL rate was higher than Ontario.

Figure 8. Potential years of life lost from leading causes of avoidable death, by sex, Middlesex County and Ontario, 2010 to 2012 average.



Data source: Ontario Mortality Data, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 21, 2018. Population Estimates, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario, Date Extracted: May 11, 2018.

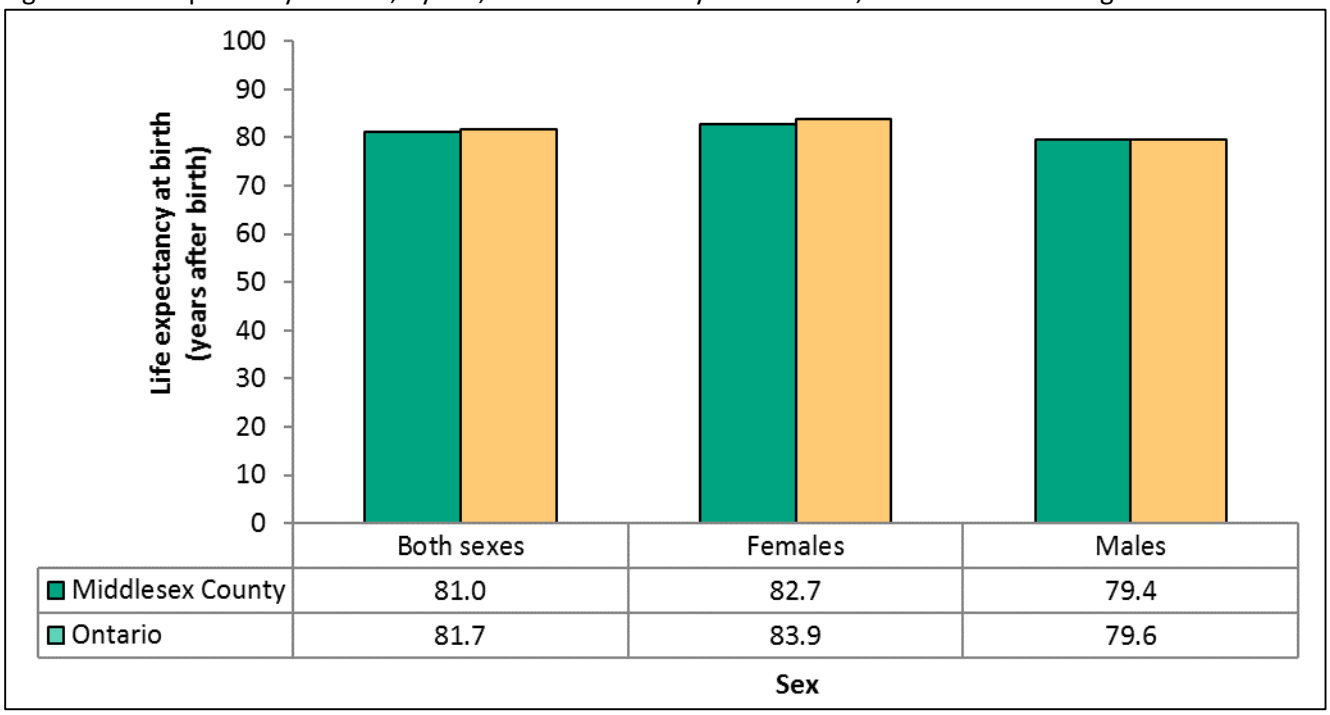
3.6. Life expectancy

- Life expectancy is the average length of time that an individual will live if subjected to the mortality experience for the specified population and time period.
- Years of life expectancy are based on life tables containing mortality rates specific to sex and age groups for Middlesex County during 2008 to 2012. The resulting life expectancies are averages which are assumed to hold true for as long as the mortality picture for that time period remains the same.
- Middlesex County residents can expect to live on average 81.0 years at birth and 19.7 more years at age 65.

3.6.1. Life expectancy at birth

- Life expectancies were higher for females than males at birth and at age 65 (Figure 9).
- Life expectancy at birth and at age 65 were slightly lower for Middlesex County compared to Ontario.

Figure 9. Life expectancy at birth, by sex, Middlesex County and Ontario, 2008 to 2012 average.

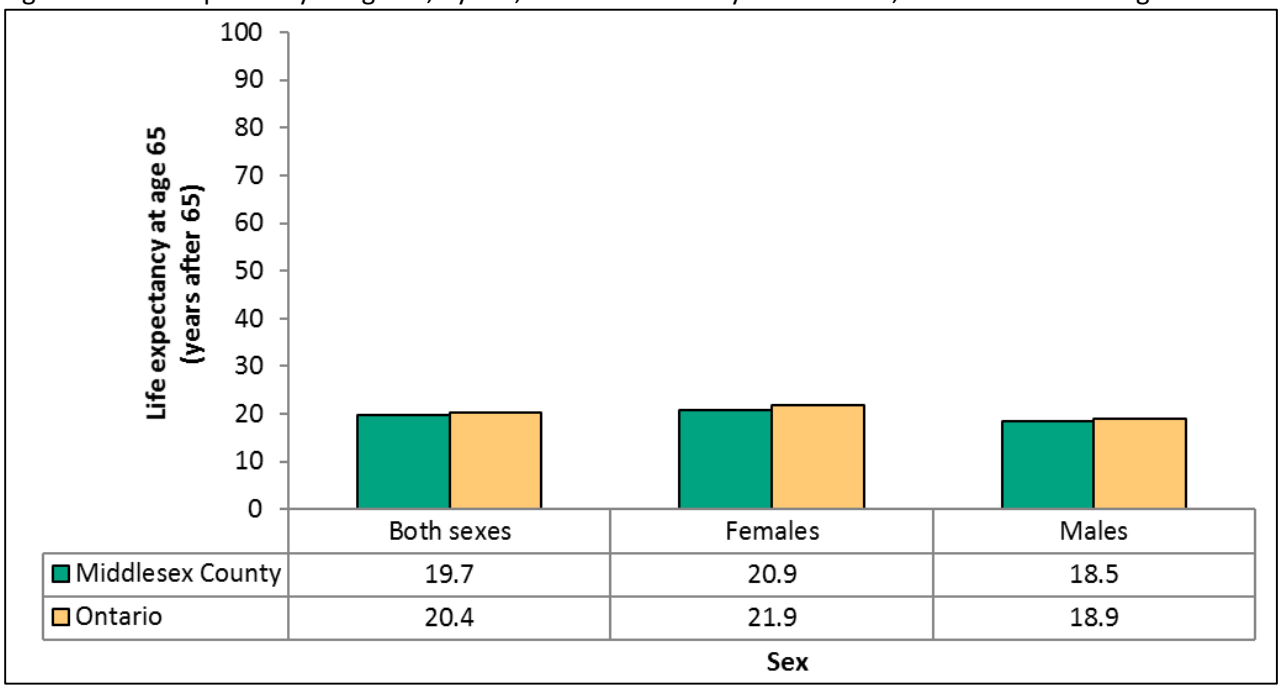


Data source: Ontario Mortality Data, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 21, 2018.

3.6.2. Life expectancy at age 65

- Life expectancy at age 65 was higher for females than males for both Middlesex County and Ontario (Figure 10).
- Middlesex County residents can expect to live on average an additional 19.7 years at age 65, compared to 20.4 years for Ontario.

Figure 10. Life expectancy at age 65, by sex, Middlesex County and Ontario, 2008 to 2012 average.



Data source: Ontario Mortality Data, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 21, 2018.

4. Illness and Injury

4.1. Summary

Chronic diseases make up the leading cause of premature death and potential years of life lost in Middlesex County. While less impactful than chronic disease, injuries are also within the top causes of death and show a large burden in potential years of life lost. Looking at trends of health services use for chronic conditions and injuries gives a sense of the diseases and conditions that affect people throughout their lives. By combining this information with leading causes of death and behavioural risk factor data, public health agencies can determine how to effectively focus health promotion and protection activities.

Healthy weight has been measured by body mass index (BMI). This is ratio of weight to height (kg/m^2). Normal weight is classified as a BMI of 18.5–24.9, overweight is a BMI of 25.0–29.9 and obese is a BMI 30.0 and above. It is an important predictor of many chronic conditions including several of the leading preventable causes of death in Middlesex County. Over 60% the population was considered overweight or obese in Middlesex County in 2013/14. This represents an area of population health risk. Diabetes is a chronic condition for which BMI is a predictor. Looking at the rates of diabetes in the population we see a fairly steady rate over time between the years of 2004 to 2017. In general, the Middlesex County rate is lower than that of the province and males are disproportionately affected with higher rates.

Injuries commonly bring people to the emergency department for care and Middlesex County is no exception. In fact, rates of emergency department (ED) visits for injury were significantly higher in Middlesex County (127.3 per 1,000 people) compared to Ontario (101.1 per 1,000 people). The rate of deaths from injuries, however, was not higher than Ontario. This indicates that residents of Middlesex County experienced more non-fatal injuries than those in the province overall. The most common reason for an injury-related visit to the ED was falls; which was higher in females than males. Being struck against or cut by objects and overexertion were the next most common causes for both sexes. Motor vehicle crashes were the fifth most common injury for females and sixth most common for males. Off-road vehicle collision rates were higher than the provincial rate; whereas, pedestrian-related injury visits are lower. There is no difference with cycling collisions.

Intentional injuries such as the ED visit rate for self-harm in Middlesex County was similar to the Ontario rate. The rate of assault-related ED visits was significantly lower than the province.

Concussion-related ED visits have also been on the rise in recent years and those in Middlesex County experience a substantially higher rate than in the province overall. Local research indicates children in rural populations who experience concussions are much more likely to have sustained the injury in a motor vehicle crash compared to their urban counterparts (Stewart, Gilliland & Fraser, 2014).

The harms associated with drug use is important to consider in light of the public health crisis related to opioids and cannabis legalization in Canada. In Ontario there has been an increase over time in emergency department visits associated with each of these substances both for poisonings and related mental or behavioural disorders. It is worth noting that rates of ED visits in Middlesex County are lower than Ontario and the difference is statistically significant for both cannabis and opioids. Cannabis visit rates have increased significantly since 2004. However, opioid ED visits have not shown a statistically

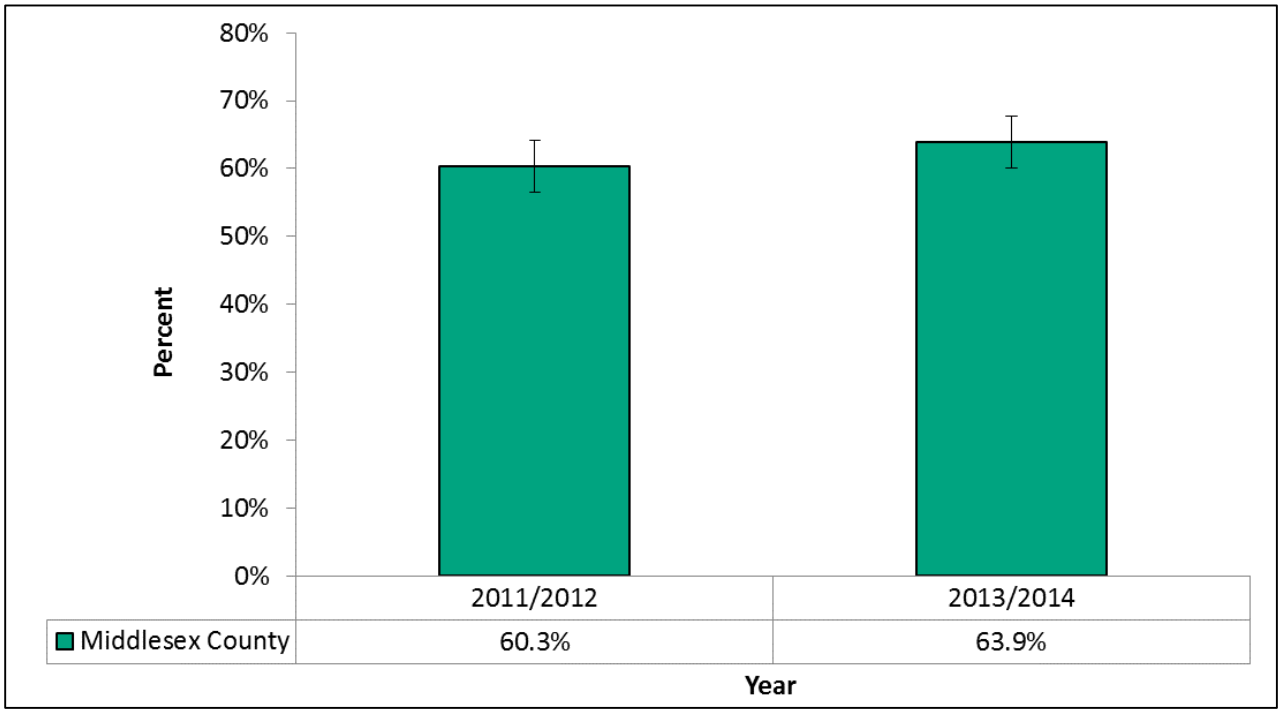
significant increase between 2004 and 2017. This is a marked difference from the trend seen in Ontario and surrounding communities.

There are approximately 70 diseases of public health significance that are reported to the local Medical Officer of Health under the *Health Protection and Promotion Act*. Between 2005 and 2017, the average reported incidence rates of HIV/AIDS, hepatitis C, and active tuberculosis cases was lower among Middlesex County residents compared to the provincial rate.

4.2. Healthy weights

- In 2013/2014, 63.9% of the adults aged 18 and over were considered overweight or obese based on their body mass index (BMI) (Figure 11).
- This was not significantly higher than the rate seen in 2011/2012 in Middlesex County.

Figure 11. Percent of population (age 18+) overweight or obese according to body mass index category, Middlesex County and Ontario, 2011–2012 and 2013-2014.

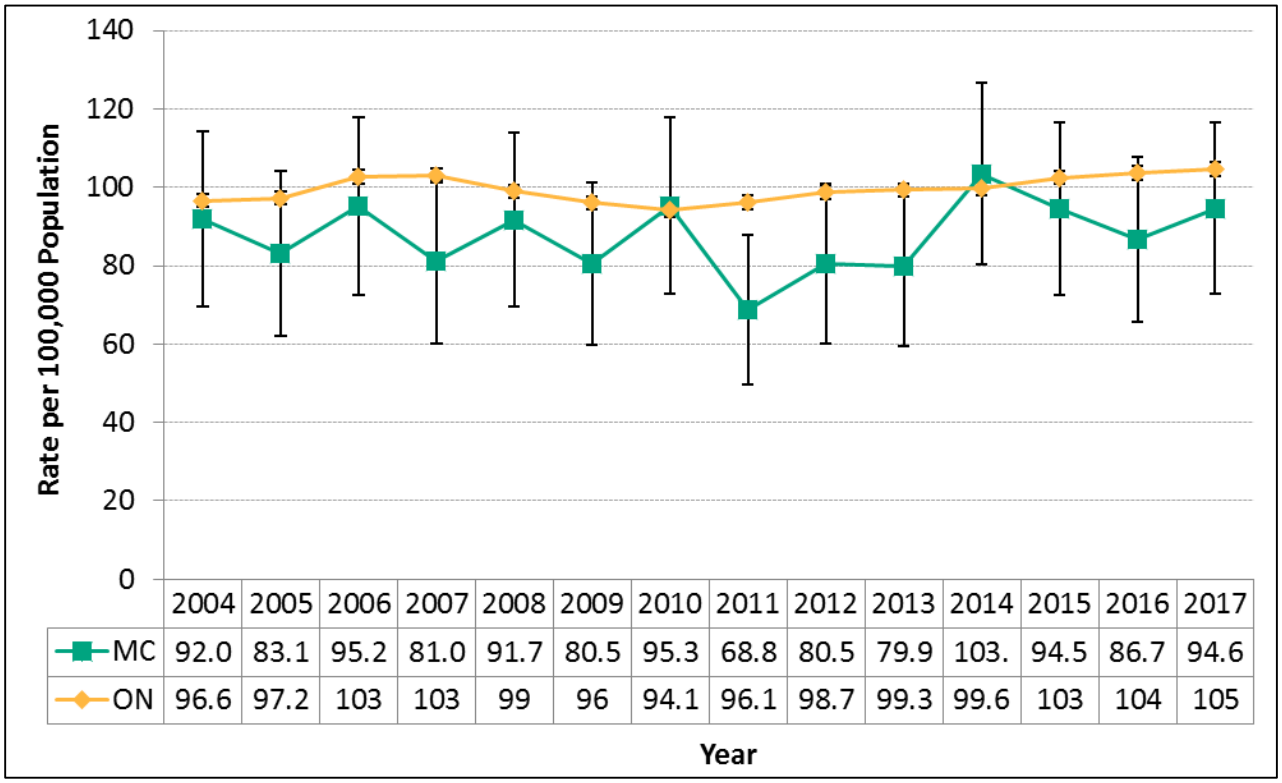


Data source: Rapid Risk Factor Surveillance System [Jan 2011 – Dec 2014], Extracted August 24, 2018

4.3. Diabetes

- The rate of hospitalizations for diabetes was 94.6 per 100,000 in 2017 (Figure 12).
- Between the years 2004 and 2017 the rate of diabetes-related hospitalizations in Middlesex County did not change significantly.
- Rates of hospitalizations for diabetes in Middlesex County were generally lower than provincial rates but not significantly. Because of small population numbers the rates varied from year to year but no clear upward or downward trend emerged over the time period.
- Males tended to have higher rates compared to females, but this difference was not statistically significant in all years (data not shown).

Figure 12. Diabetes hospitalizations, unadjusted rates per 100,000 population, Middlesex County and Ontario, 2004 to 2017.



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
MC	92.0	83.1	95.2	81.0	91.7	80.5	95.3	68.8	80.5	79.9	103.	94.5	86.7	94.6
ON	96.6	97.2	103	103	99	96	94.1	96.1	98.7	99.3	99.6	103	104	105

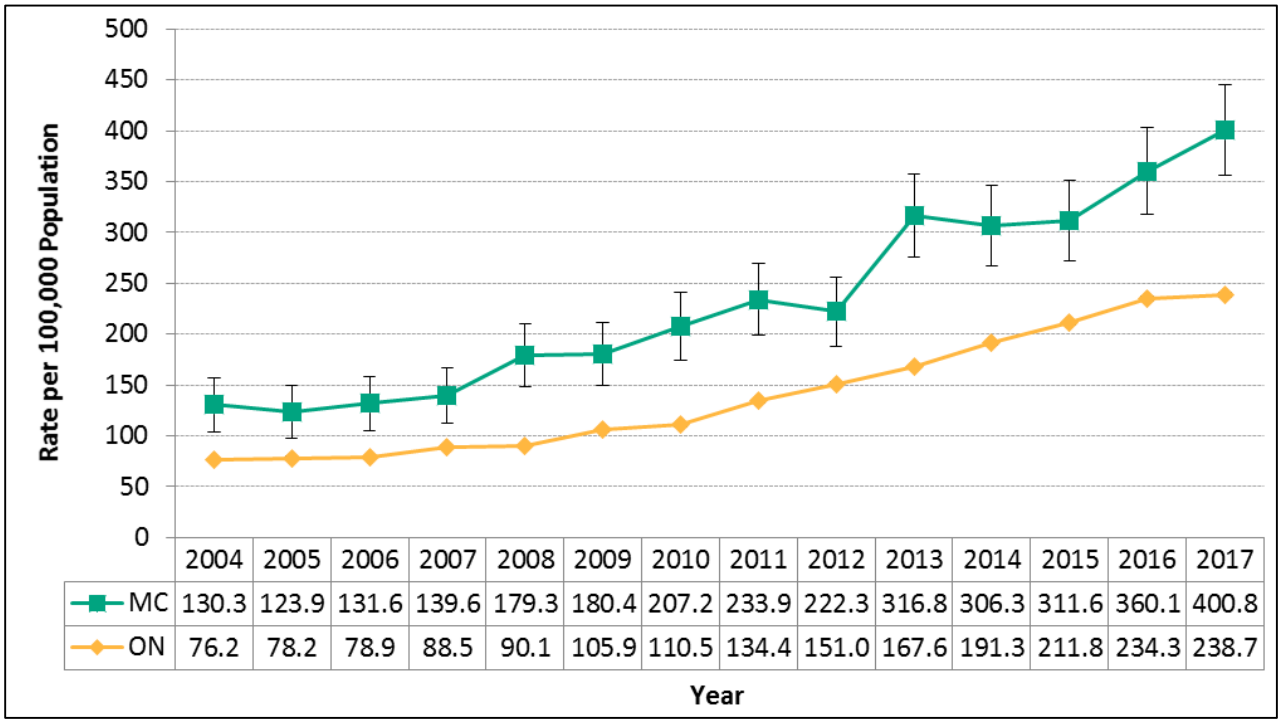
Data source: Inpatient Discharges 2004-2017, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: June 16, 2018.

4.4. Injuries

4.4.1. Concussions

- Concussion-related visits to the emergency department have been on the rise since 2004 for both Middlesex County and Ontario residents (Figure 13). The rate in 2017 was more than three times higher than it was in 2004 jumping to 400 visits per 100,000 people. This change over time is statistically significant.
- Over the entire time period the rate in Middlesex County has been significantly higher than the provincial rate.
- There was no statistically significant different in the rate between males and females (data not shown).

Figure 13. Unadjusted rates of emergency department visits for concussions per 100,000 population, Middlesex County and Ontario, 2004 to 2017.



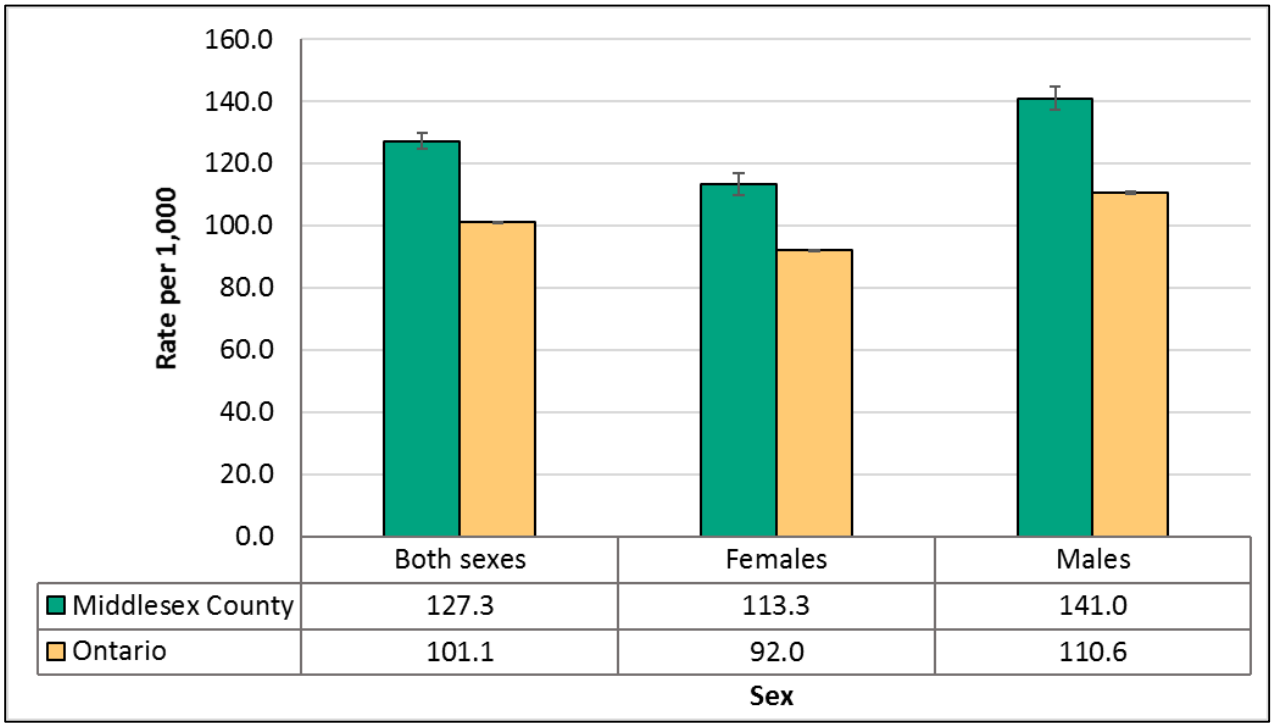
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
MC	130.3	123.9	131.6	139.6	179.3	180.4	207.2	233.9	222.3	316.8	306.3	311.6	360.1	400.8
ON	76.2	78.2	78.9	88.5	90.1	105.9	110.5	134.4	151.0	167.6	191.3	211.8	234.3	238.7

Data source: National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Health and Long-term Care, IntelliHEALTH ONTARIO, Extracted: August 9, 2018.

4.4.2. Unintentional injuries

- Unintentional injury ED visit rates were significantly higher in Middlesex County than Ontario for both sexes. The rate in males was significantly higher than females (Figure 14).
- Falls were the leading cause of injuries bringing people in Middlesex County to the emergency department between 2015 and 2017. This is, by far, the injury cause with the largest number of ED visits for females (Table 8).
- Falls were also the leading cause of death due to injury in both men and women and transport collisions the 2nd leading cause of death (data not shown).
- Injuries related to being struck or cut by objects and overexertion were the next most common causes of emergency department visits.
- Motor vehicle collisions were the fifth leading cause of injury related ED visits in females and the sixth most common in males.
- Included within the motor vehicle and other land transport collisions categories are injuries related to cycling (148.7 ± 27.5 visits per 100,000 people) off-road vehicle (110.4 ± 23.7) and pedestrian-related (30.8 ± 12.5) collisions. Note that off-road vehicle collision rates were higher than the provincial rate; whereas, pedestrian-related injury visits were lower. There is no difference with cycling collisions.
- Emergency department visit rates for intentional injuries such as self-harm in Middlesex County (124.1 ± 25.1 visits per 100,000 people) was similar to the Ontario rate whereas assault-related ED visits (160.1 ± 28.5) were significantly lower than the province.

Figure 14. Emergency department visits for all injuries, unadjusted rates per 1,000 population, by sex, Middlesex County and Ontario, 2015 to 2017 annual average.



Data source: National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Health and Long-term Care, IntelliHEALTH ONTARIO, Extracted: August 16, 2017.

Table 8. Counts and unadjusted rates per 100,000 population, by sex, Middlesex County, 2015 to 2017 annual average.

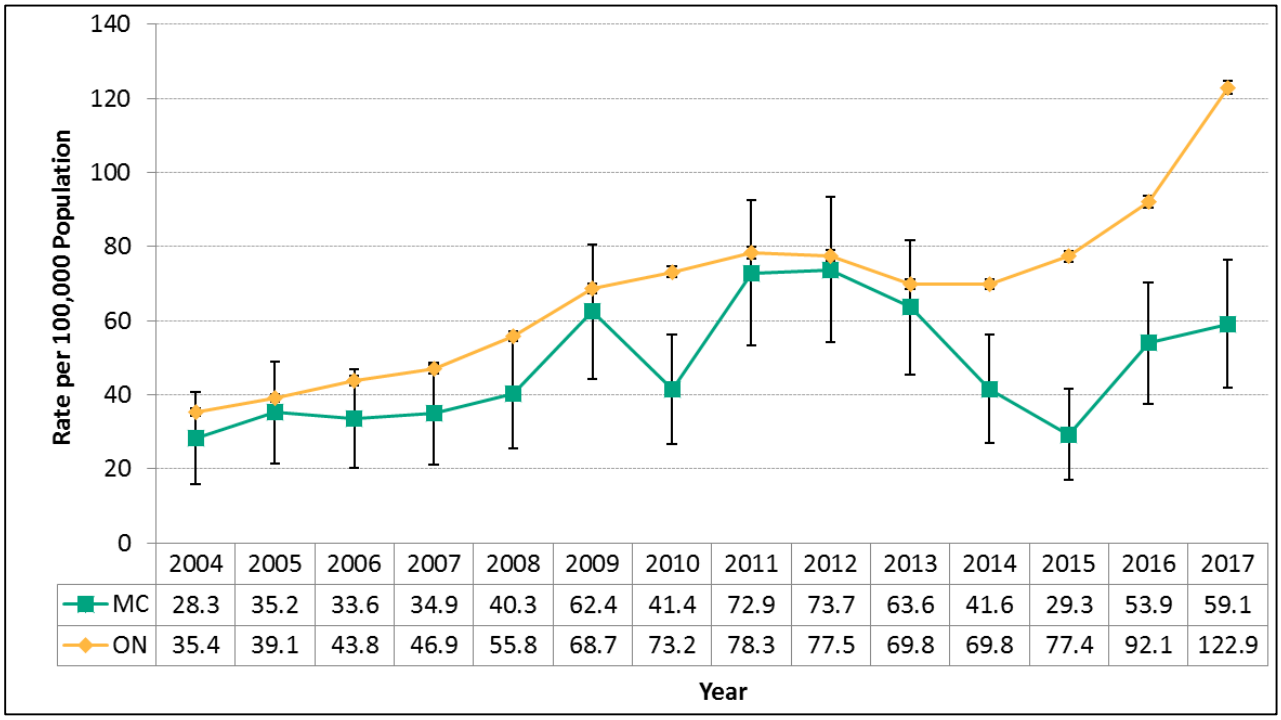
Middlesex County rank	Cause Unadjusted rate per 100,000 ± 95% Confidence Interval (Count)	
	Females	Males
1	Falls* 4,049.6 ± 203.1 (1527)	Falls* 3,377.3 ± 184.7 (1285)
2	Struck by/against object* 1,708.4 ± 131.9 (644)	Struck by/against object* 2,812 ± 168.5 (1,070)
3	Overexertion* 1,004.0 ± 101.1 (379)	Cut/pierced by object* 1,687.3 ± 130.5 (642)
4	Cut/pierced by object* 742.4 ± 87 (280)	Overexertion* 1,063.6 ± 103.6 (405)
5	Motor vehicle collision 637.2 ± 81 (240)	Foreign body in eye/orifice* 1,049.5 ± 102.9 (399)
6	Bite by Dog or other Mammal* 332.3 ± 58.2 (125)	Motor vehicle collision* 807.7 ± 90.3 (307)
7	Caught/crushed between objects* 295.2 ± 54.8 (111)	Caught/crushed between objects* 437.2 ± 66.4 (166)
8	Foreign body in eye/orifice 281.0 ± 53.5 (106)	Bite by dog or other mammal* 261.9 ± 51.4 (100)
9	Insect bite 198.9 ± 45.0 (75)	Other land transport collisions 223.4 ± 47.5 (85)
10	Other land transport collisions* 197.1 ± 44.8 (74)	Poisoning 184.9 ± 43.2 (70)
All unintentional injuries*	11,008.6 ± 334.9 (4,152)	13810.5 ± 373.4 (5,254)

Data source: National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Health and Long-term Care, IntelliHEALTH ONTARIO, Extracted: August 16, 2017.
Note: * indicates the MC sex-specific rate is statistically significantly higher than the ON sex-specific rate.

4.5. Opioids

- Emergency department visits related to opioid poisonings combined with mental or behavioural disorders due to opioids have increased in Ontario over time, however rates in Middlesex County have not (Figure 15).
- Due to small numbers the yearly rates fluctuate. Since 2013 rates declined in Middlesex County and then increased again in 2016.
- Since 2014 there has been a lower rate of opioid-related ED visits in Middlesex County compared to Ontario. This difference is statistically significant.
- Differences between males and females were not seen in Middlesex County data, whereas males have a significantly higher proportion of visits than females in province overall (data not shown).

Figure 15. Opioid-related emergency department visits, counts and unadjusted rates per 100,000 population, Middlesex County and Ontario, 2004 to 2017.



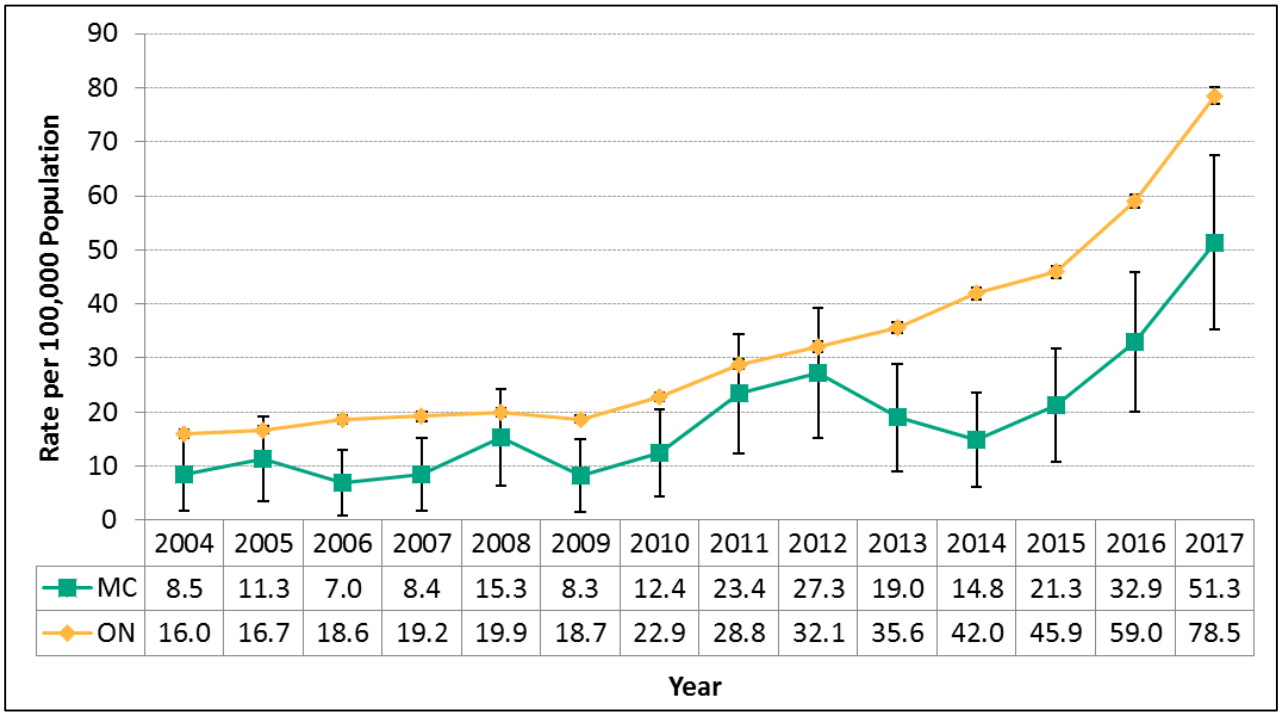
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
MC	28.3	35.2	33.6	34.9	40.3	62.4	41.4	72.9	73.7	63.6	41.6	29.3	53.9	59.1
ON	35.4	39.1	43.8	46.9	55.8	68.7	73.2	78.3	77.5	69.8	69.8	77.4	92.1	122.9

Data source: National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Health and Long-term Care, IntelliHEALTH ONTARIO, Extracted: August 23, 2018.

4.6. Cannabis

- Cannabis-related visits to the emergency department have been on the rise since 2004 for both Middlesex County and Ontario residents (Figure 16). The rate in 2017 was more than five times higher than it was in 2004 jumping from 8.5 to 51.3 visits per 100,000 people. This difference is statistically significant.
- Cannabis-related visits include poisonings and mental or behavioural disorders due to cannabis use.
- Rates since 2012 declined briefly and then began to rise steadily after 2014 until 2017.
- Since 2013, the rate in Middlesex County has been significantly lower than the provincial rate.
- Males tended to have higher rates than females but the differences between them was not significant (data not shown).

Figure 16. Cannabis-related emergency department visits, counts and unadjusted rates per 100,000 population, Middlesex County and Ontario, 2004 to 2017.



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
MC	8.5	11.3	7.0	8.4	15.3	8.3	12.4	23.4	27.3	19.0	14.8	21.3	32.9	51.3
ON	16.0	16.7	18.6	19.2	19.9	18.7	22.9	28.8	32.1	35.6	42.0	45.9	59.0	78.5

Data source: National Ambulatory Care Reporting System (NACRS), Ontario Ministry of Health and Long-term Care, IntelliHEALTH ONTARIO, Extracted: August 23, 2018.

4.7. Infectious diseases

- There are approximately 70 diseases of public health significance that are reported to the local Medical Officer of Health under the Health Protection and Promotion Act. Among these, HIV/AIDS*, hepatitis C†, and active tuberculosis§ are all infections that can have long-term impacts on effected individuals and, once diagnosed, require follow up with a health care provider.
- Between 2005 and 2017, the average reported incidence rates of HIV/AIDS, hepatitis C, and active tuberculosis cases was lower among Middlesex County residents compared to the provincial rate (Table 9).

Table 9. Reported incidence rate of HIV/AIDS, hepatitis C, and active tuberculosis, Middlesex County and Ontario, 2005–2017 average.

Infectious disease	Rate per 100,000 population	
	Middlesex County	Ontario
HIV/AIDS*	1.5	6.5
Hepatitis C†	16.9	33.3
Tuberculosis (active)§	<1.0	4.8

Data source: Middlesex County data: Middlesex London Health Unit integrated Public Health Information System (iPHIS) Cognos Report Net: custom report. Ontario Ministry of Health and Long-Term Care; Extracted August 13, 2018. Ontario data: Public Health Ontario. Infectious Diseases Query: Ontario: Case counts and crude rates of reportable diseases by public health unit and year. Ontario Agency for Health Protection and Promotion; Extracted August 15, 2018.

* HIV/AIDS cases are reported by encounter date, which is the date that public health was first notified of the case.

† Hepatitis C cases are reported by episode date, which is the earliest available of symptom onset date, specimen collection date, laboratory test date, or date reported to public health. Hepatitis C cases include all cases with a positive antibody test, and therefore includes people with acute infections, spontaneously resolved acute infections, chronic infections, and those who have received effective anti-viral therapy (cured).

§ Active tuberculosis cases are reported by the date the individual was diagnosed with active tuberculosis.

5. Behavioural Risk Factors

5.1. Summary

Historically, the leading causes of death in Middlesex County are chronic diseases and injuries which are linked to behavioural risk factors such as alcohol consumption, physical inactivity and smoking. In data from community health surveys from the years 2011 to 2014, a substantial portion of the population reported behaviours that put them at risk for chronic diseases and injuries. For instance, only about half the population reported being active or moderately active during their leisure time, averaging 1.5 or more kcal/kg/day of energy expenditure from leisure-time physical activity. This is approximately the amount of exercise that is required to experience some health benefits.

In the same time frame, only about half did not exceed the low risk alcohol drinking guidelines. These guidelines outline the maximum number of daily and weekly drinks that can be consumed to reduce the risk of both long term chronic health conditions and the risk of injury (Butt, Beirness, Gliksman, Paradis & Stockwell, 2011). Current smoking continues in about 20% of the adult population.

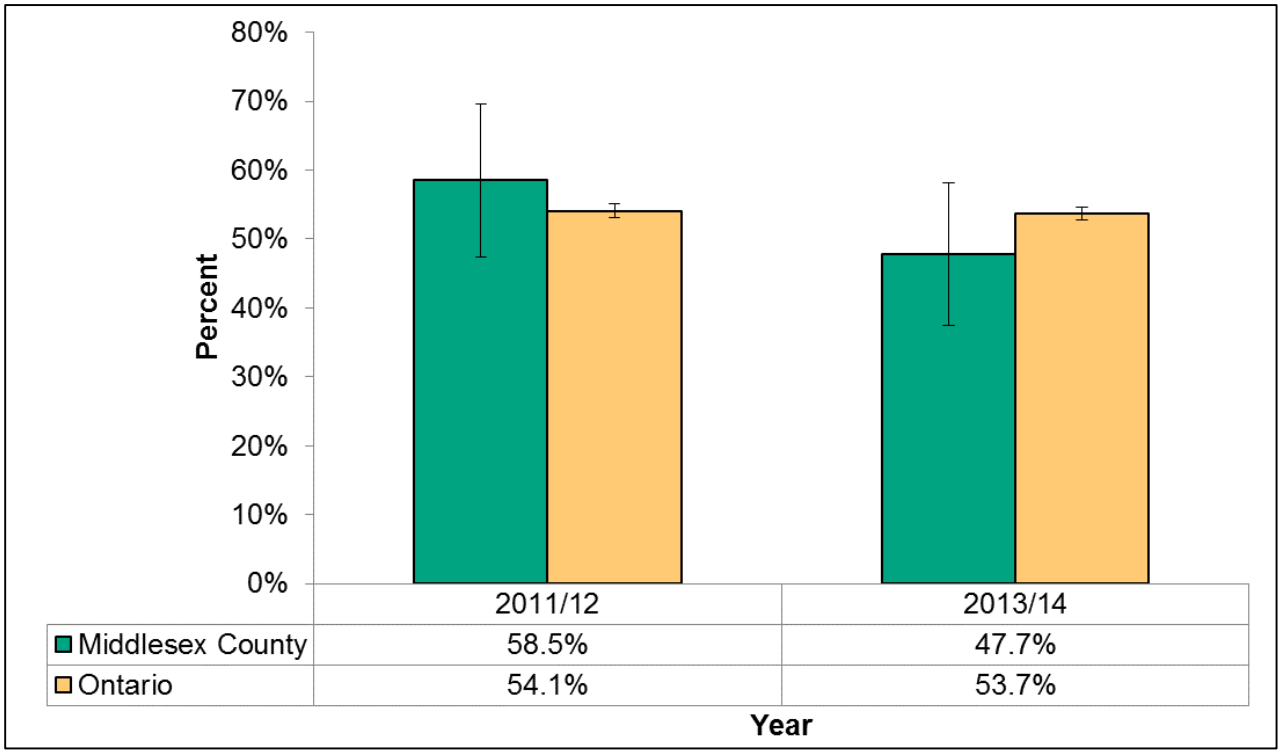
Self-rated health is a self-assessment of an individual's current health status that encompasses both experiences and understanding of the causes and impacts of disease. It has been shown to be predictive of the development of chronic conditions and mortality. Over 90% of people rated their overall health as good, very good or excellent after taking physical, mental and social well-being into consideration. Respondents are asked to consider health, not just from the perspective of absence of disease and injury but also to consider social, mental and physical aspects of their well-being.

Data indicates that Middlesex County patterns of behavioural risk factors are not different from Ontario. This could be due, partly, to a small number of people responding to the survey in Middlesex County. However, it likely indicates that lifestyle behaviour rates in Middlesex County are similar to the province.

5.2. Physical activity

- In 2013/2014, 47.7% of the Middlesex County population reported being moderately active or active during leisure time activities (Figure 17).
- While lower, there was no significant difference between Middlesex County and Ontario (Figure 17). It is also not different than the rate in 2011/2012.

Figure 17. Percent of population (age 12 years and older) who were moderately active or active during leisure time, Middlesex County and Ontario, 2011/2012 and 2013/2014.

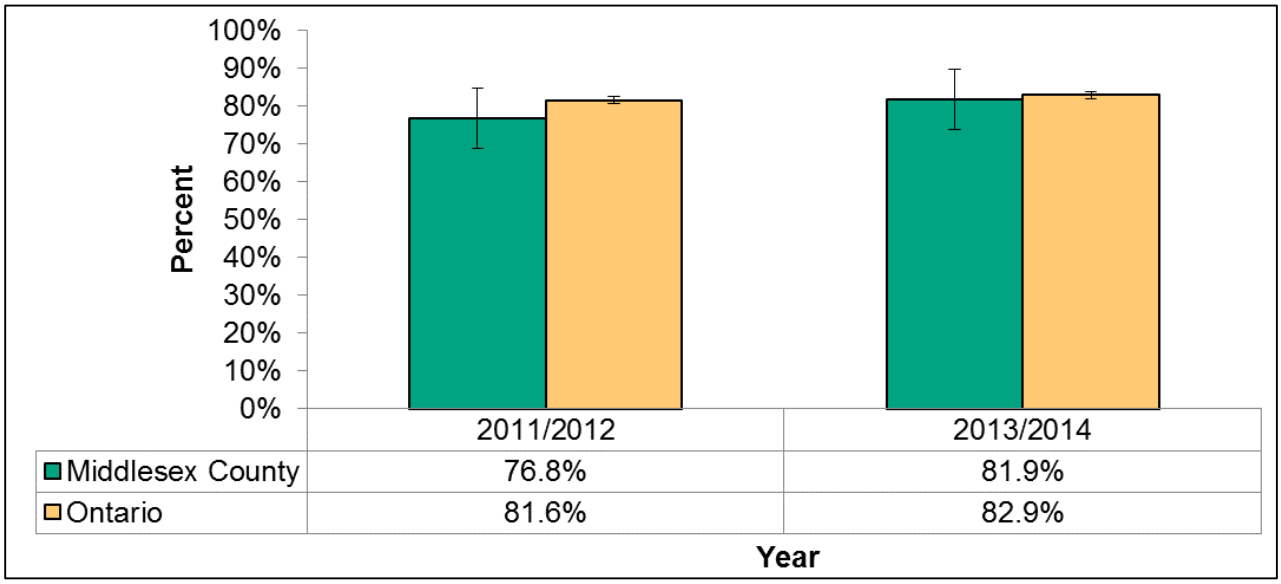


Data source: Canadian Community Health Survey, Statistics Canada, Share File, Ontario Ministry of Health and Long-Term Care.

5.3. Smoking

- In 2013/2014, 81.9% of adults aged 19 years and over in Middlesex County reported that they were non smokers (Figure 18). Compared to the province, Middlesex County had a similar proportion of non smokers.

Figure 18. Percent of non-smokers among adults age 19 years or older, Middlesex County and Ontario, 2011/2012 and 2013/2014.

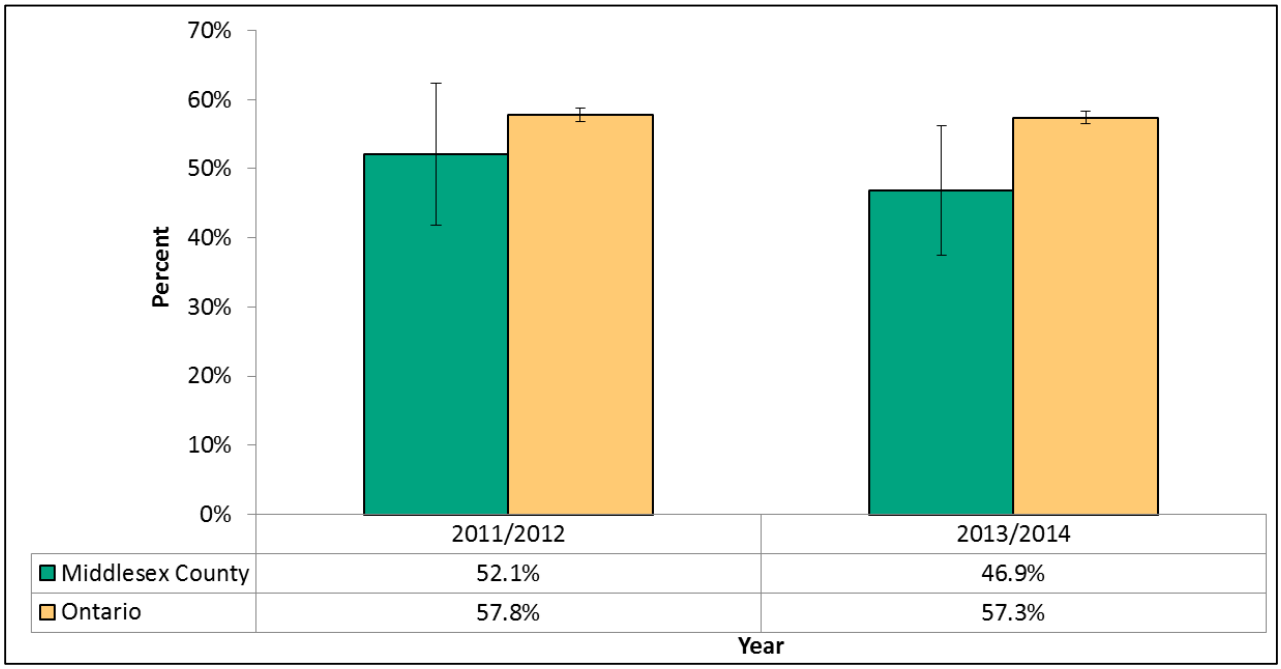


Data source: Canadian Community Health Survey, Statistics Canada, Share File, Ontario Ministry of Health and Long-Term Care.

5.4. Alcohol use

- The proportion of those aged 19 and older, in Middlesex County, who did not exceed the low risk drinking guidelines in 2013/2014 was 46.9% (Figure 19).
- There are two parts to Canada's low risk alcohol drinking guidelines (Butt *et al*., 2011):
    - Reducing your long term health risks by drinking no more than 2 standard drinks on any one day for women and no more than 3 standard drinks on any one day for men with a maximum of 10 and 15 standard drinks a week for women and men, respectively. A couple of days with no alcohol drinking should be taken each week.
    - Women can reduce their risk of injury by drinking 3 or fewer drinks and 4 or fewer drinks, for men, on any single occasion.
- The rate in Middlesex County was significantly lower than that of Ontario (57.3%) in 2013/2014, however only approximately half did not exceed the drinking guideline in both 2011/2012 and 2013/2014 (Figure 19).

Figure 19. Percent of population (age 19 years and older) who did not exceed the Low Risk Drinking Guidelines, Middlesex County and Ontario, 2011/2012 and 2013/2014.

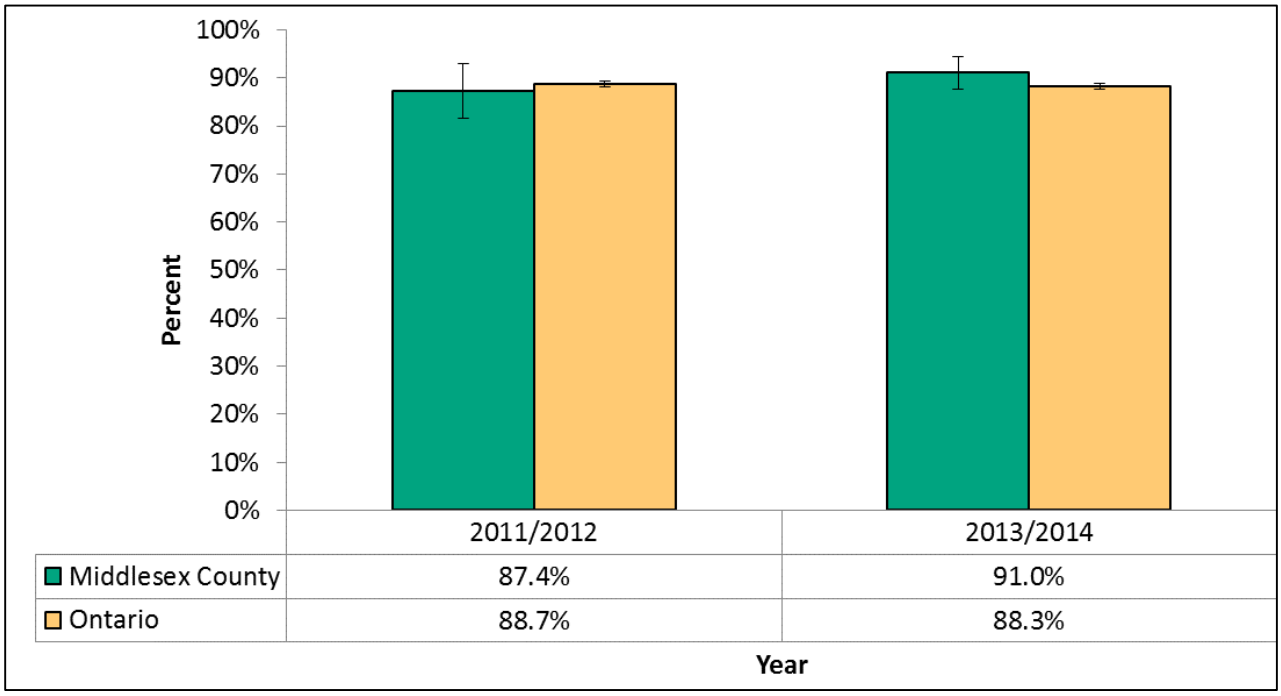


Data source: Canadian Community Health Survey, Statistics Canada, Share File, Ontario Ministry of Health and Long-Term Care.

5.5. Self-reported health

- In 2013/2014, 89.1% of the population of Middlesex County reported “excellent”, “very good” or “good health”. This was not significantly higher than the rate in Ontario (Figure 20).

Figure 20.Percent of the population (age 12 years or older) who reported “excellent”, “very good” or “good health”, Middlesex County and Ontario, 2011/2012 and 2013/2014.



Data source: Canadian Community Health Survey, Statistics Canada, Share File, Ontario Ministry of Health and Long-Term Care.

6. Reproductive Health

6.1. Summary

Pregnancy rates in Middlesex County have remained relatively stable, at a rate of approximately 8 births per 1,000 population. While stable, pregnancy rates in Middlesex County are consistently lower than those for Ontario.

Pregnant women who are particularly young (i.e., teenagers) or old (i.e., ages 35 and older) tend to experience more problems delivering the baby and with various birth outcomes—such as prematurity, low birth weight, and neonatal death. These mothers may therefore require more supports before and after birth than mothers in their twenties and early thirties.

In recent years, teen pregnancy (ages 14 to 19) rates in Middlesex County have been significantly lower than that for Ontario. And the rates have declined each year from 2013 to 2016; a downward trend also observed in the province.

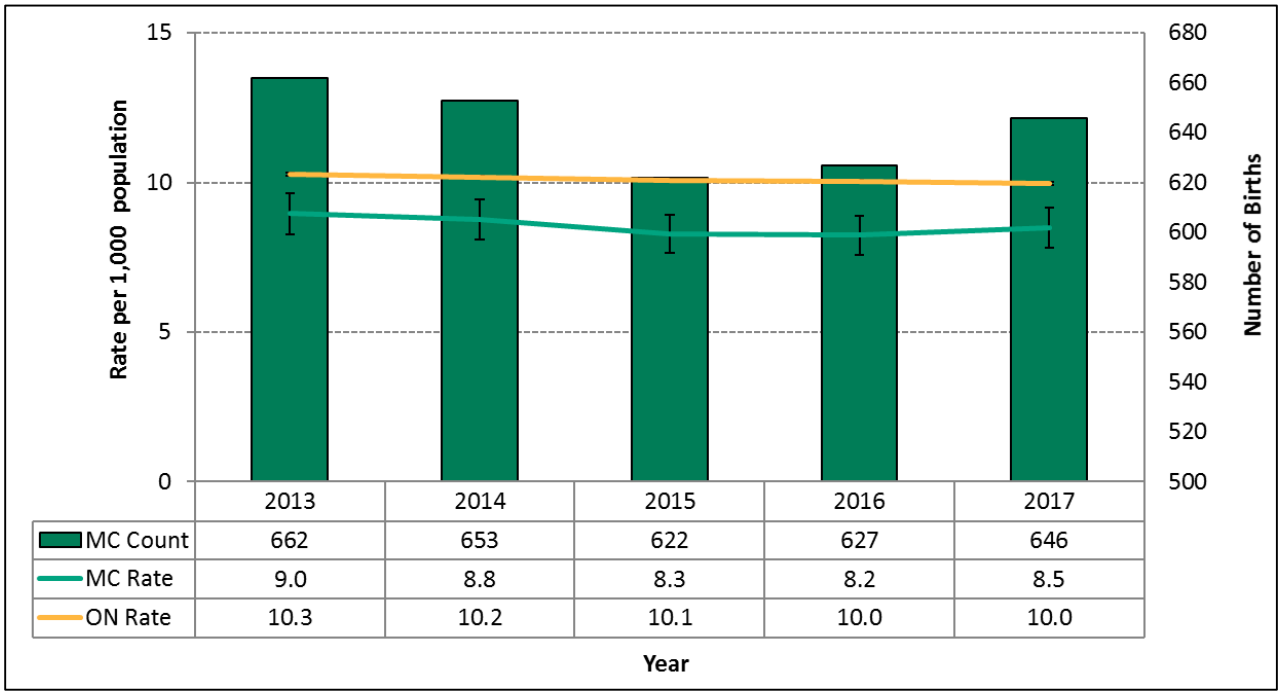
In Middlesex County and Ontario, the highest pregnancy rates are among women aged 30 to 34, followed by those aged 25 to 29. Compared to Ontario, females in Middlesex County tend to give birth at slightly younger ages: the third highest pregnancy rate is among women age 25 to 29, and pregnancy rates are significantly lower among women 35 years and older.

6.2. Pregnancy rates

6.2.1. Overall pregnancy rate

- In 2017, there were 646 pregnancies in Middlesex County, corresponding to a pregnancy rate of 8.5 per 1,000 population (Figure 21).
- Pregnancy rates in Middlesex County and Ontario were relatively stable from 2013 to 2017. During this period, pregnancy rates in Middlesex County were consistently lower than those in Ontario.

Figure 21. Count and crude birth rates per 1,000 population, Middlesex County and Ontario, 2013 to 2017.



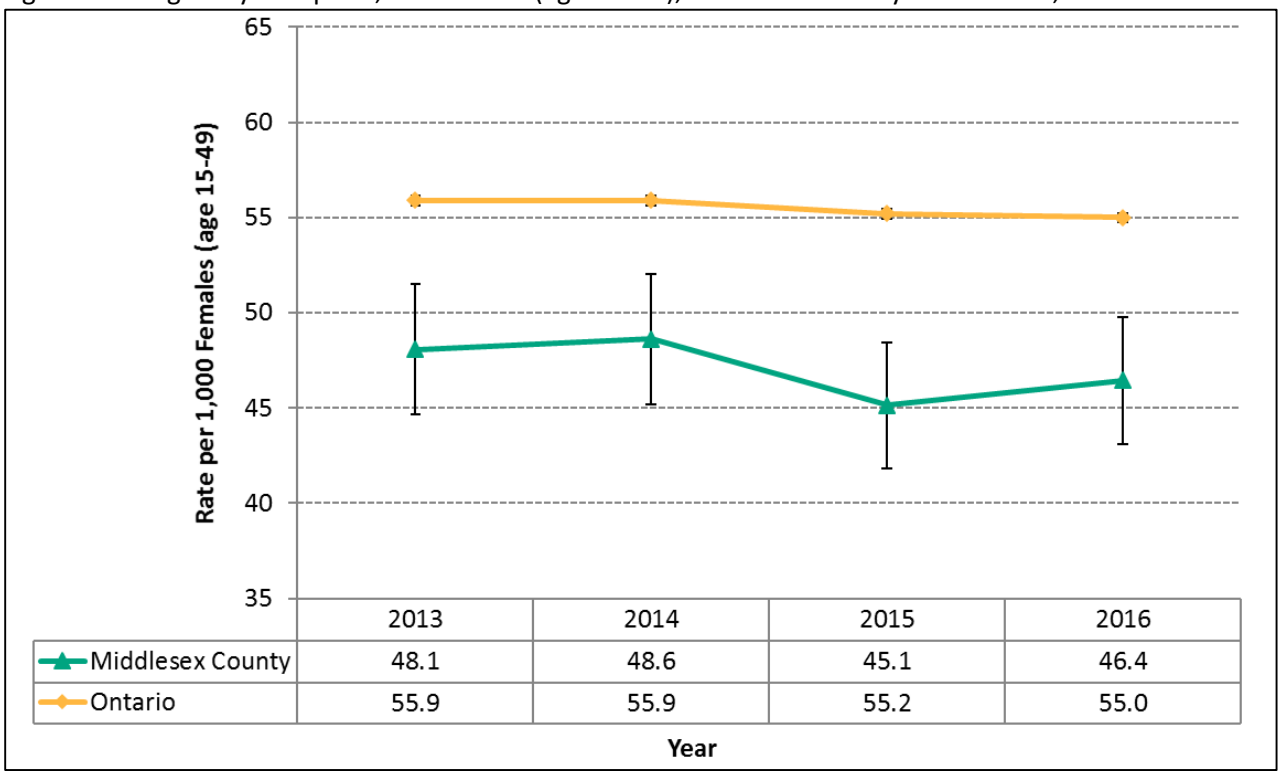
	2013	2014	2015	2016	2017
MC Count	662	653	622	627	646
MC Rate	9.0	8.8	8.3	8.2	8.5
ON Rate	10.3	10.2	10.1	10.0	10.0

Data source: BORN Information System, BORN Ontario. Information accessed on: July 7, 2018; Therapeutic abortions, Date Extracted: June 19, 2018 & Population Estimates, Date Extracted: May 11, 2018, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario.

6.2.2. Pregnancy rate per 1,000 females

- Pregnancy rates have been relatively stable from 2013 to 2016 in Ontario and Middlesex County (Figure 22).
- Between 2013 and 2016, pregnancy rates in Middlesex County were significantly lower than Ontario.

Figure 22. Pregnancy rate per 1,000 females (age 15–49), Middlesex County and Ontario, 2013 to 2016.



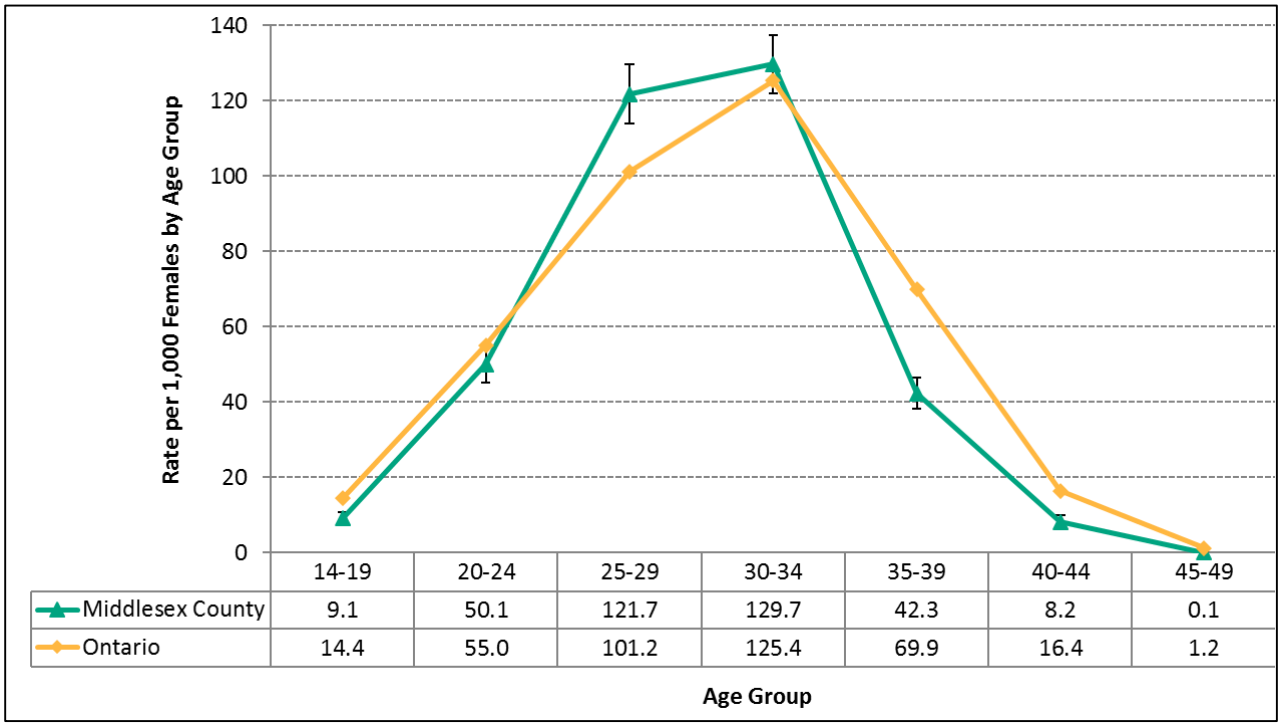
	2013	2014	2015	2016
Middlesex County	48.1	48.6	45.1	46.4
Ontario	55.9	55.9	55.2	55.0

Data source: BORN Information System, BORN Ontario. Information accessed on: July 7, 2018; Therapeutic abortions, Date Extracted: June 19, 2018 & Population Estimates, Date Extracted: May 11, 2018, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario.

6.3. Pregnancy rate by maternal age group

- Between 2013 and 2016, pregnancy rates across age groups in Middlesex County followed a trend similar to Ontario with a peak among women age 30–34 (Figure 23).
- Compared to Ontario, females in Middlesex County tended to be pregnant at slightly younger ages, with a significantly higher pregnancy rate among women age 25 to 29 and lower rates among women age 35 to 44.

Figure 23. Pregnancy rate per 1,000 females, by age group, Middlesex County and Ontario, 2013–2016 average.



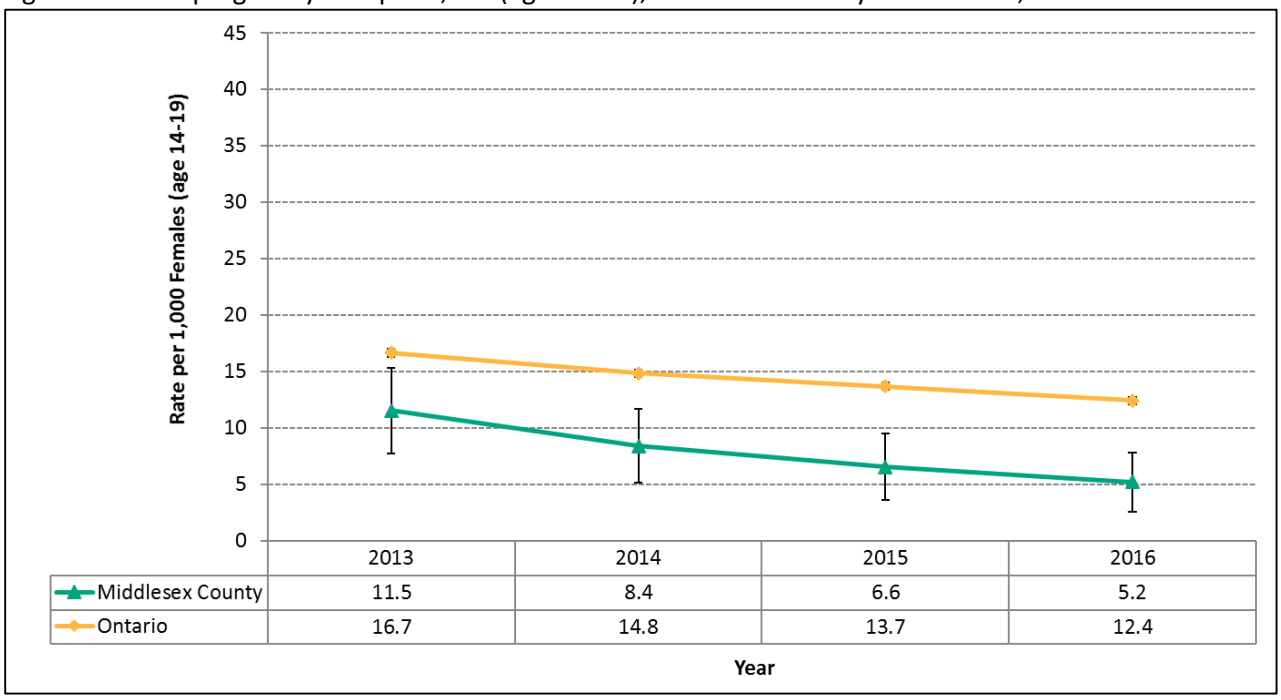
	14-19	20-24	25-29	30-34	35-39	40-44	45-49
Middlesex County	9.1	50.1	121.7	129.7	42.3	8.2	0.1
Ontario	14.4	55.0	101.2	125.4	69.9	16.4	1.2

Data source: BORN Information System, BORN Ontario. Information accessed on: July 7, 2018; Therapeutic abortions, Date Extracted: June 19, 2018 & Population Estimates, Date Extracted: May 11, 2018, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario.

6.3.1. Teenage pregnancy rates

- Between 2013 and 2016, pregnancy rates for teens (14–19) in Middlesex County were significantly lower than for Ontario (Figure 24).
- For both Middlesex County and Ontario, rate of teen pregnancy decreased from 2013 to 2016.

Figure 24. Teen pregnancy rate per 1,000 (age 14–19), Middlesex County and Ontario, 2013 to 2016.



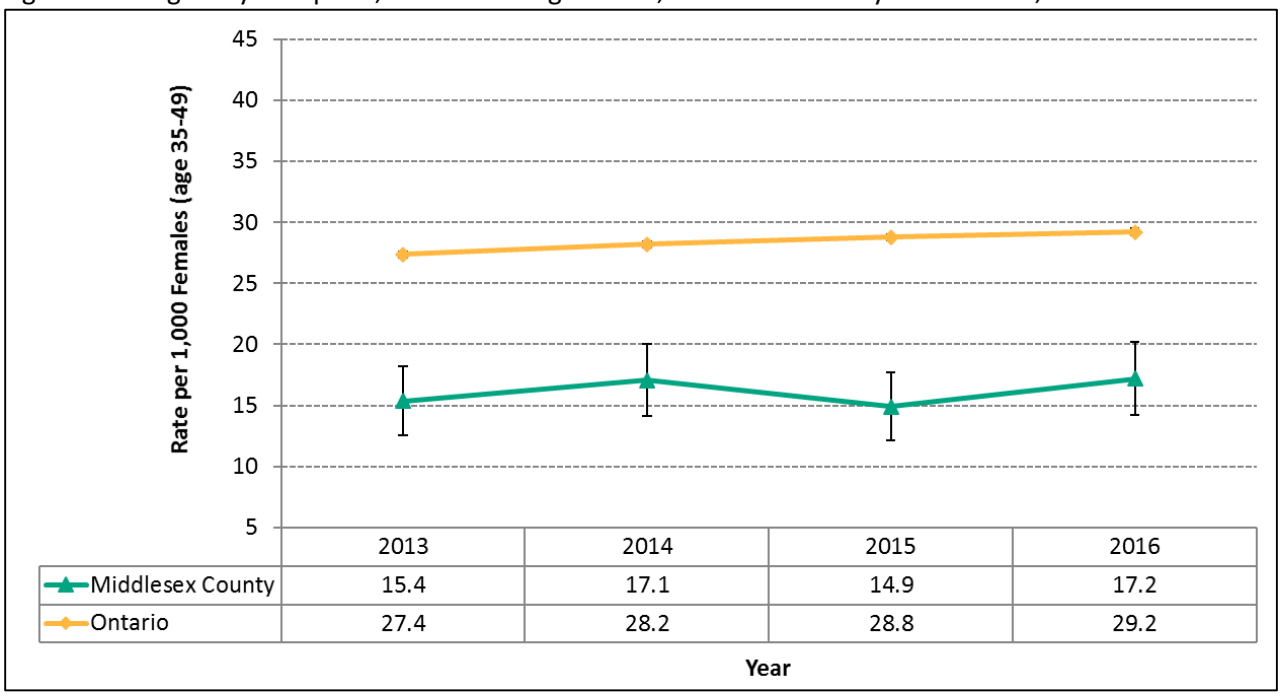
	2013	2014	2015	2016
Middlesex County	11.5	8.4	6.6	5.2
Ontario	16.7	14.8	13.7	12.4

Data source: BORN Information System, BORN Ontario. Information accessed on: July 7, 2018; Therapeutic abortions, Date Extracted: June 19, 2018 & Population Estimates, Date Extracted: May 11, 2018, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario.

6.3.2. Pregnancy rate for females 35 years of age and older

- Pregnancy rates for females age 35 to 49 in Middlesex County were significantly lower than those for Ontario from 2013 to 2016 (Figure 25).
- For Ontario, there was a slight increase over time in the rate of pregnancy among women age 35–49.

Figure 25. Pregnancy rate per 1,000 females age 35–49, Middlesex County and Ontario, 2013 to 2016.



	2013	2014	2015	2016
Middlesex County	15.4	17.1	14.9	17.2
Ontario	27.4	28.2	28.8	29.2

Data source: BORN Information System, BORN Ontario. Information accessed on: July 7, 2018; Therapeutic abortions, Date Extracted: June 19, 2018 & Population Estimates, Date Extracted: May 11, 2018, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH Ontario.

7. Child Health

7.1. Summary

Breastfeeding is the biologically natural way to provide infants with the nutrition they need for healthy growth and development. Health Canada recommends breastfeeding exclusively for the first six months, with continued breastfeeding for up to two years and beyond (Canadian Institute for Health Information, 2012). In 2017, over 93% of infants in Middlesex County were fed breastmilk at discharge from the hospital or midwifery practice group; a proportion slightly higher than the province and which has increased gradually over time since 2013.

The Early Development Instrument (EDI) is a population level measure of children's developmental health at school entry (Janus & Offord, 2007). Every three years all children in senior kindergarten in publically funded schools are assessed by their The EDI assists communities in assessing the educational and social needs of their young children, as well as monitoring children's developmental health across time. The EDI measures five areas (domains) of development: physical health and well-being, social competence, emotional maturity, language and cognitive development, communication skills and general knowledge. In Middlesex County, the proportion of children identified as vulnerable in at least one domain was lower than Ontario for all time periods. Physical health and well being was the area with the greatest proportion vulnerable when measured in 2015. This domain assesses whether children are physically ready for the school day with questions about appropriate dress for school, being late, hungry or tired. It also measures physical independence and gross and fine motor skills. Since vulnerability levels above 10% may be avoidable (Kershaw, Anderson, Warburton, and Hertzman 2009), this area represents an opportunity for improvement.

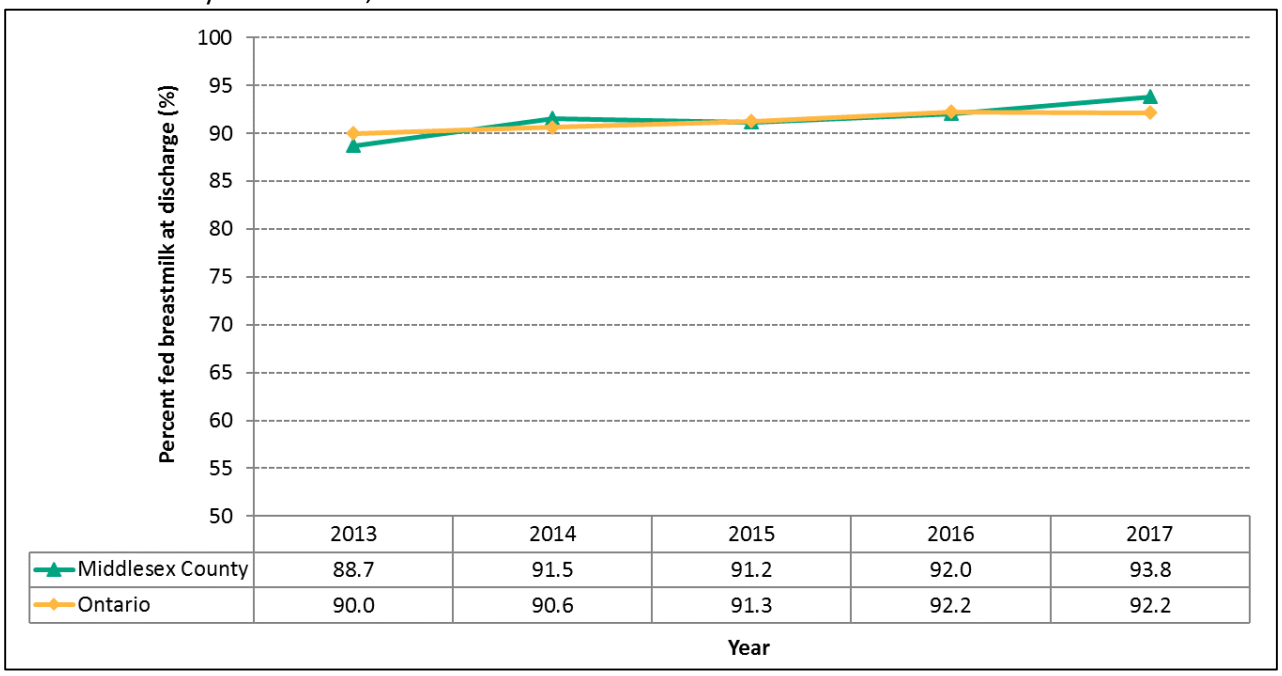
Understanding tooth decay in the school aged children population is important because of its implications for quality of life. In Middlesex County, where some drinking water is not fluoridated, tooth decay increases as children age from junior kindergarten until grade 2. The percentage of children with no cavities or decay goes down and the number of teeth affected in those with decay increases as grade level goes up. In comparison to a sample of health units making up approximately half on the Ontario population, Middlesex County rates of decay were lower in the 2015/2016 and 2016/2017 school years.

The *Immunization of School Pupils Act* identifies a number of diseases against which students need to be vaccinated. Each year, the Middlesex-London Health Unit reviews the immunization records of students attending schools in the region to ensure that their immunizations are up to date (Ontario Ministry of Health and Long-Term Care, 2016). In the 2017–2018 school year, greater than 95% of immunization records of 7-year old students in Middlesex County schools were up-to-date for seven key diseases.

7.2. Breastfeeding rate

- In 2017, 93.8% of infants in Middlesex County were fed breastmilk at discharge from hospital or Midwifery Practice Group, compared to 92.2% in Ontario (Figure 26).
- Between 2013 and 2017, the proportion of infants in Middlesex County fed breastmilk at discharge has gradually increased over time.
- The proportion of infants in Middlesex County fed breastmilk at discharge has followed a similar trend to Ontario from 2013 to 2017.

Figure 26. Proportion of infants fed breastmilk (exclusively or in combination) at discharge from hospital or Midwifery Practice Group (MPG) per the number of live births discharged home and home births, Middlesex County and Ontario, 2013 to 2017.



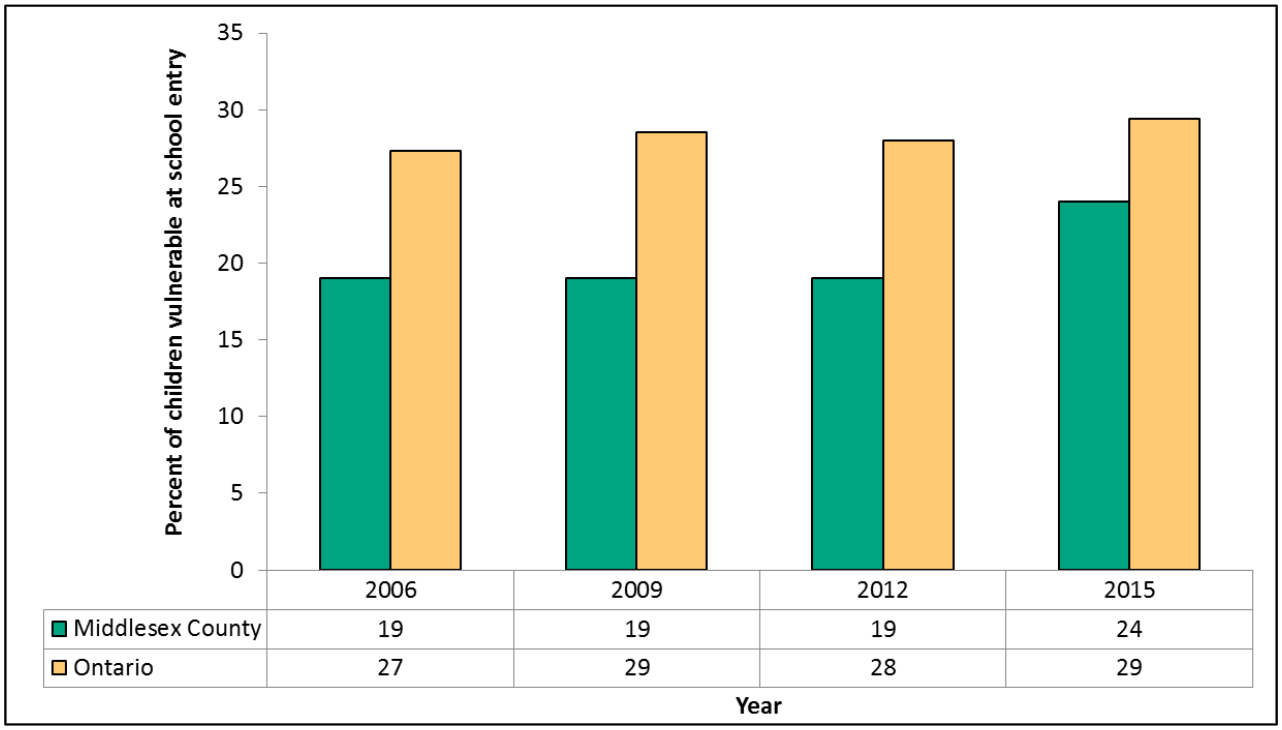
	2013	2014	2015	2016	2017
Middlesex County	88.7	91.5	91.2	92.0	93.8
Ontario	90.0	90.6	91.3	92.2	92.2

Data sources: (1) PHU – Newborn Clinical Report. BORN Information System, BORN Ontario. Information accessed on July 7, 2018. (2) Public Health Unit Analytic Reporting Tool (Cube), BORN Information System, BORN Ontario. Date Extracted: July 31, 2018.

7.3. Early development

- The percent of children entering school that were vulnerable on at least one domain of the Early Development Instrument has been lower than province since the inception of the measurement of the tool in 2006 (Figure 27). Recently, the Middlesex County rate has increased but continues to be lower than the province.
- The physical health and well-being domain has the highest proportion of vulnerable children in Middlesex County (15.9%), followed by the emotional maturity domain (Table 10). These are also the top two areas for Ontario.
- In all municipalities in Middlesex County results showed the percentage of children vulnerable from nearly all domains across all years tested to be lower than Ontario rates (data not shown).

Figure 27. Percentage of children vulnerable in one or more EDI domains, Middlesex County and Ontario, 2006, 2009, 2012, 2015.



Data source: Middlesex County Municipalities Child & Family Community Profile: Appendix 2: Early Development Instrument (EDI), 2012. (2013). Middlesex Children's Services Network. Available at https://www.middlesex.ca/sites/default/files/Appendix%202_Middlesex%20EDI%202012.pdf & Middlesex County community profile. (ca. 2016). [Unpublished report for the Middlesex Children's Service Network]. Middlesex Children's Service Network.

Table 10. Percentage of children at school entry vulnerable by EDI domain, 2015.

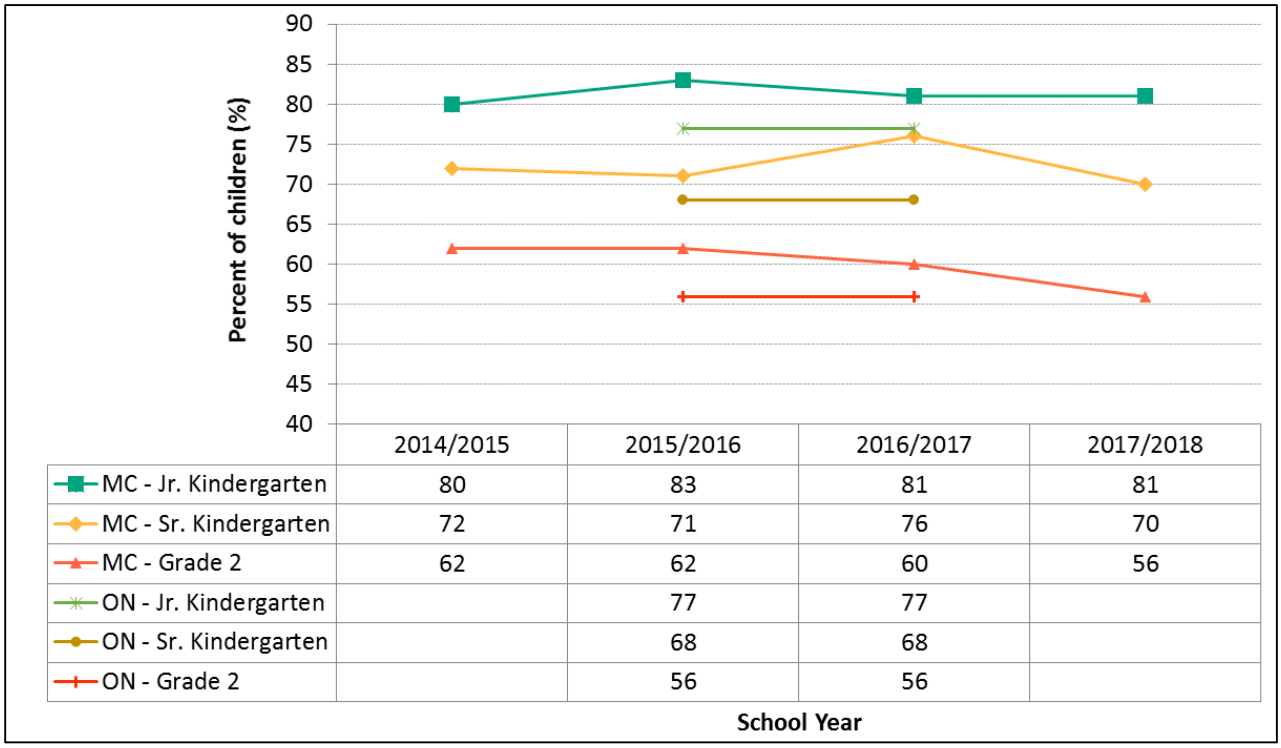
Early Development Instrument Domain	% of children vulnerable at school entry	
	Middlesex County	Ontario
Physical health and well-being	15.9	16.1
Emotional maturity	10.5	12.3
Social competence	7.3	10.7
Communication skills and general knowledge	7.2	10.2
Language and cognitive development	4.1	6.7
One or more EDI domains	24.0	29.4

Data source: Middlesex County Municipalities Child & Family Community Profile: Appendix 2: Early Development Instrument (EDI), 2012. (2013). Middlesex Children's Services Network. Available at https://www.middlesex.ca/sites/default/files/Appendix%202_Middlesex%20EDI%202012.pdf & Middlesex County community profile. (ca. 2016). [Unpublished report for the Middlesex Children's Service Network]. Middlesex Children's Service Network.

7.4. Oral health

- The proportion of children in Middlesex County with no visible tooth decay (caries free) has remained consistent over time for those in junior (81% in 2017/2018) and senior kindergarten (70% in 2017/2018) (Figure 28). The rate of those in Grade 2 with caries has increased since the 2014/2015 school year.
- In comparison to an Ontario sample in the 2015/2016 and 2016/2017 school years, there was a smaller proportion of Middlesex County children with visible tooth decay, across all grades (Figure 28).
- In all children between junior kindergarten and Grade 2 there were between three and four teeth affected by decay, in those with some decay (Figure 29). While those in Middlesex County had fewer teeth affected than a sample of Ontario children, this still represents preventable tooth decay in children.

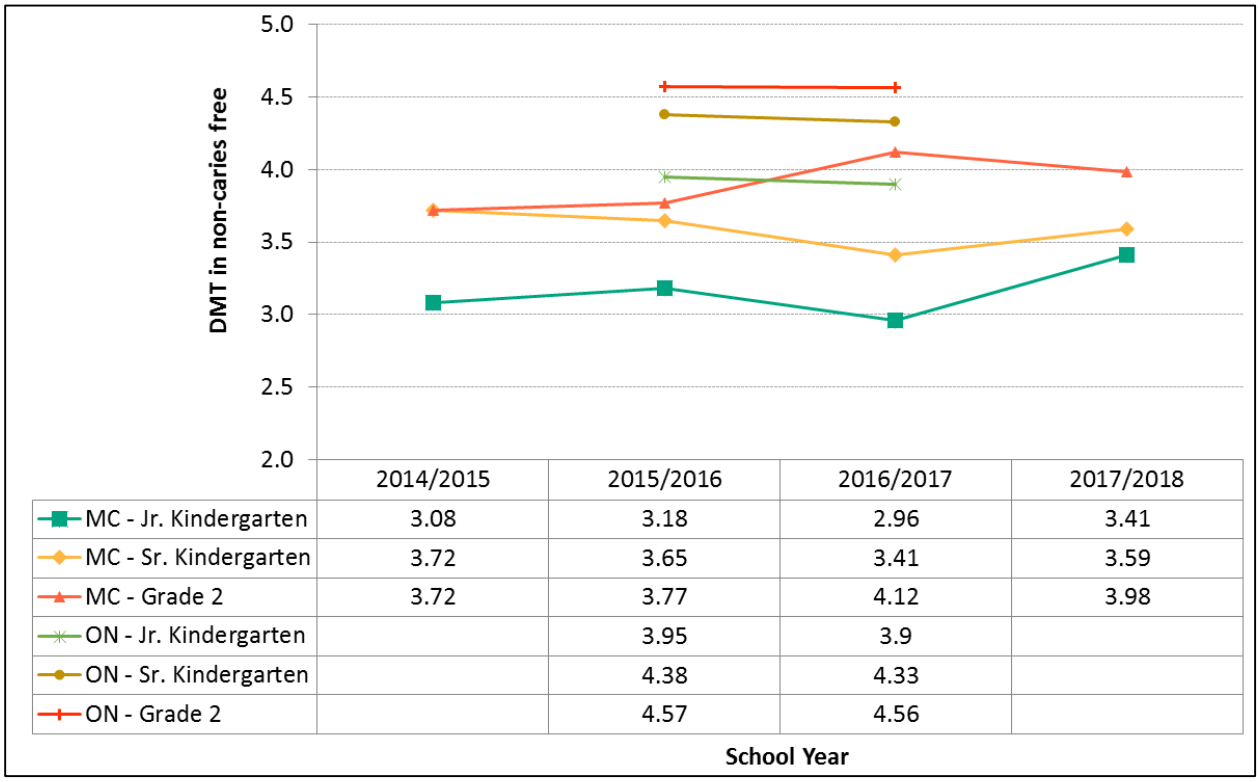
Figure 28. Percent of children who had no visible tooth decay (caries free) in Middlesex County and Ontario.



	2014/2015	2015/2016	2016/2017	2017/2018
MC - Jr. Kindergarten	80	83	81	81
MC - Sr. Kindergarten	72	71	76	70
MC - Grade 2	62	62	60	56
ON - Jr. Kindergarten		77	77	
ON - Sr. Kindergarten		68	68	
ON - Grade 2		56	56	

Data source: Oral Health Information Surveillance System (OHISS), Ministry of Health and Long-Term Care. Extracted date: July 17, 2018 & Oakley, D. 2018. Summary of 2015-2017 Oral Health Screening: Results from Participating Ontario Health Units: For the Ontario Association of Public Health Dentistry.

Figure 29. Average Decay Missing Teeth (DMT) scores for children in Middlesex County and Ontario schools, by school year and grade.



	2014/2015	2015/2016	2016/2017	2017/2018
MC - Jr. Kindergarten	3.08	3.18	2.96	3.41
MC - Sr. Kindergarten	3.72	3.65	3.41	3.59
MC - Grade 2	3.72	3.77	4.12	3.98
ON - Jr. Kindergarten		3.95	3.9	
ON - Sr. Kindergarten		4.38	4.33	
ON - Grade 2		4.57	4.56	

Data source: Oral Health Information Surveillance System (OHISS), Ministry of Health and Long-Term Care. Extracted date: July 17, 2018 & Oakley, D. 2018. Summary of 2015-2017 Oral Health Screening: Results from Participating Ontario Health Units: For the Ontario Association of Public Health Dentistry.

7.5. Immunization rates

- The Immunization of School Pupils Act identifies a number of diseases against which students need to be vaccinated. Each year, the Middlesex-London Health Unit reviews the immunization records of students attending schools in the region to ensure that their immunizations are up to date.
- In the 2017–2018 school year, greater than 95% of immunization records of 7-year old students in Middlesex County schools were up-to-date for seven key diseases (Table 11). Proportions ranged from 96.9% to 98.8% depending on the vaccine component.

Table 11. Proportion of immunization records forecast up-to-date* for childhood vaccines among 7-year olds†, Middlesex County§, 2017–2018 school year.

Vaccine component	Up-to-date status	
	Middlesex County schools estimate (%)	Middlesex County schools range (%)
Diphtheria	96.9	80.0–100
Measles	97.4	80.0–100
Mumps	97.5	80.0–100
Pertussis	96.9	80.0–100
Polio	97.1	80.0–100
Rubella	98.8	80.0–100
Tetanus	96.9	80.0–100

Data source: Middlesex-London Health Unit Panorama Enhanced Analytics and Reporting (PEAR): Forecaster Compliance for Disease by Age or School – Aggregate – STD – PR2001. Toronto ON: Ontario Ministry of Health and Long-Term Care; 2018 August 14 [cited 2018 August 14].

* Records were considered to be up to date when the immunization forecast was classified as up to date, and not eligible, due or overdue for the identified immunization based on the Publicly Funded Immunization Schedule for Ontario (Ministry of Health and Long-Term Care, 2016).

† Birth year is 2010 for the 2017-18 school year.

§ Middlesex County estimate based on enrollment of children born in 2010 in elementary schools (public and private) located in Middlesex County for which the Middlesex-London Health Unit screened immunization records in the 2017-18 school year.

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Appendix B

Literature Scan

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Review of Public Health Services in Middlesex County – Literature Scan

Executive Summary

As part of the Review of Public Health Services in Middlesex County a literature scan was undertaken to determine effective service delivery models for public health services in rural settings. The scan was limited to service delivery frameworks, models, or plans by provincial, state, or federal public health agencies, both in Canada and abroad, as well as the websites of the health agencies in the same Statistics Canada health peer group (Group A) as Middlesex-London Health Unit.

In many jurisdictions, unlike Ontario, public health is integrated within larger health authorities alongside primary care. As this literature scan was interested in public health services, in such cases effort was made to extract only information about delivering services which, in Ontario, are considered public health.

From these results, there was much consensus, the most prevalent one being that each rural community is unique, with different needs, assets, and challenges, and that there is no one-size-fits-all service delivery model that will work. The following were the most common findings:

- The need for engagement with community members, organizations, non-profits, and other health care providers in order to determine the needs of the community and how best to address them
- The importance of collecting, monitoring, and using local data for service planning and delivery
- The potential value of integration or co-location. Many jurisdictions advocate for a "health hub" type model where various primary care providers as well as social services are integrated to some extent and ideally co-located
- Leveraging community assets through collaboration and co-ordination. This could be delivering public health services out of another organization's location, using local facilities and physical environment in public health interventions, supporting other community health care providers to provide public health services themselves, or referring clients to already existing programs and services in the community
- The importance of providing services as close to home as possible, usually necessitating expanding access to services. The particular service delivery model used will depend upon the needs of the particular community, but possibilities include mobile outreach, home visits, multiple locations, extended hours, telehealth, and online services
- The potential value of appropriate staffing mixes involving multi-disciplinary teams and professionals working to their fullest scope. Role clarity is important to reduce duplication. Generalists were also perceived as being more appropriate to rural settings

Introduction

As part of the Review of Public Health Services in Middlesex County a literature scan was undertaken to determine effective service delivery models for public health services in rural settings. A difficulty encountered in this scan was the lack of universal definitions or classifications of what constitutes "rural," the lack of such impacting the potential applicability and transferability of findings to Middlesex County. In an attempt to address this, the scan was limited to service delivery frameworks, models, or plans by provincial, state, or federal public health agencies, both in Canada and abroad, the rationale being that higher-level government plans for rural settings would provide synthesized evidence, the nature of which is more likely to be generalizable. Additionally, the websites of the health agencies in the same Statistics Canada health peer group (Group A) as Middlesex-London Health Unit were also searched for service delivery frameworks, models, or plans, as their plans for service delivery would most likely be applicable and transferable to the Middlesex County setting, regardless of their definition of "rural" (Statistics Canada, 2017)

Methodology

The searches were conducted throughout the month of July using private browsing in Google to reduce aspects like previous searches, pages visited, and location from filtering the search results. Custom Google searches developed by the Ontario Public Health Libraries Association were used to search the websites of all Canadian and American health authorities (specifically public health when available) at the federal and provincial/state level as well as all Ontario public health units. Additional searches were conducted of the websites of all health authorities within the same Statistics Canada health peer group as Middlesex-London Health Unit, Australian and United Kingdom governments, and various rural health associations.

Due to Google's search word limit, multiple search strings were used to capture all combinations of the selected search terms. In essence, the search strategy combined terms for the concepts of: "rural" including rural, non-urban, peri-urban, non-metropolitan, peri-metropolitan, town, township, and county; "public health" including public health, community health, population health, health protection, health promotion, health authority, health department, outreach, chronic disease, maternal health, infectious disease, environmental health, child health, and sexual health; "service delivery" including delivery, delivering, delivery, system, structure, access, staffing mix, staffing complement, location, and infrastructure; and "framework" including framework, model, strategy, and plan. The search terms for "rural" were not included for websites which were already focussed on rural settings or for health authorities in Statistics Canada health peer group A. The searches were limited to 2008 to 2018. Results were screened by one individual, the same who conducted the data extraction, and were included if they dealt with a rural setting, were focussed on a public health issue, discussed service delivery, and were a framework, model, strategy, or plan rather than specific interventions. Results were excluded if they were not English, focussed on remote or northern settings, or were exclusively primary care without considerable public health components.

From the search results, 1 164 links were selected. Of those, 129 had their full text reviewed, with 7 additional results being added from reference lists, and 54 were eventually included for data extraction. No formal critical appraisal process was followed given the nature of the reports.

Information was extracted into a table with the following fields: the included definition of rural, whether a formal definition or the attributes of rural described such as population density or proximity to metropolitan centres (in many cases these were not provided, but rather just described as "rural"); the public health issues, areas, or services addressed; and the service delivery model or approach described. Some included papers discussed service delivery for entire health systems, including, but not exclusive to, public health components. In many of these papers, each branch of the health care system was discussed separately in terms of the issues they addressed, but then service delivery approaches were described more generally for the entire system. In these cases, the service delivery approaches were extracted unless specific to a non-public health related service (for example surgeries or EMS), but then identified as not being exclusive to public health. Outside of scope, and therefore not extracted, was information about specific interventions or programs, approaches to improve recruitment, or models or organizational structure at a government level beyond the control of an individual health unit or health authority, for example having a separate department or ministry of public health. The extracted information was then assessed for common themes or service delivery approaches to arrive at generalizable findings.

Findings

Providing public health, or any health services, in rural settings presents challenges unique from more metropolitan settings. On average, rural areas have aging populations and higher rates of unemployment and poverty as compared to more urban areas, all social determinants of health which can negatively impact health and wellbeing (White, 2011). As well, they have higher death rates due to injuries, circulatory and respiratory diseases, diabetes, and suicide which can stress the health care system (White, 2011). In addition to generally poorer health statuses, rural populations tend to have challenges accessing health services. Low population densities can make it difficult to have health care offices and providers available in every community due to a lack of critical mass and economies of scale (British Columbia Ministry of Health, 2015; Ontario Hospital Association, 2015; White, 2011). This results in rural populations often needing to travel greater distances to access services or have trouble navigating the health system as some services are available locally while others are not (Government of Newfoundland and Labrador Ministry of Health and Community Services, 2015; Iowa Department of Public Health, 2011; Island Health, 2013; Nova Scotia Health Authority Central Zone, 2017; White, 2011). The service delivery models described in the included results aim to address these challenges.

Consistent across the included papers was the idea that each rural community is unique with its own specific combination of challenges and assets. As such, there is no one-size-fits-all service delivery model that will work for rural communities. As a result, the importance of engaging with community members, community organizations, municipal government agencies, and other local health care providers to assess local needs and assets and to develop local strategies was prominent among the results (British Columbia Ministry of Health, 2015; Capital Health Primary Health Care & District Department of Family Practice, 2011; City of Hamilton Public Health Services, 2011; Drug Strategy Coordination Committee, 2017; Government of Australia Department of Health, 2011; Government of

Newfoundland and Labrador Ministry of Health and Community Services, 2015; Interior Health Authority, 2014, 2015, 2016, 2017; Iowa Department of Public Health, 2011; Nova Scotia Health Authority Central Zone, 2017; NSW Government Department of Health, 2014; Ontario Hospital Association, 2015; Queensland Government Department of Health, 2013; State of Indiana, 2012; Vancouver Island Health Authority, 2016, 2018; Virginia Department of Health, 2013; Windsor-Essex County Health Unit, 2017; Winnipeg Regional Health Authority, 2010, 2013, 2014, 2016; Winnipeg Regional Health Authority Population & Public Health, 2013b, 2015a, 2015b). To further understand local community needs and the ability to monitor progress on desired health outcomes, another prevalent theme was having systems in place to collect, monitor, analyze, and share local data. Strategies included conducting regular community health assessments, having data sharing agreements with other community organizations, and having standard Electronic Medical Records in order to aggregate local data from multiple providers (Government of Australia Department of Health, 2011; Government of Colorado, 2013; Government of Newfoundland and Labrador Ministry of Health and Community Services, 2015; Interior Health Authority, 2017; Iowa Department of Public Health, 2011; Ontario Hospital Association, 2012, 2015; Vancouver Island Health Authority, 2009; Windsor-Essex County Health Unit, 2017, 2018; Winnipeg Regional Health Authority Population & Public Health, 2012b, 2015a, 2015b).

One of the most prevalent findings, which greatly impacted the extraction and interpretation of the available information, is that Ontario is relatively unique in having a separate agency for public health. In many jurisdictions, within Canada and abroad, population and public health are departments or branches of a larger health authority also directing primary health care and emergency health services. As such, many of the included documents are plans for the service delivery of primary health care through which public health issues like chronic disease prevention, healthy lifestyles, maternal and child health, and immunizations are addressed (British Columbia Ministry of Health, 2015; Capital Health Primary Health Care & District Department of Family Practice, 2011; Government of Australia Department of Health, 2011; Government of Colorado, 2013; Government of Newfoundland and Labrador Ministry of Health and Community Services, 2015; Horizon Health Network, 2010; Interior Health Authority, 2012, 2014, 2015, 2016; Iowa Department of Public Health, 2011; Island Health, 2013; Michigan Center for Rural Health, 2008; Nevada Department of Health and Human Services, 2016; NSW Government Department of Health, 2014; Prince Edward Island Department of Health, 2008; Queensland Government Department of Health, 2013, 2014; State of Indiana, 2012; State of Victoria Department of Health, 2011; Vancouver Island Health Authority, 2009; Victoria State Government, 2017; Virginia Department of Health, 2013). In many organizations with this structure there is a focus within primary health care on population health and the social determinants of health (British Columbia Ministry of Health, 2015; Horizon Health Network, 2010; Interior Health Authority, 2014, 2015, 2016; Island Health, 2013; Ontario Hospital Association, 2012, 2015; State of Indiana, 2012). As a result, many service delivery models for primary health care are used to address issues which are, in Ontario, traditionally the territory of public health.

In settings where primary health has responsibility for population and public health outcomes, the most prevalent model proposed is that of a “health hub”, although the model goes by many different names. In essence, a health hub is a model whereby many different health care providers and services are integrated, usually with multi-disciplinary teams, and co-located or networked with other social services such as housing, education, child services, and social assistance (Capital Health Primary Health Care &

District Department of Family Practice, 2011; City of Hamilton, 2014; Horizon Health Network, 2010; Interior Health Authority, 2016; Nevada Department of Health and Human Services, 2016; NSW Government Department of Health, 2014; Prince Edward Island Department of Health, 2008; Queensland Government Department of Health, 2014; State of Indiana, 2012; Vancouver Island Health Authority, 2009, 2018; Victoria State Government, 2017). Even in settings where separate public health entities exist, such as Ontario, the health hub model is promoted for rural settings with the vision that public health will collaborate with the health hubs (Ontario Hospital Association, 2012, 2015). The health hub model helps to address several of the challenges rural communities face. Having multiple health and social services co-located or networked together can decrease operating costs such as physical and technological infrastructure (Interior Health Authority, 2012; Ontario Hospital Association, 2015). It can also decrease the amount of travelling rural residents are required to do to access various services (Ontario Hospital Association, 2015). Having health and social services integrated to various degrees can also help to address the social determinants of health by improving access to, and collaboration among, the various services and supports such as housing, education, and social assistance and streamline referrals (Vancouver Island Health Authority, 2009, 2018; Winnipeg Regional Health Authority, 2013). Increased collaboration and integration of multiple services can also improve role clarity among providers, thereby reducing duplication of services which can free up capacity and resources (Island Health, 2013; Victoria State Government, 2017).

Other strategies to improve access to services in rural communities revolve around leveraging already-existing community assets. One approach is to collaborate with community organizations and other health service providers to deliver public health services. This can consist of public health employees delivering the services, but using other organizations' facilities, which reduces operational costs, increases the number of locations through which services can be delivered, and further encourages community development (City of Hamilton, 2017; City of Hamilton Public Health Services, 2011; Drug Strategy Coordination Committee, 2017; Nova Scotia Health Authority Central Zone, 2017; Queensland Government Department of Health, 2014; Winnipeg Regional Health Authority, 2013; Winnipeg Regional Health Authority Population & Public Health, 2016a). It can also consist of already existing community organizations and health care providers addressing public health issues and providing public health services themselves, which expands potential hours and locations through which individuals can receive public health information and services, as well as reduces costs by requiring less public health-specific infrastructure and reducing duplication of efforts. In some settings, this is a component of the health care system as there are no specific public health agencies or organizations addressing specific issues (see above). In other settings, it is public health professionals educating and supporting others to deliver the services. Some examples are family doctors or pharmacists providing immunizations, health screening, and health promotion messaging and schools implementing healthy policy and delivering public-health related curricula (Drug Strategy Coordination Committee, 2017; Government of Australia Department of Health, 2011; Government of Newfoundland and Labrador Ministry of Health and Community Services, 2015; Horizon Health Network, 2010; Interior Health Authority, 2012; Island Health, 2017; National Collaborating Centre for Healthy Public Policy, 2016; Nevada Department of Health and Human Services, 2016; NSW Government Department of Health, 2014; Ontario Hospital Association, 2012, 2015; Public Health England, 2017; Queensland Government Department of Health, 2013; State of Victoria Department of Health, 2011; Virginia Department of Health, 2013; Windsor-Essex County Health Unit, 2017, 2018; Winnipeg Regional Health Authority, 2017; Winnipeg Regional Health Authority Population & Public Health, 2012a, 2012b, 2013a, 2015a, 2015b, 2016b). Similarly, public

health professionals can incorporate already existing facilities and infrastructure within the community into their public health services, such as referring clients to physical activity facilities or encouraging the use of walking trails; this reduces the amount of travel and potential costs to individuals while also not incurring operational costs for the public health system (Nova Scotia Health Authority Central Zone, 2017; Virginia Department of Health, 2013; White, 2011; Winnipeg Regional Health Authority, 2014). Several results advocate for conducting community resource inventories or gap analyses to determine what services are being delivered and by whom to reduce redundancies in service provision (Capital Health Primary Health Care & District Department of Family Practice, 2011; Government of Newfoundland and Labrador Ministry of Health and Community Services, 2015; Island Health, 2013; Vancouver Island Health Authority, 2009; Winnipeg Regional Health Authority Population & Public Health, 2012a).

While having public health issues addressed by others within the community has many benefits to improving access to services and reducing costs to the public health system, it can make it potentially challenging for community members to become aware of, and navigate to, all the different services. This emphasizes the importance of co-ordinating services. Developing formal partnerships with community stakeholders can improve co-ordination of effort, reduce duplication, incorporate non-health sector contributors to health and wellbeing, and provide consistent messaging; however, they also require planned communication to the community to raise awareness and inform how to access services (Capital Health Primary Health Care & District Department of Family Practice, 2011; Drug Strategy Coordination Committee, 2017; Government of Australia Department of Health, 2011; Government of Newfoundland and Labrador Ministry of Health and Community Services, 2015; Nova Scotia Health Authority Central Zone, 2017; NSW Government Department of Health, 2014; State of Indiana, 2012; Vancouver Island Health Authority, 2009, 2016, 2018; Virginia Department of Health, 2013; Windsor-Essex County Health Unit, 2017, 2018; Winnipeg Regional Health Authority, 2016; Winnipeg Regional Health Authority Population & Public Health, 2015b). Some jurisdictions also incorporate the role of a wellness or system navigator who connects clients to the various services in their community depending upon their health needs (Capital Health Primary Health Care & District Department of Family Practice, 2011; City of Hamilton, 2014; Government of Colorado, 2013; Iowa Department of Public Health, 2011; Winnipeg Regional Health Authority Population & Public Health, 2013b).

Another theme which emerged was the need for expanding access to services in order to meet the diverse population needs within a community. In rural communities, populations are more dispersed, most services require driving to access, and unemployment and seasonal work are more prevalent, which can make accessing services from fixed sites during regular business hours more difficult. As such, different service delivery models are usually required; however, determining the appropriate service delivery model to implement depends upon the unique needs of each community and its residents, meeting people where they are and providing services in manners that are acceptable for them (Interior Health Authority, 2012, 2017; NSW Government Department of Health, 2014; Vancouver Island Health Authority, 2018; Virginia Department of Health, 2013; Winnipeg Regional Health Authority, 2013; Winnipeg Regional Health Authority Population & Public Health, 2012a, 2016a). Suggested methods for expanding access to services include, as mentioned above, providing services through other community organizations, facilities, or service providers, thereby increasing the number of locations and potential hours. Outreach, mobile, and home visiting services are also mentioned frequently, especially in the

delivery of substance misuse, sexual health, and harm reduction services, but also to deliver maternal and child health services such as breastfeeding support (Capital Health Primary Health Care & District Department of Family Practice, 2011; City of Hamilton, 2017; City of Hamilton Public Health Services, 2011; Drug Strategy Coordination Committee, 2017; National Collaborating Centre for Healthy Public Policy, 2016; White, 2011; Windsor-Essex County Health Unit, 2018; Winnipeg Regional Health Authority, 2013, 2016; Winnipeg Regional Health Authority Population & Public Health, 2012a, 2013b). Developing formal service agreements between health authorities is another approach proposed from New South Wales in Australia to enable residents who live close to the border to access services from a neighbouring health authority should those services be closer (NSW Government Department of Health, 2014). Finally, technology is advocated as being a manner through which to deliver both direct services through telehealth, as well as health education and information through web-based resources. Live telemedicine alleviates the challenge of having a full range of professionals located in the community, while pre-recorded telemedicine or web content and web-based tools address the challenge of accessing set locations during set hours. Examples of using technology to improve service delivery include using web-based tools to support self-care for chronic disease prevention and management, migrating vaccination reporting online, supplying information about community services online, telehealth for direct patient-provider consultations using either rooms equipped with required equipment or mobile smartphone applications, and telehealth to better connect community stakeholders and health care providers for collaboration, support, and professional development (City of Hamilton, 2017; Interior Health Authority, 2014, 2017; NSW Government Department of Health, 2014; Prince Edward Island Department of Health, 2008; Victoria State Government, 2017).

A final theme which emerged through the included results was that of staffing mix and its impact on maximizing service delivery and available resources. While mainly discussed within the context of primary health care teams whose services addressed public health issues, a prevalent model is multidisciplinary teams working together to provide services. The composition of these teams is dependent upon the needs of the specific community but can include not just physicians and nurses, but also allied health professionals, community health workers, and social service providers (Capital Health Primary Health Care & District Department of Family Practice, 2011; Government of Newfoundland and Labrador Ministry of Health and Community Services, 2015; Nevada Department of Health and Human Services, 2016; Ontario Hospital Association, 2012, 2015; Winnipeg Regional Health Authority, 2013; Winnipeg Regional Health Authority Population & Public Health, 2013b). Having multiple disciplines on the same team can improve the quality of care and reduce the need to travel as different disciplines are available together to provide their expertise. It can also improve the timeliness and cost-effectiveness of care as clients can receive service from the most appropriate professional, not necessarily the most expensive, for example receiving an immunization from a nurse practitioner or pharmacist rather than waiting to see the physician, who is then available to provide services outside of other professions' scopes. Success of this model necessitates that professionals practice at the full scope of their profession and with clear role delineation, thereby increasing the variety of services that are available in the community, often at reduced costs (First Nation's Health Authority, 2015; Government of Australia Department of Health, 2011; Government of Newfoundland and Labrador Ministry of Health and Community Services, 2015; Interior Health Authority, 2012; Iowa Department of Public Health, 2011; NSW Government Department of Health, 2013, 2014; State of Victoria Department of Health, 2011; Victoria State Government, 2017; Virginia Department of Health, 2013; White, 2011). Along those lines, several results also advocated for the increased use of generalist, as opposed to specialist professionals

as they can provide a greater breadth of services, important in rural areas which may have difficulty recruiting or affording health care professionals or not have the volume of requests to support a specialist (British Columbia Ministry of Health, 2015; Iowa Department of Public Health, 2011; NSW Government Department of Health, 2014). Increasing the use of lay health educators or community health workers was also promoted as a more cost effective means of providing education and outreach, connecting clients to community resources, and possibly performing direct services such as screening and rapid tests (Capital Health Primary Health Care & District Department of Family Practice, 2011; Government of Colorado, 2013; Nevada Department of Health and Human Services, 2016; Virginia Department of Health, 2013).

Discussion

Isolating service delivery models for rural public health has some challenges. For one, issues which public health traditionally addresses are not solely the realm of public health professionals and systems anymore, but rather are becoming a priority and service component of other fields such as primary health care. As such, some components of service delivery used by primary health care to address public health may make sense for a public health-specific organization whereas others may not. Another challenge is the lack of a consistent definition of "rural," which makes it difficult to assess the applicability and transferability of findings to the Middlesex County setting. Many of the included papers which focussed on rural settings do not even define "rural." In an attempt to address this issue, papers were sought that either focussed on rural settings, by any definition, or were from health authorities which are in the same Statistics Canada health region peer group as Middlesex-London Health Unit, regardless if they considered themselves rural or not. A possibility was that service delivery models articulated in the self-identified rural papers would not agree with those articulated by Middlesex-London Health Unit's peer group members. Generally speaking, this was not the case, with the themes and strategies outlined above appearing in both sets of results.

It should also be noted that some components of public health are to a large degree lacking from the results, namely services which typically are associated with environmental health and infectious disease control. While terms for these public health components were included in the search strategy, ultimately the results which were included did not address these areas.

An additional limitation to this literature scan is that it was conducted by a single individual and therefore is at increased risk of bias. These findings should be incorporated into other forms of evidence for decision-making purposes.

Conclusion

Each rural community is unique, facing its own challenges and containing its own assets. As such, there is no one-size-fits-all service delivery model that will work across all rural settings; however, there are several consistent considerations for planning how to deliver services: determining the needs, assets, and challenges of the local community through collecting local data and engaging with community members and stakeholders, the better to tailor approaches to that community; collaborating and co-ordinating services, using assets and providers already existing in the community or technology, to enable more services to be delivered locally and with greater accessibility and to better address the social determinants of health; and incorporating many different disciplines and professions within the

staffing mix, working to their fullest scope, to maximize the variety of services and expertise available with available staff.

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Appendix C

Municipal Council Survey

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Introduction

As part of the process to understand the community needs and identify strategies to enhance access to public health services, the Middlesex-London Health Unit commissioned an online survey of municipal councillors to assess their areas of public health priority, how the Health Unit can increase accessibility, and gather feedback on way to improve services.

Specifically, in order to ensure that the Health Unit is meeting the needs of its Middlesex County residents, this consultation was conducted to keep key decision makers informed, and to understand and acknowledge the interests and concerns that can be integrated into decision-making.

Results from this survey will be used to inform future strategies to improve service delivery.

The survey was conducted by Middlesex-London Health Unit staff during the period of June 4th, 2018 to August 31st, 2018.

Study Implementation

Survey Instrument

A survey instrument was developed by the Middlesex-London Health Unit in order to collect information about municipal council needs and priorities for Health Unit service. The final instrument consisted of 13 items.

Survey Sample

The survey was distributed to all municipal councillors at lower-tier council meetings attended during June and August 2018. It was distributed in pre-addressed postage paid envelopes with an option to complete the survey online using CheckMarket Survey software. An additional reminder email was sent to all councillors in August 2018. At the time of survey distribution, there were 52 councillors.

Survey Fielding

The overall completion rate was 26.9%, with a total of 14 surveys completed. Average completion time of the survey was 11 minutes and 20 seconds. Only completed surveys were included for analysis.

Survey Limitations

There are a number of study limitations given the sampling strategy used for conducting this online self-administered survey.

Due to the nature of the self-administered survey, respondents were not able to clarify questions that they may have at the time of survey completion. However, there was contact information for the Project Manager available to participants at the outset of the survey in order to provide the opportunity to seek clarification if questions did arise.

The main limitation of a sampling strategy is that municipal councillors, while elected, may not be representative of the views of all Middlesex County residents.

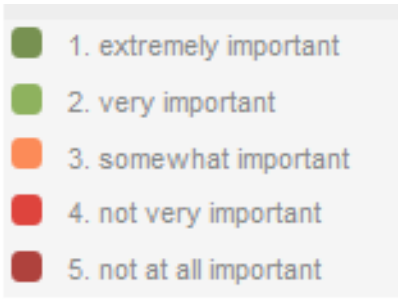
Furthermore, participants could have completed the online survey more than once as there was no method established to control for this issue.

1. How familiar are you with MLHU's programs and services?

N=13

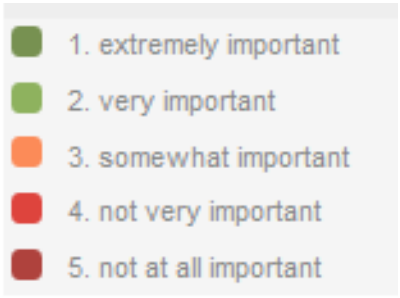
2. How important is it for MLHU to focus on the following areas of public health program and service delivery in Middlesex County?

Sub-questions	Resp.	% of responses
Safe Water	13	69 / 31
Infectious and Communicable Disease Prevention and Control	13	69 / 23 / 8
Food Safety	13	62 / 31 / 8
Immunization	12	58 / 25 / 17
Chronic Disease Prevention and Well-Being	13	38 / 46 / 15
School Health	13	23 / 62 / 15
Substance Use and Prevention	13	31 / 46 / 23
Healthy Growth and Development	12	42 / 25 / 33
Healthy Environments	13	15 / 62 / 23



3. How important is it for MLHU to focus on the following foundational standards for public health practice?

Sub-questions	Resp.	% of responses
Health Equity	12	33 / 58 / 8
Effective Public Health Practice	13	8 / 85 / 8
Emergency Management	13	31 / 38 / 23 / 8
Population Health Assessment	13	8 / 69 / 23



4. Please describe the public health issues that are of primary concern to Middlesex County residents.

Respondents were asked to give their own opinions and comments about the primary concern to Middlesex County residents.

A wide range of concerns were mentioned across the commentary. The most frequent responses were related to opioids and drug addiction, immunization and vector-borne disease.

Issues outside the authority of public health (access to primary care providers and specialists, home care, etc.) were not included in the counts below.

Concern	Count
Opioids & Drug Addiction	4
Immunization	3
Vector Borne Disease	3
Mental Health	2
Prenatal Health	2
Safe Water	2
Sexual Health	2
Accessibility of Physical Locations	2
Early Growth and Development	1
Food Safety	1
Health Equity	1
Infectious Disease Control	1
Marijuana Legalization	1
Parenting	1

5. How accessible (physically, with outreach programs, and virtually) are MLHU's programs and services to residents of Middlesex County?

N = 13

6. How could MLHU increase accessibility for Middlesex County residents?

Theme	Count
Provide programming in each community	3
Offer more programming in Strathroy	3
Participate in the regional transportation initiative	2
Utilize municipal/county spaces	2
Offer rotating / mobile clinics around the county	2
Improve the efficiency of responding to questions online or over the phone	1
Offer programming through other health care providers / private sector	1

7. What are the best ways for MLHU to share information to assist partners with their understanding of public health issues and/or opportunities?

Theme	Count
Social media	3
Share information at other locations (libraries, schools, town hall, doctors offices, etc.)	3
Online newsletters	2
Regular visits to municipal councils	2
Information sessions	2
Information in tax notices	2
Digital media	2
Print media	2
Service clubs	1

8. What are the best ways for MLHU to obtain feedback from community partners on public health issues and/or opportunities?

Theme	Count
Social media	3
Share information at other locations (libraries, schools, town hall, doctors offices, etc.)	3
Online newsletters	2
Regular visits to municipal councils	2
Information sessions / community meetings	2
Information in tax notices	2
Digital media	2
Print media	2
Service clubs	1

9. What are the best ways for MLHU to consider the concerns and needs of community partners for public health issues and/or opportunities?

Theme	Count
Formal feedback mechanisms	2
Work with community partners	2
Consultation sessions	2
Delegations to municipal councils	1
Social media	1

10. What are the best ways for MLHU to with engage community partners in decision-making for public health issues and/or opportunities?

Theme	Count
Delegations to municipal councils	3
Listen to community about issues	3
Hold public meetings regarding budget priorities and other priorities	2
Work with community partners	1
Develop good relationships with municipal officials	1
Social media	1

11. What are the best ways for MLHU to place final decision-making in the hands of the community partners for public health issues and/or opportunities?

Theme	Count
Ensure that mandates for decision-making are clear	2
Work with committees that have broad community representation	2
Gather information from public meetings and present finding to decision-making bodies like municipalities	2
Define what success looks like when empowering decision-makers	1

12. What are the community assets (individuals, associations, institutions, physical assets, and connections, etc.) in Middlesex County that you feel MLHU should be aware to enhance public health program and service delivery?

Theme	Count
Local service clubs	4
Existing health providers	3
Education system	3
Public transit providers	3
Work closely with municipal councils	2
Social service agencies and not-for-profits	4
Faith-based organizations	2
Community centres	2
Private businesses	2
Libraries	2
Work closely with municipal administrators	1
Local media outlets	1
Municipal offices	1
Parks	1
Arenas	1
Sports clubs	1

13. Please share any additional thoughts about how the Middlesex-London Health Unit can enhance services that have not previously been addressed.

Theme	Count
Enhanced communication and visibility	2
Increase physical presence in county if financially viable	1
Continuous dialogue with public and community partners	1
Enhance outreach in-person and electronic	1
Ensure low cost travel to programs and facilities	1
Partner and coordinate with existing service providers	1
Offer mobile services	1

Appendix D

Key Informant Interviews

AUGUST 2018

For information, please contact:

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Introduction

As part of the process to understand the community needs and identify strategies to enhance access to public health services, the Middlesex-London Health Unit reached out to Mayors and Deputy Mayors of municipalities in Middlesex County to understand their perspectives on public health services being provided to their residents and opportunities for improvement.

The key informant interviews were conducted by Middlesex-London Health Unit staff during the period of July 19th, 2018 to September 6th, 2018.

Study Implementation

Survey Instrument

A survey instrument was developed by the Middlesex-London Health Unit in order to collect information from key informants regarding the services provided to rural populations. The final instrument consisted of 9 items.

Survey Sample

All mayors, deputy mayors or designates were invited to participate.

Survey Fielding

A total of three telephone interviews were completed. Average completion time of the survey was 30 minutes.

Survey Limitations

There are a number of study limitations given the sampling strategy used for conducting the interviews.

The main limitation of a sampling strategy is that there were few respondents and it was not possible to reach data saturation. Additionally, municipal councillors, while elected, may not be representative of the views of all Middlesex County residents.

1. Please describe the public health issues that are of primary concern to Middlesex County residents.

Opioids and Drug Addictions

- Opioids and drug addition was raised as a public health issue of concern by two of the three key informants interviewed
- One key informant noted that there is a stigma associated with drug and drug addiction and many try to turn a blind eye
- This issue is intertwined with other issues such as housing and mental health

Mental Health

- Mental health was a concern of two of the three key informants
- It was felt that is an issue that requires the involvement of many different community organizations to solve and not just the Health Unit
- With limited resources, the response will depend on communication and awareness – about where people can access services, and partnerships between those who have resources in the county

Vector-borne disease (West Nile Virus)

- Vector-borne disease (West Nile Virus) was commented on by two of the three key informants
- West Nile Virus is present in North Middlesex and the larviciding program is important to county residents

Other public health issues of concern

- Prenatal and postnatal health and support for mothers and families who have to balance jobs and other priorities
- Vaccination (no details provided)
- Bullying

Other comments not specific to public health issues

- The relationship with municipalities is important
- Continue to by present physically in the community
- The public has a difficult time knowing who we are and what we do. There could be improvement in the ways we communicate (using newsletters, visits to councils, working with community partners, etc.)

2. How accessible (physically, with outreach programs, and virtually) are MLHU's programs and services to residents of Middlesex County?

Transportation Challenges

- All respondents noted that transportation is a significant challenge for their residents, particularly the most vulnerable residents. There is a lack of public transportation options for county residents. Many residents are not familiar with our locations and how accessible we are and it can be difficult for residents to get to downtown London for services

Libraries as Community Hubs

- All respondents noted that libraries are becoming the hub of many communities and provides a space for information to be shared and services to be delivered in a way that people would not be stigmatized for accessing health unit services

Community Partnerships

- All respondents touched upon the need to collaborate with community partners to share information and to use spaces that are already existing in the community.
- Some of the places to share information include schools, hospitals, primary care providers, town halls, municipality-specific web pages, local media, etc.
- Some of the physical spaces to use include schools, community rooms, grocery stores, libraries, town hall, social housing, etc.

3. What are some of the items of public health importance that municipalities and community partners should be informed of?

- The Health Unit could inform residents of items of public health importance through:
  - Newsletters to municipal councils (could be sent as correspondence)
  - Speaking at service organizations
  - Tax bill inserts
  - Specific websites (i.e. Strathroy Buy and Sell)
  - Billboards and portable signs
  - Social media
  - Communication with schools

4. What are some of the items of public health importance that municipalities and community partners should be consulted on?

- The Health Unit should consult municipalities regarding the opioid crisis and where consumption sites might be located
- The Health Unit should also consult with municipalities regarding where clinics could best be located
- Suggested methods to effectively consult include:
  - Delegations to municipal councils
  - Speaking at service organizations

5. What are some of the items of public health importance that municipalities and community partners should be involved in the planning and decision-making?

- Issues regarding wind turbines and municipal land use were mentioned by key informants
- One key informant noted that the Health Unit board is the body responsible for decision-making and that municipalities and community partners should be comfortable in having the Health Unit make decisions
- Suggested methods to effectively involve municipalities and community partners in decision-making included:
  - Surveys (although they can be unreliable)
  - Open houses
  - Conversations with municipalities and decision-makers
  - Regularly scheduled engagement opportunities

6. What are some of the items of public health importance that municipalities and community partners should be collaborating with MLHU on?

    - Key informants noted that the Health Unit could collaborate with municipalities on safe consumptions facilities, movies in the park, dental for low-income adults, mental health, bullying and infectious disease outbreaks
    - One informant felt that any issues that is controversial or could have significant impact on people should involve collaboration

7. What are some of the items of public health importance that municipalities and community partners should be making the final decisions on?

    - One key informant noted that zoning is an issue that municipalities have the final decision on but that the Health Unit should have input if there is a public health impact

8. What are the community assets (individuals, associations, institutions, physical assets, and connections, etc.) in Middlesex County that you feel MLHU should be aware to enhance public health program and service delivery?

    - All of the key informants noted the importance of schools, service groups in their community,
    - Two of the key informants noted libraries as physical infrastructure
    - Other community assets included:
        - Faith-based organizations
        - Community centres and halls
        - Not-for-profits
        - For-profit businesses
        - Primary care providers
        - Retirement and nursing homes

9. Do you have any additional thoughts about how the Middlesex-London Health Unit can enhance services that have not previously been addressed?

    - Communicating to the public is paramount to ensuring people know who we are, where to find our programs and services and how to contact us
    - Utilize community events to reach municipal residents and be physically present

Appendix E

Environmental Scan of Ontario Public Health Units

AUGUST 2018

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Introduction

As part of the process to understand the community needs and identify strategies to enhance access to public health services, the Middlesex-London Health Unit reached out to Ontario Public Health Units with similar demographics to understand their strategies for servicing rural populations.

Specifically, in order to ensure that the Health Unit is considering all possible strategies and best practices, this environmental scan sought to identify potential service improvements for Middlesex County residents.

The environmental scan was conducted by Middlesex-London Health Unit staff during the period of July 19th, 2018 to August 31st, 2018.

Study Implementation

Survey Instrument

A survey instrument was developed by the Middlesex-London Health Unit in order to collect information from Ontario Public Health Units regarding the services they provide to rural populations. The final instrument consisted of 9 items.

Survey Sample

The survey was distributed to 14 health units during July and August 2018. It was distributed to the business administrators via email to complete using an online survey.

Survey Fielding

The overall completion rate was 35.7%, with a total of 5 surveys completed. Average completion time of the survey was 7 minutes and 28 seconds. Only completed surveys were included for analysis.

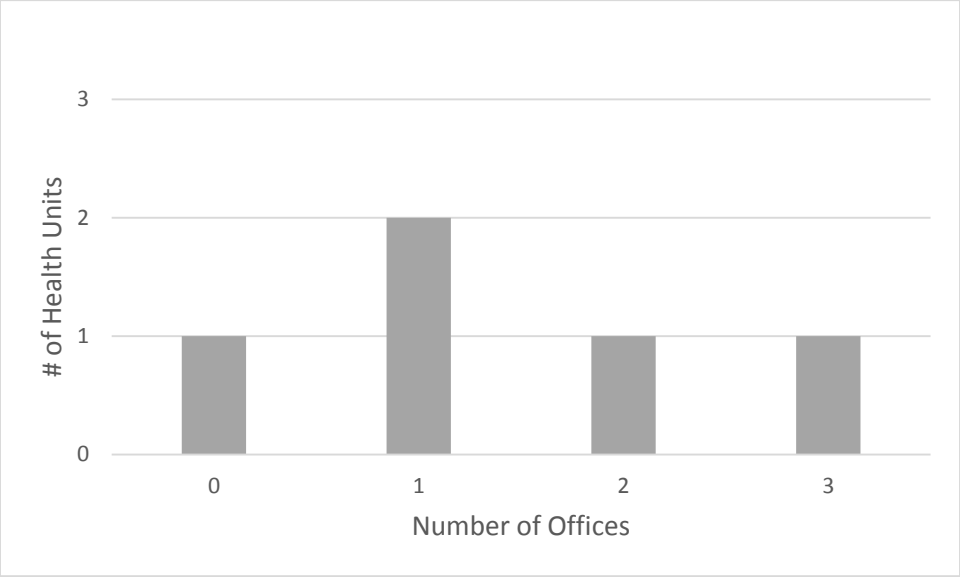
Survey Limitations

There are a number of study limitations given the sampling strategy used for conducting this online self-administered survey.

Due to the nature of the self-administered survey, respondents were not able to clarify questions that they may have at the time of survey completion. However, there was contact information for the Project Manager available to participants at the outset of the survey in order to provide the opportunity to seek clarification if questions did arise.

The main limitation of a sampling strategy is that each health unit has different community needs, strategies and characteristics that must be considered.

1. Do you have satellite offices in the rural communities the health unit serves? If yes, how many satellite sites does the Health Unit have?



- Three of the health units also noted the use of other shared office spaces and "service centres"

2. If yes, what public health programs and services are available at the satellite sites?

- Two health units noted almost all services are provided at satellite sites
- Other health units noted:
    - Sexual health services
    - Infant feeding supports
    - Tobacco cessation
    - Oral health
    - Environmental health programs
    - Mother and young child clinics

3. Does the Health Unit use community spaces (e.g. library, community centres) to deliver public health programs and services?

- One health unit indicated they do but not on a regular basis
- Other health units indicated they utilize:
    - Libraries
    - Community centres
    - Social housing common areas
    - Recreation centres
    - Municipal offices
    - Schools spaces
    - Community health centres
    - Community hubs
    - Early years centres
    - Hospitals
    - Faith-based organization spaces

4. Besides physical locations, what does your Health Unit do to increase the accessibility of its public health programs and services to rural residents?

- Website, social media and other internet applications
- Phone service
- Information at municipal offices
- Drop off sites for water testing in rural communities
- Mobilize and build capacity with community groups and partners to deliver services (health care providers, other social services, volunteers, etc.)
- Board meetings are rotated between municipal and First Nation sites
- Partnerships with neighbouring health units when residents may have closer options
- Have staff working in schools across rural areas
- Staff attendance at community events
- Rotate the location of classes and courses
- Offer taxi vouchers

5. How do you provide rural residents / municipalities with balanced and objective information to assist them in understanding the problems, alternatives and/or solutions?

- Website
- Town hall meetings and presentations
- Board of Health reports and meeting minutes are accessible
- Communication team ensure that strategies are in place to reach all residents
- Maintain listing of people and organizations to disseminate information to

6. How do you obtain rural residents/municipalities feedback on analysis, alternatives and/or decisions?

- Surveys
- Community meetings
- Feedback is build into program delivery and evaluation (each program ensures they are obtaining feedback)

7. How do you work directly with rural residents / municipalities throughout the process to ensure that public concerns and aspirations are consistently understood and considered?

- Ensure that residents and municipalities are involved in the planning process
- A community engagement strategy has been developed to guide this work

8. How do you partner with the rural residents / municipalities in aspects of decision-making including the development of alternatives and the identification of the preferred solution?

    - Ensure that residents and municipalities are involved in all aspects of planning, implementation and evaluation
    - Have staff that act as liaisons between stakeholder groups
    - Use a community development approach
    - Ensure board representation of the community
    - Build and use coalitions

9. When do you place final decision-making in the hands of the rural residents / municipalities?

    - Public health units can provide advice to municipalities when they make decisions regarding public health matters

10. Please provide any additional comments you would like to share about engaging with rural residents/municipalities

    - It is difficult to obtain data specific to rural municipalities
    - Engage with candidates for municipal offer by having a conversation café to help them understand key public health issues

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 058-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 September 20

2017-2018 SCHOOL-BASED DENTAL SCREENING RESULTS

Recommendation

It is recommended that Report No. 058-18 Re: "2017-2018 School-Based Dental Screening Results" be received for information.

Key Points

- MLHU continues to work on strategies to improve oral health outcomes among children in the community, and to increase awareness of the School-Based Dental Screening and Fluoride Varnish programs.

Middlesex-London 2016–17 School-Based Dental Screening Results

During the 2017–18 school year, the Health Unit screened 16,038 students (77%) in 133 elementary schools through the School-Based Dental Screening Program. For 3,450 students (17%), parents did not consent to screening. In addition, 1,114 students (5%) were absent on the day(s) that screening was happening at their school. The percentage of excluded and absent students is similar to the previous year's percentage. The percentages of Junior Kindergarten (JK), Senior Kindergarten (SK) and Grade 2 (Gr 2) students screened who were caries-free (i.e., have never had cavities or the removal or filling of a tooth because of tooth decay) were 77%, 68% and 55%, respectively. These percentages are similar to the previous year: 77%, 68% and 57%, respectively.

The Ontario Association of Public Health Dentistry collects surveillance data for participating health units in Ontario. The percentage of children in Ontario that were surveyed is 57%. For all surveyed children, the percentages of JK, SK and Gr 2 students who were caries-free were 75%, 65% and 54%, respectively. For all children in the South West region (Grey Bruce, Chatham-Kent, Windsor-Essex, Norfolk, Elgin, Oxford, Middlesex, Perth, Huron and Grey Bruce), the percentages of JK, SK and Gr 2 students who were caries-free were 77%, 65% and 52%, respectively. Children surveyed in Middlesex-London have similar rates of decay in comparison to Ontario and regions in South West. In the past, the Ministry of Health and Long Term Care (MOHLTC) has not required Public Health Units (PHUs) to collect surveillance data, making it challenging to obtain province wide information. However, the MOHLTC has now mandated health units to collect surveillance data for JK students (decayed, missing and filled teeth) starting in the 2018-2019 school year. This data will become available to PHUs in the future.

When screening for school intensity level, it was found that only 7% of Grade 2 students screened had two or more teeth with tooth decay. Of the students screened, 1,776 (11.1%) were found to have urgent dental needs, making them clinically eligible to receive Healthy Smiles Ontario Essential and Emergency Care funding for their dental care. This is similar to the previous school year findings. The Health Unit continues to work with school boards to increase awareness of the School-Based Dental Screening and Fluoride Varnish programs. The full Oral Health Report can be found in Appendix A.

This report was prepared by the Oral Health Team, Healthy Living Division.

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

Appendix A to Report No. 058-18

Annual Oral Health Report

MIDDLESEX-LONDON HEALTH UNIT

September 20, 2018

For information, please contact:

Misty Deming
Manager Oral Health
Healthy Living Division
Middlesex-London Health Unit

Purpose

To provide information about the findings of the Health Unit's school-based dental screening program from the last school year: September 2017 to June 2018.

Methodology

Publicly funded elementary schools and private schools participated in the school-based dental screening program. Students in Junior Kindergarten, Senior Kindergarten, and Grade 2 at publicly funded schools were screened in accordance with the Oral Health Assessment and Surveillance Protocol of the Ontario Public Health Standards.

Based on the screening results of the Grade 2 students at each school, the school was categorized into the following levels of screening intensity: "Low", "Medium", or "High", as per the Protocol. Increased screening intensity level requires that additional grades be screened.

The parents of the students in these grades who decline to have their children screened advise their school administrators who then pass this information on to Health Unit staff. Children whose parents have consented to screening but who are absent on the day of screening may be screened on a subsequent screening day.

Student level data was collected by five Registered Dental Hygienists employed by the Health Unit. The need for and urgency of dental care was recorded and parents were advised during the required follow-up. As well, indicators of previous dental caries were recorded. Data was collected and stored in accordance with the Oral Health Assessment and Surveillance Protocol, the Health Protection and Promotion Act, the Municipal Freedom of Information and Protection of Privacy Act, and the Personal Health Information Protection Act.

The Ministry of Health and Long-Term Care's Oral Health Information Support System was used to generate summary statistics from the student level data. Historical aggregate data was accessed from archived Health Unit spreadsheets. These data were further analyzed using Microsoft Excel.

Key Findings

Participation. Of the 20,759 students who were offered dental screening at the schools that participated in the school-based dental screening program, 16,038 or 77% were screened (Figure 1). For the 2017-2018 school year, the Health Unit did not have parental consent to screen 3,607 (17%) students, and 1,114 (5%) were absent on the day(s) that staff were screening at their schools. The percentage of absent and excluded students is similar to the previous year's percentage.

Screening intensity. Among the 130 elementary schools with Grade 2 in the Health Units jurisdiction, 93 (72%) were categorized as Low intensity, 17 (13%) as Medium intensity, and 20 (15%) as High intensity as per the Oral Health Assessment and Surveillance Protocol which is described in the sidebar (Figure 2).

Dental caries. The percentages of Junior Kindergarten, Senior Kindergarten, and Grade 2 students screened who were caries-free, (i.e. have never had tooth decay or the removal or filling of a tooth because of caries) were 77%, 68%, and 55%, respectively (Figure 3). These percentages are similar to the previous school year which were 77%, 68%, and 57% respectively. Two hundred and fifty-nine (7%) of Grade 2 students screened had two or more teeth with tooth decay (Figure 4).

Urgent dental needs. One thousand seven hundred and seventy-six (1776) students or 11.1% of those screened were found to have urgent dental needs which deemed them clinically eligible to receive Healthy Smiles Ontario Essential and Emergency Care funding for their dental care (Figure 5). The percentage of students found to have urgent dental needs is similar to the previous school year. To date, most students found to have urgent dental needs were referred to local dental offices for treatment. Most students began treatment, and the few cases that have not are monitored to ensure treatment begins shortly.

Next Steps

- The Health Unit will continue to increase the capacity of the school-based and daycare-based fluoride varnish programs to address the percentages of students who are caries-free.
- The Health Unit continues to work with elementary schools to promote awareness of the dental screening program and assist eligible children to enroll in the Healthy Smiles Ontario program.
- The Health Unit continues to work with Aboriginal schools and daycares to offer the dental screening and fluoride varnish programs.

Appendix A - Results

Figure 1. Number of students screened, absent and refused by school year.

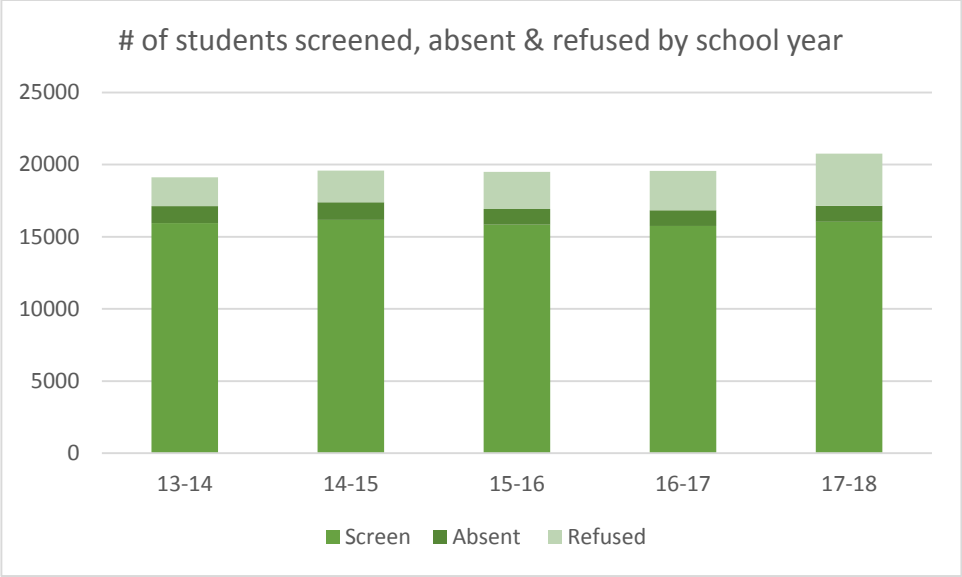


Figure 2. Screening intensity of schools by school year.

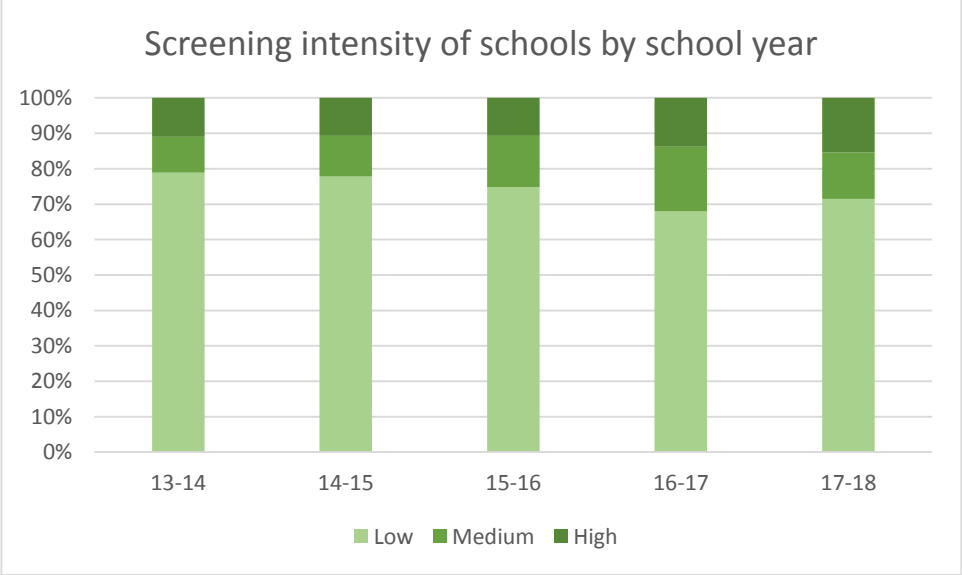


Figure 3. Percentage of students screened who were caries-free by grade.

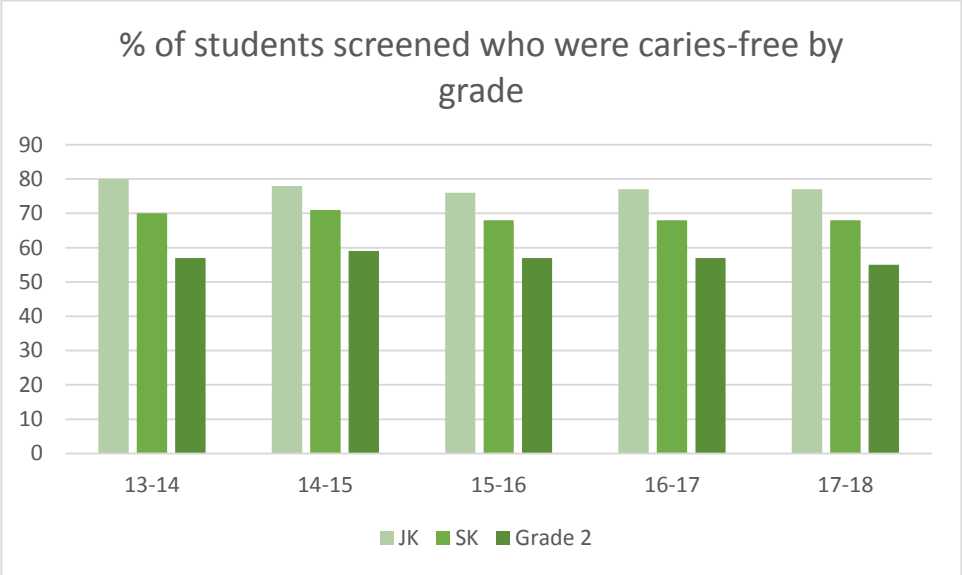


Figure 4. Number of Grade 2 students screened with two or more teeth affected by caries (decay, removals, or fillings) by school year.

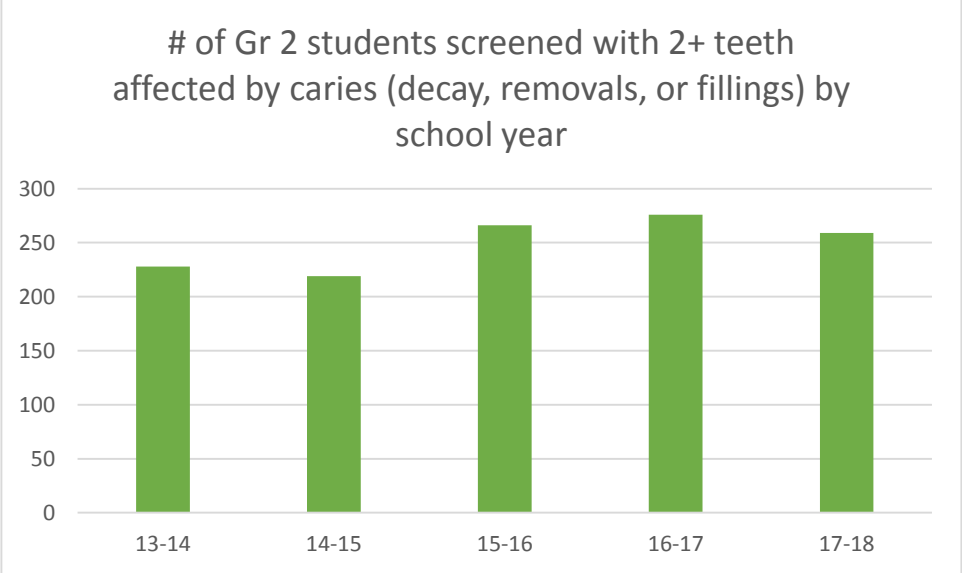
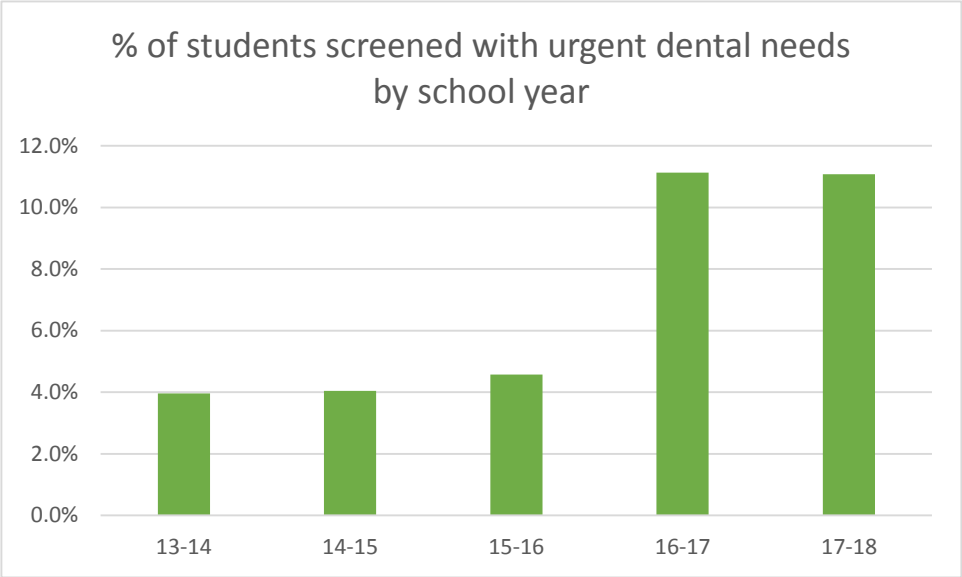


Figure 5. Percentage of students screened with urgent dental needs by school year.



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 056-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 September 20

SUMMARY INFORMATION REPORT FOR SEPTEMBER 2018

Recommendation

It is recommended that Report No. 056-18 re: "Summary Information Report for September 2018" be received for information.

Key Points

- Since August 2017, it has not been possible to provide physician-led services in the Sexual Health Clinic on Thursday evenings due to a lack of physician availability. Services remain available to clients at other clinic times. Nursing services continue to be delivered at the clinic on Thursday evenings.
- The Minister of Finance hosted a roundtable discussion with community leaders in London on August 23, 2018, to gather input on considerations related to the privatization of cannabis retail sales. An additional consultation focused on the legal and fiscal issues was conducted in Toronto by the Attorney General and the Minister of Finance. The Health Unit participated, and prepared a written submission, attached as Appendix A.

Sexual Health Clinic Change in Service

The Sexual Health Team operates clinics on Monday, Wednesday, and Thursday from 4:30 p.m. to 7:00 p.m., and on Friday from 8:30 a.m. to 10:30 a.m. On Thursday nights, the clinic provides family planning services to the community. Historically there have been two physicians assigned to the Thursday-night clinic, but due to the reassignment of one physician and the resignation of another, physician-led services have not been provided on Thursdays since August 2017. Despite recruitment of new physicians, none has been available to work on Thursday evenings due to circumstances such as leaves and locums. Services such as pregnancy testing, STI test results, counselling, STI medication, contraceptive, and needle distribution all continue to be delivered at the clinic on Thursday evenings by Public Health Nurses, but we have been unable to provide family planning exams or consultations at that time. Physician-provided exams and consultations are still available to the public at the clinic on Mondays, Wednesdays, and Fridays.

Public Health Considerations Related to the Privatization of Cannabis Retail

On August 13, the Provincial Government announced its intention to privatize the retail sale of cannabis in Ontario. Online access to cannabis in Ontario will be available starting October 17, 2018, with plans to have privately run storefronts ready for operation by April 1, 2019, pending required legislative changes. Prior to the announcement to change the retail framework, the *Ontario Cannabis Act, 2017* (OCA) and *the Ontario Cannabis Retail Corporation Act, 2017* mandated a government-run corporation to provide sale and distribution of cannabis in Ontario. A government-run system without commercialization of cannabis sales is in alignment with a public health approach to legalization, which was endorsed by the Middlesex-London Board of Health during the 2017 public consultation process.

To help facilitate this change in direction, the Province conducted a series of consultations in late August to help inform the development of the new private retail system. On August 23, Doug Downey, Parliamentary

Assistant to the Minister of Finance, hosted a roundtable discussion to gather input on how best to create a well-regulated, well-enforced system that protects youth and keeps our roads and communities safe. Health Unit staff prepared a written submission, attached as Appendix A, to provide the Health Unit's perspective pertaining to: types of eligible cannabis-retail businesses and rules by which they would operate; the roles of municipalities; how to protect youth and children; and how to divert consumers from the illegal market. The evidence from alcohol and tobacco control research shows that greater retail access, higher density of outlets, and extended hours of sale contribute to an increase in use and harms. Effective controls at the provincial and municipal levels can minimize these potential harms and help to mitigate the public health concerns related to a privatized cannabis retail market.

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

PA Consultation Document: Cannabis

Contact Information	
City	London
Organization	Middlesex-London Health Unit
Stakeholder Name	Linda Stobo, Program Manager Chronic Disease Prevention and Tobacco Control Melissa Knowler, Public Health Nurse Substance Use Portfolio
Stakeholder Email	linda.stobo@mlhu.on.ca melissa.knowler@mlhu.on.ca
Stakeholder Phone	519-663-5317 ext. 2388 519-663-5317 ext. 2252

Please enter feedback on page 2.

Once complete please return to David.Artemiw@ontario.ca.

Stakeholder Feedback	
License Eligibility and Allocation / Contracting *Should there be province-wide restrictions on where a retail outlet can be placed?* *(e.g. restrictions around proximity to a school, proximity to another private store, number of stores per region, etc.)* *Other than private residences, should there be other spaces where cannabis can be used (e.g. lounge, bar)? If so, should those establishments be regulated and how should they be regulated? (e.g. licences)*	***Retail Outlet Restrictions*** Best practice evidence from tobacco control literature provides insight regarding product accessibility and its impact on tobacco use initiation. Greater availability of retail outlets and density of retail outlets increases consumption, increases the normalization of use, decreases ability to succeed in quit attempts and undermines health warnings. Consideration needs to be given to vulnerable populations (e.g., children and youth, those with co-addictions, etc.) and the inequitable impact that chosen site locations may have on particular populations within a community. Similarly, we see alcohol availability as a contributor to alcohol normalization, alcohol use, and resulting alcohol harm. We have less evidence to draw upon for cannabis; however, it is fair to assume that the same precautionary approach should apply. Proactive planning, including comprehensive provincial regulations around density and proximity to vulnerable populations, will help to ensure that the risks are minimized. Utilizing our past history with other substances, the following are some recommendations to consider when siting cannabis store locations: • require retail cannabis location to be at a **minimum of 500m away** from any **youth-oriented services** including elementary schools, secondary schools, municipal libraries, community centres, playgrounds and sporting fields, the Boys and Girls Club, the YMCA, and other family-oriented centres; • require retail cannabis locations to be at a **minimum of 500m away** from any other **vulnerable populations site** (e.g., addiction services, mental health services, methadone clinics, hospitals and healthcare centres, and payday loan stores); • require retail cannabis locations to be at a **minimum 500m away** from and **alcohol, tobacco or cannabis-related businesses;** • provide an opportunity for each community to have input into store locations prior to approvals of store sites; and, • limit the number of cannabis stores provincially, on a per capita basis, and implement density and distance controls to prevent stores from clustering, while also keeping buffer zones around well-defined areas where children and youth frequent.

	Cannabis Consumption Lounges • **Licensed cannabis consumption lounges that would allow smoking or vaping of cannabis should <u>not</u> be permitted.** Ontario has a history of enacting policies that aim to protect children, youth and employees from second-hand tobacco smoke and the potential harms from exposure to vapour through provincial legislation and municipal bylaws. The proposed *Smoke-Free Ontario Act, 2017* will expand that protection to include vapour and medical cannabis smoke. Permitting smoking and vaping of cannabis in licensed cannabis lounges would be a step backwards from the gains that we have made to normalize a smoke-free culture. Through amendments to the *Smoke-free Ontario Act* and municipal bylaws, we have substantially reduced exposure to smoke and the use of smoking products in public spaces and workplaces. • **The licensing of cannabis lounges for the consumption of edible products requires more consultation and careful consideration.** It has been proposed that the legalization of the retail sale of edible cannabis products would not occur until 2019 after extensive effort by the Government to establish the edible product framework. Therefore, it is difficult to provide comment on edible cannabis lounges until that framework is established. Ontario is committed to "a safe and sensible framework to govern recreational cannabis in the province". Once the edible product framework has been drafted, stakeholders will be better positioned to provide comment from a public health perspective. ***Multi-Unit Housing*** • Health Canada recommends a ban on smoking in multi-unit housing. An unintended consequence of prohibitions on the use of cannabis in public spaces is an increase in second-hand smoke exposure within multi-unit dwellings. Since there is no safe level of exposure to second-hand smoke, where feasible, multi-unit housing providers should be provided with exemptions under Ontario's proposed *Cannabis Act* to allow for the provision of a designated smoking area outside on the grounds, keeping in mind location and child/youth exposure.

Store Operations *Should there be restricted hours of sale?* *How should pricing be structured to combat the illegal market? Should there be a minimum retail price for cannabis products?* *Should staff working in stores require provincially mandated training as a condition of employment and store licensing?* *Who should deliver staff training? (e.g. Ontario Cannabis Store, accredited third party)*	**Business Regulation and Retail** • Set minimum standards and guidelines provincially, and license provincially (using liquor licensing as an example) so that there are common rules and regulations across Ontario, in line with the evidence that we can draw upon from tobacco and alcohol sales. • Ensure price/tax is based on THC levels (higher price/tax for products with higher THC) to help deter price-sensitive consumers, such as youth, from purchasing. • Establish provincial maximum THC and minimum CBD thresholds to eliminate high potency product availability. • While balancing the need to redirect consumers from the illegal market to the regulated market, there remains the need to establish a provincial minimum price to ensure that cannabis products remain sensitive to pricing measures, including taxation. Pricing measures are the single most effective way to prevent initiation and to reduce consumption. • Mandate that cannabis retail operators must complete standardized cannabis education as part of their application process, and ensure that standardized evidence-based health education is provided at point of sale. • Training should be standardized at a provincial level with requirements for ongoing re-certification to ensure it is consistent and current. • Limit hours of operation to restrict availability late at night and early in the morning (e.g. no earlier than 10:00 a.m., and no later than 9:00 p.m.). • Enact legislation that mandates that cannabis retail operators restrict youth under the age of 19 years from entering their stores. • Restrict signage and advertising to minimize visibility and promotion to youth from outside the store and enact provincial legislation that bans the promotion of cannabis and cannabis-related products, including promotion and sponsorship activities within places of entertainment. • Enforce youth possession, supply and sales restrictions utilizing best practices from tobacco control (e.g. test shopping and mandated annual inspections). • Cannabis retail establishments should be restricted to selling only cannabis and products related to the use of cannabis. Stores that are in the business of selling pharmaceuticals and/or other strictly regulated products, like lottery, alcohol and tobacco, should not be permitted to sell cannabis to minimize

	product normalization and exposure to other products that can result in problematic use. • Public Health has a wealth of experience related to the enforcement of vendor compliance with tobacco and e-cigarette retailer legislation (e.g. test shopping, mandated annual inspections, and the provision of retailer obligations under the law). If Public Health is called upon to support cannabis retail enforcement activities at the local level, funding for additional staff and training would be required.
Role of Municipalities *Should municipal/First Nation community approval be required prior to licensing?* *Should municipal/First Nations communities be able to zone for private stores?* *Should municipalities/First Nations communities be able to set further restrictions on the operation of stores beyond those set by the provincial government and/or regulator, to account for local circumstances? These restrictions could include, but are not limited to:* • *location (e.g. distance buffers from schools, daycares, community centres);* • *hours of operation; and* • *number of stores per municipality/community.* *How should municipalities best police private stores and eliminate illegal dispensaries?* *Should the province make public education training available to municipalities and First Nations communities? Should this training be delivered by the province and/or by an accredited third party?*	**Community Approval** Providing an opportunity for each community to have input into store locations prior to approvals and licensing of store sites is imperative. There are several potential planning issues that should be addressed at a municipal/First Nation community level prior to siting cannabis retail stores to protect the health and safety of our community. The Middlesex-London Health Unit is committed to a public health approach to the legalization of cannabis, which includes a closely regulated retail market, and welcomes the opportunity to work collaboratively with our municipalities, our First Nation communities and our enforcement partners. Attached to this submission is a letter from the Middlesex-London Health Unit to the City of London to help inform the development of the "*Siting of Cannabis Retail Stores in London Bylaw*". **Consumption of Cannabis** The prohibitions on the public use of non-medical cannabis need to be promoted to support voluntary compliance. In addition, the restrictions need to be adequately enforced to promote compliance when education is inadequate. There are lessons that can be drawn upon from tobacco control: • Research has confirmed that e-cigarette use among youth increases the likelihood of youth smoking tobacco, potentially leading to a lifetime of smoking cigarettes, with all of the risk that this entails. It is recommended that provincial legislation be enacted that prohibits the use of vaping products, whether or not it contains cannabis, nicotine or tobacco, in the same public locations where smoking tobacco is already restricted to reduce the risk and prevent normalization of smoking and vaping to the youth population.

	• Municipalities have a rich history of enacting smoke-free bylaws to address the health concerns of second-hand smoke. To avoid varying levels of protection from second-hand cannabis smoke exposure between municipalities, an opportunity exists to level the playing field by expanding the prohibition on the smoking or holding of lit tobacco, as outlined under the *Smoke-free Ontario Act (SFOA),* to include ***the smoking or holding of lit cannabis, whether or not it is used for medical purposes.*** The *SFOA* outlines employer and proprietor obligations that support the promotion and enforcement of the regulations, which addresses community, municipal and provincial concerns regarding the public use of cannabis in workplaces and public places, including places where children and youth frequent.
Additional Comments/Other Issues	**Research and Evaluation** • Ensure there is a plan for a provincial cannabis legalization monitoring strategy, with appropriate, common, population-level indicators to monitor the impacts of policy implementation. **Public Health Funding** • Dedicated public health funding to support prevention, harm reduction and protection/enforcement strategies to mitigate harms associated with cannabis use is required. • Public Health has a wealth of experience related to the enforcement of vendor compliance with tobacco and e-cigarette retailer legislation (e.g. test shopping, mandated annual inspections, and the provision of retailer obligations under the law). If Public Health is called upon to support cannabis retail enforcement activities at the local level, funding for additional staff and training would be required.

BUREAU DE SANTÉ DE
MIDDLESEX-LONDON
HEALTH UNIT

November 21, 2017

Orest Katolyk
Chief Municipal Law Enforcement Officer
London City Hall
300 Dufferin Avenue
London, ON
N6A 4L9

Re: City of London identified as site for stand-alone cannabis store by July 2018

Dear Orest,

The City of London was identified in the Ministry of Finance's November 3rd, 2017 announcement as one of the initial 14 Ontario municipalities scheduled for a stand-alone cannabis store by July 2018. It is the Middlesex-London Health Unit's understanding from that announcement that staff from the Ministry of Finance and the LCBO will meet with City of London staff to discuss the guidelines and process for siting stores and consideration of local interests. We would like to offer our public health perspective as it pertains to establishing cannabis retail locations and the potential community impact that locations may have, and future considerations as the retail market expands over the next few years.

Best practice evidence from tobacco control literature provides insight regarding product accessibility and its impact on tobacco use initiation. Greater availability of retail outlets and density of retail outlets increases consumption, increases the normalization of use, decreases ability to succeed in quit attempts and undermines health warnings. Consideration needs to be given to vulnerable populations (e.g., children and youth, those with co-addictions, etc.) and the inequitable impact that chosen site locations may have on particular populations within a community. Similarly, we see alcohol availability as a contributor to alcohol normalization, alcohol use and resulting alcohol harm. We have less evidence to draw upon for cannabis; however, it is fair to assume that the same precautionary approach should apply.

Although we understand that only one cannabis store has been identified for the City of London currently, it is quite feasible that there will be others in the future. Proactive planning, including comprehensive by-laws, will help to ensure that the risks are minimized for our community throughout the Ontario government's safe and sensible approach to cannabis legalization. We hope that we are able to share our public health knowledge and past experiences as we forge into this new future.

Utilizing our past history with other substances, the following are some recommendations to consider when siting the City of London's first cannabis store location:

- require retail cannabis locations to be at a **minimum of 500m away** from any **youth-oriented services** including elementary schools, secondary schools, municipal libraries, community centers, playgrounds and sporting fields, the Boys and Girls Club, and other family-oriented centres;
- require retail cannabis locations to be at a **minimum of 500m away** from any other **vulnerable population site** (e.g., addiction services, mental health services, methadone clinics, hospitals and healthcare centres, and payday loan stores); and,
- require retail cannabis locations to be at a **minimum of 500m away** from any **alcohol, tobacco or cannabis-related businesses.**

We look forward to the opportunity to sit down with you and our City partners to work together as we prepare for the legalization of cannabis. There are challenges and opportunities at the local level and we are happy to assist, as we can, to share resources and to minimize harm and negative health impacts, now and into the future.

As we have mentioned, plans are underway to host a municipal knowledge exchange day in the new year, to bring together municipal staff and elected officials from across Middlesex County and the City of the London, local police services, the Health Unit, and the Association of Municipalities of Ontario to facilitate dialogue. We are also extending invitations to the Cannabis Secretariat at the Ministry of Health and Long-Term Care with hopes to get the most up to date information to contribute to our discussions and to identify potential local implications. We are happy to receive input from you directly to inform the agenda and timing.

If you have any further questions or wish to discuss the recommendations cited above, please don't hesitate to contact us.

Sincerely,

Linda Stobo
Program Manager
Chronic Disease Prevention and Tobacco Control
linda.stobo@mlhu.on.ca

David Pavletic
Program Manager
Food Safety and Healthy Environments
david.pavletic@mlhu.on.ca

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 057-18

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2018 September 20

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR SEPTEMBER

Recommendation

It is recommended that the Board of Health receive Report No. 057-18 re: "Medical Officer of Health Activity Report for September" for information.

The following report presents activities of the Medical Officer of Health for the period of July 6, 2018, to September 4, 2018.

July 6	Met with Dr. Rick Mann, Coroner, to discuss the opioid crisis
July 10	Interviewed by Gary Ennett, CBC, in advance of an in-studio interview on July 11
July 11	Interviewed by Julianne Hazelwood, CBC, in regard to Toronto MOH's proposal to decriminalize all drugs for personal use
July 12	Attended tour of the Temporary Overdose Prevention Site (TOPS) with senior staff of the City of London
July 13	With Health Unit staff, met with staff from the City and Regional HIV/AIDS Connection (RHAC) to discuss strategies for improving needle recovery in the community
July 16	Attended the Community and Protective Servies meeting at City Hall in regard to funding for the relocation of the Health Unit
July 17	Led a class (Global MINDS Fellowship Program, Summer Institute, Western University) on the topics of poverty and mental health Interviewed by Shannon Coulter, *London Free Press* (LFP), about TOPS extension request Interviewed by Paula Duhatschek, CBC London, about TOPS extension request
July 18	Phone call with Brian Schwartz, Public Health Ontario, for their regular update Met with Jeff Yurek, Minister of Natural Resouces and Forestry, at Queen's Park
July 19	Interviewed by Mike Stubbs, 980 CFPL, about TOPS extension request Interviewed by Darrel Newcombe, CTV News, about TOPS extension request Teleconference with community partners about upcoming community information meetings for Supervised Consumption Facilities (SCFs) Attended Board of Health meeting
July 20	Met with Mark Henshaw and Patrick Sackville to discuss supervised consumption Phone call with Peter Fragiskatos, MP for London North Centre, about SCFs and TOPS extension request
July 23	Live interview with Craig Needles, 980 CFPL, about TOPS extension request

July 24	Co-facilitated session at the Global MINDS Fellowship Program, Western University, titled “Partnerships and Influencing Decision-Makers”
July 25	Teleconference with the alPHa 2018 Municipal Election Task Force Attended two community information meetings organized to provide information on the proposed SCF sites
July 26	Live interview with Travis Dhanraj and Liny Lamberink, Global News, about the London opioid crisis
July 27	Met with Adam Thompson, Manager, Government and External Relations, City of London, to discuss City of London participation in AMO meeting
July 30	Teleconference with the Toronto Drug Strategy Secretariat re: supervised consumption
July 31	Teleconference with Dr. Vera Etches, Medical Officer of Health, to discuss plans for the upcoming Urban Public Health Network Conference
August 1	Teleconference with Dr. Eden, Regional Supervising Coroner for Inquests, London Police Services, and the Ministry of Community Safety and Correctional Services
August 2	Met with Megan Walker, Executive Director, London Abused Women’s Centre, to discuss SCF issues
August 7	Met with Kate Young, MP for London West, and Peter Fragiskatos, MP for London North Centre, to discuss various public health issues and tour the TOPS
August 9	Interviewed by Murray Hunter, management consultant, for research on leadership Interviewed by Shannon Coulter, LFP; Chris dela Torre, CBC Radio One; Scott Kitching, BlackburnNews.com; and Gerry Dewan, CTV News, about TOPS extension and funding
August 10	Interviewed by Craig Needles, AM980 News, about TOPS extension
August 13	Attended site/building design meeting for the 446 York Street location
August 14	Delegation status at the Middlesex County Council meeting. Discussed and answered questions about the County Services Review, which MLHU is currently conducting Interviewed by Jonathan Sher, LFP, about TOPS Met with Ronnie Grigg to discuss Insite, Vancouver’s SCF
August 15	Met with the London & Middlesex Housing Corporation to discuss SCFs Presented to the Pharmacy Student Conference, at St. Joseph’s Hospital, on the London opioid crisis Phone call with Mayor Matt Brown to discuss SCFs
August 16	Met with City of London staff to discuss water quality in London Met with Joe Antone, Southwest Ontario Aboriginal Heatlh Access Centre (SOAHAC), to discuss his counselling work and future opportunities Met with Jake Skinner, Principal, Blackridge Strategies, for a tour of the TOPS

August 23 Met with Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care, regarding SCFs; presented document "The Business Case for Supervised Consumption in London, Ontario."

September 6 Attended Finance & Facilities Committee meeting
Participated in stakeholder meeting about people who inject drugs coordinated by the South West Local Health Integration Network (LHIN) and London Health Sciences Centre

This report was submitted by the Office of the Medical Officer of Health.

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The Business Case for Supervised Consumption in London, Ontario

MIDDLESEX-LONDON
HEALTH
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September 2018

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Executive Summary

The Opioid Crisis

Like many major cities in Canada, London, Ontario is in the midst of a drug crisis which has resulted in significant health, social and financial costs that are borne directly by our residents, local municipalities and the province. Over 400 Londoners have lost their lives to overdose in the past decade, there have been tens of millions of dollars spent on the treatment of infectious disease associated with drug use, and there are concerns about both the public consumption of drugs and discarded needle waste being found in the community. New solutions are urgently needed to not only control the financial pressures on government, but to help those who are affected to receive rehabilitation, prevent overdose deaths, stop the spread of disease, and reduce harm to the broader community.

The Opportunity

Supervised Consumption Facilities (SCFs) are designed to provide a safe, supervised space where people can consume drugs they obtained on their own and receive information about, and referrals to, health and social support services in the community. While clients *are not* provided with drugs at the site, they do receive sterile injecting equipment and instruction on safer injecting and / or consumption practices.

A healthcare provider supervises the clients' injection / consumption in a room dedicated for this purpose and can intervene in the case of any medical emergencies. Clients dispose of injecting equipment waste prior to leaving the consumption room, before being directed to a waiting room where they will continue to be observed for any negative reactions.

The connection with the healthcare provider is key; not only because a relationship can develop with the client, but because they can also provide referrals to support services including outreach workers, addiction services, housing and withdrawal management, when the client is ready to take that step.

The Benefits

The benefits of SCFs are clear and supported by research literature and the experiences in other jurisdictions. These benefits include:

- Preventing overdose deaths;
- Limiting the spread of infectious disease;
- Increasing the use of detox programs and addiction treatment;
- Reducing the sharing of needles and other injection equipment;
- Reducing public disorder; and,
- Increasing safer injection behaviours.

Concerns

Several potential risks associated with SCFs have become common points of debate among members of the public and in the media. Some of the concerns expressed during the community consultations held in London were:

- Increased presence of people who use drugs in the neighbourhood;
- Increased drug trafficking in the area;
- Negative impact on reputation or the image of the community;
- Decrease in property values;
- Increased drug use;
- Decline in neighbourhood cleanliness / quality of life; and,
- Decreased personal safety.

While these concerns have not been demonstrated in the empirical evidence generated to date, they do require further follow-up and attention.

Costs

SCFs can generate cost savings when the analysis takes into account their capacity to reduce the transmission of blood-borne diseases, namely HIV and hepatitis C, and their role in reducing infections such as Endocarditis and invasive Group A Streptococcal (iGAS).

In terms of real dollars, annual operating costs are approximately $1.2M. This is funded through the Ministry of Health and Long-Term Care, which is the largest beneficiary of the cost savings associated with prevented illness. These dollars provide the means to staff, equip and operate an SCF facility.

Another significant cost is political capital. SCFs are controversial interventions that seek to help a marginalized population within the community who often face extreme stigmatization. It takes leadership and the ability to navigate controversy to successfully rally the community around this kind of intervention.

Background

Canada is experiencing a serious and growing opioid crisis. In 2016, there were 2,946 apparent opioid-related deaths across the country and it is expected that this count will rise (Public Health Agency of Canada, 2018). Like many major cities in Canada, London, Ontario has felt the burden of this crisis through increasing health, social, and financial costs. In London specifically, over 400 residents have lost their lives to overdose in the past decade.

London has a large population of injection drug users, believed to be one of the largest in the country relative to its population. While the exact size of the population of people who inject drugs (PWID) remains largely unknown, it has been estimated that there are approximately 6,000 PWID in London (about 2% of London's total population of 385,000) (Middlesex-London Health Unit, 2017).

Death rates have been fluctuating in Middlesex-London since 2005. The highest rate of deaths related to opioid toxicity was seen in 2012 (Public Health Ontario, 2017). In Ontario the death rate has been slowly increasing. The most recent data from 2015 and 2016 indicates that the rate of opioid-related deaths in Middlesex-London has been similar to that of Ontario (between 5 and 6 deaths per 100,000 people) (Public Health Ontario, 2017).

Additionally, in 2016, the rates of invasive Group A Streptococcal (iGAS) infections, HIV, and Hepatitis C infection were significantly higher in Middlesex-London when compared to provincial rates, and these increases were felt to be related, in part, to the use of injection drugs by community members (Middlesex-London Health Unit, 2018).

In June 2016, the Middlesex-London Health Unit (MLHU) declared a public health emergency due to the increase in the number of HIV and other infections in London. On December 7, 2017, and as a new strategy to address the opioid crisis, Health Canada issued an exemption to Ontario's Ministry of Health and Long-Term Care to establish temporary Urgent Public Health Need Sites (referred to as Overdose Prevention Sites) in Ontario. The Overdose Prevention Sites (OPS) were to be established for a time-limited basis (3-6 months), with the possibility of extension (Ministry of Health and Long-Term Care, 2018).

In collaboration with Regional HIV/AIDS Connection (RHAC), London's Temporary Overdose Prevention Site (TOPS) opened on February 12th, 2018 and became the first legally-sanctioned site of its kind in Ontario. TOPS is intended to:

- Prevent overdose deaths;
- Reduce the spread of infectious disease;
- Increase access to harm reduction services;
- Reduce unsafe consumption practices;
- Potentially reduce health care costs;
- Minimize the burden on the health care system;
- Reduce the amount of discarded needles and syringes found in public spaces (and the risks associated with potential injury); and,

- Improve access to other health and social services (Ministry of Health and Long-Term Care, 2018).

In the months since the facility opened, nearly ten percent of the client population has been referred to rehabilitation. In the first 150 days of operation alone, 150 people were successfully connected to addictions treatment. As of August 31, 2018, there have been 31 overdoses at the facility, most of which were fentanyl-related – with none resulting in death.

New diagnoses of HIV are also on the decline, even though testing rates continue to increase. Endocarditis, an infection of the lining of the heart which is associated with injection drug use, previously cost London hospitals approximately $7 million per year, yet clinicians have reported a decrease in the occurrence of this disease as well.

Due in part to the positive outcomes that have been observed so far, the London Chamber of Commerce and Downtown London Business Improvement Area have both indicated their support for supervised consumption services. Their letters of support are appended to this document.

As of June 2018, there were 30 supervised consumption sites approved to operate in Canada; of these, 10 were in Ontario, and another 10 open site applications were awaiting federal approval (Government of Canada, 2018). These sites can offer services ranging from supervised injection, to intranasal and oral consumption, to referrals or information on health and social services, including housing services, primary health care, and addictions support.

Multiple studies have been conducted to explore the impact and effectiveness of supervised consumption services, both on the people they are intended to serve, as well as the broader community in which they operate. The majority of these studies have been conducted in British Columbia (BC) where the first legal supervised drug injection site in North America, Insite, was founded in 2003. Research conducted in BC has shown multiple benefits that have resulted from the implementation of a supervised consumption facility, including:

- Overdose deaths averted (Milloy, Kerr, Tyndall, Montaner, & Wood, 2008);
- Increased use of detox programs and addiction treatment (Tyndall et al., 2006; Wood, Tyndall, Zhang, Montaner, & Kerr, 2007);
- Reduction in syringe sharing and rushed injections (Stoltz et al., 2007);
- No negative changes in community drug use patterns, including injection drug use (Kerr, Small, Moore, & Wood, 2007; Kerr et al., 2006; Kerr, Tyndall, et al., 2007);
- Reduction in public disorder (Wood et al., 2004);
- Increases in safer injection behaviours (Small, Wood, Lloyd-Smith, Tyndall, & Kerr, 2008; Stoltz et al., 2007); and
- No increase in drug-related crime (Myer & Belisle, 2018).

A systematic review by Potier, Laprevote, Dubois-Arber, Cottencin, and Rolland (2014) reviewed 75 articles related to SCFs. Of these articles, 85% originated from Vancouver, BC or Sydney, Australia. This review further demonstrates the benefits of the implementation of SCFs. The research literature on SCFs demonstrated that these sites were effective in attracting people who inject drugs, promoting safer

injection conditions, increasing access to additional services such as primary care, and reducing the frequency of overdoses. The research also found that these services do not increase drug injecting, drug trafficking or crime in the vicinity of the facilities, in addition to reducing the amount of public drug injections and improperly discarded syringes.

However, the TOPS is, as its name indicates, temporary. The class exemption that has been granted by the province of Ontario will expire on September 30th 2018. The OPS/SCF review being conducted by the Minister of Health and Long-Term Care is expected to be completed by the end of September, at which time the Ontario Government's decision whether or not to renew the exemption, or the funding for these sites, will be made.

To address the need for a permanent SCF in London, an Ontario Integrated Supervised Injection Site Feasibility Study was conducted by the Ontario HIV Treatment Network in 2016. This study explored the potential willingness to use supervised injection services (SIS) among local people who use injection drugs in Middlesex-London. A total of 199 PWID participated in this study. In total, 170 (86%) participants reported a willingness to use SIS, if one was available, while another 14 (7%) said they would not be willing to use SIS. Overall, the study demonstrated a high rate of willingness to use SIS in Middlesex-London, if one were available (Ontario HIV Treatment Network, 2017).

To meet the requirements of Health Canada's application process for an SCF, a community consultation process was conducted in November and December of 2017 to better understand the local needs, benefits, concerns and recommendations, in order to inform a potential site location and operations (Centre for Organizational Effectiveness, 2018). This consultation had 2,145 survey responses, 334 community participants and 56 focus group participants. The consultation found that Londoners want to support people who use drugs and saw the benefits of a SCF across a wide range of domains, including those outlined in this business case.

It is clear that supervised consumption services alone will not solve the drug crisis that this community currently faces. As such, London is on the cusp of launching a comprehensive Community Drug and Alcohol Strategy. The Middlesex-London Community Drug and Alcohol Strategy (CDAS) is a long-term comprehensive strategy to address substance use in London and the surrounding area based on a four pillar philosophy of prevention, treatment, harm reduction and enforcement. The CDAS partnership consists of more than 30 committed community partner organizations representing diverse sectors inducing health and social services, education, enforcement, municipalities, business, and people with lived expertise.

This business case further articulates the need for SCFs in the Middlesex-London area, focusing on three significant challenges: overdoses, infectious disease and harms associated with drug use.

Addressing these challenges associated with the opioid crisis through an investment in SCFs would have a tangible impact on the community. Most importantly it would save lives; but it would also reduce the healthcare costs associated with drug use, improve neighbourhood safety, improve health outcomes, and reduce the spread of infections such as HIV.

Overdoses

Current Situation

The number of overdoses continues to rise with the arrival of new and highly toxic forms of opioids such as fentanyl and carfentanil. Between August 1st and 31st, there were 23 overdoses at the Temporary Overdose Prevention Site. Fortunately, all were reversed due to interventions by staff members who were on-site.

Data on non-fatal overdoses is limited, and is not collected in a systematic way. Many people who use drugs will experience a non-fatal overdose, but may not seek medical attention. This is especially true of those who use illicit drugs and often experience stigma and discrimination in the health care system. One available indicator of non-fatal overdoses is the number of emergency department visits and hospital admissions for opioid-related issue.

The number of Emergency Department visits has generally been higher in the Middlesex-London region than the rest of Ontario since 2004 and increasing since 2014; in fact, there were 188 overdose-related Emergency Department visits in 2016 (Middlesex-London Health Unit, 2018). Hospitalizations for overdoses have also been increasing over time in both Middlesex-London and Ontario. Yet, in recent years, the rate in Middlesex-London has been increasing at a greater pace than the rest of the province (Middlesex-London Health Unit, 2018).

In 2013, Middlesex-London EMS responded to 602 drug overdoses-related calls, averaging more than one overdose per day (Middlesex-London Health Unit, 2014). Furthermore, in the Ontario Integrated Supervised Injection Service Feasibility Study Report conducted in London, participants identified that one in four (25%) reported a history of overdose (Ontario HIV Treatment Network, 2016).

The local opioid market has historically been dominated by diverted prescription drugs (Middlesex-London Health Unit, 2014). With the introduction of prescribing guidelines in September, 2017, it was expected that the availability of prescription opioids would decrease, and that more potent versions of illegally produced drugs such as fentanyl and carfentanil would become more common locally. This change could lead to an increase in the number of opioid overdoses and deaths.

In October 2016, the Minister of Health and Long-Term Care released a “Strategy to Prevent Opioid Addiction and Overdose” (Opioid Strategy), which included ongoing work to: enhance data collection and surveillance; modernize prescription and dispensing practices; improve access to high-quality addiction treatment services; and enhance harm reduction services and supports (Ministry of Health and Long-Term Care, 2016). On June 12, 2017 and in order to support implementation of the Opioid Strategy’s harm reduction pillar, the Minister of Health and Long-Term Care announced that funding would be provided to boards of health to build on existing harm reduction programs and services, and to improve local opioid response capacity and initiatives (Ministry of Health and Long-Term Care, 2017).

Current Services Provided

On February 12, 2018, London's Temporary Overdose Prevention Site (TOPS) was opened in collaboration with Regional HIV/AIDS Connection (RHAC). Since then, TOPS has seen more than 7,000 visits by 2,000 unique individuals. As of September 16, 2018, there have been 31 overdoses at the facility, most of which were fentanyl-related – with no deaths.

The number of naloxone kits distributed in the Middlesex-London region has steadily increased since 2014. Naloxone is a drug which can reverse the effects of an opioid overdose long enough for that individual to get medical attention and care. There was also a steep rise in the number of people reporting that they had administered naloxone in 2017. Regional HIV/AIDS Connection in collaboration with the Middlesex-London Health Unit and several community agencies across the city provide harm reduction services, which include, but are not limited to, the distribution of safer drug use supplies and naloxone, safer drug use education and referrals to agencies that provide addiction treatment.

Impact of SCF on Overdoses

Research evidence has reported that Supervised Consumption Facilities improve access to overdose care and reduce the number of overdose fatalities (Ontario HIV Treatment Network, 2014). A study conducted at Insite, one of Vancouver's SCFs, reported that each year staff intervene in two to 12 potentially fatal overdoses (Milloy et. al, 2008). Studies from Europe have reported a decline in overdose fatalities after SCFs had opened (Dolan et al., 2000). In Australia, the number of ambulance calls related to overdose emergencies has been reported to decline significantly after an SCF had opened and calls had continued to remain lower during the hours the site was operating (Salmon, van Beek, Amin, Kaldor, & Maher, 2010).

Kerr, Small, Moore, and Wood (2007) reported that the Vancouver sites provide opportunities for PWID to reduce the risks of overdosing, when compared to if they were to inject alone. Participants acknowledged that if an overdose were to occur in a public space, it may be less likely for an onlooker to intervene and seek medical attention for the person who had overdosed. They noted the benefit of having medical staff directly at Insite, who could recognize and assist if an overdose were to occur there, rather than at a public location, such as an alleyway or behind a dumpster (Kerr, Small, et al., 2007).

Infectious Disease

Current Situation

In February 2016, an investigation was initiated by the Middlesex-London Health Unit to understand the increase in new cases of HIV because of concerns raised by local Infectious Diseases (ID) physicians. In the first six weeks of 2016, six new cases of HIV were reported to MLHU. This was considerably higher compared to what had been observed previously.

The investigation began with identifying the number of cases and rate of HIV compared to similar jurisdictions and Ontario, in general. Additional data was requested from Public Health Ontario (PHO) to understand whether this increase could be explained by other factors, such as an increase in HIV testing in London. MLHU also determined in which population(s) the new infections were occurring. MLHU was able to confirm that the HIV rates were, in fact, increasing in Middlesex-London. On the contrary, HIV rates across the province had been declining over the past decade. PWID have, at their highest, represented just under 10% of new HIV cases in Ontario. In contrast, two-thirds of new HIV cases in Middlesex-London were attributed to PWID (Middlesex-London Health Unit, 2018).

Simultaneously, an investigation of hepatitis C (Hep C) was initiated by MLHU to understand whether there was a similar pattern in terms of risk factors and trends over time. The rate of Hep C in Middlesex-London has been higher than the provincial rate for several years; however, the rates have been stable in recent years (Middlesex-London Health Unit, 2018). While HIV and Hep C investigations were underway, MLHU began an investigation of Invasive Group A Streptococcal (iGAS) cases. As a result of this investigation, an iGAS outbreak was declared in May of 2016. This outbreak is ongoing and shares similar characteristics with HIV and Hep C outbreaks and it is predominantly concentrated in the PWID population. In addition, ID physicians also reported a concerning increase in cases of infective endocarditis in the PWID population. In 2008, there were less than 200 total days of hospital stay due to injection drug use-associated infective endocarditis, in comparison to approximately 2,000 total days in 2015. The estimated healthcare costs due to endocarditis alone were estimated at $7.7 million in 2015, or $112,150 per case.

In addition to outbreak investigations, MLHU consulted with key local stakeholders who provide services and support to people living with HIV, such as Regional HIV/AIDS Connection, London Intercommunity Health Centre (LIHC) and ID physicians. Stakeholder consultations and meetings were also organized by MLHU to inform key organizations on the alarming increase in HIV cases and to understand their perspectives on the potential causes of this rise. National and international experts and other public health units were consulted, as well as research evidence and best practice guidelines on preventing HIV among PWID.

The lifetime costs for a single case of HIV are estimated at $1.3 million (Kingston-Riechers, 2011). Based on this finding, London's HIV outbreak would have an estimated cost of $50 million. Hepatitis C (single course treatment) costs $70,000. London's HIV outbreak prompted MLHU to declare a public health emergency in June of 2016. The intent was to raise awareness among key stakeholders and the community about the outbreaks affecting vulnerable people and, more specifically, PWID. To address this public health emergency, a number of key strategies were implemented, including the development of an HIV Leadership Team with representation from key organizations in Middlesex-London. They aimed to

create a comprehensive strategy to respond to these outbreaks and request support from the Public Health Agency of Canada, in the form of a field epidemiologist to assist with the investigation.

What MLHU knows thus far is that this public health emergency is multifactorial and requires a multi-pronged approach to addressing the interwoven issues.

Current Services Provided

In response to the public health emergency, and through consultations, the Middlesex-London Health Unit and community stakeholders identified the lack of tailored outreach services to facilitate access to HIV "treatment as prevention" or addiction services for hard-to-reach HIV-positive individuals. Following an internal review of effective strategies to address HIV in PWID, internal resources from MLHU were reallocated to form a small street level outreach team, made up of three staff: a team lead, an outreach nurse, and an outreach worker. The purpose of the street level outreach team is to enhance access to HIV treatment for vulnerable populations experiencing difficulties in accessing traditional services.

In September 2015, The "My Care" program was implemented at London Intercommunity Health Centre in collaboration with the St. Joseph's Infectious Diseases Care Program. The "My Care" program team includes a registered nurse, a nurse practitioner, a social worker and a physician. The program's objectives include: identifying at-risk individuals living with HIV and engaging and retaining individuals through a novel flexible outreach model of HIV care. This program has been very successful in not only engaging and providing treatment, but also in maintaining viral load suppression among HIV-positive patients who historically have had difficulty maintaining adherence to treatment. However, due to the absence of sustainable funding, the LIHC has suspended the intake of new HIV-positive patients since August 2016. At that time, the clinic had a client roster of 56 patients. Currently, the My Care Program has 48 clients enrolled in care.

Addiction services are an important part of a comprehensive strategy for increasing adherence to HIV treatment and improving the quality of life of PWID. The uptake of these services, especially opioid maintenance therapy, among HIV-positive individuals who have concurrent addiction disorders, positively influences the likelihood of adherence to HIV treatment. The situation in London appears to be unique in that there is a high rate of concomitant opioid and crystal methamphetamine use. While addiction services are available through Addiction Services of Thames Valley, the Canadian Mental Health Association (CMHA) and independent physician providers in London, there is a lack of service coordination and of capacity for low-threshold comprehensive addiction services geared toward high-risk PWID. According to the Ontario Integrated Supervised Injection Site (OISIS) survey, only 5% of 199 PWID surveyed received addiction services in the previous six months, and 8% reported difficulty accessing addiction services (Ontario HIV Treatment Network, 2017).

Impact of SCFs on Infectious Diseases

The literature suggests that SCFs can prevent the spread of blood-borne infections, reducing the rate of new diagnoses and the burden on the healthcare system. Findings from a prospective study of an SCF in Montreal suggest that 11 cases of HIV and 65 cases of Hepatitis C can be prevented each year (Jozaghi, Reid, & Andresen, 2013). Salmon, van Beek, Amin, Grulich and Maher (2009) estimated that the annual cost savings from the number of HIV infections prevented at InSite in Vancouver was between $2.85 million and $8.55 million.

Indirect Harms Associated with Drug Use

Current Situation

Between 2008 and 2012, London Police Services responded to an average of 730 incidents per year related to drug possession, and an average of 230 calls per year related to trafficking, distribution and possession of controlled drugs and substances (LexisNexis, 2018). Additionally, the Ontario Integrated Supervised Injection Services Feasibility Study, that gathered data from 199 people who use drugs in the Middlesex-London region, identified injection in public spaces and discarded drug use equipment as indirect harms associated with drug use (Ontario HIV Treatment Network, 2017).

In Middlesex-London, there is a high percentage of people who use drugs in public spaces, which often results in discarded drug equipment. Out of the 199 people who were surveyed, 72% of participants reported injecting drugs in public spaces in the last six months (Ontario HIV Treatment Network, 2017). Public drug use also presents potential harm to people who use drugs, through the use of unsafe consumption practices, which can increase the risk of overdose and the spread of diseases, such as hepatitis C and HIV.

Discarded equipment, such as used needles, pose a potential risk of injury for those who use public spaces where people inject drugs. In 2016, according to data provided by RHAC, there were over 3 million needles distributed along with other sterile injection equipment in the Middlesex-London region, of these approximately 1.8 million used needles were returned.

Current Services Provided

Regional HIV/AIDS Connection in collaboration with the Middlesex-London Health Unit and several community agencies across the city provide harm reduction services to people who use drugs. These services include, but are not limited to, distribution of safer drug use supplies and naloxone, safer drug use education and referrals to agencies that provide addiction treatment.

RHAC's Counterpoint Needle Syringe Program is funded by MLHU, the AIDS Bureau, and the Ministry of Health and Long-Term Care. This service has been acknowledged as one of the busiest needle exchange programs in Ontario. According to data provided by RHAC, in 2016, there were 17,140 interactions with Counterpoint clients, more than 3 million needles and syringes distributed from both fixed and mobile delivery programs, and over 6,000 used sharps containers recovered.

Despite the Counterpoint program, there is an urgent need to increase the availability of harm reduction supplies across London and Middlesex County. MLHU and RHAC are currently working together to enhance harm reduction services and increase the availability of supplies through small fixed satellite sites, as well as increasing hours of operation and the availability of harm reduction supplies on weekends.

Impact of SCFs on the Indirect Harms Associated with Drug Use

Other jurisdictions that have implemented SCFs have demonstrated the impact of these facilities in reducing the number of incidents and calls related to drug possession, trafficking and distribution and possession of controlled drugs and substances, as well as a reduction in the indirect harms associated with drug use.

Research conducted in Sydney, Australia has shown that there was no increase in the rates of robbery, theft, drug-related loitering or drug-related incidents in the vicinity following the opening of a SCF (Freeman et al., 2005). Other studies have also demonstrated the impact of these facilities in Sydney. Salmon, Thein, Kimber, Kaldor, and Maher (2007) found that after five years of operation, local business owners reported a significant reduction in public drug use and discarded drug equipment, as well as no change in drug dealing in the vicinity of the facility. Findings related to a reduction in public drug use and discarded drug equipment are consistent with a study conducted in 2007 in Vancouver by Petrar et al. This study found that people who use drugs reported less public drug use and less discarded drug equipment following the opening of InSite, North America's first SCF (Petrar et al., 2007). Similar findings have been shown in another study that demonstrated that the opening of Insite was associated with reductions with public drug use and discarded drug equipment in the facility's neighbourhood (Wood et al., 2004). Lastly, survey results related to SCFs in Europe have also demonstrated that these sites had also led to reductions in public drug use and discarded drug equipment in their respective communities (Kimber, Dolan, & Wodak, 2001).

Given the research gathered about SCFs in other jurisdictions, it is clear that the implementation of these facilities would have a high potential to reduce drug-related incidents, public injection, and discarded drug equipment in Middlesex-London.

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Appendix A – Letters of Support

From: Janette MacDonald [mailto:janette@downtownlondon.ca]
Sent: April-20-18 2:40 PM
To: Christopher Mackie <Christopher.Mackie@mlhu.on.ca>
Subject: Fwd: Mobile Supervised Consumption Facility

Chris:

Downtown London acknowledges the severity of the opiod crisis and our members are affected by it on a day to day basis.

We obviously want to be part of the solution to save lives, provide social justice and economic resiliency.

We would support a mobile site in principal as long as there is a permanent site that is set up to offer wrap around services to ensure that the affected population are provided with every opportunity to receive treatment and counselling.

If the permanent site is located at one of the proposed locations on Simcoe or York St the downtown area would still have to be serviced and a mobile site - with the locations carefully selected with consultation from our members and adjusted as issues or more appropriate locations arise. Then we can offer our support for a mobile site.

We look forward to working with you to save lives.

Best regards,

Janette.

Janette MacDonald,
CEO and General Manager.
Downtown London
123 King St,
London, ON. N6A 3N7.
Office: 519 432 8389
Cell: 519 859 2632.

London Chamber of COMMERCE

OFFICE OF THE MAYOR

RECEIVED JUN 29 2018

Referred to:
Subsequent Referrals
☐ For Action ☐ For Report
☐ For Information ☐ For File

June 28, 2018

His Worship Mayor Matt Brown and Members of City Council
The City of London
300 Dufferin Avenue
London, Ontario, N6A 4L9

Dear Mayor Brown and Members of Council:

Re: Principle Based Support for Supervised Consumption Sites

The London Chamber of Commerce (Chamber) on the recommendation of its Government Affairs Committee would like to voice its support for certain guiding principles regarding the establishment of Supervised Consumption Sites (formerly known as Safe Injection Sites) in the City of London.

As you are no-doubt aware, London is currently facing a drug crisis. In the words of Dr. Chris Mackie (London/Middlesex Medical Officer of Health), we are a medium sized city, with a big city drug problem. In December of 2017, the Minister of Health and Long Term Care recognized the existence of a "public health emergency in Ontario due to the opioid crisis, and formally requested that the federal government allow Ontario to approve and fund overdose prevention sites".

By way of background, an Opioid Crisis Working Group was formed in 2017, including representatives from The City of London, Middlesex-London Health Unit, Regional HIV AIDS Connection (RHAC), London InterCommunity Health Centre (LIHC), Addiction Services of Thames Valley, London Police Service, London CARes, Southwest LHIN, London Health Sciences Centre (LHSC), EMS, as well as an Indigenous community leader and a person with lived experience. Council endorsed the Committee in September of 2017.

The health unit has applied for a federal exemption to open two supervised consumption sites – a place where people can go to use drugs with medical professionals nearby, or to be connected with support services – in London.

The city already is home to a temporary overdose prevention site, the first of its kind in Ontario, which is a short-term version of a permanent supervised facility. Since opening in February, the overdose prevention site has served nearly 700 different people. Recently, a record-setting 59 people came through its doors in one day.

In addition to connecting vulnerable residents with support services, both the short and long-term sites are expected to help reduce the number of needles littering city streets and public spaces. That's one of the benefits for the wider community, according to Dr. Mackie. However, there are many other benefits that professionals cite that can accrue to public health in a community. These include:

- Reduction in drug consumption within public places — eg. bathrooms, alleyways, civic spaces and parks
- Reduction in infectious diseases that impose public health risks — eg. HIV, Hepatitis C

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- Reduction in overdose emergency room visits and associated costs
- Reduction in overdose deaths
- Health supports for vulnerable populations that are engaged in drug use
- Referrals and navigation to drug addiction, detox and other related support services
- Safety for persons using drugs, during their high when they can be vulnerable
- Reduction in public disorder during their high
- Opportunity for community connections
- Teaching of clean consumption practices
- Reduction in the number of used needles disposed in public places

London's clean needle distribution program currently distributes approximately 3 million needles per year – more than the City of Toronto. Often times these needles are discarded, which causes problems for local business owners, families and organized sports participants not to mention the poor image it portrays to those visiting our city.

Statistics on drug related deaths and complications in London are among the worst in the province including:

- 40 fentanyl related deaths per year
- 80-90% of all new HIV cases due to infected needles
- 30-40 deaths per year caused by drug induced endocarditis (a serious heart infection)

This can only harm our ability to attract new businesses and capital to our region.

In addition to the human cost of the current drug epidemic, it also takes a massive toll on our economy. In terms of health care costs and lost productivity, endocarditis costs our economy $7 million per year, while a single case of HIV costs 1.3 million.

While much attention has been paid to opioids (eg. heroin, oxycodone, morphine, hydromorphone, fentanyl), other drugs such as stimulants (eg. cocaine, methamphetamine, and ecstasy) and depressants (eg. alcohol) also represent a major part of the drug addiction and overdose crisis. Not only can drug addiction undermine an individual's mental and physical health, it can generate associated community health risks that have created overlapping drug-related crises in the London community:

- Overdose — emergency care and death
- HIV infection
- Hepatitis C infection
- Infective endocarditis
- Needle recovery
- Public drug use

Given all that is at stake, we believe it is important that Supervised Consumption Sites be established within the city as the research on the matter is quite clear that these sites help to get drug users off the streets and help save lives. Since Insite, Vancouver's first Supervised Injection Site opened 13 years ago, overdose deaths in 500 m radius of the facility have decreased by more than 35%. And while there have been overdoses at the centre, there have been no deaths. Furthermore, research shows those who use Insite have a 30% greater chance of entering long term addiction treatment and detoxification programs.

We support the recommendation of Dr. Chris Mackie that the city establish two permanent sites and one mobile site.

A study in Vancouver found that there was no increase in crime once a Supervised Consumption Site was established. Additionally, a major review of Europe's drug consumption rooms commissioned by the EU's European Monitoring Centre for Drugs and Drug Addiction found that not only was there no increase in crime but there was a decrease in the level of "public nuisance" after they were opened.[I] As London's own Chief of Police stated, the drug addiction problem in the city is not something that we can arrest our way out of.

Despite the positive research however, we understand that there is a great deal of anxiousness surrounding these sites. Those who live or do business in areas where potential sites may be located, will naturally wonder how such sites will affect them and any potential negative impact should be minimized. For this reason we recommend that the following principles be developed and adhered to in the establishment of such sites:

1. A comprehensive communication and engagement strategy for all affected stakeholders including owners of surrounding businesses.
2. The development of a neighbourhood safety plan in collaboration with the community and affected neighbourhoods which includes perimeter security.
3. Develop a model that works on the principles of human kindness because when people are treated like animals, they tend to act like animals.
4. Ensure that the After Care Room has the resources to link individuals with support services to help solve issues such as homelessness, mental health conditions, and drug and alcohol rehabilitation.
5. An effective needle waste collection plan.

Respectfully,

Gerry Macartney, CEO
London Chamber of Commerce
Copies: Chamber Board of Directors, Government Affairs Committee

[I] https://www.dublininquirer.com/wp-content/uploads/2015/08/consumption_rooms_report.pdf

Appendix B – Steps to Ensure a Positive Impact on Neighbourhoods

While research indicates that supervised consumption services have a positive impact on public disorder in neighbourhoods where they are placed, the Middlesex-London Health Unit and partners have taken additional steps to ensure that London's Temporary Overdose Prevention Site has a positive impact. These steps will be used for permanent sites as well.

Facility Design:

- Adequate waiting space to eliminate loitering
- Aftercare room so that clients are not put directly back on the street after using
- Crime Prevention Through Environmental Design (CPTED) review conducted in partnership with London Police Services, with findings implemented prior to opening
- Fire Safety Plan in place
- All municipal and provincial safety requirements met
- Security cameras
- Additional lighting

Service Design:

- Security Guard to patrol the perimeter of the site
- Code of Conduct for clients. People who use the facility are very committed to helping it be successful and sustainable. As such, they have been helpful in ensuring a positive impact on neighbours. The Client Code of Conduct ensures that clients commit to:
    - Respect others while on site
    - Help create and maintain a safe place
    - Not cause physical harm to other participants or staff
    - Not deal, exchange, share or pass drugs to anyone else on-site or in the immediate area
    - Not use alcohol, smoke or ingest drugs other than by injection while on-site
    - Reduce harm by not sharing rigs or equipment, disposing of used supplies in the sharps container, and not walking around with uncapped rigs
    - Not display weapons or money on-site or in the immediate area
    - Not bring outside conflicts into the site
    - Not engage in solicitation of any kind on site or in the immediate area
    - Respect the property and privacy of others in the site and in the immediate area
    - Follow the reasonable directions of staff
    - Bring concerns or complaints to the attention of the Responsible Person In-Charge
- Staff equipped with two-way radios
- Frequent needle sweeps of the immediate area and surrounding neighbourhood
- Regular meetings with neighbouring businesses and residents to address any issues that may arise.

Staff are continually monitoring for any unexpected issues and adjusting the service to meet the needs of both clients and the broader community. This dual commitment is seen as crucial to long-term success.

2019 Draft Board of Health, Governance Committee and Finance & Facilities Committee Meeting Dates

DRAFT Board of Health & Governance Committee Meeting Dates

Thurs. Jan. 24	BOH	
Thurs. Feb. 21	BOH	
Thurs. Mar. 21	BOH	*Governance Committee
Thurs. April 18	BOH	
Thurs. May 16	BOH	
Thurs. June 20	BOH	*Governance Committee
Thurs. July 18	BOH	
Thurs. Aug. 15	BOH	*This meeting is usually cancelled
Thurs. Sept. 19	BOH	*Governance Committee
Thurs. Oct. 17	BOH	
Thurs. Nov. 21	BOH	*Governance Committee
Thurs. Dec 12	BOH	

DRAFT FFC Meeting Dates

Thurs. Feb 7	
Thurs. Mar 7	
Thurs. Apr 4	
Thurs. May 2	
Thurs. June 6	
Thurs. July 4	
Thurs. Aug 1	*This meeting is usually cancelled
Thurs. Sept 5	
Thurs. Oct 3	
Thurs. Nov 7	
Thurs. Dec 5	