

**AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH**

Thursday, April 21, 2022, 7:00 p.m.
Microsoft Teams

MISSION - MIDDLESEX-LONDON HEALTH UNIT

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

MEMBERS OF THE BOARD OF HEALTH

Ms. Maureen Cassidy
Ms. Aina DeViet
Mr. John Brennan
Ms. Kelly Elliott
Ms. Mariam Hamou
Mr. Matt Reid
Mr. Mike Steele
Ms. Tino Kasi
Mr. Selomon Menghsha
Dr. Alexander Summers (Medical Officer of Health, ex-officio member)
Ms. Emily Williams (Chief Executive Officer, ex-officio member)

SECRETARY

Ms. Emily Williams

TREASURER

Ms. Emily Williams

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

MINUTES

Approve: March 17, 2022 –Board of Health meeting

Receive: April 7, 2022 – Finance and Facilities Committee meeting

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Reports and Agenda Items						
1	X	X	X	Finance and Facilities Committee Meeting Summary from April 7, 2022 (Report No. 20-22)	April 7, 2022 Agenda	To provide an update on reports reviewed at the April 7, 2022 Finance and Facilities Committee meeting. Lead: Mr. Mike Steele, Chair, Finance and Facilities Committee
2	X	X	X	Verbal Governance Committee Meeting Summary from April 21, 2022	April 21, 2022 Agenda	To provide a verbal update on reports reviewed at the April 21, 2022 Governance Committee meeting. Lead: Ms. Aina DeViet, Chair, Governance Facilities Committee
3			X	Canadian Public Health Week 2022 at Middlesex-London Health Unit (Report No. 21-22)	Appendix A	To provide information on initiatives within MLHU to celebrate Canadian Public Health Week and to highlight the work of the Health Unit. Leads: Dr. Alexander Summers, Medical Officer of Health and Ms. Emily Williams, CEO
4		X	X	Feedback on Vaping-Related Provisions of the Tobacco and Vaping Products Act (Report No. 22-22)	Appendix A Appendix B	To provide information on MLHU's legislative feedback to Health Canada on the <i>Tobacco and Vaping Products Act</i> . Leads: Ms. Maureen MacCormick, Director, Healthy Living and Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control
5		X	X	Update of Urban and Rural Health Indicators within the Middlesex-London Region (Report No. 23-22)	Appendix A	To share epidemiological population health data on Middlesex County. Leads: Dr. Alexander Summers, Medical Officer of Health and Ms.

						Alison Locker, Manager, Population Health Assessment and Surveillance
6			X	MLHU 2022 Vaccine Preventable Diseases Operational Plan (Review No. 24-22)	Appendix A	To update the Board of Health on the MLHU 2022 Vaccine Preventable Diseases Operational Plan. Leads: Ms. Mary Lou Albanese, Director, Environmental Health and Infectious Disease and Ms. Tracey Gordon, Manager, Vaccine Preventable Disease
7	X		X	Verbal COVID-19 Disease Spread and Vaccine Campaign Update		To provide an update on COVID-19 matters. Lead: Dr. Alexander Summers, Medical Officer of Health
8			X	Medical Officer of Health Activity Report for March (Report No. 25-22)		To provide an update on external and internal meetings attended by the Medical Officer of Health since the last Board of Health meeting. Lead: Dr. Alexander Summers, Medical Officer of Health
9			X	Chief Executive Officer Activity Report for March (Report No. 26-22)		To provide an update on external and internal meetings attended by the Chief Executive Officer since the last Board of Health meeting. Lead: Ms. Emily Williams, Chief Executive Officer
Correspondence						
10		X	X	April 2022 Correspondence		To receive items a) and c) for information and to endorse items b) and d).

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is a Special Meeting of the Board of Health on Thursday, April 28 at 6:00 p.m.

The next regular meeting of the Middlesex-London Board of Health is Thursday, May 19 at 7:00 p.m.

CONFIDENTIAL

The Middlesex-London Board of Health will move into a confidential session to approve previous confidential Board of Health minutes and to discuss matters which pertain to one or more of the following, as per section 239(2) of the *Municipal Act, 2001, S.O. 2001, c. 25*:

- (a) the security of the property of the municipality or local board;
- (b) personal matters about an identifiable individual, including municipal or local board employees;
- (c) a proposed or pending acquisition or disposition of land by the municipality or local board;
- (d) labour relations or employee negotiations;
- (e) litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;
- (f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
- (g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act;
- (h) information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;
- (i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the municipality or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;
- (j) a trade secret or scientific, technical, commercial or financial information that belongs to the municipality or local board and has monetary value or potential monetary value; or
- (k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board.

ADJOURNMENT



PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, March 17, 2022, 7:00 p.m.
Microsoft Teams

MEMBERS PRESENT: Mr. Matt Reid (Chair)
Ms. Kelly Elliott (Vice-Chair)
Mr. John Brennan
Mr. Mike Steele
Ms. Mariam Hamou
Ms. Maureen Cassidy
Ms. Aina DeViet
Ms. Tino Kasi (Joined 7:02p.m.) (Left 7:16)

REGRETS Mr. Selomon Menghsha

OTHERS PRESENT: Ms. Carolynne Gabriel, Executive Assistant to the Board of Health and Communications Coordinator (Recorder)
Dr. Alexander Summers, Medical Officer of Health
Ms. Emily Williams, Chief Executive Officer/Director, Health Organization
Ms. Heather Lokko, Director, Healthy Start/Chief Nursing Officer
Ms. Maureen MacCormick, Director, Healthy Living
Ms. Mary Lou Albanese, Director, Environmental Health and Infectious Diseases
Ms. Rhonda Brittan, Manager, Healthy Communities and Injury Prevention
Mr. David Jansseune, Assistant Director, Finance
Ms. Cynthia Bos, Manager, Human Resources
Ms. Janet Roukema, Human Resource Specialist, Diversity and Inclusion
Mr. Dan Flaherty, Communications Manager
Mr. Jason Micallef, Marketing Coordinator, Communications
Mr. Parthiv Panchal, Information Technology, End User Support Analyst

Chair Matt Reid called the meeting to order at **7:01p.m.**

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by **Ms. Mariam Hamou, seconded by Ms. Kelly Elliott, that the AGENDA for the March 17, 2022 Board of Health meeting be approved.**

Carried

APPROVAL OF MINUTES

It was moved by **Mr. John Brennan, seconded by Mr. Michael Steele, that the:**

- 1) *MINUTES of the February 16, 2022 Special Meeting of the Board of Health be approved;*
- 2) *MINUTES of the February 17, 2022 Board of Health meeting be approved;*
- 3) *MINUTES of the March 3, 2022 Special Meeting of the Board of Health be approved;*
- 4) *MINUTES of the March 7, 2022 Special Meeting of the Board of Health be approved;*
- 5) *MINUTES of the February 17, 2022 Governance Committee meeting be received; and*
- 6) *MINUTES of the March 3, 2022 Finance & Facilities Committee meeting be received.*

Carried

REPORTS AND AGENDA ITEMS

Finance & Facilities Committee Meeting Summary from March 3, 2022 (Report No. 11-22)

Mr. Steele, Chair, Finance and Facilities Committee introduced Ms. Emily Williams, CEO to introduce this report. Ms. Williams highlighted that: the budgeting process this year was expedited by the Ministry of Health by six weeks to accommodate the upcoming election; additional revenue sources are documented in the 2022 budget; some line items have been separated out in an effort to increase transparency for the Health Unit's funders and the Board of Health; and the Health Unit was directed to add a one per cent increase in base funding by the Ministry which was applied to the 2019 funding rate.

Ms. Williams then introduced Mr. David Jansseune, Assistant Director, Finance who presented a PowerPoint presentation which provided an overview of the budget and budgeting process. The following were noted during Mr. Jansseune's presentation:

- To enable programs to be delivered, MLHU identifies two companies based upon their fiscal years, one occurring January to December and the other from March to April. Between these two companies there are six divisions and 61 departments, operating 47 programs.
- The presented budget for 2022 is a departmental budget, which will need to be re-created into a program budget for the Ministry, known as the Annual Service Plan.
- Funding sources for MLHU include:
 - Ministry of Health and Long-Term Care (MOH) (80%)
 - Ministry of Children, Community & Social Services (MCCSS) (4%)
 - City of London (12%)
 - The County of Middlesex (2%)
 - Public Health Agency of Canada (PHAC) (0.5%)
 - Public Health Ontario (0.2%)
 - Miscellaneous Revenue through Client Services (1.3%)

Note: The percentage of funding is based on a total envelope of \$65 million for 2022
- The budgeting process for salaries and wages for 2022 used the amounts from 2021 (\$20,383,659) as a baseline and then added 1.7% for inflation (\$345,106) and 0.3% for step increases for staff as required by Collective Agreements (\$67,497) to reach a 2022 budget baseline of \$20,796,263. To the 2022 baseline was then added Board-approved PBMA investments (1.4%; \$283,681; 4.5 FTE), the electronic medical records special project (1.0%; \$200,000; 2 FTE), and CLIF funding, which has no budgetary impact as increased funding was received to offset the expenses.
- Benefits with Canada Life are incorporated into the 2022 budget as they were negotiated in January 2022. Premiums for life, AD&D and LTD increased by 7.3% or \$101,685 with additional increases on the ASO policy covering EHC (health, drug, vision) by 5.3% and dental by 10.6%.
- General expenses include expenses other than salaries, wages and benefits. Determining general expenses was a rigorous process and involved comparing four years of actual expenses to four years of budgets. Increases in the general expenses budget included:
 - \$138,952 for retiree benefits to align budget with actual spending;

- \$51,000 for six maintenance projects scheduled at the Strathroy and CitiPlaza offices;
- \$29,490 for cyber insurance;
- a general increase of 5.6% (\$449,315), \$342,171 of which has no impact as there is offsetting increased funding; this leaves a balance of \$107,144 for software licensing with Microsoft.
- PBMA savings through an ASO cash withdrawal of \$150,000 offset with \$4,000 miscellaneous expenses.
- Extraordinary costs are COVID-19-related and funded by the Province; as a result, they do not have a large impact on the budget. Within these costs are budgets for case and contact management, vaccine, and recovery. These budgets used a zero-based approach.
 - \$12,517,509 budgeted for vaccine, based on 75% of the 2021 COVID-19 vaccine budget.
 - \$13,981,346 budgeted for case and contact management, based on 14 Board-approved PBMA proposals.
 - \$1,570,039 budgeted for recovery work based on 16 initiatives employing an FTE of 18.25.
- The Health Unit's second company includes programs with fiscal years from April to March and which are 100% funded; this means the funding equals the total expenditures. As such, this company has a net impact of zero to the main budget.
- There is a budgeted gap of \$1,613,768, up from \$1,257,473 in 2021. The gap bridges the difference between expenses and funding/revenue to balance the budget. There is confidence that expenditures will be reduced, specifically in salary and wages. The budget is based on a full staffing complement, so the challenge will be met throughout the year through savings on the staffing line, including delays in filling vacancies, new hires usually starting at a lower pay band, and staff redeployed to COVID-19 when programs are delayed with restarting.
- The absence of inflationary compensation from the Ministry over the past three years has contributed to the budgeted gap.
- There is a risk of losing mitigation funding next year, which would result in a \$1.3 million gap in the budget.
- The total budget for 2022 is \$65,310,006.

It was moved by **Mr. Steele**, seconded by **Ms. Aina DeViet**, that the Board of Health:

- 1) Approve the 2022 Proposed Budget in the gross amount of \$65,310,006 as illustrated in the attached Appendix A – Budget Summary;
- 2) Forward Report No. 05-22FFC and Appendix A – Budget Summary to the City of London and the County of Middlesex for information; and
- 3) Direct staff to submit the 2022 Proposed Budget in the various formats required by the different funding agencies and stakeholders.

Carried

Implementation of the Intervention for Health Enhancement and Living (iHEAL) (Report No. 12-22)

This report was introduced by Ms. Heather Lokko, Director, Health Start/Chief Nursing Officer. Ms. Lokko thanked the Board members who attended the iHEAL webinars. She outlined that in 2020 the Board of Health endorsed five priority recovery areas, of which domestic violence is one. Through the 2021 PBMA process, the Board of Health supported enhancing the public health nursing complement to support the iHEAL program.

Discussion about the report included:

- The iHEAL program is a promising intervention delivered by public health nurses guided by trauma-and violence-informed care, relational practices, cultural safety, and harm reduction.

- The intervention supports women who are in the transition of separating from an abusive partner.
- The nurses visit the women in a safe place and focus on different components that women identify as priority topics. The program runs from six to eight months with typically 10 to 18 visits during the course of the program. The program is completely voluntary and flexible to meet the needs of the women participating.
- MLHU is implementing the iHEAL program in three ways: as a standalone program, integrated into the Nurse Family Partnership (NFP), and integrated into the Healthy Babies Healthy Children program (HBHC).
- Implementation of the program started with fairly intensive education for the initial nurses providing the intervention and their supervisors, then shifted the focus to community outreach, the violence against women (VAW) sector and other community partners which might refer women.
- The report outlines the number of referrals the program has received, and in the past couple of weeks, the program has seen a spike in referrals. It is anticipated that the demand will significantly increase as more women become aware of the program.
- A second cohort of education is coming up in a couple weeks and the team is looking forward to more nurses being able to provide this program.
- An implementation research grant has been granted by the Public Health Agency of Canada which will be providing additional funding for this program.
- Gender-based violence has been identified as an issue by the Women's Caucus of Middlesex County Council, particularly in rural areas because they cannot access resources as easily and are often isolated in their homes. Additionally, there is only one women's shelter in the County, located in Strathroy.
- To spread awareness of the iHEAL program in the County, the program has been partnering with the Rural Women's Resource Centre in Strathroy as well as with the Health Unit's Healthcare Provider Outreach program, which connects with primary care providers and other providers like OB/GYNs who can refer their patients. Additionally, the Health Unit is connected with a number of community partners through other programs and services. Information about the program is on the MLHU website, and following the release of research results, the program can be promoted more publicly.
- It is not yet known whether the resources the iHEAL program currently has are sufficient to meet the need since it is a new program. This year will provide a better sense if the program can meet demand with the resources it has.

It was moved by **Ms. Maureen Cassidy, seconded by Ms. Elliott**, that the Board of Health receive Report No. 12-22 re: "Implementation of the Intervention for Health Enhancement and Living (iHEAL)" for information.

Carried

Healthy Living Strategic Review (Report No. 13-22)

This report was introduced by Ms. Maureen MacCormick, Director, Healthy Living who introduced Ms. Rhonda Brittan, Manager, Healthy Communities and Injury Prevention. Ms. MacCormick outlined:

- The Healthy Living Division currently has a unique opportunity because many program areas within the Division have been reduced or put on hold during the pandemic.
- As the Division is repatriating staff back it is strategically looking at priorities across the entire division with the goal of enhancing the Division's population health impact.
- As per Appendix A to the report, the Division delivers a large number of public health programs and services which span a diverse and broad number of public health standards, protocols and guidelines and that covers a wide range of topic areas and includes areas like direct-client support, health promotion, health communication, education, harm reduction, and influencing healthy public policy.

- The breadth of scope limits the Division’s ability to focus its efforts and maximize the impact at the population health level.
- The Healthy Living Review will look to determine if the Division and its teams are structured and resourced to meet outcomes efficiently and will alter structure and resources as needed. The review will seek to determine what the most critical needs are, where there is a very strong public health value added from the programs, and what the Division’s core areas are. It will then look at enhancing those particular areas in the Division.
- It is anticipated that there will be some changes in how the teams are structured within programs and across the Division as a result of this review.
- Ms. Cassidy inquired if there is any research that investigates the impact of the pausing or reduction of the programs delivered by the Healthy Living Division during the pandemic over the past two years. Ms. MacCormick indicated that there is a body of research as well as anecdotes from community partners of unintended consequences from focusing on COVID-19 at the expense of other programs, for example, to chronic disease and substance use.
- The Health Unit does a lot of mental health promotion; while it does not provide direct counselling-type interventions, mental health underpins much of the work at the Health Unit. Mental health, substance use, and violence have many common risk and protective factors and focusing on those can have a broader impact.

It was moved by **Mr. Steele, seconded by Ms. Cassidy**, that the Board of Health receive Report No. 13-22 re: “Healthy Living Strategic Review” for information.

Carried

Public Sector Salary Disclosure Act – 2021 Record of Employees’ Salaries and Benefits (Report No. 14-22)

This report was introduced by Ms. Williams. Discussion on the report included:

- As per legislation, the Middlesex-London Health Unit, as a publicly funded organization, annually discloses the names, salaries, and taxable benefits of all employees who earn over \$100,000.
- In 2020, this list included 63 names from MLHU; in 2021 it included 94.
- This increase in the number of MLHU staff who earned over \$100,000 is due in part to:
 - Overtime which was earned in 2020 but was paid in 2021;
 - Unused vacation time in 2020 which was paid out in 2021 to minimize the 2021 vacation banks; and
 - Overtime accumulated in 2021 to enable comprehensive COVID-19 case and contact management and the COVID-19 vaccine campaign.
- The Medical Officer of Health and Associate Medical Officer of Health salaries are prescribed by the Ministry of Health, the reason being to ensure equitable pay across all health units and to assist rural health units with their recruitment.
- Unionized staff overtime is compensated as per collective agreements and non-unionized staff overtime is reimbursed at straight time.
- In the first quarter of 2022 the amount of overtime accumulated has decreased and current forecasting predicts it will continue to decrease.

It was moved by **Ms. Hamou, seconded by Ms. DeViet**, that the Board of Health receive Report No. 14-22 re: “Public Sector Salary Disclosure Act – 2021 Record of Employees’ Salaries and Benefits” for information.

Carried

Health Unit General Insurance Policy Renewal (Report No. 15-22)

This report was introduced by Ms. Williams who introduced Mr. Jansseune.

Mr. Jansseune provided an overview of the Health Unit's general insurance. The policy is for 12 months and is with Intact Insurance. The premium has increased from \$92,000 to \$104,000, much of which is for general liability. Mr. Jansseune noted that the Health Unit has not changed its coverage or deductible; however, the policy has added additional language around what is excluded for cyber security, which is not a concern as the Health Unit has a separate cyber insurance policy.

It was moved by **Mr. Brennan, seconded by Ms. Cassidy**, *that the Board of Health approve the renewal of the Health Unit's General Insurance Policy as outlined in Report No. 15-22 re: "Health Unit General Insurance Policy Renewal"*.

Carried

Diversity and Inclusion Assessment: MLHU Employment Systems Review Update (Report No. 16-22)

This report was introduced by Ms. Williams who introduced Ms. Cynthia Bos, Manager, Human Resources. Ms. Bos then introduced Ms. Janet Roukema, Human Resources Specialist, Diversity and Inclusion. This position is new, approved through the 2021 PBMA process to move forward the recommendations of the Employment Systems Review from the Diversity and Inclusion Assessment.

Ms. Roukema highlighted the following:

- The Employment Systems Review (ESR) included 88 recommendations, categorized into four categories: policy and document reviews (27 recommendations), recruitment and selection processes and practices (42 recommendations), office space (five recommendations), and employee perspectives (14 recommendations).
- All 88 recommendations were scored and prioritized, considering the inputs required and impacts anticipated for each recommendation. The recommendations with logical linkages were then grouped together to ensure integrated implementation.
- Twelve recommendations have been implemented over the past eight months. As organizational policies came up for review, relevant recommendations were incorporated into the updated policies. This practice will continue as additional policies come up for review in the coming months.
- Preliminary meetings have occurred with Strategic Projects to finalize a project charter for completion of all recommendations from the ESR as well as smaller work plans for the groupings of recommendations.
- The HR team is looking for opportunities to re-engage with the Diversity and Inclusion Advisory Committee.
- The prioritization process identified that work on the *Accessibility for Ontarians with Disabilities Act (AODA)* policy and a stand-alone accommodation policy focusing on religion and other human rights-protected grounds should be prioritized first due to their strong legislative requirements.
- Work will begin on an employment equity policy with the Health Equity and Indigenous Reconciliation Team (HEART) in the lead, the principles of which will be the foundation for a major project to implement the 42 recommendations related to recruitment and selection. A work plan for this project is expected to be in place by September 2022.
- Work will also be done towards implementing the recommendations in the remaining groups, including a plan to communicate changes to all staff, training for leadership and all staff, and updating the Health Unit's Code of Conduct and creating a new conflict of interest policy.

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

- 1) *Receive Report No. 16-22 re: "Diversity and Inclusion Assessment: MLHU Employment Systems*

- Review Update” for information; and*
- 2) *Endorse the prioritization of recommendations within the Employment Systems Review for implementation at the Middlesex-London Health Unit*

Carried

Verbal COVID-19 Disease Spread and Vaccine Campaign Update

Dr. Alexander Summers, Medical Officer of Health, provided a verbal update on the COVID-19 spread and vaccine campaign in London and Middlesex-County. This update included:

- The last month has seen favourable trends when cases, hospitalizations and the ICU rate in the region are considered.
- Updated projections from the COVID-19 Science Advisory and Modelling Consensus Tables were released today. The key findings included that:
 - COVID-19 case numbers, hospitalizations and ICU occupancies have stopped declining; however, there is considerable regional variation.
 - Transmission and hospital and ICU occupancy are anticipated to increase over the next few weeks as a result of the relaxation of public health measures; however, the increase is anticipated to be less than in January 2022 and for a limited period of time, if changes in behavior are only moderate.
 - The extent of the increases and of a person’s risk of contracting COVID-19 will depend on their number of close contacts, vaccination status, and the spread of the more transmissible BA.2 subvariant.
 - Older adults, those who are immunocompromised, those who are unvaccinated, and marginalized individuals and groups are still susceptible to severe illness from COVID-19.
 - A complete vaccine series (currently two doses in children, three doses in adults, four in long-term care residents and other eligible high-risk groups) is the best defense against getting and spreading COVID-19.
- In London and Middlesex County, the Omicron wave has seen a significant spike and a quick decline which has plateaued. It must be noted that the numbers are an under-representation of actual cases due to current eligibility criteria for testing. The incident rate locally is consistently following the province.
- The Science Table’s current projections for hospitalizations and ICU occupancy are not as significant as what was seen in the Omicron wave based on a scenario of a moderate increase in transmission. A moderate transmission scenario is predicated on increased contacts, 50 per cent mask use, and a rise in the BA.2 subvariant.
- The impact of the vaccine and booster remains remarkable. Two doses of vaccine protect against severe outcomes; however, the immune protection begins to wane at seven months after the second dose. One month after a third dose produces notably higher levels of antibodies than two doses, and even six months after the booster dose, while the antibodies do reduce, they remain higher than one month after the second dose. It is likely that a fourth dose will be necessary, but the timelines are unknown.
- Between December 18, 2022 and January 15, 2022 MLHU saw the rate of booster doses in the region rise remarkably among all age brackets. Since January the vaccination increase has plateaued, but there was still notable increase in the booster dose coverage among those aged 70 and above and those aged 50 to 54.
- Modelling suggests booster doses reduced hospitalizations by 34 per cent and ICU occupancy by 30 per cent at the peak of the Omicron wave compared to if no boosters had been given.
- The Science Table recommendations for all Ontarians include:
 - Have a complete vaccine series, including three doses for adults and four for eligible high-risk groups;
 - Use high-quality masks whenever necessary to protect vulnerable people and themselves; and

- Stay home when sick or symptomatic.
- The Science Table recommendations at the provincial and policy level include:
 - Continue improvement of ventilation and air filtration in public indoor spaces;
 - Create rapid paths to testing and treatment with a focus on equity;
 - Be prepared to renew mass COVID-19 vaccination campaigns, if needed;
 - Be prepared to renew vaccine certificates requiring a recent booster dose for high-risk settings, if needed;
 - Be prepared to reintroduce mask mandates, if needed; and
 - Maintain protective measures that are appropriate for the general health and wellbeing of those living and working in congregate care settings, such as long-term care.
- Utilization of Section 22 Orders by local medical officers of health has received a lot of interest due to many provincial public health measures and mandates set to be lifted on Monday, March 21, 2022. Dr. Summers will not be issuing a Section 22 Class Order regarding masking at this time with regards to COVID-19 for the following reasons:
 - Section 22 Orders are supposed to be focused, time-limited, and used sparingly for a medical officer of health to respond to an urgently acute situation within their jurisdiction.
 - The Province has the jurisdiction to make the decision regarding mask mandates and has based its decision on the same data available to the Middlesex-London Health Unit. In the current situation, there is no new or emerging risk in the jurisdiction of the Middlesex-London Health Unit of which the provincial government is unaware. Therefore, should the Medical Officer of Health for the Middlesex-London Health Unit issue a Section 22 Order for masking, he would be overriding the decision of the democratically-elected Government of Ontario.
 - Examples of instances where a local Section 22 Order would be appropriate include: a COVID-19 outbreak in a long-term care home where staff and management refuse to follow public health measures; a new variant of COVID-19 emerging rapidly at the local level; and a new infectious disease outbreak in a congregate setting where there is insufficient time to determine the nature of the disease and its transmission.
 - Regardless of the lifting of the province-wide masking requirements, masking is still strongly recommended and has been demonstrated to reduce the risk of COVID-19 transmission, notably as an effective form of source control. Masking is an important tool for protecting the most vulnerable which is why it is still required in high-risk settings (e.g. long-term care homes, retirement homes). There is still autonomy for organizations to make decisions within their own context with regards to masking. As an example, MLHU is still requiring masking in its office spaces, as well as its clinical spaces where masks are still mandated as a healthcare setting.
 - Municipalities can consider if a local mask mandate is a tool they would like to implement, within the context of high vaccination coverage among those aged 12 and older, gradually increasing vaccination rates among those aged five to 11, and continued lower risk for severe disease.
- Ms. Cassidy inquired what Dr. Summers thinks would need to occur for the Province to re-instate mandatory masking in all indoor public spaces. Dr. Summers indicated he believes there would need to be the arrival of a new variant with a completely different behavior type and response to vaccination, or a rapid rise in the severity of the disease.
- Ms. Cassidy inquired if the COVID-19 case numbers and related deaths were lower than currently when London City Council implemented a by-law requiring masking in July 2020. Dr. Summers confirmed they were; however, the differences between the current situation and earlier in the pandemic when the by-law was implemented are the vaccination campaign and the improved knowledge regarding the transmissibility of COVID-19 and the efficacy of masking.
- Ms. Cassidy inquired if Dr. Summers could provide insight into how long a masking by-law may be necessary, if enacted, to protect against COVID-19 during the remaining colder weather when people congregate inside. Dr. Summers hesitated to provide a timeline. While respiratory illnesses

subside as the weather improves and people spend more time outdoors, there are many other considerations, such as a new variant, where masking could be beneficial. The unknowns make it challenging to say how long public health measures should be used. As an employer, the Middlesex-London Health Unit will continue to require masks in all clinical and office spaces until likely the end of April, at which time it will be reassessed.

- Ms. Cassidy inquired if Dr. Summers expected to see a spike in COVID-19 cases five to seven days following St. Patrick's Day. Dr. Summers indicated this could potentially happen; however, it would be difficult to draw a direct line back to any particular day. Typically, when a spike occurs following an event, it is also related to a broad change in public health policy and the and the collective mobility and behaviour of society.
- Ms. Cassidy inquired if Dr. Summers would expect there to be fewer COVID-19 infections and lower hospitalization, ICU occupancy, and death rates if London City Council implemented a masking by-law. Dr. Summers indicated that this would be hard to measure at a local level. Theoretically, there would be a decline, but the willingness of the population to adhere as well as movement within the province between municipal jurisdictions would impact the outcomes of the by-law.
- Ms. Hamou inquired if testing of wastewater for infection levels is still occurring. Dr. Summers indicated that there are several indicators which are still being monitored, including wastewater, hospitalization rates, ICU rates, deaths, and percent positivity. These indicators have been plateauing and it is expected that they will increase. Part of the transition from an emergency response to a longitudinal response is the fact that COVID-19 is endemic and it needs to be determined what interventions society will tolerate long-term. There are tools like vaccination, masking, and reducing social contact which are possible interventions, but it is unknown how long society will accept using those interventions.

It was moved by **Ms. DeViet, seconded by Ms. Elliott**, that the Board of Health receive the Verbal update re: "COVID-19 Disease Spread and Vaccine Campaign" for information.

Carried

Acting Medical Officer of Health Activity Report for February (Report No. 17-22)

Ms. Cassidy expressed her happiness at seeing the title of Medical Officer of Health presenting this report.

It was moved by **Ms. Cassidy, seconded by Ms. Elliott**, that the Board of Health receive Report No. 17-22 re: "Acting Medical Officer of Health Activity Report for February" for information.

Carried

Chief Executive Officer Activity Report for February (Report No. 18-22)

It was moved by **Ms. Cassidy, seconded by Ms. DeViet**, that the Board of Health receive Report No. 18-22 re: "Chief Executive Officer Activity Report for February" for information.

Carried

CORRESPONDENCE

It was moved by **Mr. Steele, seconded by Ms. Hamou**, that the Board of Health endorse item a) of correspondence.

Carried

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is Thursday, April 14 at 7:00 p.m.

CONFIDENTIAL

At **8:36 p.m.**, it was moved by **Ms. Elliott, seconded by Ms. Cassidy**, *that the Board of Health will move in-camera to approve previous confidential Board of Health minutes, for the purpose of educating or training the members, and to consider matters regarding identifiable individuals, including Board employees.*

Carried

At **8:59 p.m.**, it was moved by **Ms. Hamou, seconded by Ms. Cassidy**, *that the Board of Health rise and return to public session.*

Carried

ADJOURNMENT

At **8:59 p.m.**, it was moved by **Mr. Steele, seconded by Ms. Elliott**, *that the meeting be adjourned.*

Carried

MATT REID
Chair

EMILY WILLIAMS
Secretary



PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
Microsoft Teams
Thursday, April 7, 2022 9:00 a.m.

MEMBERS PRESENT: Mr. Mike Steele (Chair)
Mr. Matt Reid
Ms. Maureen Cassidy
Mr. Selomon Menghsha

REGRETS: Ms. Kelly Elliott

OTHERS PRESENT: Ms. Stephanie Egelton, Senior Executive Assistant to the Medical Officer of Health (Recorder)
Dr. Alexander Summers, Medical Officer of Health
Ms. Emily Williams, Chief Executive Officer
Mr. David Jansseune, Assistant Director, Finance
Mr. Pat Harford, Manager, Information Technology
Ms. Carolynne Gabriel, Communications Coordinator and Executive Assistant to the Board of Health
Mr. Brian Glasspoole, Consultant, Finance
Ms. Mary Lou Albanese, Director, Environmental Health and Infectious Diseases
Ms. Mariam Hamou, Board Member

At **9:03 a.m.**, Chair Mike Steele called the meeting to order.

DISCLOSURES OF CONFLICT OF INTEREST

Chair Steele inquired if there were any disclosures of conflict of interest. None were declared.

APPROVAL OF AGENDA

It was moved by **Ms. Maureen Cassidy**, seconded by **Mr. Matt Reid**, that the **AGENDA** for the April 7, 2022 Finance & Facilities Committee meeting be approved.

Carried

APPROVAL OF MINUTES

It was moved by **Ms. Cassidy**, seconded by **Mr. Selomon Menghsha**, that the **MINUTES** of the March 3, 2022 Finance & Facilities Committee meeting be approved.

Carried

NEW BUSINESS

Cyber Security Training (Report No. 06-22FFC)

Ms. Emily Williams, Chief Executive Officer introduced Mr. Pat Harford, Manager, Information Technology to present the Cyber Security Training report.

Ms. Williams noted that the Health Unit has successfully secured cyber security insurance, as a result of the training program that has been implemented.

Highlights of this report include:

- Training sessions involve short videos on different cyber security topics, with a quiz at the end to test knowledge.
- The first sessions were to educate all staff and test knowledge on “phishing” and “CEO scams.”
- The current completion rate is 32% on the first training and 22% on the second.
- There were two rounds of testing for staff, pre and post training in early 2022.
- The first testing resulted with 24% (258) of staff clicking on the link and 17% (189) providing their credentials to a fake site, created by the IT team.
- Repeat testing showed improved results with 12% (131) following the link and 2% (25) providing credentials.

Ms. Williams noted that Senior Leadership has made this training mandatory for all staff.

It was also suggested that staff receive recognition for completing cyber security training and passing the required quizzes, along with adding cyber security training to the Board of Health member orientation session on April 28.

It was moved by **Ms. Cassidy, seconded by Mr. Reid**, *that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 06-22FFC, re: Cyber Security Training for information.*

Carried

Financial Borrowing Update (Report No. 07-22FFC)

Ms. Williams introduced Mr. David Jansseune, Assistant Director, Finance to present the Financial Borrowing Update report.

Key highlights of this report included:

- There is a \$10.5 million positive bank balance, as of December 2021.
- The COVID-19 extraordinary funding is \$24,884,000 during 2021 with an additional \$2,226,900 flowing in 2022 to fully offset the remaining 2021 expenses incurred by the health unit.
- Currently, we have not drawn funds from our line of credit.
- The bank loan that the Health Unit has is for \$4.2 million, with an outstanding balance of approximately \$4,016,119.
- Loan payments are made on a monthly basis, paying down interest and principal
- Loan rates are negotiated for 5-year, renewable terms. The Health Unit has three more years left in the term. Further, if the Board of Health wishes to increase loan payments, this can be disclosed during the budget process and request that payments be increased on the variable portion of the loan.
- Inflation has been addressed in budgeting, with items such as cyber security insurance and liability insurance being budgeted with inflationary increases.

Ms. Williams noted that the goal for 2023 is to work towards paying down further debt, which will be assisted by improved financial reporting and understanding the variance in a timely fashion. Further, it is anticipated that due to significant gapping, the Health Unit will have a surplus.

It was moved by **Mr. Reid, seconded by Ms. Cassidy**, *that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 07-22FFC, re: Financial Borrowing Update for information.*

Carried

2021 Vendor and Visa Payments (Report No. 08-22FFC)

Mr. Jansseune noted that the report on 2021 Vendor and Visa payments included vendors with payments of over \$100,000 and a summary of purchases paid with Health Unit corporate credit cards.

Staff will follow up with the Finance and Facilities Committee members on how many Health Unit credit cards are active and being used by staff.

It was moved by **Mr. Reid, seconded by Mr. Menghsha**, *that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 08-22FFC, re: 2021 Vendor and VISA Payments for information.*

Carried

2021 Board of Health Remuneration (Report No. 09-22FFC)

Mr. Jansseune provided a report on Board of Health Remuneration. It was noted that 2021 remuneration for Board members was \$38,126, with the budget being \$39,000.

It was moved by **Mr. Menghsha, seconded by Ms. Cassidy**, *that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 09-22FFC, re: 2021 Board of Health Remuneration for information.*

Carried

Q4 Financial Update and Factual Certificate (Report No. 10-22FFC)

Mr. Jansseune provided a financial update on Q4 and the most current factual certificate.

Key highlights of this report included:

- The Ministry of Health has confirmed funding to cover all MLHU COVID-19 extraordinary expenses in 2021.
- 2021 was a balanced budget for the Health Unit.
- County of Middlesex and City of London funding contributions were held at 2019 levels, which resulted in a savings/refund to both parties (County of Middlesex received back \$122,000 and the City of London received back \$640,000).
- Mandatory programs supported COVID-19 response with \$5,228,094.

Dr. Alexander Summers, Medical Officer of Health noted that the organization has been reviewing risks and the current structures of programs and leadership. At this time, the Infectious Disease Control (IDC) and Vaccine Preventable Disease (VPD) programs (which are supporting the COVID-19 response) leadership structures have been stabilized. The current concern is stabilizing the staffing within these programs and ensuring there are enough resources to respond to an expected rapid rise in cases throughout April and beyond. In addition, the traditional community case management aspect of COVID-19 programming is no longer required which relieves some demands upon the COVID-19 response. There will be a surge response shift if there is an arrival of a new variant and redistribution of vaccine.

Ms. Williams added that the Health Unit has budgeted for full mandatory/regular programming and full COVID-19 programming. It was noted that the Human Resources Team is hiring specific COVID-19 staff to have a distinct team to respond to the pandemic. The COVID-19 program is budgeted at 100%, in accordance with the Board-approved PBMA proposal. The COVID-19 Vaccine program is budgeted at 75% of actual spend from last year (for COVID-19 vaccine).

Dr. Summers noted that while COVID-19 is still occurring, ensuring that staff and leaders have opportunities for engagement and debriefing the past two years is important. Senior Leadership is holding sessions for leaders on the Joy in Work framework, which will assist in creating tangible strategies to implement over one to three months for the organization. At this time, it is noted that leadership overtime hours have decreased since last year.

It was moved by **Mr. Reid, seconded by Ms. Cassidy**, *that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 10-22FFC, re: Q4 Financial Update and Factual Certificate for information.*

Carried

OTHER BUSINESS

The next meeting of the Finance and Facilities Committee will be held on Thursday, May 5, 2022 at 9 a.m.

ADJOURNMENT

At **9:46 a.m.**, it was moved by **Mr. Menghsha, seconded by Ms. Cassidy**, *that the meeting be adjourned.*

Carried

MICHAEL STEELE
Chair

EMILY WILLIAMS
Secretary



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 20-22

TO: Chair and Members of the Board of Health
FROM: Emily Williams, Chief Executive Officer
DATE: 2022 April 21

FINANCE & FACILITIES COMMITTEE MEETING – April 7, 2022

The Finance & Facilities Committee (FFC) met at 9 a.m. on Thursday, April 7, 2022.

Reports	Recommendations for Information and Board of Health Consideration
Cyber Security Training (Report No. 06-22FFC)	It was moved by Ms. Cassidy, seconded by Mr. Reid , <i>that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 06-22FFC, re: Cyber Security Training for information.</i> <p style="text-align: right;">Carried</p>
Financial Borrowing Update (Report No. 07-22FFC)	It was moved by Mr. Reid, seconded by Ms. Cassidy , <i>that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 07-22FFC, re: Financial Borrowing Update for information.</i> <p style="text-align: right;">Carried</p>
2021 Vendor and Visa Payments (Report No. 08-22FFC)	It was moved by Mr. Reid, seconded by Mr. Menghsha , <i>that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 08-22FFC, re: 2021 Vendor and VISA Payments for information.</i> <p style="text-align: right;">Carried</p>
2021 Board of Health Remuneration (Report No. 09-22FFC)	It was moved by Mr. Menghsha, seconded by Ms. Cassidy , <i>that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 09-22FFC, re: 2021 Board of Health Remuneration for information.</i> <p style="text-align: right;">Carried</p>
Q4 Financial Update and Factual Certificate (Report No. 10-22FFC)	It was moved by Mr. Reid, seconded by Ms. Cassidy , <i>that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 10-22FFC, re: Q4 Financial Update and Factual Certificate for information.</i> <p style="text-align: right;">Carried</p>

This report was prepared by the Chief Executive Officer.

A handwritten signature in cursive script that reads "E. Williams". The signature is written in black ink on a light-colored background.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer



TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2021 April 21

CANADIAN PUBLIC HEALTH WEEK 2022 AT MIDDLESEX-LONDON HEALTH UNIT

Recommendation

It is recommended that the Board of Health receive Report No. 21-22, re: “Canadian Public Health Week 2022 at Middlesex-London Health Unit” for information.

Key Points

- Canadian Public Health Week’s inaugural recognition of public health agencies was held April 4 – April 8, 2022.
- MLHU recognized this event through social media, staff trivia contests, a staff Town Hall, and an open house “Coffee Break” for staff and dignitaries.
- In [Appendix A](#), select initiatives and activities from across the organization are highlighted, showcasing the different work that public health does to support the community.

Background

The inaugural Canadian Public Health Week celebrates and recognizes public health agencies across Canada during the week of April 4 – 8, 2022.

The Canadian Public Health Association highlights that “Public health is the invisible guardian of our health. The COVID-19 pandemic has made public health more visible and its efforts more appreciated. Canadian Public Health Week is a time to recognize the contributions of public health and highlight issues that are important to improving our health and well-being.” During the week, the Canadian Public Health Association provided resources, information, and engagement by providing webinars on topics such as:

- A Vision to Transform Canada’s Public Health System
- Our Planet, Our Health, Our Public Health Responsibility
- The Impact of COVID-19 On Public Health: Comparing experiences and sharing recommendations for the future
- Advocacy for Income as a Social Determinant of Health: Lessons learned from the Basic Income and Decent Work Movements

Middlesex-London Health Unit celebrates Canadian Public Health Week

The Middlesex-London Health Unit celebrated Canadian Public Health Week through a series of events, taking the opportunity to share with the community how the agency protects and promotes the health of the City of London and the County of Middlesex.

Over the week of April 4 – 8, the Health Unit conducted the following activities for Canadian Public Health Week:

- Shared a media release regarding Canadian Public Health Week to the community and media partners on April 4.

- Provided information to staff at the all-staff Virtual Town Hall on April 1 and April 8.
- Hosted trivia sessions throughout the week with the support of the BeWell Program.
- Shared highlights of each division on social media.
- Created an “all staff collage” for Canadian Public Health Week shared on social media, highlighting the faces of public health.
- Hosted a “Coffee Break” with staff and dignitaries (the Mayor, the Warden, the Board of Health Chair and Board Members) on April 8.
- Disseminated to staff a compilation of select initiatives, activities, and highlights from each division to highlight the different work the organization does to support the community (see [Appendix A](#) for full list).

This report was prepared by the Senior Leadership Team.



Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health



Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

Celebrating Canadian Public Health Week 2022 – MLHU in Action!

April 2022

Environmental Health and Infectious Diseases:

1. On average PHIs investigate approximately 1200 reported animal bites in MLHU (with 11 rabies positive animals identified in Ontario 2021, and 49 in 2020)
2. Over 700 Immunizers were trained for COVID-19 vaccine clinics.
3. There were 17,000 letters recently that will be sent out to Grade 9 to Grade 12 students (cohort of approximately 25,000) that have not reported or have not been immunized for required vaccines.
4. MLHU's customer service representatives (CSRs) completed 111,000 surveys for data capture since the start of the pandemic, reflecting the number of phone calls to the Health Unit over that time.
5. Sexual Health managed 2,673 cases of Syphilis, HIV, Hep B and C, Chlamydia and Gonorrhea in 2018, 2,823 in 2019 and 2,313 in 2021.
6. Through the pandemic, Public Health Inspectors continued to inspect restaurants and pools, and expanded their support to other businesses and premises. They answered regulatory questions for sports leagues, dance facilities, dog groomers, non-food manufacturing plants, and construction sites.

Healthy Living:

1. The Healthy Living Division champions and influences public policy in a broad range of areas impacting population health. Examples include: built environment and healthy community design; food systems; prevention of injury; substance-related policy and more!
2. On average, the Oral Health Team screens approximately 21,000 elementary school children per year. To date, the Oral Health Team has identified 883 children in need of urgent dental care.
3. Prior to COVID-19, nurses in secondary schools conducted over 2000 situational supports with students per school year. Approx. 60 to 65% of visits are about matters of sexual health.
4. Since 2019, Tobacco Enforcement Officers have conducted 2,340 youth test shopping inspections at tobacco and vapour product retailers to assess their compliance with preventing sales to people under the age of 19 years.
5. In partnership with the Southwest Tobacco Control Area Network, 'Dog and Tom' is an evidence-informed social marketing campaign on Instagram that aims to increase smoking abstinence and to prevent the escalation of addiction in young adult males aged 19-24 working in industry, trades, hospitality and the sales sector. Dog and Tom are cartoon characters who deliver impactful messages that resonate with young adults.

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6. In 2022, with the support of the City of London COVID Recovery fund, the Middlesex-London Food Policy Council (MLFPC), of which MLHU is one of the founding members, is updating the 2016 Community Food Assessment with a focus on the impact of climate change and COVID-19 on the local food system. The results will help to inform recommendations for future action by the MLFPC and its members.
7. In 2022, over \$200 000 of Harvest Bucks (vouchers redeemable for fresh vegetables and fruit at local markets) will be distributed to community members through over 50 community programs.

Healthy Start:

1. Pregnant individuals and families with young children are supported by public health nurses through the Healthy Babies Healthy Children (HBHC) and the Nurse-Family Partnership® (NFP) home visiting programs. The HBHC program supports prenatal families with children up to school age, and the NFP program supports young, first-time parents during their pregnancy and the first two years of their child's life. Home visits are also provided to those experiencing significant breastfeeding challenges.
2. The MLHU has a program called iHEAL that is for women that have experienced any type of violence from a partner or ex-partner. iHEAL provides support to help women manage common challenges on their pathway to happier, healthier, safer lives.
3. In total, Healthy Start Division has completed 27,980 home/community visits in the last 5 years. In non-pandemic times, the division provides approximately 7,000 visits each year.
4. Since its launch in October 2021, the iHEAL program has had 99 significant interactions and visits.
5. MLHU offers prenatal e-learning that can be done in the comfort of your home at your own pace. Our website also has lots of information to help you have a healthy pregnancy. For more information about prenatal support, please visit <https://www.healthunit.com/prenatal-health>.
6. MLHU also has information, booklets, videos and facts sheets – some in multiple languages. For more information, visit our website!

Healthy Organization

1. The Operations team procured over 500,000 masks since the start of the pandemic. MLHU also packaged, organized, and delivered more than 40,000 COVID-19 PCR swabs to the community for testing, mostly to support long-term care homes and retirement homes.
2. Since mid-2018 the Strategic Projects team has managed, lead, or supported over 35 large scale organizational projects including the relocation to Citi Plaza and the introduction of the electronic client record system.
3. Over the past 4 years, the Privacy Office has responded to 23 PHIPA and 51 MFIPPA access requests and has had 100% compliance meeting deadlines.

4. Since the start of the pandemic 3.9 million users have visited the MLHU’s website. The most visited pages in that time have been the COVID-19 landing page (4.5 million page views), the COVID-19 vaccine eligibility page (3.2 million page views) and the Summary of local COVID-19 cases / Power Bi dashboard (2.9 million page views).
5. The Finance team will oversee the administration of about \$65 million dollars during 2022, and processes bi-weekly payroll for about 850 staff.
6. During the COVID-19 response, the IT team provided support to an expanded MLHU workforce of over 900 Staff. The team also created a robust and redundant IT system to support four Mass Vaccination Sites serving the London and Middlesex Areas.
7. The Human Resources team was recognized as a finalist for “Best Remote Work Strategy” at the 2021 Canadian HR Awards. In 2021, the HR team recruited and onboarded an average of 66 new employees each month, with the highest being 122 employees in March. Prior to the pandemic, the team typically recruited just under 100 employees over the course of a full year.

Office of the Medical Officer of Health:

1. MLHU has a newly-formed Anti-Black Racism Advisory Group with 18 community members who will support and guide the implementation of our [Anti-Black Racism Plan](#).
2. Colonialism and its historical and ongoing impacts are a key determinant of health for Indigenous peoples, and systemic inequities imposed on Indigenous peoples must be addressed. MLHU is committed to sustaining efforts to realize change – [Taking Action on Reconciliation: An Organizational Plan for the Middlesex-London Health Unit](#).
3. The harms associated with crystal methamphetamine use is an emerging public health issue. Between 2018 and 2020, the rate of deaths involving crystal methamphetamine toxicity among Middlesex-London residents was significantly higher than provincial rates. In 2021, MLHU developed and released a new [crystal methamphetamine data dashboard](#).
4. Looking for information about the health the Middlesex-London community? Check out MLHU’s [Community Health Status Resource](#) for information about healthy development, child health, chronic diseases, and much, much more!

COVID-19 Response:

1. So far, the MLHU Communications Department has hosted 250 Virtual Media Briefings during the COVID-19 pandemic. The first was held on April 6th, 2020. For comparison’s sake there were only 236 episodes of Friends between 1994 and 2004.
2. The COVID-19 Vaccine Distribution program supports 42 long-term care homes/retirement homes/hospitals and 51 Primary care sites, totaling 93 sites with a fulsome training and support to provide COVID-19 vaccines.

4. There have been well over 2,000 users trained in the COVID-19 Vaccine provincial database (COVAX) to record vaccinations. 85% of all long-term care homes and retirement homes now participate in the program to independently give COVID-19 vaccine to their staff and residents.
5. The Infectious Disease Control team responded to 715 reported cases of COVID-19 at the peak of the Omicron wave, ensuring timely direction and guidance regarding isolation and quarantine.
6. Throughout the COVID-19 pandemic, MLHU's [COVID-19 data dashboard](#) has helped keep the community informed. Between May 2020 when the site was launched and the end of March 2022:
 - The site has been visited more than 3.6 million times from MLHU's website. This doesn't include those who may have bookmarked the site!
 - The data was reconciled and refreshed more than 630 times.
 - The site content was enhanced and updated 33 times, to better meet the needs of MLHU and community partners as the COVID-19 situation evolved.
7. Between December 23, 2020 when the first COVID-19 vaccine doses were given in the Middlesex-London region and February 28, 2022:
 - More than 760,000 doses of COVID-19 vaccine were administered at mass vaccination and hospital-based clinics.
 - Nearly 19,000 doses of COVID-19 vaccine were administered in long-term care homes and retirement homes by MLHU and the homes themselves, providing protection for staff and residents in these high-risk settings.
 - Pharmacies have given more than 230,000 vaccinations, helping to provide protection to all community members in convenient, local settings.
 - MLHU has administered more nearly 42,000 COVID-19 vaccines in mobile and pop-up settings, including clinics in malls, schools, community centres, and in the homes of those who are unable to get out to a clinic.



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 22-22

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health & Emily Williams, Chief Executive Officer

DATE: 2022 April 21

FEEDBACK ON VAPING-RELATED PROVISIONS OF THE TOBACCO AND VAPING PRODUCTS ACT

Recommendation

It is recommended that the Board of Health:

- 1. Receive Report No. 22-22 re: “Feedback on Vaping-Related Provisions of the Tobacco and Vaping Products Act” for information;*
- 2. Endorse and submit feedback prepared by Middlesex-London Health Unit staff, attached as [Appendix A](#), to the Tobacco Control Directorate of Health Canada, expressing its support and providing its perspective on the operation of the vaping-related provisions of the Tobacco and Vaping Products Act (TVPA); and,*
- 3. Endorse and submit feedback prepared by the Southwest Tobacco Control Area Network, attached as [Appendix B](#), to the Tobacco Control Directorate of Health Canada on behalf of the seven public health units in southwestern Ontario.*

Key Points

- On March 16, 2022, Health Canada opened a [public consultation](#) to fulfill the mandated 3-year legislative review of the *Tobacco and Vaping Products Act*, with a particular emphasis on the *Act*'s ability to address youth vaping.
- Health Unit staff prepared a submission for Board of Health approval, attached as [Appendix A](#), to express its support and propose recommendations for strengthened measures and improved public health messaging.
- Staff from the Southwest Tobacco Control Area Network prepared a submission, attached as [Appendix B](#), for endorsement and submission by the Middlesex-London Board of Health, on behalf of the seven public health units in southwestern Ontario.

Mandated Legislative Review of the *Tobacco and Vaping Products Act*

The federal *Tobacco and Vaping Products Act (TVPA)* came into force on May 23, 2018, amending the former *Tobacco Act (1997)*. The *TVPA* intended to create a new legal framework, in conjunction with other pieces of federal legislation and corresponding regulations to:

- address the increasing availability and use of vapour products with and without nicotine; and,

- to ensure that Canadians would be best informed about the potential risks associated with these products.

Due to limitations in the available scientific evidence used to inform government policy, the rapid exponential growth of the vapour product marketplace, and concerning trends regarding youth initiation, the *TVPA* includes, as a legal requirement, a legislative review of its provisions three years after coming into force, and every two years thereafter. The Tobacco Control Directorate is seeking [public input](#) to support and help inform the analysis and review of the legislation.

Growing Scientific Body of Research

In 2018, the US National Academy of Science, Engineering and Medicine (NASEM) released a comprehensive review and critically assessed the state of emerging evidence about e-cigarettes and their impact on health. NASEM's publication, "[Public Health Consequences of E-Cigarettes](#)" compiled the body of scientific evidence that was available, exploring both the potential benefits of e-cigarettes as a cessation aid and the potential pitfalls/harms from their use. NASEM provided recommendations that were used to inform many of the policy decisions that were made at that time, and highlighted the need for improved, ongoing research to address the gaps in the current literature.

According to Physicians for a Smoke-Free Canada, the NASEM assessment was based on one-third of the scientific research available today. Scientific understanding of the various harms now known to be associated with vapour product use has significantly increased. Public health messaging and government policy need to be reviewed and updated to reflect all available evidence to better address concerns related to: youth and young adult prevalence; health harms associated with vapour product use (including dual use); and, clarity of messaging related to smoking cessation.

Feedback on the *Tobacco and Vaping Products Act* and Regulations

Since March 2019, the Middlesex-London Board of Health has submitted feedback to Health Canada stressing the importance of restricting the availability of flavoured and high nicotine concentration vapour products and protecting youth and young adults from vapour product advertising and promotion. In response to the current call for input, both the Chronic Disease Prevention and Tobacco Control and the Southwest Tobacco Control Area Network Teams within the Healthy Living Division have prepared submissions to Health Canada, for Board of Health approval and submission, attached as [Appendix A](#) and [Appendix B](#) respectively. The submissions are a culmination of previous submissions. In addition, the submission includes the following recommendations:

- that Health Canada explores the enactment of WHO's policy options to address on-screen tobacco and vaping imagery, as part of a comprehensive approach to prevent youth uptake;
- that Health Canada's messaging on vaping and the safety of vapour products be updated to reflect all available evidence, including harms associated with dual use and the damage that vapour products cause to respiratory and circulatory systems; and,
- that Health Canada's messaging on vaping as a potential cessation aid be updated to reflect that vapour products, when used as a consumer product, have not proven to be effective cessation aids.

This report was submitted by the Healthy Living Division.

Handwritten signature of Alexander T. Summers in black ink.

Dr. Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Handwritten signature of Emily Williams in black ink.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer



Manager, Legislative Review
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 Controlled Substances and Cannabis Branch, Health Canada
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Middlesex-London Health Unit (Ontario) Submission to the Legislative Review of the *Tobacco and Vaping Products Act*

The Middlesex-London Health Unit (MLHU) applauds the steps that Health Canada has taken to prevent the initiation of vaping by youth, young adults and non-smokers. Since March 2019, the MLHU has made several submissions providing comments and feedback on the *Tobacco and Vaping Products Act (TVPA)* and Regulations. The MLHU is pleased to submit further comments to the Department's mandated 3-year review of the *Act* focusing on its vaping regulation sections and their ability to protect young persons from the harms of vapour products.

SECTION 1

PROTECT YOUNG PERSONS AND NON-USERS OF TOBACCO PRODUCTS FROM INDUCEMENTS TO USE VAPING PRODUCTS

- Q.1 Are the current restrictions on advertising and promotional activities adequately protecting youth?*
- Q.2 Are the restrictions within the Act and its regulations sufficient to address potential inducements to use these products by youth and non-users of tobacco products?*
- Q.3 Are there other measures the Government could employ to protect youth and non-users from inducements to use tobacco products?*
- Q.4 Does the TVPA contain the appropriate authorities to effectively address a rapidly evolving product market and emerging issues such as the observed increase in youth vaping?*
- Q.5 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?*

Health Canada Messaging about Vapour Products

Vaping prevalence rates have skyrocketed in recent years, particularly among youth and young adults. The nation-wide prevalence of vaping among students (grades 7-12) has doubled, rising from 10% in 2016-2017 to 20.2% in 2018-2019. (Health Canada, 2018;2019).

Since the 2018 publication of the assessment of vaping ("Public Health Consequences of E-Cigarettes") by the US National Academy of Science, Engineering and Medicine (NASEM), scientific understanding of the various harms now known to be associated with e-cigarette use by young people has significantly increased. As noted by colleagues at [Physicians for a Smoke-Free Canada](#) (PSC), the NASEM assessment was based on only one-third of the evidence available today (PSC, 2022). PSC's blogpost on the current status of Health Canada's messaging on vaping and its impact on younger users reads, in part, as follows:

“In its 2018 assessment, the NASEM panel of experts explored the scientific evidence behind 47 conclusions finding that there was conclusive or substantial scientific evidence for only 18, moderate evidence for 8, and limited or no evidence for 21 of the conclusions. Fifteen of the 18 conclusions for which there was strong or substantial level of confidence confirmed potential harms from these products and only two conclusions related to potential benefits of vaping” (PSC, 2022). The NASEM panel of experts concluded that e-cigarette users who entirely quit using tobacco products and transition to vapour products were exposed to fewer of the chemicals found in cigarette smoke and they experienced short-term health consequences in some organ systems (PSC, 2022).

The amount of available scientific evidence regarding the safety and dangers of vapour products is growing, and since 2018, other governments have tasked scientists to conduct reviews. There is a scientific consensus that is building that warns that vaping is dangerous and not particularly useful as a cessation method, especially when purchased and regulated as a consumer product (PSC, 2022). At present, there is no updated authoritative document that has brought together available systematic reviews, meta-analyses and reports from researchers and pertinent health/government agencies; however, according to Physicians for a Smoke-Free Canada (2022), some conclusions can be drawn that warrant significant consideration when considering public health messaging and government legislation:

1. *“E-cigarettes have increased the number of young nicotine users in some countries;*
2. *Young people who use e-cigarettes are more likely to smoke conventional cigarettes;*
3. *Dual use is common and harmful;*
4. *When purchased as consumer products, e-cigarettes are not effective cessation aids;*
5. *E-cigarettes cause damage to respiratory and circulatory systems;*
6. *Other governments have provided more recent scientific assessments.” (PSC, 2022)*

The Middlesex-London Health Unit recommends that Health Canada’s messaging on vaping and the safety of vapour products be reviewed, revised and updated to reflect all available evidence.

Vapour Product Flavouring and Additives

The plethora of flavours in vapour products has posed significant challenges in public health efforts to halt vapour product uptake, especially by young people. Youth consider the flavour of vaping products to be the most important factor when trying e-cigarettes, and vaping initiation is more likely to occur with fruit, sweet, menthol and cherry flavoured products (Zare et al. 2018). Additionally, when non-traditional flavours are restricted and mint and menthol remain on the market, young people shift their purchasing and consumption preferences toward mint and menthol flavour (Morean et al., 2018; Diaz et al., 2020). The exclusion of menthol and mint flavours from the pending ban on flavours under the *Tobacco and Vaping Products Act* and regulations needs to be revisited. According to Al-Hamdani, Hopkins, and Davidson (2021) and the 2020-2021 Youth and Young Adult Vaping Project, almost all vapour product users consumed a flavoured vape juice both at initiation (91.9%) and at present (90.3%). In addition, in most provinces, berry, mango and mint/menthol were the most reported flavours being used (Al-Hamdani, et al., 2021).

The Middlesex-London Health Unit highly recommends Health Canada to adopt the regulation to ban all vapour product and e-substance flavours, including mint and menthol or a combination of mint/menthol, except for tobacco flavoured products, without delay.

Vapour Product Promotion and Advertising

The current restrictions on advertising and promotional activities do not adequately protect youth. Vaping products should be brought under the same advertising and promotion control framework as tobacco. Advertising at such places as recreational facilities, restaurants, places of entertainment, post-secondary institutions, broadcast media, in print publications and online/social media should be prohibited given the potential for youth exposure. Vapour product advertising should only be information advertising or brand preference advertising, which would align the vaping product promotional framework with the approach applied to tobacco products. A 2019 national Leger poll found that 86% of Canadians believe that the government should apply the same advertising restrictions to vaping products with nicotine as it does to tobacco products in order to protect youth (Leger, 2019). Additionally, there should be a complete ban on offering free or discounted vaping products. There is a substantial body of evidence that supports price control measures and strong taxation regimes for reducing youth and young adult smoking initiation, as they are more sensitive to price increases (Public Health Ontario, 2017). According to Huang, Tauras and Chaloupka (2013) and research conducted by Corrigan and colleagues (2021), policies increasing the price of vapour products, either through a taxation regime or limiting rebates, discount pricing, and coupons/bulk buying incentives could dissuade relatively few older adult cigarette smokers from switching to e-cigarettes while at the same time, be highly effective at preventing youth and young adults from initiating the use of vapour products.

The Middlesex-London Health Unit highly recommends that Health Canada implement a comprehensive framework that strictly regulates advertising and promotional activities in alignment with current controls in place for tobacco products. Further, the inclusion of product pricing measures and prohibitions on incentive and bulk buying programs are required.

On-screen Impressions of Smoking and Vaping

For over a decade, the MLHU has been an active member of the Ontario Coalition for Smoke-Free Movies (OCSFM) and has closely followed emerging evidence about the impact on youth when they observe tobacco and vapour product use on screen.

OCSFM's extensive experience on this issue, including frequent interactions with colleagues and researchers from the United States has led to the conclusion that frequent exposure of youth to both smoking and vaping on theatre screens, on television and on-line continuously encourages youth to try or continue using both tobacco and vapour products (Truth Initiative, 2021; Bennett et al., 2022; US Surgeon General, 2012).

Prior to the introduction of multiple viewing platforms and ubiquitous streaming services for both movies and episodic series, the on-screen presence of tobacco products was largely limited to combustibles, usually cigarettes, and usually seen in movies in theatres. Smoking impressions and tobacco imagery within movies in North America has very rarely been the subject of a "restricted" movie rating. Internationally replicated research that began in the early 2000s demonstrated that youth were often influenced to start smoking by seeing movie characters smoking on screen (Dalton et al., 2003). The American film industry has significant global influence, and the influence that tobacco imagery within movies has on youth should not be underestimated (Polansky, Driscoll and Glantz, 2019).

By 2016, researchers had confirmed and replicated their conclusions to the point that the World Health Organization called on signatories of the Framework Convention on Tobacco Control (FCTC), of which Canada is one, to implement the following policy measures, in line with the guidelines of article 13, to reduce the impact that smoking in the movies is having on youth tobacco use initiation:

- Require adult ratings for films with tobacco imagery to reduce overall exposure of youth to tobacco imagery in films;
- Certify within movie credits that film producers received nothing of value for using or displaying tobacco products in a film;
- Prohibit the display and identification of tobacco brands in films;
- Make media production companies ineligible for public subsidies and grants if they show smoking or tobacco brands, or identify a relationship with the tobacco industry; and,
- Require strong anti-smoking advertisements to be shown prior to showing films that contain tobacco imagery through all distribution channels (cinemas, televisions, online, etc) (World Health Organization, 2015).

The platforms on which youth can access movies, episodic series and other content today have multiplied since the 2000s. Streamed films and episodic series are readily accessible in the home, in theatres and on various portable media devices. While these products are often preceded by advisories about violence, drug use, explicit sexual content, or mature themes, only Netflix and Disney+ make any mention of smoking. The WHO's policies noted above are entirely disregarded. This disregard takes on even greater importance as new research from the United States shows that when youth see tobacco smoking on-screen, many youth respond by initiating the use of vapour products (Bennett et al., 2022). According to the US Truth Initiative, "...research shows **on-screen exposure to tobacco imagery makes young people more likely to start vaping**. A landmark 2020 study published in [Preventive Medicine](#), found that exposure to smoking images through episodic programming can triple a young person's odds of starting to vape nicotine" (Truth Initiative, 2022). The Truth Initiative's 2021 report, [While You were Streaming: Nicotine on Demand](#) shows that 60% of young people's top 15 favorite streaming and broadcast season shows released in 2020 featured smoking, exposing an estimated 27 million youth to tobacco imagery (Truth Initiative, 2021). The report also highlights the poor performance of Netflix, one of the most popular on-line streaming platforms with viewers of all ages. Despite efforts by the US National Association of Attorneys General to urge US streaming services and creative guilds to limit tobacco depictions in programming appealing to youth, Netflix "remains the worst offender four years in a row based on its new 2020 season releases and popular binge-worthy shows" (Truth Initiative, 2022). Canadian youth watch much the same media content as their counterparts in the United States; therefore, the latest findings should be cause for alarm as there is no evidence-based reason to conclude that Canadian youth are less-susceptible to the influence of frequent exposure to on-screen smoking and (increasingly) vaping.

At present, there are no provincial restrictions in place to prevent – or reduce the likelihood of - youth exposure to on-screen smoking or vaping. While Ontario did at one time have a legislated requirement that film advertising had to contain an advisory of tobacco use if warranted, recent legislation removed that requirement. The 2020 *Ontario Film Content Information Act* cancelled the province's previous film rating system, and now asks "exhibitors" to advise moviegoers about film content, but without prescribed regulations specifying how this requirement should be achieved.

In light of the increasing evidence about the pervasiveness of on-screen smoking and its effect on the initiation of youth smoking and vaping, the Middlesex-London Health Unit recommends that Health Canada explores the enactment of WHO's policy options to address on-screen tobacco and vaping imagery.

SECTION 2***PROTECT THE HEALTH OF YOUNG PERSONS AND NON-USERS OF TOBACCO PRODUCTS FROM EXPOSURE TO AND DEPENDENCE ON NICOTINE THAT COULD RESULT FROM THE USE OF VAPING PRODUCTS***

Q.1 Are the current restrictions in the Act and its regulations sufficient to protect the health of young persons from exposure to and dependence on nicotine that could result from the use of vaping products?

Q.2 Are the new restrictions on nicotine concentration levels sufficient to protect youth and non-users of tobacco products from nicotine exposure? If not, what additional measures are needed?

Q.3 Are there other measures that the Government could employ to protect the health of young persons from exposure to and dependence on nicotine from vaping products?

Q.4 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?

Nicotine Concentration and Uniform Dosing Levels

Data from the 2018-19 Canadian Student Tobacco Alcohol and Drugs (CSTADS) survey showed that 20.2% of Canadian students (approximately 418,000) had used an e-cigarette (with or without nicotine) in the past 30 days (Health Canada, 2019). Students that reported vaping (with or without nicotine) in the past 30 days were vaping regularly, with approximately 40% reporting daily or almost daily use (Health Canada, 2019). CSTADS also showed that vaping had led to an overall increase in nicotine use by youth, which suggested that vaping had not replaced smoking behaviours among young people. In fact, the total prevalence of vaping and smoking among young people was much higher than the prevalence of smoking in that population a decade ago. By far, most of the youth in Canada who vaped were using devices that contained nicotine, with 87.6% of all current grade 7 – 12 students vaping nicotine (Health Canada, 2019). In addition, according to the 2020-2021 Youth and Young Adult Vaping project, of the 3000 individuals between the ages of 16 and 24 who were interviewed, 64.3% reported using vape juice containing the highest possible concentrations of nicotine (50-60 mg/ml) (Al-Hamdani et al., 2021).

Nicotine is a highly addictive substance that poses significant risk, especially to young people. The brain continues to develop until an individual reaches the approximate age of 25. Exposure to nicotine during brain development can result in nicotine addiction, mood disorders, permanent lowering of impulse control, and changes to attention and learning (NASEM, 2018). Other health impacts include increased blood pressure, increasing risk of heart disease and stroke (Gonzalez and Cooke, 2021), and the potential for increased risk of the spread breast cancer to the lungs (Huynh et al., 2020). The adverse effects from the use of high concentrations of nicotine include vomiting, headaches, dizziness, nausea and in extreme cases, fainting and nicotine poisoning (NASEM, 2018).

As MLHU noted within its [submission in January 2020](#) to Health Canada's consultation on the [Vaping Products Promotion Regulations](#), federal regulation of nicotine levels offers consistent protection from nicotine addiction for youth across Canada, by bringing the current patchwork of provincial regulations into alignment across Canada. The MLHU strongly supported the federal regulation to limit nicotine concentration in vaping products to a maximum of 20 mg/ml. Nicotine is a highly addictive substance and reported youth preferences for products with the highest levels of nicotine (Al-Hamdani et al., 2021) justifies the requirement for Health Canada to monitor the scientific evidence on an ongoing basis and adjust product limits accordingly.

Another important factor related to nicotine concentration levels is the application of vapour product design standards to ensure the consistent and uniform dosing of nicotine to vapour product users. According to the European Union's (EU) Commission investigating the latest available evidence on vapour products, at present, vapour products are not held to design and manufacturing standards that ensure that the device delivers the same amount of nicotine per puff by the user (European Union SHEER, 2021). Given that cigarettes are engineered to deliver consistent doses of nicotine, it appears logical that e-cigarettes should do the same if they are to effectively replace nicotine delivered from cigarettes.

The Middlesex-London Health Unit supports the immediate enactment of the 20 mg/ml nicotine concentration level maximum for vapour products, along with the development of an annual review of available scientific evidence which would allow for downward adjustments if necessary. Further, it is recommended that Health Canada impose product engineering standards to ensure uniform nicotine dosing so that users know how much nicotine they are inhaling.

SECTION 3

PROTECT THE HEALTH OF YOUNG PERSONS BY RESTRICTING ACCESS TO VAPING PRODUCTS.

Q.1 Are measures in the Act sufficient to prevent youth from accessing vaping products? If not, what more could be done to restrict youth access to vaping products?

Q.2 Are there other measures that the Government could employ to protect youth from accessing vaping products?

Q.3 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?

Retailer Prohibitions of Sales of Tobacco and Vaping Products

Between 2020 and 2022, MLHU observed an increase in the number of tobacco youth access test shopping failures, as well as an all-time high rate of vapour product youth access test shopping failures. Prior to 2020, MLHU's tobacco and vapour product youth access compliance rates were ~99.9%. Tobacco Enforcement Officers (TEOs) within Middlesex-London are noting an alarming trend. Since October 2021, TEOs and youth test shoppers have completed 200 youth access checks for vapour products that have resulted in 21 failures (89.5% compliance rate), with more retailers yet to be inspected. The majority of the youth access failures were at non-specialty vape stores, including convenience stores and gas stations, using youth test shoppers who are between 15 and 16 years of age -- well below the legal age of 19 years in Ontario.

Under the *Smoke-Free Ontario Act, 2017 (SFOA, 2017)*, only vapour products flavoured with mint, menthol and tobacco can be sold in non-specialty vape stores (e.g. convenience stores, gas station kiosks, grocery stores, etc.); whereas, vapour products that contain other flavours must only be sold in age-restricted specialty vape stores. Furthermore, under the *SFOA, 2017*, vapour products that have a nicotine concentration of greater than 20 mg/ml can only be sold in age-restricted specialty vape stores. In the Middlesex-London area, during this latest round of youth access inspections, many of the vapour products that were sold to youth test shoppers from non-specialty vape stores were flavoured with fruit and candy-flavoured additives and had a nicotine concentration of greater than 20 mg/ml, despite the provincial legislation. The illegal sale of these products has resulted in the issuance of charges for the sale of prescribed vapour products in a prohibited place and the seizure of these products. Between June 2021 and March 2022, tobacco enforcement officers (TEOs) for MLHU have conducted a total of 5 vapour

product seizures, with estimated values ranging from \$200 - \$25,000 from each establishment. In addition to the loss of merchandise, fines under the *SFOA, 2017* are also applied for each offence; however, it has become apparent that the fines and seizures of vapour products are an insufficient deterrent.

Under the *SFOA, 2017*, routine non-compliance with tobacco sales offences results in the issuance of an automatic prohibition order under Section 22. At present, there is no automatic prohibition lever that can be applied to retailers who continue to sell vapour products to persons under the age of 19 years, nor for non-specialty vape stores that continue to sell vapour products that should only be available for sale in age-restricted stores in Ontario. Operators have shared with MLHU TEOs that the total revenue from sales of vapour products alone far exceeds both the fine amounts and the risk of product seizures and is viewed as a cost of doing business. Based on the current compliance rate and reported retailer behaviors, current vapour product regulations are insufficient.

The Middlesex-London Health Unit recommends that Health Canada implement an automatic prohibition regime for both tobacco and vaping products under the TVPA modelled after Section 22 of the *Smoke-Free Ontario Act, 2017*, for repeated convictions against retailers who:

- **sell tobacco and/or vaping products to persons under the legal age;**
- **sell flavoured tobacco and vaping products prohibited by law; and,**
- **sell vaping products with nicotine concentration levels that exceed 20 mg/ml.**

Reciprocal Relationships and Cooperation Between Federal and Provincial Inspectors

In Ontario, the display, promotion and sale of tobacco and vaping products at retail are regulated by both provincial and federal legislation. The *TVPA* is enforced by Health Canada Inspectors exclusively, who are responsible for monitoring and ensuring compliance with the *Act* and the Regulations. In Ontario, public health unit staff are designated by the authority outlined under the *Smoke-Free Ontario Act, 2017*, to enforce the requirements and restrictions at retail under provincial legislation exclusively, with no authority under the *TVPA*.

This means that if non-compliance with the *TVPA* and/or Regulations are observed by the local public health inspectors, the only recourse available is to refer the non-compliance and possible infraction to the Health Canada Inspectorate. Given the size and scope of jurisdiction that falls to the Health Canada Inspectorate, it is difficult for their Inspectors to respond to the referral in a timely matter. This means that in many cases, vapour products, prescribed by federal law to be “illegal” and subject to federal seizure, remains within the store for continued sale. There is significant consumer demand for this product; therefore, despite warnings issued by provincial inspectors, product will remain on store shelves available for sale or for distribution through other illegal means. In Ontario, there has been some success with reciprocal relationships and collaboration between Ontario Ministry of Finance Inspectors (enforcement of the *Tobacco Tax Act*) and public health staff (enforcement of the *SFOA, 2017*). For example, if illegal tobacco products (under the *Tobacco Tax Act*) are found within a retailer, and a Ministry of Finance Inspector is not within the jurisdiction, under direction of the Ministry of Finance Inspector, the Health Unit Inspector will safely secure the product off site until the Ministry of Finance Inspector can attend to seize the product for their investigation. Not only does this reciprocal and collaborative relationship help to remove illegal products from the marketplace, but it also increases public and retailer perception of a greater enforcement presence, which contributes to greater compliance overall. It is recommended that a similar arrangement be explored between federal and provincial enforcement agencies given the continued availability of flavoured and high nicotine concentration products. Alternatively, the cross designation of provincial and federal inspectorate for sections of the *TVPA* and Regulations that pertain to retail could also be explored.

The Middlesex-London Health Unit recommends that Health Canada engage with provincial Ministries of Health and representatives from local public health enforcement to explore the options that exist to support more timely enforcement action.

Tighten Restrictions for Online Retail Marketing

Besides the availability of vapour products at retail outlets such as convenience stores, gas stations, grocery stores, and specialty vape stores, vapour products are widely available for sale through websites and social media (Hammond, et al., 2015). While many online vendors use age-verification measures during online purchase, people under the age of 18 years are still able to purchase vapour products online (Hammond et al., 2015). In 2017, the Canadian Tobacco and Drug Survey (CTADS) indicated that more than 75% of youth age 15-19 years who tried a vaping product borrowed, shared or bought it from a friend or relative (Health Canada, 2018). In 2019, the Canadian Tobacco and Nicotine Survey showed that social access of vaping products among those aged 15-19 years had dropped to 58%, and 43% of this age group purchase from retail sources, including online vendors (Health Canada, 2019).

Underage youth who purchase vaping products online either falsely claim to be of legal age when they access the website, or they are not required to show proof of age. A content analysis of internet e-cigarette vendor practices discovered that most vape vendors (over 60%) did not require age verification or relied on ineffective strategies such as checking a box to verify legal age (Williams et al., 2018). Similarly, Gaiha and colleagues (2020) found that more than a quarter of underage e-cigarette users surveyed were not required to verify their age when purchasing e-cigarettes online.

The local experience within Middlesex-London is in congruence with the evidence. Since resuming in-person learning within Middlesex-London schools in the fall of 2021, approximately 80% of youth are telling TEOs they buy vapour products online. Young people are reporting that they find it easy to get vaping products through online sources. One youth stated that the vapour products are delivered to their mailbox and that he can easily conceal the purchase from his parents because it is his responsibility to pick up the mail after school.

Some specialty vape stores that formerly operated a brick and mortar store within the Middlesex-London jurisdiction have shifted to manufacturing and wholesale, and/or to online-based operation to continue to sell flavoured and high nicotine concentration products to all ages, with less enforcement scrutiny. These products are shipped directly to customers' houses or offered through curbside pickup. This process applies the obligation of age verification to the agents/agencies used for delivery. Enforcement agencies, at both the federal and provincial levels, are challenged to be able to effectively monitor retailer compliance with youth access provisions.

Industry brand-incentive programs, like the "Vuse – Click and Collect" program, are also operating within the Middlesex-London jurisdiction. This program allows customers to place their orders online and then pick up the vapour products, including all flavours and nicotine concentrations, at select convenience stores. Programs like this appear to have been able to find legislative loopholes and they contribute to the erosion of progress that had been made to prohibit youth access to tobacco and vapour products and to restrict access to flavoured and high nicotine concentration vapour products.

The *TVPA* prohibits youth access to vaping products in a public place or in a place to which the public has access, which includes online retailing. The *Act* specifies that a person, including a retailer, must verify the age of a person purchasing vaping products, however it does not specify how age verification is to be implemented. The current system on many websites of clicking a box to attest to being of age has obvious pitfalls.

The Middlesex-London Health Unit recommends that Health Canada works with provincial Ministries of Health to implement consistent and strict requirements to regulate online sales, including the following measures:

- **Require online retailers to post information advising prospective customers that the sale of vaping and tobacco products are restricted to persons of legal age;**
- **Require two-step age verification for online retailing - the two-step process should involve two authentication methods performed one after the other to verify identity;**
- **Require online retailers to utilize third-party verification services;**
- **Require tobacco and vapour products to contain a label that states that age verification is required at delivery;**
- **Upon delivery, require that a signature be obtained, and packages must not be left on doorsteps;**
- **Require that delivery be restricted to prescribed carriers.**

Enactment of a Tax and Vapour Product Pricing Regime

There is unequivocal evidence documented in the tobacco control literature that price increases result in decreased demand and use of cigarettes, and increased intentions to quit smoking (SFO-SAC, 2017). Many provinces have proposed or passed legislation to tax vapour products, including British Columbia, Alberta, Prince Edward Island, Saskatchewan and Newfoundland Labrador. There exists the opportunity to enact a national tax regime on vapour products to reduce the consumption of vapour products by youth and young adults as they tend to be more price sensitive than adults (U.S. Department of Health and Human Services, 2000). The revenue from taxes from tobacco products along with the revenue from the taxation regime applied to vapour products could be used to fund comprehensive tobacco and vapour product control programming, including prevention and cessation efforts, increased compliance monitoring and enforcement, and ongoing research. A complementary measure to increase the retail price of tobacco and vapour products is to mandate a minimum pre-tax set price minimum (Feighery, et al., 2005). Setting minimum price limits inhibits the manufacturers' ability to use discount pricing and the retail sale of low-cost brands or devices to offset the price increases from taxation (SFO-SAC, 2010). Minimum price policies are effective and widely used to reduce alcohol consumption and harms (Anderson, et al., 2009). The taxation level and the set price minimums for vapour products should be set independently from tobacco products, with careful consideration being given to ensure that e-cigarettes do not become more expensive than cigarettes but set high enough to deter youth and young adult initiation. The 2021 federal budget announced the Government of Canada's intention to introduce a new taxation framework for vaping products in 2022.

The Middlesex-London Health Unit recommends that Health Canada enact a comprehensive, national vapour product taxation and pricing regime without delay, to reduce youth and young adult consumption and associated harms from vapour product use.

SECTION 4

PREVENT THE PUBLIC FROM BEING DECEIVED OR MISLED WITH RESPECT TO THE HEALTH HAZARDS OF USING VAPING PRODUCTS

Q.1 Are the current measures in place sufficient to prevent the public from being deceived or misled about the health hazards of vaping products?

Q.2 What additional measures would help reduce the misconceptions about the health hazards of vaping products?

Q.3 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?

Appealing Vapour Product Marketing and Unsubstantiated Health Claims

Websites selling vapour products online are ubiquitous and use marketing tactics that are appealing to youth. In 2019, the Ontario Tobacco Research Unit (OTRU) collected samples of flavoured vaping products from online Canadian vape stores and found several examples of flavoured vaping products with attractive packaging, design elements, names and descriptors with youth-appeal (O'Connor, et al., 2019). Furthermore, researchers who conducted a systematic content and legal analysis of the claims made by e-cigarette manufacturers and retailers on their websites concluded that the vast majority of websites made at least one health-related claim, focusing on potential health benefits while minimizing or eliminating information about possible harmful effects of vaping products (Klein, et al., 2016). Grana and Ling's (2014) content analysis of e-cigarette retail websites also discovered that health claims and cessation messages that are unsupported by current scientific evidence are frequently used by vapour product retailers to sell vaping products (Grana and Ling, 2014). Vaping products have not been approved by Health Canada as a smoking cessation aid because they are not currently tested, manufactured, and regulated as such in Canada. Therefore, claims about vapour product efficacy as a cessation tool should be strictly prohibited.

Enforcement reports from Health Canada inspectors reinforce the lack of compliance by online retailers with current promotion and advertising restrictions under the *TVPA*. Between July 2020 and March 2021, Health Canada inspectors conducted inspections of Instagram social media accounts to assess vapour product industry compliance, with a focus on publicly accessible online promotions. Inspectors reviewed 304 accounts on Instagram and observed non-compliance on 53% of the accounts, resulting in the issuance of a warning letter (Health Canada, 2021) Increased enforcement (issuance of fines) and stricter prohibitions on vapour product advertising are required.

The Middlesex-London Health Unit recommends Health Canada to prohibit online vapour product retailers from making health claims, using celebrity and medical professional endorsements, and promoting e-cigarettes as a cessation aid. Increased compliance monitoring and the use of progressive enforcement measures (Part I charges and Part III summonses) are required.

Vapour Product Appearance and Packaging Design

In November 2019, Canada implemented plain and standardized tobacco product packaging regulations. With strict promotion and advertising rules in effect for tobacco products across Canada, the tobacco package became an important marketing tool, using colours, images, logos and distinctive fonts, finishes and sizing. According to Moodie, Mackintosh, Hastings and Ford, (2011), studies have determined that the colour, shape and size of a package can influence consumer behaviour and contributes to consumer perceptions of the product. Package design can make its contents appear safe to use, undermining the visibility, credibility and effectiveness of health warnings. The same body of evidence can be applied to the regulation of vapour products and packaging. Devices are being manufactured to look like small, discrete everyday objects, so that youth can vape discretely, hiding their nicotine addiction from parents, employers and teachers. Within the Middlesex-London jurisdiction, the ability to "stealth vape" in school washrooms and classrooms undermine the efforts that school staff and public health unit staff are taking to promote and enforce the *Smoke-Free Ontario Act, 2017* on school property. The devices can be customized, which complements the lifestyle messaging that youth are receiving from the internet and on social media.

The Middlesex-London Health Unit recommends that Health Canada apply a similar plain and standardized packaging regime to vapour products that Health Canada has already applied to commercial tobacco and cannabis products.

SECTION 5

ENHANCE PUBLIC AWARENESS OF HEALTH HAZARDS

Q.1 Have public awareness efforts been effective at educating Canadians about the health risks of vaping products?

Q. 2 What more could be done to educate Canadians about the health risks of vaping products?

Q.3 Are there still knowledge gaps to fill with regard to the health risks of vaping products? If so, what areas should research focus on?

Q.4 What approach should be taken to close the gap between scientific evidence and public perception so that youth and non-users of tobacco products are aware of the health risks of using vaping products, while adults who smoke are aware that they are a less harmful alternative to tobacco if they switch completely to vaping?

Comprehensive Review of Available Scientific Evidence Required

There has been a concerted effort to increase the body of scientific evidence available to assess the potential harms and potential benefits associated with vapour products, in an attempt to keep up with the ever-expanding vapour product market. According to a 2022 published report from [Grandview Research](#), the global vapour product market size was valued at \$18.13 billion USD in 2021 and is expected to expand at a compound annual growth rate of 30% between 2022 to 2030; North America dominated the global market with a share of over 40% in 2021 (Grandview Research, 2022). They note that the projected market growth expansion is due to the “rising awareness about e-cigarettes being safer than traditional cigarettes, especially among young people”. They go on to explain that the growing online retail market amid the COVID-19 pandemic is also projected to factor into the market growth (Grandview Research 2022). The increase in the availability of vapour products by youth and young adults combined with the apparent belief and pervasive messaging found online that “less harmful” means that vapour products are safe is a significant public health concern.

As noted by Physicians for a Smoke-Free Canada (2022), the 2018 NASEM assessment of evidence on e-cigarette and vapour products relied on only one-third of the evidence that is available today. Since the release of the publication, researchers have developed a greater understanding of the potential harms associated with e-cigarette use, including health harms from dual use of vapour products and cigarettes and the potential for vapour products to aid in smoking cessation. Messaging available on Health Canada web pages require review and revision to incorporate findings from the growing body of scientific evidence.

- ***Dual use of combustible cigarettes and e-cigarettes is common and harmful***

Health Canada’s webpage on Vaping and Quitting Smoking (2020) states that if an individual completely switches completely from smoking cigarettes to using vapour products, the individual will experience short-term general health improvements. The challenge with this messaging is that research has shown that in Canada, 38% of Canadian vapers are people who both smoke cigarettes and vape (PSC, 2021). In addition, the 2020 Canadian Tobacco and Nicotine Survey results showed that although youth and young adults between the ages of 15 and 24 made up only 15% of the surveyed population, they represented 40% of those who reported that they vape. The emphasis on the harm reduction approach clouds the fact that there is scientific consensus that using both vapour

products and conventional cigarettes is likely more harmful than only smoking or only using vapour products (PSC, 2022), and youth and young adults are then more susceptible to trying vapour products because ‘they aren’t as bad as smoking’.

▪ ***E-cigarettes cause damage to respiratory and circulatory systems.***

The available scientific evidence regarding the impact of vapour product use on respiratory and circulatory systems has increased substantially, with hundreds of studies examining the health harms in laboratory studies of both animals and humans.

- Researchers have concluded that the damage caused by vapour products leads to lung and heart disease and stroke (Keith and Bhatnagar, 2021). Vapour product use may also compromise the ability to remove microbial pathogens, increasing the risk of infection from viruses, fungi and bacteria (Keith and Bhatnagar, 2021).
- In another comprehensive review of cardiovascular effects, findings from Buchanan and colleagues (2020) suggest that vapour product use is associated with inflammation, oxidative stress and haemodynamic imbalance increasing risk of cardiovascular disease (Buchanan et al., 2020).
- In a review of 38 studies measuring cardiovascular effects of e-cigarettes, “most studies suggest potential for cardiovascular harm from electronic cigarette use, through mechanisms that increase risk of thrombosis and atherosclerosis” (Kennedy et al, 2019).
- A 2020 review and meta-analyses of vapour product impact on lung health showed that e-cigarette use was associated with a 39% increase in the risk of asthma and a 51% increase in the risk of developing chronic obstructive pulmonary disease; studies conducted within laboratories showed influence on biological processes that contribute to respiratory harm and illness (Wills et al., 2020).
- According to Lauren Davis and colleagues (2022), based upon a review of the pulmonary effects of long-term vaping product use, they conclude that e-cigarette use is “...likely to result in irreversible parenchymal lung tissue damage and impaired gas exchange, contributing to chronic lung conditions in long-term vapers”.

▪ ***There is insufficient evidence to support/promote vapour products as a cessation tool when sold and regulated as a consumer product.***

Health Canada’s web page on [Vaping and Quitting Smoking](#) reads that “quitting smoking can be difficult, but it is possible. Vaping products and e-cigarettes deliver nicotine in a less harmful way than smoking cigarettes”. The web page further states that “while evidence is still emerging, some evidence suggests that using e-cigarettes is linked to improved rates of success” (Health Canada, 2020). There has been a growing body of scientific evidence to evaluate the effectiveness of vapour products to help those addicted to tobacco to quit, with mixed results. Physicians for a Smoke-Free Canada (2021) compiled a [summary](#) of scientific reports published after both the release of NASEM (2018) and the release of European Union’s scientific advisors “[Final Opinion on Electronic Cigarettes](#)” (2021). The following conclusions were drawn that warrant further investigation by Health Canada:

- Published studies to date, including longitudinal data analysis, randomized control trials and meta-analysis of e-cigarettes as consumer products (i.e. not regulated or monitored in a clinical setting), when dual use of smoking and vaping was assessed, found high levels of dual use. Further, those that successfully quit smoking had a high prevalence of sustained use of e-cigarettes (PSC, 2021).

- Vapour products may be helpful as smoking cessation aids, but the available evidence indicates that this is only observed in clinical settings with strict product oversight. Vapour products may have the potential to be as effective as other approved methods for cessation (e.g. nicotine replacement therapy, varenicline, bupropion, etc.); however, they do not meet minimum threshold levels for safety for widespread use. In Canada, vapour products are regulated, marketed and sold as a consumer product (not a drug). Due to the high risk of dual use, sustained addiction to vapour products, growing scientific consensus regarding respiratory and cardiovascular harms associated with use, and the high risk of uptake of vapour products by never smokers, a precautionary approach remains prudent (PSC, 2021).

At present, vaping products have not been approved by Health Canada as a smoking cessation aid because they are not currently tested, manufactured, and regulated as such in Canada. Therefore, until an intensive review of the latest evidence is completed, Health Canada's messaging is confusing and contributing to misperceptions of perceived product safety.

The Middlesex-London Health Unit recommends that Health Canada's messaging on vaping and the safety of vapour products be reviewed, revised and updated to incorporate all available evidence for public consumption and comprehension. Any legislated health warnings on vapour products or product promotional materials should be reviewed to ensure congruence with the growing body of scientific evidence available for vapour products.

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Southwest Tobacco Control Area Network (Ontario) Submission to the Legislative Review of the *Tobacco and Vaping Products Act*

The Southwest Tobacco Control Area Network (SWTCAN) commends Health Canada for the steps taken to prevent the initiation of vaping by youth, young adults and non-smokers. Since March 2019, the member public health units of the SWTCAN have made submissions providing comments and feedback on the *Tobacco and Vaping Products Act (TVPA)* and Regulations. The SWTCAN is pleased to submit further comments to the Department's mandated 3-year review of the *Act* focusing on its vaping regulation sections and their ability to protect young persons from the harms of vapour products.

SECTION 1

PROTECT YOUNG PERSONS AND NON-USERS OF TOBACCO PRODUCTS FROM INDUCEMENTS TO USE VAPING PRODUCTS

- Q.1 Are the current restrictions on advertising and promotional activities adequately protecting youth?*
- Q.2 Are the restrictions within the Act and its regulations sufficient to address potential inducements to use these products by youth and non-users of tobacco products?*
- Q.3 Are there other measures the Government could employ to protect youth and non-users from inducements to use tobacco products?*
- Q.4 Does the TVPA contain the appropriate authorities to effectively address a rapidly evolving product market and emerging issues such as the observed increase in youth vaping?*
- Q.5 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?*

Health Canada Messaging about Vapour Products

Vaping prevalence rates have skyrocketed in recent years, particularly among youth and young adults. The nation-wide prevalence of vaping among students (grades 7-12) has doubled, rising from 10% in 2016-2017 to 20.2% in 2018-2019. (Health Canada, 2018;2019).

Since the 2018 publication of the assessment of vaping ("Public Health Consequences of E-Cigarettes") by the US National Academy of Science, Engineering and Medicine (NASEM), scientific understanding of the various harms now known to be associated with e-cigarette use by young people has significantly increased. As noted by colleagues at [Physicians for a Smoke-Free Canada](#) (PSC), the NASEM assessment was based on only one-third of the evidence available today (PSC, 2022). PSC's blogpost on the current status of Health Canada's messaging on vaping and its impact on younger users reads, in part, as follows:

“In its 2018 assessment, the NASEM panel of experts explored the scientific evidence behind 47 conclusions finding that there was conclusive or substantial scientific evidence for only 18, moderate evidence for 8, and limited or no evidence for 21 of the conclusions. Fifteen of the 18 conclusions for which there was strong or substantial level of confidence confirmed potential harms from these products and only two conclusions related to potential benefits of vaping” (PSC, 2022). The NASEM panel of experts concluded that e-cigarette users who entirely quit using tobacco products and transition to vapour products were exposed to fewer of the chemicals found in cigarette smoke and they experienced short-term health consequences in some organ systems (PSC, 2022).

The amount of available scientific evidence regarding the safety and dangers of vapour products is growing, and since 2018, other governments have tasked scientists to conduct reviews. There is a scientific consensus that is building that warns that vaping is dangerous and not particularly useful as a cessation method, especially when purchased and regulated as a consumer product (PSC, 2022). At present, there is no updated authoritative document that has brought together available systematic reviews, meta-analyses and reports from researchers and pertinent health/government agencies; however, according to Physicians for a Smoke-Free Canada (2022), some conclusions can be drawn that warrant significant consideration when considering public health messaging and government legislation:

1. *“E-cigarettes have increased the number of young nicotine users in some countries;*
2. *Young people who use e-cigarettes are more likely to smoke conventional cigarettes;*
3. *Dual use is common and harmful;*
4. *When purchased as consumer products, e-cigarettes are not effective cessation aids;*
5. *E-cigarettes cause damage to respiratory and circulatory systems;*
6. *Other governments have provided more recent scientific assessments.” (PSC, 2022)*

The Southwest Tobacco Control Area Network recommends that Health Canada’s messaging on vaping and the safety of vapour products be reviewed, revised and updated to reflect all available evidence.

Vapour Product Flavouring and Additives

The plethora of flavours in vapour products has posed significant challenges in public health efforts to halt vapour product uptake, especially by young people. Youth consider the flavour of vaping products to be the most important factor when trying e-cigarettes, and vaping initiation is more likely to occur with fruit, sweet, menthol and cherry flavoured products (Zare et al. 2018). Additionally, when non-traditional flavours are restricted and mint and menthol remain on the market, young people shift their purchasing and consumption preferences toward mint and menthol flavour (Morean et al., 2018; Diaz et al., 2020). The exclusion of menthol and mint flavours from the pending ban on flavours under the *Tobacco and Vaping Products Act* and regulations needs to be revisited. According to Al-Hamdani, Hopkins, and Davidson (2021) and the 2020-2021 Youth and Young Adult Vaping Project, almost all vapour product users consumed a flavoured vape juice both at initiation (91.9%) and at present (90.3%). In addition, in most provinces, berry, mango and mint/menthol were the most reported flavours being used (Al-Hamdani, et al., 2021).

The Southwest Tobacco Control Area Network highly recommends Health Canada to adopt the regulation to ban all vapour product and e-substance flavours, including mint and menthol or a combination of mint/menthol, except for tobacco flavoured products, without delay.

Vapour Product Promotion and Advertising

The current restrictions on advertising and promotional activities do not adequately protect youth. Vaping products should be brought under the same advertising and promotion control framework as tobacco. Advertising at such places as recreational facilities, restaurants, places of entertainment, post-secondary institutions, broadcast media, in print publications and online/social media should be prohibited given the potential for youth exposure. Vapour product advertising should only be information advertising or brand preference advertising, which would align the vaping product promotional framework with the approach applied to tobacco products. A 2019 national Leger poll found that 86% of Canadians believe that the government should apply the same advertising restrictions to vaping products with nicotine as it does to tobacco products in order to protect youth (Leger, 2019). Additionally, there should be a complete ban on offering free or discounted vaping

products. There is a substantial body of evidence that supports price control measures and strong taxation regimes for reducing youth and young adult smoking initiation, as they are more sensitive to price increases (Public Health Ontario, 2017). According to Huang, Tauras and Chaloupka (2013) and research conducted by Corrigan and colleagues (2021), policies increasing the price of vapour products, either through a taxation regime or limiting rebates, discount pricing, and coupons/bulk buying incentives could dissuade relatively few older adult cigarette smokers from switching to e-cigarettes while at the same time, be highly effective at preventing youth and young adults from initiating the use of vapour products.

The Southwest Tobacco Control Area Network highly recommends that Health Canada implement a comprehensive framework that strictly regulates advertising and promotional activities in alignment with current controls in place for tobacco products. Further, the inclusion of product pricing measures and prohibitions on incentive and bulk buying programs are required.

On-Screen Impressions of Smoking and Vaping

For over a decade, staff members from the Southwest Tobacco Control Area Network have been active members of the Ontario Coalition for Smoke-Free Movies (OCSFM) and have closely followed emerging evidence about the impact on youth when they observe tobacco and vapour product use on screen.

OCSFM's extensive experience on this issue, including frequent interactions with colleagues and researchers from the United States has led to the conclusion that frequent exposure of youth to both smoking and vaping on theatre screens, on television and on-line continuously encourages youth to try or continue using both tobacco and vapour products (Truth Initiative, 2021; Bennett et al., 2022; US Surgeon General, 2012).

Prior to the introduction of multiple viewing platforms and ubiquitous streaming services for both movies and episodic series, the on-screen presence of tobacco products was largely limited to combustibles, usually cigarettes, and usually seen in movies in theatres. Smoking impressions and tobacco imagery within movies in North America has very rarely been the subject of a "restricted" movie rating. Internationally replicated research that began in the early 2000s demonstrated that youth were often influenced to start smoking by seeing movie characters smoking on screen (Dalton et al., 2003). The American film industry has significant global influence, and the influence that tobacco imagery within movies has on youth should not be underestimated (Polansky, Driscoll and Glantz, 2019).

By 2016, researchers had confirmed and replicated their conclusions to the point that the World Health Organization called on signatories of the Framework Convention on Tobacco Control (FCTC), of which Canada is one, to implement the following policy measures, in line with the guidelines of article 13, to reduce the impact that smoking in the movies is having on youth tobacco use initiation:

- Require adult ratings for films with tobacco imagery to reduce overall exposure of youth to tobacco imagery in films;
- Certify within movie credits that film producers received nothing of value for using or displaying tobacco products in a film;
- Prohibit the display and identification of tobacco brands in films;
- Make media production companies ineligible for public subsidies and grants if they show smoking or tobacco brands, or identify a relationship with the tobacco industry; and,
- Require strong anti-smoking advertisements to be shown prior to showing films that contain tobacco imagery through all distribution channels (cinemas, televisions, online, etc) (World Health Organization, 2015).

The platforms on which youth can access movies, episodic series and other content today have multiplied since the 2000s. Streamed films and episodic series are readily accessible in the home, in theatres and on various portable media devices. While these products are often preceded by advisories about violence, drug use, explicit sexual content, or mature themes, only Netflix and Disney+ make any mention of smoking. The WHO's policies noted above are entirely disregarded. This disregard takes on even greater importance as new research from the United States shows that when youth see tobacco smoking on-screen, many youth respond by initiating the use of vapour products (Bennett et al., 2022). According to the US Truth Initiative, "...research shows **on-screen exposure to tobacco imagery makes young people more likely to start vaping**. A landmark 2020 study published in [Preventive Medicine](#), found that exposure to smoking images through episodic programming can triple a young person's odds of starting to vape nicotine" (Truth Initiative, 2022). The Truth Initiative's 2021 report, [While You were Streaming: Nicotine on Demand](#) shows that 60% of young people's top 15 favorite streaming

and broadcast season shows released in 2020 featured smoking, exposing an estimated 27 million youth to tobacco imagery (Truth Initiative, 2021). The report also highlights the poor performance of Netflix, one of the most popular on-line streaming platforms with viewers of all ages. Despite efforts by the US National Association of Attorneys General to urge US streaming services and creative guilds to limit tobacco depictions in programming appealing to youth, Netflix “remains the worst offender four years in a row based on its new 2020 season releases and popular binge-worthy shows” (Truth Initiative, 2022). Canadian youth watch much the same media content as their counterparts in the United States; therefore, the latest findings should be cause for alarm as there is no evidence-based reason to conclude that Canadian youth are less-susceptible to the influence of frequent exposure to on-screen smoking and (increasingly) vaping.

At present, there are no provincial restrictions in place to prevent – or reduce the likelihood of – youth exposure to on-screen smoking or vaping. While Ontario did at one time have a legislated requirement that film advertising had to contain an advisory of tobacco use if warranted, recent legislation removed that requirement. The 2020 *Ontario Film Content Information Act* cancelled the province’s previous film rating system, and now asks “exhibitors” to advise moviegoers about film content, but without prescribed regulations specifying how this requirement should be achieved.

In light of the increasing evidence about the pervasiveness of on-screen smoking and its effect on the initiation of youth smoking and vaping, the Southwest Tobacco Control Area Network recommends that Health Canada explores the enactment of WHO’s policy options to address on-screen tobacco and vaping imagery.

SECTION 2

PROTECT THE HEALTH OF YOUNG PERSONS AND NON-USERS OF TOBACCO PRODUCTS FROM EXPOSURE TO AND DEPENDENCE ON NICOTINE THAT COULD RESULT FROM THE USE OF VAPING PRODUCTS

Q.1 Are the current restrictions in the Act and its regulations sufficient to protect the health of young persons from exposure to and dependence on nicotine that could result from the use of vaping products?

Q.2 Are the new restrictions on nicotine concentration levels sufficient to protect youth and non-users of tobacco products from nicotine exposure? If not, what additional measures are needed?

Q.3 Are there other measures that the Government could employ to protect the health of young persons from exposure to and dependence on nicotine from vaping products?

Q.4 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?

Nicotine Concentration and Uniform Dosing Levels

Data from the 2018-19 Canadian Student Tobacco Alcohol and Drugs (CSTADS) survey showed that 20.2% of Canadian students (approximately 418,000) had used an e-cigarette (with or without nicotine) in the past 30 days (Health Canada, 2019). Students that reported vaping (with or without nicotine) in the past 30 days were vaping regularly, with approximately 40% reporting daily or almost daily use (Health Canada, 2019). CSTADS also showed that vaping had led to an overall increase in nicotine use by youth, which suggested that vaping had not replaced smoking behaviours among young people. In fact, the total prevalence of vaping and smoking among young people was much higher than the prevalence of smoking in that population a decade ago. By far, most of the youth in Canada who vaped were using devices that contained nicotine, with 87.6% of all current grade 7 – 12 students vaping nicotine (Health Canada, 2019). In addition, according to the 2020-2021 Youth and Young Adult Vaping project, of the 3000 individuals between the ages of 16 and 24 who were interviewed, 64.3% reported using vape juice containing the highest possible concentrations of nicotine (50-60 mg/ml) (Al-Hamdani et al., 2021).

Nicotine is a highly addictive substance that poses significant risk, especially to young people. The brain continues to develop until an individual reaches the approximate age of 25. Exposure to nicotine during brain development can result in nicotine addiction, mood disorders, permanent lowering of impulse control, and changes to attention and learning (NASSEM, 2018). Other health impacts include increased blood pressure, increasing risk of heart disease and stroke (Gonzalez and Cooke, 2021), and the potential for increased risk of the spread breast cancer to the lungs (Huynh et al., 2020). The adverse effects from the use of high concentrations of nicotine include vomiting, headaches, dizziness, nausea and in extreme cases,

fainting and nicotine poisoning (NASEM, 2018).

Federal regulation of nicotine levels offers consistent protection from nicotine addiction for youth across Canada, by bringing the current patchwork of provincial regulations into alignment across Canada. The federal regulation to limit nicotine concentration in vaping products to a maximum of 20 mg/ml has been supported by many public health agencies across Canada and is in alignment with the European Union Commission. Nicotine is a highly addictive substance and reported youth preferences for products with the highest levels of nicotine (Al-Hamdani et al., 2021) justifies the requirement for Health Canada to monitor the scientific evidence on an ongoing basis and adjust product limits accordingly.

Another important factor related to nicotine concentration levels is the application of vapour product design standards to ensure the consistent and uniform dosing of nicotine to vapour product users. According to the European Union's (EU) Commission investigating the latest available evidence on vapour products, at present, vapour products are not held to design and manufacturing standards that ensure that the device delivers the same amount of nicotine per puff by the user (European Union SHEER, 2021). Given that cigarettes are engineered to deliver consistent doses of nicotine, it appears logical that e-cigarettes should do the same if they are to effectively replace nicotine delivered from cigarettes.

The Southwest Tobacco Control Area Network supports the immediate enactment of the 20 mg/ml nicotine concentration level maximum for vapour products, along with the development of an annual review of available scientific evidence which would allow for downward adjustments if necessary. Further, it is recommended that Health Canada impose product engineering standards to ensure uniform nicotine dosing so that users know how much nicotine they are inhaling.

SECTION 3

PROTECT THE HEALTH OF YOUNG PERSONS BY RESTRICTING ACCESS TO VAPING PRODUCTS.

Q.1 Are measures in the Act sufficient to prevent youth from accessing vaping products? If not, what more could be done to restrict youth access to vaping products?

Q.2 Are there other measures that the Government could employ to protect youth from accessing vaping products?

Q.3 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?

Retailer Prohibitions of Sales of Tobacco and Vaping Products

The Middlesex-London Health Unit (MLHU), a member public health unit of the SWTCAN reported that between 2020 and 2022, they observed an increase in the number of tobacco youth access test shopping failures, as well as an all-time high rate of vapour product youth access test shopping failures. Prior to 2020, MLHU's tobacco and vapour product youth access compliance rates were ~99.9%. Tobacco Enforcement Officers (TEOs) within Middlesex-London are noting an alarming trend. Since October 2021, TEOs and youth test shoppers have completed 200 youth access checks for vapour products that have resulted in 21 failures (89.5% compliance rate), with more retailers yet to be inspected. The majority of the youth access failures were at non-specialty vape stores, including convenience stores and gas stations, using youth test shoppers who are between 15 and 16 years of age -- well below the legal age of 19 years in Ontario.

Under the *Smoke-Free Ontario Act, 2017 (SFOA, 2017)*, only vapour products flavoured with mint, menthol and tobacco can be sold in non-specialty vape stores (e.g. convenience stores, gas station kiosks, grocery stores, etc.); whereas, vapour products that contain other flavours must only be sold in age-restricted specialty vape stores. Furthermore, under the *SFOA, 2017*, vapour products that have a nicotine concentration of greater than 20 mg/ml can only be sold in age-restricted specialty vape stores. In the Middlesex-London area, during this latest round of youth access inspections, many of the vapour products that were sold to youth test shoppers from non-specialty vape stores were flavoured with fruit and candy-flavoured additives, and had a nicotine concentration of greater than 20 mg/ml, despite the provincial legislation. The illegal sale of these products has resulted in the issuance of charges for the sale of prescribed vapour products in a prohibited place and the seizure of these products. Between June 2021 and March 2022, tobacco enforcement officers (TEOs) for MLHU have conducted a total of 5 vapour product seizures, with estimated values ranging from \$200 - \$25,000 from each establishment. In addition to the loss of merchandise, fines under the *SFOA, 2017* are also applied for each offence; however, it has become apparent that the fines and seizures of vapour products are an insufficient deterrent.

Under the *SFOA, 2017*, routine non-compliance with tobacco sales offences results in the issuance of an automatic prohibition order under Section 22. At present, there is no automatic prohibition lever that can be applied to retailers who continue to sell vapour products to persons under the age of 19 years, nor for non-specialty vape stores that continue to sell vapour products that should only be available for sale in age-restricted stores in Ontario. Operators have shared with MLHU TEOs that the total revenue from sales of vapour products alone far exceeds both the fine amounts and the risk of product seizures and is viewed as a cost of doing business. Based on the current compliance rate and reported retailer behaviors, current vapour product regulations are insufficient.

The Southwest Tobacco Control Area Network recommends that Health Canada implement an automatic prohibition regime for both tobacco and vaping products under the TVPA modelled after Section 22 of the *Smoke-Free Ontario Act, 2017*, for repeated convictions against retailers who:

- sell tobacco and/or vaping products to persons under the legal age;
- sell flavoured tobacco and vaping products prohibited by law; and,
- sell vaping products with nicotine concentration levels that exceed 20 mg/ml.

Reciprocal Relationships and Cooperation Between Federal and Provincial Inspectors

In Ontario, the display, promotion and sale of tobacco and vaping products at retail are regulated by both provincial and federal legislation. The *TVPA* is enforced by Health Canada Inspectors exclusively, who are responsible for monitoring and ensuring compliance with the *Act* and the Regulations. In Ontario, public health unit staff are designated by the authority outlined under the *Smoke-Free Ontario Act, 2017*, to enforce the requirements and restrictions at retail under provincial legislation exclusively, with no authority under the *TVPA*.

This means that if non-compliance with the *TVPA* and/or Regulations are observed by the local public health inspectors, the only recourse available is to refer the non-compliance and possible infraction to the Health Canada Inspectorate. Given the size and scope of jurisdiction that falls to the Health Canada Inspectorate, it is difficult for their Inspectors to respond to the referral in a timely matter. This means that in many cases, vapour products, prescribed by federal law to be “illegal” and subject to federal seizure, remains within the store for continued sale. There is significant consumer demand for this product; therefore, despite warnings issued by provincial inspectors, product will remain on store shelves available for sale or for distribution through other illegal means. In Ontario, there has been some success with reciprocal relationships and collaboration between Ontario Ministry of Finance Inspectors (enforcement of the *Tobacco Tax Act*) and public health staff (enforcement of the *SFOA, 2017*). For example, if illegal tobacco products (under the *Tobacco Tax Act*) are found within a retailer, and a Ministry of Finance Inspector is not within the jurisdiction, under direction of the Ministry of Finance Inspector, the Health Unit Inspector will safely secure the product off site until the Ministry of Finance Inspector can attend to seize the product for their investigation. Not only does this reciprocal and collaborative relationship help to remove illegal products from the marketplace, but it also increases public and retailer perception of a greater enforcement presence, which contributes to greater compliance overall. It is recommended that a similar arrangement be explored between federal and provincial enforcement agencies given the continued availability of flavoured and high nicotine concentration products. Alternatively, the cross designation of provincial and federal inspectorate for sections of the *TVPA* and Regulations that pertain to retail could also be explored.

The Southwest Tobacco Control Area Network recommends that Health Canada engage with provincial Ministries of Health and representatives from local public health enforcement to explore the options that exist to support more timely enforcement action.

Tighten Restrictions for Online Retail Marketing

Besides the availability of vapour products at retail outlets such as convenience stores, gas stations, grocery stores, and specialty vape stores, vapour products are widely available for sale through websites and social media (Hammond, et al., 2015). While many online vendors use age-verification measures during online purchase, people under the age of 18 years are still able to purchase vapour products online (Hammond et al., 2015). In 2017, the Canadian Tobacco and Drug Survey (CTADS) indicated that more than 75% of youth age 15-19 years who tried a vaping product borrowed, shared or bought it

from a friend or relative (Health Canada, 2018). In 2019, the Canadian Tobacco and Nicotine Survey showed that social access of vaping products among those aged 15-19 years had dropped to 58%, and 43% of this age group purchase from retail sources, including online vendors (Health Canada, 2019).

Underage youth who purchase vaping products online either falsely claim to be of legal age when they access the website, or they are not required to show proof of age. A content analysis of internet e-cigarette vendor practices discovered that most vape vendors (over 60%) did not require age verification or relied on ineffective strategies such as checking a box to verify legal age (Williams et al., 2018). Similarly, Gaiha and colleagues (2020) found that more than a quarter of underage e-cigarette users surveyed were not required to verify their age when purchasing e-cigarettes online.

The local experience within the Middlesex-London jurisdiction is in congruence with the evidence. Since resuming in-person learning within Middlesex-London schools in the fall of 2021, approximately 80% of youth are telling TEOs they buy vapour products online. Young people are reporting that they find it easy to get vaping products through online sources. One youth stated that the vapour products are delivered to their mailbox and that he can easily conceal the purchase from his parents because it is his responsibility to pick up the mail after school.

Some specialty vape stores that formerly operated a brick and mortar store within the Middlesex-London jurisdiction have shifted to manufacturing and wholesale, and/or to online-based operation to continue to sell flavoured and high nicotine concentration products to all ages, with less enforcement scrutiny. These products are shipped directly to customers' houses or offered through curbside pickup. This process applies the obligation of age verification to the agents/agencies used for delivery. Enforcement agencies, both at the federal and provincial levels are challenged to be able to effectively monitor retailer compliance with youth access provisions.

Industry brand-incentive programs, like the "Vuse – Click and Collect" program, are also operating within southwestern Ontario. This program allows customers to place their orders online and then pick up the vapour products, including all flavours and nicotine concentrations, at select convenience stores. Programs like this appear to have been able to find legislative loopholes and they contribute to the erosion of progress that had been made to prohibit youth access to tobacco and vapour products and to restrict access to flavoured and high nicotine concentration vapour products.

The *TVPA* prohibits youth access to vaping products in a public place or in a place to which the public has access, which includes online retailing. The *Act* specifies that a person, including a retailer, must verify the age of a person purchasing vaping products, however it does not specify how age verification is to be implemented. The current system on many websites of clicking a box to attest to being of age has obvious pitfalls.

The Southwest Tobacco Control Area Network recommends that Health Canada works with provincial Ministries of Health to implement consistent and strict requirements to regulate online sales, including the following measures:

- **Require online retailers to post information advising prospective customers that the sale of vaping and tobacco products are restricted to persons of legal age;**
- **Require two-step age verification for online retailing - the two-step process should involve two authentication methods performed one after the other to verify identity;**
- **Require online retailers to utilize third-party verification services;**
- **Require tobacco and vapour products to contain a label that states that age verification is required at delivery;**
- **Upon delivery, require that a signature be obtained, and packages must not be left on doorsteps;**
- **Require that delivery be restricted to prescribed carriers.**

Enactment of a Tax and Vapour Product Pricing Regime

There is unequivocal evidence documented in the tobacco control literature that price increases result in decreased demand and use of cigarettes, and increased intentions to quit smoking (SFO-SAC, 2017). Many provinces have proposed or passed legislation to tax vapour products, including British Columbia, Alberta, Prince Edward Island, Saskatchewan and Newfoundland Labrador. There exists the opportunity to enact a national tax regime on vapour products to reduce the consumption of vapour products by youth and young adults as they tend to be more price sensitive than adults (U.S.

Department of Health and Human Services, 2000). The revenue from taxes from tobacco products along with the revenue from the taxation regime applied to vapour products could be used to fund comprehensive tobacco and vapour product control programming, including prevention and cessation efforts, increased compliance monitoring and enforcement, and ongoing research. A complementary measure to increase the retail price of tobacco and vapour products is to mandate a minimum pre-tax set price minimum (Feighery, et al., 2005). Setting minimum price limits inhibits the manufacturers' ability to use discount pricing and the retail sale of low-cost brands or devices to offset the price increases from taxation (SFO-SAC, 2010). Minimum price policies are effective and widely used to reduce alcohol consumption and harms (Anderson, et al., 2009). The taxation level and the set price minimums for vapour products should be set independently from tobacco products, with careful consideration being given to ensure that e-cigarettes do not become more expensive than cigarettes, but set high enough to deter youth and young adult initiation. The 2021 federal budget announced the Government of Canada's intention to introduce a new taxation framework for vaping products in 2022.

The Southwest Tobacco Control Area Network recommends that Health Canada enact a comprehensive, national vapour product taxation and pricing regime without delay, to reduce youth and young adult consumption and associated harms from vapour product use.

SECTION 4

PREVENT THE PUBLIC FROM BEING DECEIVED OR MISLED WITH RESPECT TO THE HEALTH HAZARDS OF USING VAPING PRODUCTS

Q.1 Are the current measures in place sufficient to prevent the public from being deceived or misled about the health hazards of vaping products?

Q.2 What additional measures would help reduce the misconceptions about the health hazards of vaping products?

Q.3 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?

Appealing Vapour Product Marketing and Unsubstantiated Health Claims

Websites selling vapour products online are ubiquitous and use marketing tactics that are appealing to youth. In 2019, the Ontario Tobacco Research Unit (OTRU) collected samples of flavoured vaping products from online Canadian vape stores and found several examples of flavoured vaping products with attractive packaging, design elements, names and descriptors with youth-appeal (O'Connor, et al., 2019). Furthermore, researchers who conducted a systematic content and legal analysis of the claims made by e-cigarette manufacturers and retailers on their websites concluded that the vast majority of websites made at least one health-related claim, focusing on potential health benefits while minimizing or eliminating information about possible harmful effects of vaping products (Klein, et al., 2016). Grana and Ling's (2014) content analysis of e-cigarette retail websites also discovered that health claims and cessation messages that are unsupported by current scientific evidence are frequently used by vapour product retailers to sell vaping products (Grana and Ling, 2014). Vaping products have not been approved by Health Canada as a smoking cessation aid because they are not currently tested, manufactured, and regulated as such in Canada. Therefore, claims about vapour product efficacy as a cessation tool should be strictly prohibited.

Enforcement reports from Health Canada inspectors reinforce the lack of compliance by online retailers with current promotion and advertising restrictions under the *TVPA*. Between July 2020 and March 2021, Health Canada inspectors conducted inspections of Instagram social media accounts to assess vapour product industry compliance, with a focus on publicly accessible online promotions. Inspectors reviewed 304 accounts on Instagram and observed non-compliance on 53% of the accounts, resulting in the issuance of a warning letter (Health Canada, 2021) Increased enforcement (issuance of fines) and stricter prohibitions on vapour product advertising are required.

The Southwest Tobacco Control Area Network recommends Health Canada to prohibit online vapour product retailers from making health claims, using celebrity and medical professional endorsements, and promoting e-cigarettes as a cessation aid. Increased compliance monitoring and the use of progressive enforcement measures (Part I charges and Part III summonses) are required.

Vapour Product Appearance and Packaging Design

In November 2019, Canada implemented plain and standardized tobacco product packaging regulations. With strict promotion and advertising rules in effect for tobacco products across Canada, the tobacco package became an important marketing tool, using colours, images, logos and distinctive fonts, finishes and sizing. According to Moodie, Mackintosh, Hastings and Ford, (2011), studies have determined that the colour, shape and size of a package can influence consumer behaviour and contributes to consumer perceptions of the product. Package design can make its contents appear safe to use, undermining the visibility, credibility and effectiveness of health warnings. The same body of evidence can be applied to the regulation of vapour products and packaging. Devices are being manufactured to look like small, discrete everyday objects, so that youth can vape discretely, hiding their nicotine addiction from parents, employers and teachers. Across southwestern Ontario, the ability to “stealth vape” in school washrooms and classrooms undermine the efforts that school staff and public health unit staff are taking to promote and enforce the *Smoke-Free Ontario Act, 2017* on school property. The devices can be customized, which complements the lifestyle messaging that youth are receiving from the internet and on social media.

The Southwest Tobacco Control Area Network recommends that Health Canada apply a similar plain and standardized packaging regime to vapour products that Health Canada has already applied to commercial tobacco and cannabis products.

SECTION 5

ENHANCE PUBLIC AWARENESS OF HEALTH HAZARDS

Q.1 Have public awareness efforts been effective at educating Canadians about the health risks of vaping products?

Q. 2 What more could be done to educate Canadians about the health risks of vaping products?

Q.3 Are there still knowledge gaps to fill with regard to the health risks of vaping products? If so, what areas should research focus on?

Q.4 What approach should be taken to close the gap between scientific evidence and public perception so that youth and non-users of tobacco products are aware of the health risks of using vaping products, while adults who smoke are aware that they are a less harmful alternative to tobacco if they switch completely to vaping?

Comprehensive Review of Available Scientific Evidence Required

There has been a concerted effort to increase the body of scientific evidence available to assess the potential harms and potential benefits associated with vapour products, in an attempt to keep up with the ever-expanding vapour product market. According to a 2022 published report from [Grandview Research](#), the global vapour product market size was valued at \$18.13 billion USD in 2021 and is expected to expand at a compound annual growth rate of 30% between 2022 to 2030; North America dominated the global market with a share of over 40% in 2021 (Grandview Research, 2022). They note that the projected market growth expansion is due to the “rising awareness about e-cigarettes being safer than traditional cigarettes, especially among young people”. They go on to explain that the growing online retail market amid the COVID-19 pandemic is also projected to factor into the market growth (Grandview Research 2022). The increase in the availability of vapour products by youth and young adults combined with the apparent belief and pervasive messaging found online that “less harmful” means that vapour products are safe is a significant public health concern.

As noted by Physicians for a Smoke-Free Canada (2022), the 2018 NASEM assessment of evidence on e-cigarette and vapour products relied on only one-third of the evidence that is available today. Since the release of the publication, researchers have developed a greater understanding of the potential harms associated with e-cigarette use, including health harms from dual use of vapour products and cigarettes and the potential for vapour products to aid in smoking cessation. Messaging available on Health Canada web pages require review and revision to incorporate findings from the growing body of scientific evidence.

▪ ***Dual use of combustible cigarettes and e-cigarettes is common and harmful***

Health Canada’s webpage on Vaping and Quitting Smoking (2020) states that if an individual completely switches completely from smoking cigarettes to using vapour products, the individual will experience short-term general health improvements. The challenge with this messaging is that research has shown that in Canada, 38% of Canadian vapers are people who both smoke cigarettes and vape (PSC, 2021). In addition, the 2020 Canadian Tobacco and Nicotine Survey results showed that although youth and young adults between the ages of 15 and 24 made up only 15% of the surveyed population, they represented 40% of those who reported that they vape. The emphasis on the harm reduction approach clouds the fact that there is scientific consensus that using both vapour products and conventional cigarettes is likely more harmful than only smoking or only using vapour products (PSC, 2022), and youth and young adults are then more susceptible to trying vapour products because ‘they aren’t as bad as smoking’.

▪ ***E-cigarettes cause damage to respiratory and circulatory systems.***

The available scientific evidence regarding the impact of vapour product use on respiratory and circulatory systems has increased substantially, with hundreds of studies examining the health harms in laboratory studies of both animals and humans.

- Researchers have concluded that the damage caused by vapour products leads to lung and heart disease and stroke (Keith and Bhatnagar, 2021). Vapour product use may also compromise the ability to remove microbial pathogens, increasing the risk of infection from viruses, fungi and bacteria (Keith and Bhatnagar, 2021).
- In another comprehensive review of cardiovascular effects, findings from Buchanan and colleagues (2020) suggest that vapour product use is associated with inflammation, oxidative stress and haemodynamic imbalance increasing risk of cardiovascular disease (Buchanan et al., 2020).
- In a review of 38 studies measuring cardiovascular effects of e-cigarettes, “most studies suggest potential for cardiovascular harm from electronic cigarette use, through mechanisms that increase risk of thrombosis and atherosclerosis” (Kennedy et al, 2019).
- A 2020 review and meta-analyses of vapour product impact on lung health showed that e-cigarette use was associated with a 39% increase in the risk of asthma and a 51% increase in the risk of developing chronic obstructive pulmonary disease; studies conducted within laboratories showed influence on biological processes that contribute to respiratory harm and illness (Wills et al., 2020).
- According to Lauren Davis and colleagues (2022), based upon a review of the pulmonary effects of long-term vaping product use, they conclude that e-cigarette use is “...likely to result in irreversible parenchymal lung tissue damage and impaired gas exchange, contributing to chronic lung conditions in long-term vapers”.

▪ ***There is insufficient evidence to support/promote vapour products as a cessation tool when sold and regulated as a consumer product.***

Health Canada’s web page on [Vaping and Quitting Smoking](#) reads that “quitting smoking can be difficult, but it is possible. Vaping products and e-cigarettes deliver nicotine in a less harmful way than smoking cigarettes”. The web page further states that “while evidence is still emerging, some evidence suggests that using e-cigarettes is linked to improved rates of success” (Health Canada, 2020). There has been a growing body of scientific evidence to evaluate the effectiveness of vapour products to help those addicted to tobacco to quit, with mixed results. Physicians for a Smoke-Free Canada (2021) compiled a [summary](#) of scientific reports published after both the release of NASEM (2018) and the release of European Union’s scientific advisors “[Final Opinion on Electronic Cigarettes](#)” (2021). The following conclusions were drawn that warrant further investigation by Health Canada:

- Published studies to date, including longitudinal data analysis, randomized control trials and meta-analysis of e-cigarettes as consumer products (i.e. not regulated or monitored in a clinical setting), when dual use of smoking and vaping was assessed, found high levels of dual use. Further, those that successfully quit smoking had a high prevalence of sustained use of e-cigarettes (PSC, 2021).
- Vapour products may be helpful as smoking cessation aids, but the available evidence indicates that this is only observed in clinical settings with strict product oversight. Vapour products may have the potential to be as effective as other approved methods for cessation (e.g. nicotine replacement therapy, varenicline, bupropion, etc.); however, they do not meet minimum threshold levels for safety for widespread use. In Canada, vapour

products are regulated, marketed and sold as a consumer product (not a drug). Due to the high risk of dual use, sustained addiction to vapour products, growing scientific consensus regarding respiratory and cardiovascular harms associated with use, and the high risk of uptake of vapour products by never smokers, a precautionary approach remains prudent (PSC, 2021).

At present, vaping products have not been approved by Health Canada as a smoking cessation aid because they are not currently tested, manufactured, and regulated as such in Canada. Therefore, until an intensive review of the latest evidence is completed, Health Canada's messaging is confusing and contributing to misperceptions of perceived product safety.

The Southwest Tobacco Control Area Network recommends that Health Canada's messaging on vaping and the safety of vapour products be reviewed, revised and updated to incorporate all available evidence for public consumption and comprehension. Any legislated health warnings on vapour products or product promotional materials should be reviewed to ensure congruence with the growing body of scientific evidence available for vapour products.

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TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health

DATE: 2022 April 21

UPDATE OF URBAN AND RURAL HEALTH INDICATORS WITHIN THE MIDDLESEX-LONDON REGION

Recommendation

It is recommended that the Board of Health:

- 1) Receive Report No. 23-22, re: “Update of Urban and Rural Health Indicators within the Middlesex-London Region” for information; and*
- 2) Direct staff to provide a summary of this report to Middlesex County Council.*

Key Points

- Urban and rural comparisons within the Middlesex-London region for some key indicators were previously presented to Middlesex County Council in February 2020.
- Data drawn from 2020 emergency department visit data is currently the most up-to-date complete year of data available. There was no new mortality (death) data or behavioural risk factor data available since the last update.
- The COVID-19 pandemic was declared in March 2020 and has many yet-to-be-seen impacts on people’s behaviour patterns and health outcomes. The trends seen in non-COVID-19 population health indicators over the course of the pandemic may or may not be sustained in the years to come.
- In the Middlesex-London region, it is critical to understand the health status of neighbourhoods and communities within the region, including the health status of rural and County residents, as this helps to inform the need for unique interventions across the region. The Health Unit will continue to monitor, assess, and report relevant public health indicators moving forward.

Background

This brief report provides an update of the urban and rural population comparisons within the Middlesex-London region for some key indicators previously presented to Middlesex County Council in February 2020. The data is drawn from 2020 emergency department visit data which is currently the most up-to-date complete year of data available. There was no new mortality (death) data or behavioural risk factor data available since the last update; this may be due to data collection and processing delays associated with the COVID-19 pandemic.

The most recent full year of emergency department visit (EDV) data is for 2020. For this review, the most recent year of available data is presented as well as the rates over the past six years to see if there were any notable changes over time. The urban and rural classifications were based on postal codes linked to Statistics Canada 2016 Census geography.

Overview of Available Indicators

Falls and Motor Vehicle Collisions

The six-year trend for fall-related injuries EDVs rates showed a statistically significant increase between 2015 and 2019, except for a temporary ‘flattening’ between the years 2016 and 2017, for both urban and rural populations. Across all five years, the rate among rural populations was significantly higher than the urban rate, with the rural rate being 40% to 46% higher than the urban rate, depending on the year. In 2020, fall-related injuries EDVs dramatically decreased compared to 2019 data (statistically significant difference) for both urban and rural populations. This decrease is likely due to decreased activities and mobility in the population because of the COVID-19 pandemic and related public health measures that were introduced. However, the 2020 rural rate continued to be about one-third (33.4%) higher than the urban rate (statistically significant) ([Appendix A](#), Figure 1).

From 2015 and 2019, rates of motor vehicle collision injury EDVs increased for both rural and urban populations, however, the increase was statistically significant only for urban populations. However, in all years, the rate among rural populations was 44% to 73% higher than among urban populations, depending on the year. Like falls injury EDVs, motor vehicle collisions EDVs also dramatically decreased in 2020 compared to 2019 data (statistically significant) for both rural and urban populations. The marked decrease is likely related to the decreased mobility of the population in response to the COVID-19 pandemic. However, the 2020 rural rate continue to be 51% higher compared to the urban rate (statistically significant) ([Appendix A](#), Figure 2).

Opioid-related Poisoning

The six-year trend for opioid-related poisoning EDVs shows that rates have significantly increased for both urban and rural populations since 2015. Compared to rural rates, urban rates were statistically significantly higher in every year except 2018. Unfortunately, unlike the decreases in other EDVs observed with the start of the COVID-19 pandemic, the 2020 data for opioid-related EDVs showed increases over the 2019 rates for both the urban and rural populations in the Middlesex-London region (difference not statistically significant). The 2020 rates of opioid-related EDVs among rural populations increased by 90% compared to 2019, whereas the 2020 urban rate increased by 15%. However, the 2020 urban rate was still 62% higher than the rural rate ([Appendix A](#), Figure 3).

Summary and Next Steps

Population health indicators are influenced by many different things, including public health interventions and services. These indicators often do not shift quickly, and therefore ongoing, longitudinal assessment is necessary to understand community health trends.

The COVID-19 pandemic was declared in March 2020 and has many yet-to-be-seen impacts on people’s behaviour patterns and health outcomes. The trends seen in non-COVID-19 population health indicators over the course of the pandemic may or may not be sustained in the years to come. Further assessment will be required.

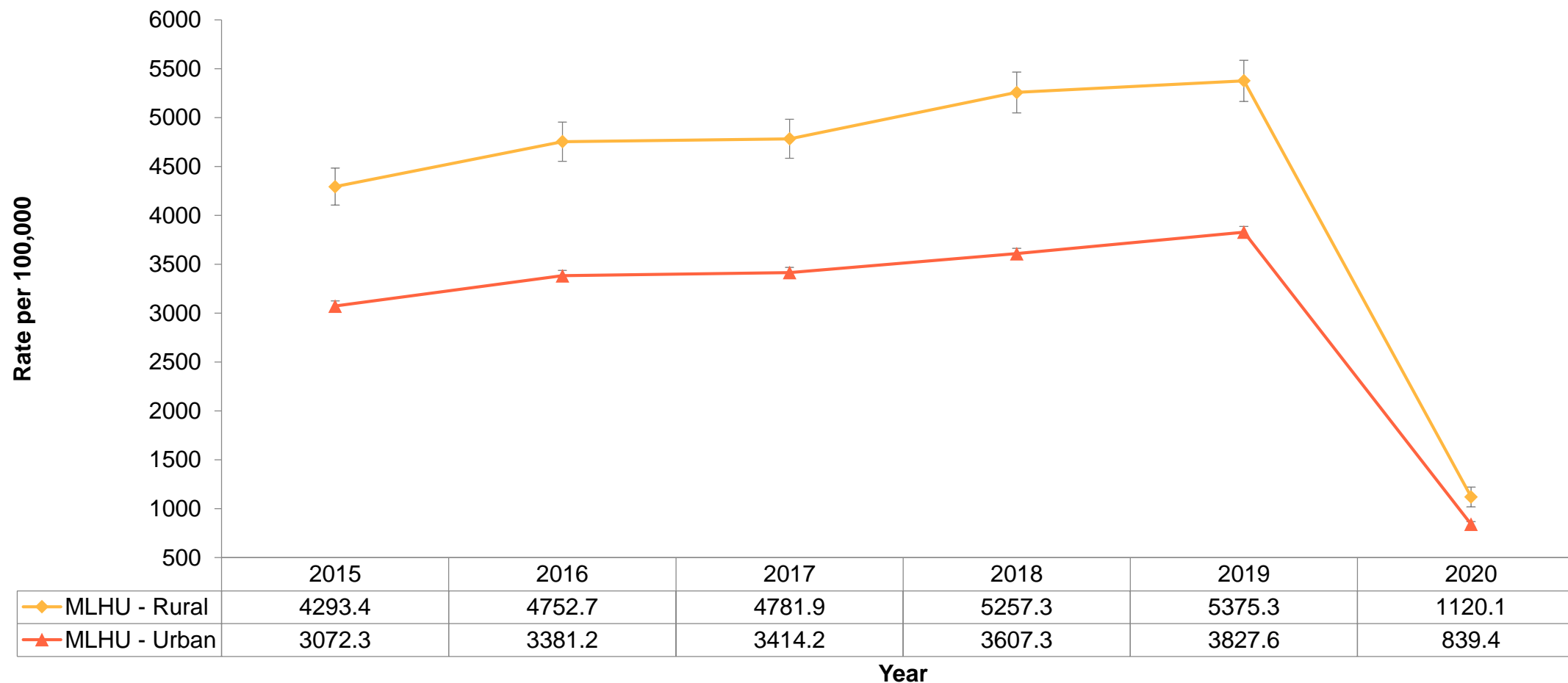
Population health assessment is a foundational component of the work of public health as it can inform the work of public health agencies, other community organizations, and decision-makers. In the Middlesex-London region, it is critical to understand the health status of neighbourhoods and communities within the region, including the health status of rural and County residents, as this helps to inform the need for unique interventions across the region. The Health Unit will continue to monitor, assess, and report relevant public health indicators moving forward.

This report was prepared by the Population Health Assessment and Surveillance Team, Office of the Medical Officer of Health division.

A handwritten signature in black ink that reads "Alexander T. Summers". The signature is written in a cursive style with a long horizontal flourish at the end.

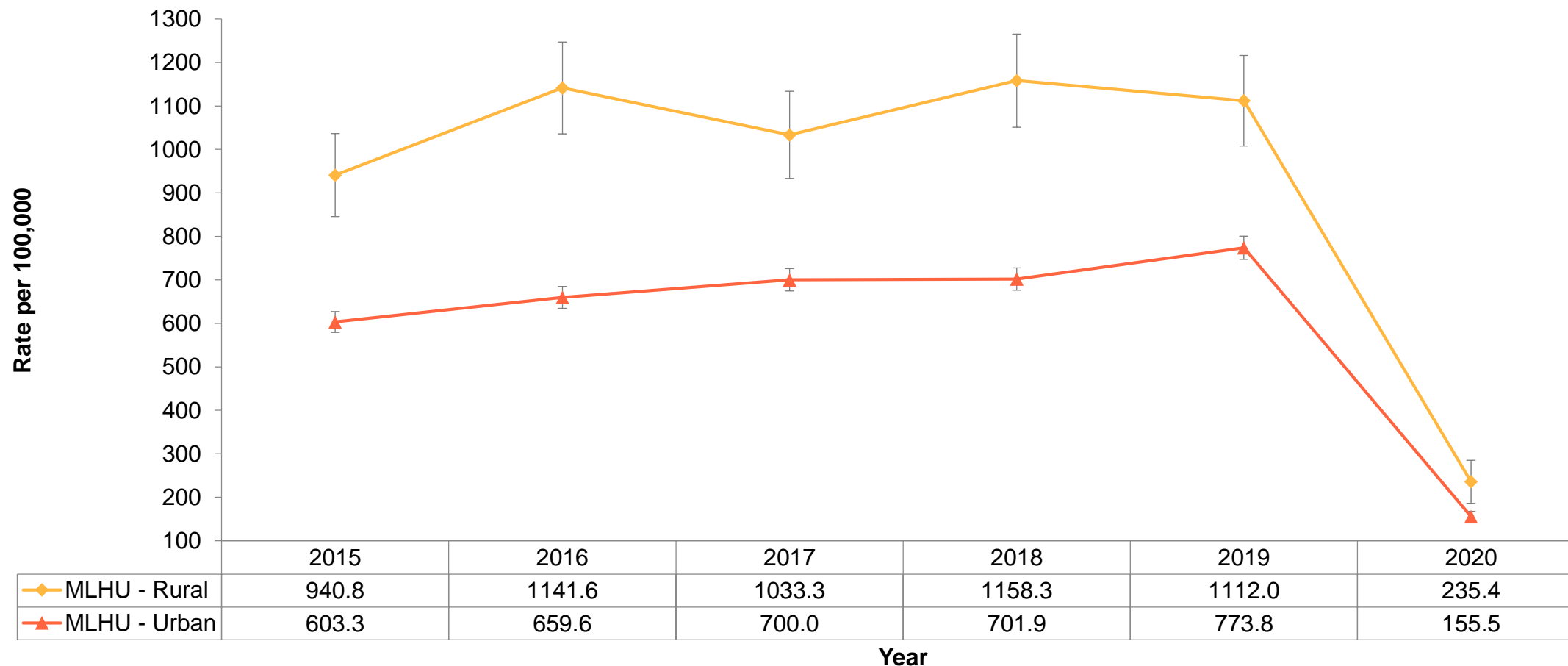
Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Figure 1: Age standardized rate of emergency department visits for fall-related injuries by rural or urban status, Middlesex-London, 2015-2020



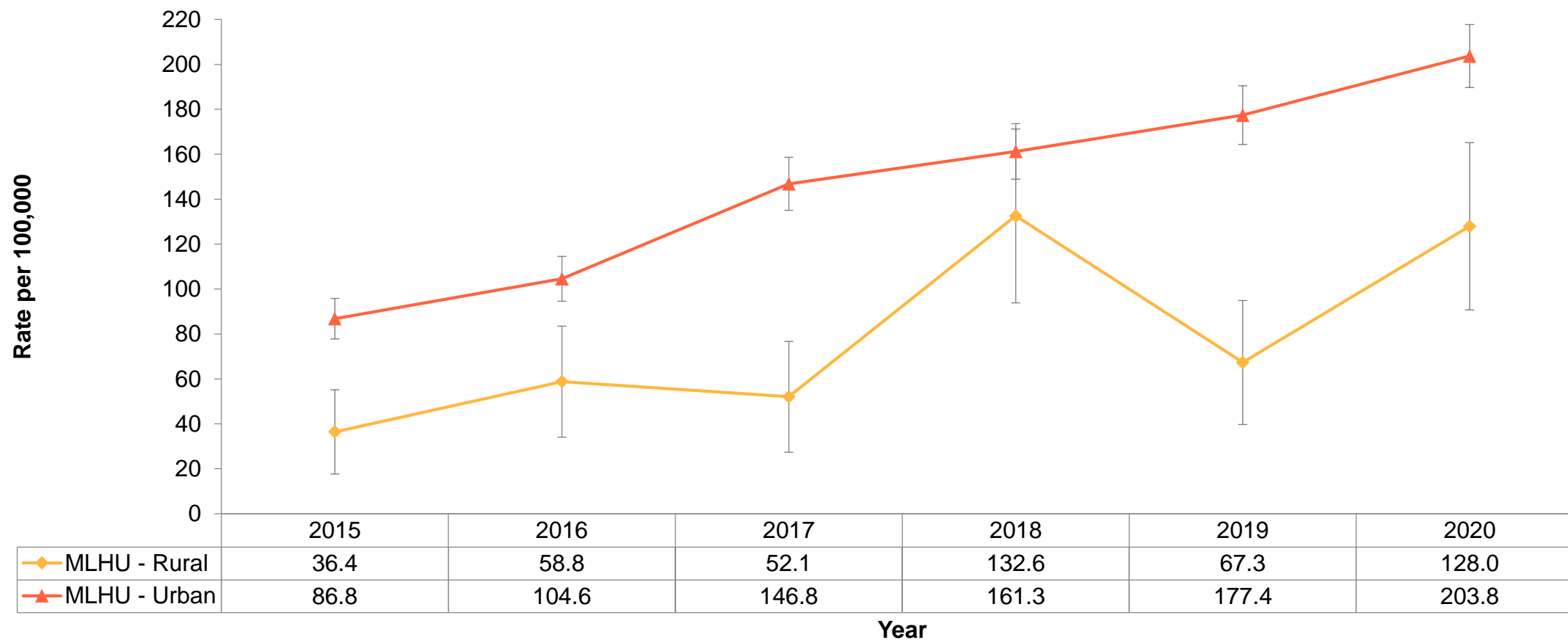
Ambulatory Emergency External Cause [2021], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: October 26, 2021; Population Estimates [2020], Statistics Canada, Date Extracted: October 27, 2021

Figure 2: Age standardized rate of emergency department visits for motor vehicle collision injuries by rural or urban status, Middlesex-London, 2015-2020



Ambulatory Emergency External Cause [2021], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: October 26, 2021; Population Estimates [2020], Statistics Canada, Date Extracted: October 27, 2021

Figure 3: Age standardized rate of emergency department visits for opioid-related poisoning by rural or urban status, Middlesex-London, 2015-2020



Ambulatory Emergency External Cause [2021], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: October 26, 2021; Population Estimates [2020], Statistics Canada, Date Extracted: October 27, 2021



TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2022 April 21

MLHU 2022 VACCINE PREVENTABLE DISEASES OPERATIONAL PLAN

Recommendation

It is recommended that the Board of Health receive Report No. 24-22, re: “MLHU 2022 Vaccine Preventable Diseases Operational Plan” for information.

Key Points

- As of March 26th, 2022, 91.6% of individuals 12 years of age and older have completed their primary COVID-19 vaccine series; of individuals 5 to 11 years of age, 46.8% have completed their primary series.
- Additional COVID-19 booster doses will likely be required in 2022, and MLHU must maintain infrastructure and health human resources to respond to episodic increases in demand for the COVID-19 vaccine.
- The *MLHU 2022 Vaccine Preventable Diseases Operational Plan* articulates the strategic vision and operational plan to guide the Middlesex-London Health Unit’s (MLHU) distribution and administration of the COVID-19 vaccine. It also outlines the integration of COVID-19 immunization operations with non-COVID-19 immunization operations.
- During periods of low demand for COVID-19 vaccine, MLHU will leverage operational resources to maximize non-COVID-19 immunization coverage of school-age children, as well as ensure broad and equitable access to the influenza vaccine in the fall of 2022.

Background

The first laboratory-confirmed case of COVID-19 in Middlesex-London was reported to the Middlesex-London Health Unit (MLHU) on January 24th, 2020. Since that first case and the declaration of the pandemic on March 11th, 2020, MLHU operations have evolved and adapted to address the case and contact management and vaccination needs of the community.

Vaccines were introduced to Middlesex-London in December of 2020. Under the strategic and operational leadership of MLHU, by January of 2022 over 1,116,000 vaccines have been delivered in the region. Distribution of the vaccine started in December 2020 through the mass immunization clinic at the Western Fair Agriplex, operated by the London Health Sciences Centre (LHSC). In the months to follow, MLHU added three more mass immunization sites (Caradoc Community Center in Mt. Brydges, and Earl Nichols Arena and North London Optimist Community Centre in London), and operated a significant number of mobile and pop-up clinics. In October 2021, MLHU took over operations of the Agriplex clinic. Additionally, MLHU created and implemented a vaccine distribution program to onboard, train, and provide vaccine to long-term care homes, retirement homes and primary care clinics. Along with pharmacy partners, these strategies have resulted in very high vaccination rates in the region; as of March 26th, 2022, 91.6% of individual 12 years of age and older have completed their primary COVID-19 vaccine series and of individuals 5 to 11 years of age, 46.8% have completed the primary series.

MLHU 2022 Vaccine Preventable Diseases Operational Plan

The *MLHU 2022 Vaccine Preventable Diseases Operational Plan* ([Appendix A](#)) articulates the strategic vision and operational plan to guide the Health Unit's distribution and administration of the COVID-19 vaccine. It also outlines the integration of COVID-19 immunization operations with non-COVID-19 immunization operations.

Due to waning immunity and the anticipated emergence of new COVID-19 variants, additional COVID-19 booster doses will be required in 2022 and beyond. MLHU must maintain infrastructure and health human resources to respond to episodic increases in demand for the COVID-19 vaccine. The Vaccine Preventable Disease (VPD) Team, within the Environmental Health and Infectious Diseases Division, has been restructured and expanded to meet this demand. A critical focus has been the hiring and development of leadership staff, as well as the cross-training of front-line staff. The team is operationally responsible for all the Ontario Public Health Standards and Protocols referencing or pertaining to immunization, including the administration and distribution of COVID-19 vaccines.

During periods of low demand for COVID-19 vaccine, MLHU will leverage operational resources to maximize non-COVID-19 immunization coverage of school-age children, as well as ensure broad and equitable access to the influenza vaccine in the fall of 2022. During the pandemic, portions of the routine work of the VPD team were minimally maintained or put on hold, including the screening of school-age children to ensure adherence with the *Immunization of School Pupils Act* (ISPA). With the periodic decrease in demand for COVID-19 vaccine, the additional health human resources will be used to screen students to ensure they are up-to-date in regards to all vaccines required under the ISPA, as well as provide expanded opportunities for vaccination through school-based mobile clinics and the mass immunization clinics (MICs). The VPD team will also offer expanded access to the influenza vaccines in the fall of 2022 through the MICs.

Moving Forward

Vaccination is a key public health intervention in the prevention of infectious diseases and has been integral to mitigating the impacts of the COVID-19 pandemic. In 2022, MLHU is prepared to respond to fluctuating needs and demands to administer and distribute the COVID-19 vaccine, as well as increase immunization coverage for critical non-COVID-19 vaccines. The *MLHU 2022 Vaccine Preventable Diseases Operational Plan* ensures that the VPD Team is prepared to pivot and adjust to the needs of the community.

Beyond 2022, the role of a local public health unit in the administration and distribution of vaccines, such as the COVID-19 vaccine, is not yet known. Health Unit leadership will continue to seek clarity from provincial officials and adjust operational parameters as required.

This report was prepared by the Environmental Health and Infectious Diseases Division.



Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health



Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

MLHU 2022 Vaccine Preventable Diseases Operational Plan

APRIL 2022

VERSION 1.0

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Summary

The **MLHU 2022 Vaccine Preventable Diseases Operational Plan** articulates the strategic vision and operational plan to guide Middlesex-London Health Unit's (MLHU) distribution and administration of the COVID-19 vaccine. It also outlines the integration of COVID-19 immunization operations with non-COVID-19 immunization operations.

This plan is a working document informed by the evidence and experience of the MLHU team. It will require revisions as new learnings are realized at the agency and local level, and as international, national and provincial guidance and directives related to the COVID-19 vaccine are modified.

Background

The first laboratory-confirmed case of COVID-19 in Middlesex-London was reported to MLHU on January 24, 2020. Since that time, the impact on residents of the Middlesex-London community has been profound. Vaccines were introduced to Middlesex-London in December of 2020 and under the strategic and operational leadership of MLHU, by January of 2022 over 1,000,000 vaccines have been delivered in the region. Distribution of the vaccine started in December 2020 through the London Health Sciences Centre (LHSC) operated mass immunization clinic at the Western Fair Agriplex. In the months to follow, MLHU added 3 more mass immunization sites (Caradoc Community Center in Mt. Brydges, Earl Nichols Arena, North London Optimist Community Center), while also operated a significant number of mobile and pop up clinics. In October 2021, MLHU also took over operations of the Agriplex clinic. MLHU also created and is running a vaccine distribution program to onboard, train, and provide vaccine to long-term care homes, retirement homes and primary care clinics. Along with pharmacy partners, these strategies have resulted in very high vaccination rates in the region (over 91% of people 12 years of age or older have had 2 doses as of February 2022).

Purpose and Objectives

Purpose

The purpose of the **MLHU 2022 Vaccine Preventable Diseases Operational Plan** is to provide a framework that outlines a strategic, equity-oriented, coordinated and integrated approach to the ongoing provision of COVID-19 vaccine to all eligible residents. The plan also outlines the integration of COVID-19 immunization operations with non-COVID-19 immunization operations, specifically focusing on the annual influenza vaccine campaign and the distribution of vaccines for school-aged children.

Objectives

The objectives of the COVID-19 immunization program are to:

1. Ensure prioritized and accessible administration and distribution of vaccine to minimize severe health outcomes and death associated with COVID-19, in keeping with provincial parameters.
2. Plan vaccine administration and distribution from a health equity lens.
3. Maintain staffing complement to meet human resource needs for the distribution of the COVID-19 vaccine.
4. Provide clear, consistent and transparent information and education about the vaccine.
5. Maintain and increase public confidence and uptake of COVID-19 vaccine.

Principles

Consistent with the provincial Ethical Framework for COVID-19 Vaccine Distribution, MLHU's Vaccine Preventable Diseases program will be guided by the following principles:

- Minimize harm and maximize benefits
- Equity
- Fairness
- Transparency
- Legitimacy
- Public trust

Leadership and Governance

The MLHU will provide leadership and direct the COVID-19 immunization program in the Middlesex-London region, collaborating closely with municipal, health, and non-health sector partners. Key stakeholders and their respective roles in the COVID-19 immunization program are articulated in [Appendix A](#).

MLHU Structure for 2022 Vaccine Preventable Diseases Program

The Vaccine Preventable Diseases (VPD) team has been re-structured and is now responsible for the COVID-19 vaccine program and the immunization standards and protocols as per the Ontario Public Health Standards (OPHS). The new VPD structure consists of a Manager who will over-see all of operations. In addition, there are Associate Managers and Supervisors included in the structure assigned to various portfolios to ensure that the immunization standards per OPHS are being met, including COVID-19 immunization program requirements.

To successfully implement the immunization plan, the support from internal stakeholders, such as human resources (HR), information technology (IT), logistics, planning and evaluation are essential. The Vaccine Informatics and Planning team (VIP) is currently supporting the distribution program, planning, inventory, appointment management, data quality and COVaxON support.

Planning Assumptions

- Local public health is responsible for the oversight and leadership of the COVID-19 immunization program including the distribution of vaccine to high risk settings e.g. Long-Term Care and Primary Care.
- Execution of the program will require close collaboration with other sectors.
- COVID-19 vaccines will be supplied by the province.
- Prioritization and eligibility of recipients will be determined by the province.
- Each vaccine has specific storage and handling requirements that require careful oversight and monitoring.
- COVaxON will continue to be available through the Province and will be used to track COVID-19 vaccine administration.
- COVaxON support will continue to be provided to clinics and distribution sites.
- Multiple doses of vaccine will be required, including booster doses.
- Mass immunization clinics will be required to allow for surge capacity.

- Additional human resources will be required to staff mass immunization clinics at times of increased vaccine demand.

Assumed 2022 priorities

- [Booster Dose Campaigns](#)
- [Primary Series to Children Under 5 Years of Age](#)
- [Long Term Care and Retirement Homes](#)
- [Ontario Publicly Funded Vaccines Catch-Up Clinics](#)
- [Influenza Vaccines](#)
- [Ongoing Mobile Clinics](#)
- [Ongoing Support and Engagement of Primary Care](#)
- [Pharmacy Engagement Working Group](#)
- [Promotion of Vaccination and Addressing Vaccine Hesitancy](#)
- [COVaxON Update](#)
- [Data Quality](#)

Strategies to Address 2022 Priorities

In the Middlesex-London region, mass immunization clinics, mobile clinics, pop up clinics, distribution to partners, and delivery by pharmacies will be key components of a rapidly scalable infrastructure for vaccine administration. At different points throughout the year and in different situations, different methods will be more heavily relied upon. The internally-oriented Vaccine Operations Committee (VOC) meetings have been designed to host these strategy conversations involving key internal stakeholders. The VOC meeting cadence is dependent on Middlesex-London community vaccine administration requirements.

Booster Dose Campaigns

The protection from the vaccine wanes over time and it is anticipated that additional booster doses will be required. When these doses become available, there will be a brief increase in demand for vaccine. This change in demand will require changes to the clinic operations and the COVID-19 immunization program.

The following items that need to be considered if a booster dose campaign is initiated:

- Staffing (re-deployment, hiring, bringing back temporary employees)
- Training
 - o If more staff are needed, training and re-training will be required (ex. COVaxON, clinic processes, etc.)
- Number of mass immunization clinics (MICs)
- Mobile clinics frequency
- Appointment numbers in Verto
- Vaccine inventory and the distribution of vaccine to appropriate sites
- Information needing to be shared with the public
- Impact on the distribution program – communication, orders, etc.
- Communication with pharmacies
- Internal reporting requirements (utilization report, clinic day numbers, etc.)

Increased demand - booster doses

When a large number of doses are required, the main delivery strategy will be the utilization of mass immunization clinics (MICs). Additional sites, staff, appointments, training and inventory will be needed. Other vaccine programs, such as catch-up vaccine clinics for school-aged children and mobile clinics, may need to be put on hold. All changes need to be communicated to the public.

Decreased demand before and after the booster doses

After an initial surge in vaccine demand, there tends to be a lower, steady period followed by an even lower maintenance level. When demand starts to reduce, appointments at MICs may need to be lowered and less staff may be required at each site. Decrease demand at MIC will enable MLHU to shift to more mobile/pop-up clinics and continue administration of catch up vaccinations to school-aged children. Typically, when demand at MIC slows down, so do the orders for distribution to primary care and long-term care homes.

Primary Series to Children Under 5 Years of Age

There will be multiple options that will be employed to ensure there is equitable access to the vaccine for children under 5 years of age. The options used for previous age groups could be utilized with a combination of MICs, mobile clinics, pop up clinics and primary care.

If MICs, mobile clinics, and/or pop-up clinics will be used, the following must be considered:

- Changes to the appointment booking site
- Appointment types and numbers in Verto
- Ordering the new vaccine (if applicable)
- Staff training for a new and younger population
- Re-design clinics to support the new and younger population (child friendly working group)

Primary Care may be required to take on a larger role in COVID-19 vaccination when children under 5-year-old become eligible as these families are visiting their physicians for well-baby appointments. MLHU supports primary care through the [Vaccine Distribution Program](#) and engages them through Health Care Provider webinars and email-distributed newsletters and alerts. Additional recruiting and onboarding of primary care offices may be required to ensure that more families with children under 5 have various options available to them.

Pharmacies are also equipped to vaccinate this population and should be engaged in communication as a broader strategy is created.

Long-Term Care and Retirement Homes

In 2021, MLHU mobile teams supported long-term care homes (LTCH) and retirement homes (RH) by going into the facilities to vaccinate their staff and residents. This is not a sustainable long-term method. Therefore, LTCH/RHs have been onboarded through the [Vaccine Distribution Program](#) and will need to be supported to deliver booster doses to their residents (including 5th doses) in the future. There are a few retirement homes who have not yet onboarded into COVaxON. They will be encouraged and supported to do this or to come up with an alternate strategy to ensure that they can reliably offer vaccination to all of their staff and residents. Going forward, COVaxON refreshers will be necessary with all agencies as they experience staffing changes and periodic use of the system.

Ontario Publicly Funded Vaccines Catch-Up Clinics

When there is time between COVID-19 vaccine surges, the Ministry of Health has approved using the MICs to run catch-up vaccination clinics for school aged children. Specifically, the goal is to ensure that children are up to date for vaccines required in the *Immunization of School Pupils Act (ISPA)*. It is the Ministry's expectation that operational costs associated with the delivery of non-COVID-19 vaccines are reported separately. The immunization records for all school-aged children are currently being reviewed. The parent or guardian of any child that is not up to date will be notified and provided with the opportunity to submit updated records. If the child has not received all required vaccines, they will be provided with opportunity through clinics hosted at the MICs or in school. Staff from the MICs have been trained on the non-COVID-19 vaccine database called Panorama and will be able to assist and provide immunization services. The mass immunization catch-up clinics will be run for specific age groups by appointment only to ensure that all necessary vaccines are available.

Influenza Vaccines

In the fall of 2021, the MICs piloted providing influenza vaccines at the same time as COVID-19 vaccines. This was successful and new processes were created that could be implemented for 2022. To provide influenza vaccine at MICs, approval and funding (base or extra-ordinary funding) will be required from the Ministry of Health.

Ongoing Mobile Clinics

The objective of mobile clinics is to administer COVID-19 vaccines to groups who are unable to access the mass immunization clinic sites. Using a health equity lens, mobile and pop-up clinics are positioned in the community where individuals may live, work or attend school. Mobile clinic staff have reached out to shelters, group homes, schools, community centers, religious organizations, and other community organizations. Ongoing work is being done to identify communities for mobile clinics including leveraging [community partnerships](#), doing [mapping exercises](#) and using data provided by the Ministry of Health. There is a subcommittee of VOC designated to continue to identify targeted populations for mobile clinics which includes a representative from the Health Equity and Reconciliation Team (HEART) and from Communications.

Mobile teams need to be fluid and agile and staffed according to the expected turn out. If turn-out drops and small high-risk area clinics are provided, "micro teams" may be sent out to the same site for a one-week period. A homebound program has also been created to provide immunization for clients who are unable to leave their homes for health or other reasons. This program only requires one nurse to vaccinate the person in their residence. In the past for additional surge capacity, in collaboration with MLHU, the Middlesex London Paramedic Services (MLPS) have provided mobile clinics in the community and could be called upon if required in the future.

Ongoing Support and Engagement of Primary Care

Primary Care practitioners have been supporting the efforts to immunize clients in the area through varying strategies. They have joined the Vaccine Distribution Program, responded to requests for immunizers at the MICs and run select cultural clinics. The MLHU meets routinely with the London Middlesex Primary Care Alliance (LMPCA) to discuss the ongoing role of primary care.

Pharmacy Engagement Working Group

Pharmacies are large contributors to the local vaccine roll-out, and although they operate independent of the MLHU COVID-19 vaccine program, engagement would assist with creating a coordinated approach to ensure good COVID 19 vaccine coverage in the population. A working group would allow for a communication channel to be established to support surges in vaccine demand, transfer of product between MLHU AO (Authorized Organization) and the pharmacies when needed, and consistent public messaging. The working group would need to include various pharmacy models (franchises, chains, and independent pharmacies). MLHU partners with pharmacies on other important public health measures and these partnerships should be leveraged.

Promotion of Vaccination and Addressing Vaccine Hesitancy

MLHU will continue to develop materials to support the immunization program, in addition to amplifying provincial messages through the Health Unit's social media channels. MLHU continues to use the website, social media, public service announcements (PSA) and media advisories to educate and promote the importance of the immunization program. These initiatives will continue to encourage vaccination in all populations including those groups with a lower vaccination rate.

Other strategies such as partnerships and Instagram live sessions with primary care, hospital partners, community groups, athletes, etc. have all been employed to continue to address vaccine hesitancy. School letters were sent out through the school boards that provided parents with the opportunity to speak to a public health nurse about any vaccine related questions.

COVaxON Update

The Ministry of Health has announced that a new version of COVaxON will be released in early June. This will require new processes to be identified, job aids to be created, and training for all staff and Vaccine Deployment Program participants.

Data Quality

The Vaccine Informatics and Planning (VIP) team has been responsible for reconciling outstanding inventory discrepancies and attempting to improve the data quality of what has been captured in COVaxON. Throughout 2022, attempts should be made to improve the completeness and accuracy of all COVaxON data in the MLHU health unit region and in our vaccination events. Additionally, the team will be exploring processes to collect even better data when future doses are required. This includes strategies to collect social determinants of health data and complete all other fields accurately.

Social determinants of health data collection

The social determinants of health (SDOH) module is a secondary data collection form within COVaxON and can be utilized to collect data on every person being vaccinated. In 2021, when clinics were very busy, this practice was not being followed regularly and data is not complete. Training, accountability forms, and reminders are being used to encourage staff to gather this data on every client.

Conclusion

The unpredictability of the pandemic and demand for the COVID-19 vaccine by the public has required flexibility and adaptability in planning. By being anticipatory and proactive, MLHU will be prepared to respond to increases or decreases in COVID-19 vaccine demand. Maintaining a minimum of two MICs

open throughout 2022 and utilizing the MICs as catch-up clinics during low demand periods, along with cross training VPD staff, positions MLHU well for episodic surges in demand. Screening all students and incorporating student catch up vaccinations at the MICs during low demand periods will enable MLHU to increase non-COVID-19 vaccination coverage in the region.

The strategies identified in this report will enable MLHU to continue to protect the community from COVID-19 and other vaccine preventable diseases.

Operational requirements

Mass Immunization Clinics

Mass immunization clinics (MICs) are purpose-designed to efficiently deliver vaccine to a large population in a short period of time. Mass immunization clinics rely on the compartmentalization of components of the vaccination process to ensure scalability and efficiency. They are an essential delivery strategy. Locations that have been used can be found in [Appendix B](#).

Staffing

Each clinic site will have one designated associate manager. The program will be centrally supported with regards to human resources, scheduling, and client bookings. The staffing required daily for each mass immunization clinic is dependent on the projected throughput of the clinic and the process flow utilized to optimize efficiency (staffing positions can be found in [Appendix C](#)).

Client Scheduling

Client scheduling takes place through a web-based system call Verto, using a gating webpage to ensure eligibility, or through a booking phone line. Regular maintenance of the gating webpage is managed by the VIP team in consultation with Communications. The gating webpage needs to be updated with any eligibility or operational change.

Other Vaccines

The mass immunization clinics have been running with 3 different antigens with 4 different doses (Moderna full dose, Moderna half dose, Pfizer and Pediatric Pfizer). This has proven that the mass immunization clinics can be leveraged to deliver other vaccines including [school catch-up vaccines](#) and [influenza vaccines](#).

Mobile Clinics

The purpose of these clinics is to administer COVID-19 vaccines to groups who are unable to access the mass immunization clinic sites. Locations where these clinics have taken place in the past are listed in [supplemental documents](#) and can be used again in the future. Locations are informed through consultation with community partners and assessment of vaccine coverage.

Staffing

The mobile immunization program currently has one associate manager. This will be re-examined based on need and may be increased to two. The number of teams that will be functioning at any particular time, will fluctuate between 1 to 3 teams based on capacity and public demand/uptake.

Each mobile team will consist of:

- 1-2 Team Leaders
- 2-6 Vaccinators/re-constituters
- 2-6 Assistants (navigation and data entry)

The number of staff will vary in number depending on size of the clinic. Additional staff for re-constitution may be required, depending on product.

Client Scheduling

All mobile and pop up clinics are walk-in only. When lines become too long, a ticketing system will be implemented to encourage people to return later. Once the clinic is full for the day, a social media post is sent out to reduce the number of clients coming to the clinic that day.

Distribution to Primary Care and Long-Term Care Homes/Retirement Homes

A COVID-19 vaccine distribution program that has been developed to ensure that primary care and agencies in the community have access to ordering COVID-19 vaccine for distribution to their clientele. This program is a collaboration between VIP and VPD. It involves an expression of interest, signing a memorandum of understanding, training on COVaxON, ordering vaccine, recording vaccinations and inventory management in COVaxON. Information can be found on the website:

<https://www.healthunit.com/covid-19-vaccine-distribution-program>.

Communications

A proactive and responsive communications strategy from a trusted local source is crucial to the success of the COVID-19 vaccine program. The MLHU is the central source of COVID-19 information locally and continues to leverage established relationships, communication channels and expertise throughout the vaccine rollout to increase awareness and confidence in COVID-19 vaccines.

Communication Platforms

Website

MLHU has been keeping its website up-to-date with all the latest COVID-19 vaccine related information: <https://www.healthunit.com/covid-19-vaccine>

Information on the website includes the science of vaccines, information about who is eligible for vaccines, and more. This page is intended to be a “one-stop shop” for all vaccine-related information and will continue to be updated as more information becomes available.

Social Media

The Middlesex-London Health Unit also has a well-established social media presence, including active engagement with large audiences on Facebook, Twitter, Instagram, YouTube and TikTok. The use of multiple social media channels allows for MLHU content to be shared with a wider audience, increasing the overall reach of Health Unit messages.

Traditional Media

In addition to issuing periodic media releases and public service announcements, the Health Unit also hosts weekly virtual media briefings about COVID-19-related matters in London and Middlesex County. These media briefings will also serve as an important tool that will help inform the public about the COVID-19 immunization program. Local media will also be engaged to help deliver the vaccination message to a wider audience through interviews with key MLHU staff and appearances on local radio talk shows and television news.

Non-Traditional Media

MLHU partners with community, religious, and other leaders who have non-traditional distribution channels such as podcasts and large WhatsApp groups.

Community Partnership and Engagement

Purposeful and respectful engagement and inclusion of diverse populations, including First Nations, Inuit, and Métis peoples, and other racialized populations has been essential to ensure equitable distribution of the vaccine.

First Nation, Métis, and Inuit populations

The urban Indigenous population has been engaged through partnership with the Southwest Ontario Aboriginal Health Access Center (SOAHAC). MLHU will continue to support the distribution of vaccine to SOAHAC, as well as supplement resources as necessary.

The First Nations communities in the area include the Chippewa of the Thames First Nation (Anishinaabe), the Oneida Nation of the Thames (Haudenosaunee), and the Munsee-Delaware Nation (Leni-Lunaape). These communities have worked together to vaccinate their populations and will continue to have support from MLHU as requested.

Racialized populations

MLHU is actively connecting with specific racialized populations to support vaccination efforts and offer mobile clinics in spaces that are appropriate and preferred by the community. The success of these clinics is dependent on strong partnerships with community leaders.

Schools and Post-Secondary Students

MLHU has strong partnerships with all school boards in the region, as well as all post-secondary institutions. These relationships are critical for engaging younger demographics and encouraging vaccine uptake. The school boards have supported after-school COVID-19 immunization clinics at 35 different sites and have distributed information to parents.

Western University has been providing vaccination through the distribution program and has vaccinated over 9,000 people.

Supplies Management and Distribution

The MLHU's Vaccine Preventable Disease team has extensive expertise in the storage, handling and cold chain maintenance requirements of vaccines. Vaccine distribution is managed as per the manufacturer requirements.

Equipment

MLHU uses purpose-built or pharmaceutical-grade equipment to store vaccines.

Receiving, Storing and Handling Vaccine

The MLHU Citi Plaza Site has a designated loading dock and Shipping and Receiving personnel with the expertise to receive, store and handle the vaccine per current Ministry of Health Vaccine Storage and Handling Protocol. All freezers, fridges and vaccination equipment are housed in a locked area adjacent to the loading dock to allow for ease of distribution.

MLHU receives and stores frozen vaccines and thaws the vaccines in accordance with guidelines and standards issued by the Ministry of Health or other industry or government agencies.

All Mass immunization clinic sites have the capacity to store large amounts of vaccine. Each site has a fridge and freezer, with one of the sites also having an ultra-low temperature (ULT) freezer. Security and monitoring set up as per Ministry guidelines.

Cold Chain

MLHU ensures an uninterrupted power supply for all freezers and fridges at all storage sites. Cold chain is monitored 24/7 through a live system (Blue Rover) which includes remote monitoring and notification to MLHU leadership if any temperature changes occur. This system is supplemented with an on-call answering service (Bearcom) to ensure temperature notifications will not be missed.

If there is a concern with the equipment, the vaccine will be moved to one of the other secure sites to be stored.

Physical Security

All vaccine product is secured behind multiple card access doors with card-controlled access. At the MLHU Citi Plaza Site, seventeen security cameras provide site surveillance. Additional cameras were added to increase surveillance to the vaccine area. These cameras are monitored by on-site security and the area is patrolled multiple times per day to ensure the vaccine area remains secure.

When vaccine is stored at the mass immunization sites, it is behind a card entry system that can only be accessed by the associate manager, site supervisor and team leader. Cameras as well as security personal are on site 24 hrs to ensure the vaccine remains secure.

Inventory Management

Each mass immunization clinic manages their inventory and reports supply levels daily to central inventory management (VIP team). The Informatics Support staff reconcile the numbers against what is in COVaxON to make sure that inventory is properly accounted for. The VIP team monitors inventory levels at each clinic, orders vaccine from the Province or surrounding health units and recommends movement of vaccine between clinic sites as required. The VPD ordering team actions the transfers between sites with the clinical teams and the courier.

When distributing vaccine to any distribution site all doses are accounted for. Any wastage is to be documented including numbers and reason.

Vaccine Ordering

From the Ministry

To order vaccine or vaccination supplies from the Ministry of Health, MLHU staff submit an order through the provincial Shopify Store. The Ministry typically delivers the vaccine that is ordered within a week. There is currently an ordering deadline of Monday at noon.

From other Health Units

In certain times, a process has been established to request vaccine from neighbouring health units (e.g. one site has vaccine that is expiring soon, a site is in desperate need for vaccine or sites have too much vaccine in their freezers or fridges). Southwestern Public Health (SWPH), Huron Perth Public Health (HPPH) and MLHU created a process for vaccine sharing arrangements of thawed or frozen vaccine between sites as required.

Inventory Reporting to the Ministry of Health

Regular reporting will be communicated to the Ministry of Health as mandated. If disruptions to vaccination storage or administration occur, the Ministry will be notified as soon as possible.

Distribution Program (Ordering)

Once a site has been onboarded with the distribution program, they can order COVID-19 vaccine through the vaccine ordering app. The order is reviewed by Program Assistants in the VPD team and approved, packed and sent with a courier. This ordering system is also being broadened to support all vaccines available through MLHU.

Logistics

Finance

The MLHU is committed to transparent and efficient use of public resources.

All program costs associated with the COVID-19 immunization program will be tracked separately from any other Board of Health approved cost-shared budget. These costs will also be tracked independently from those associated with case and outbreak management of COVID-19 and those of traditional publicly funded vaccines.

Information Technology

The MLHU will oversee the integration of all IT solutions, with a focus on the provincial solution COVaxON with support from partners as applicable.

All teams who support the COVID-19 immunization clinics will be trained on COVaxON, as it is used for documenting the administration of each vaccine administered in the Middlesex-London region.

Paper-based contingency plans are in place should the digital solutions fail.

Human Resources

Recruitment

The MLHU Human Resources team will continually monitor staffing requirements and will ensure appropriate staffing to meet the evolving needs of the COVID-19 vaccine program.

Staff Scheduling

A centralized staff scheduling process is being utilized to ensure the pool of human resources is optimized and operations is not compromised in the event of short-term absences. The existing MLHU Human Resources software platform, Dayforce, is being leveraged for its scheduling functionality including self-scheduling.

Orientation and Training

The current COVID-19 team that will be integrated into the Vaccine Preventable Disease program has developed a training curriculum for new staff. This curriculum will be expanded to include training videos, and will include topics such as:

- Proper use of PPE
- COVaxON – Informatics Support can also provide hands on training or problem solving
- Vaccine and medical directive considerations
- Clinic processes

- Cultural safety
- Vaccine storage and handling
- Physical security of vaccine
- Information security
- AEFI reporting processes
- Out of Province and Out of Country submissions review and data entry
- Vaccination Exemption monitoring, review, and data entry
- Asking about Social Determinants of Health

Surveillance, Monitoring and Reporting

Surveillance and monitoring are critical to the planning, oversight and management of the COVID-19 vaccine program, in addition to meeting provincial and local reporting requirements.

Internal Reporting

The Vaccine Informatics and Planning team collects and documents critical operational information, including vaccine availability and supply, daily and cumulative number of vaccines administered, and other key operational metrics.

External Reporting

The [MLHU COVID-19 Dashboard](#) provides a public-facing summary of the COVID-19 situation in the Middlesex-London region. Vaccine relevant metrics have been incorporated into this dashboard, in order to provide routine updates on the local vaccine distribution campaign. Key metrics include:

- Total cumulative doses administered to Middlesex-London residents
- Percentage of Middlesex-London residents who have completed vaccine series, stratified by relevant priority populations where possible

Mapping

The mapping of vaccine rates for all neighbourhoods is used to help determine where mobile/pop-up and micro clinics will be situated. Additionally, mapping data is being provided by the Ministry of Health to supplement the information available at the health unit level. Specific reports, such as the rate of vaccination in children age 5-11 or recipients of Social Assistance, are used for planning mobile clinic location and density.

Vaccine Safety

MLHU adheres to the provincially-mandated Adverse Event Following Immunization (AEFI) surveillance process.

Out of Province Reporting

An application was developed to make submitting out of Province doses of COVID-19 vaccines easier. It allows people to submit online and have MLHU staff to review and follow up if required. These doses were also reported in COVaxON when people came for future doses. This information is needed to ensure complete vaccination data.

Contingency Planning

In anticipation of potential disruptions to the vaccine distribution, redundancies are being incorporated in to all aspects of the vaccine plan, including but not limited to:

- Keeping a strategic number of mass immunization clinic sites open at basal levels to be able to ramp up in a timely way. (Agrisplex, Mt. Brydges, Citi Plaza) Additional sites may be re-opened as necessary should demand increase and vaccine needs to be delivered quickly.
- Cross-training for all staff and positions
- Non-digital downtime processes
- Alternate storage for vaccine product if primary units are compromised

Contingency plans are constantly being considered in anticipation of potential disruptions to service, including:

- Severe weather events
- Labour disruptions
- Infectious disease outbreaks

Communications plans are key to ensuring public notification of disruptions and service changes.

Evaluation and Quality Improvement

Various evaluations have taken place and will continue to take place for the vaccine roll out. Real time evaluations have been done to support continuous quality improvement in our processes and procedures, clinic set-up and broader strategic decision-making.

Conclusion

The COVID-19 Immunization Program achieved its 2021 objective of vaccinating 75% of the population quickly (within 6 months). The plan for 2022 is to prepare for subsequent booster doses of COVID-19 vaccine, ensure access to vaccine for those who have had difficulties accessing COVID-19 vaccine to date, increase confidence in vaccine, and to increase uptake of non-COVID-19 vaccines amongst school-aged children.

Appendix A – Stakeholder Roles and Responsibilities

Stakeholder Group	Roles & Responsibilities
Board of Health	Approve and support plan and financial considerations
Medical Officer of Health	As Incident Commander, the MOH leads the roll out of vaccines to the community
City Council	Support by providing municipal locations for mass immunization clinics, resources (human and physical) and assistance as required
County Council	Support by providing municipal locations for mass immunization clinics resources (human and physical) and assistance as required
Project team	Taking a leadership role in the local vaccination plan including, planning, coordinating, and executing.
General MLHU Staff	Be informed as the vaccination plan is rolled out and asked to support messaging as appropriate
Partner Organizations	
Hospitals	Onboarded with COVaxON and delivering vaccines within the hospital system and in clinics.
Middlesex London Paramedic Services (MLPS)	MLPS can run mobile clinics as required.
Community Health Centers	SOAHAC collaborated with MLHU to create an urban Indigenous vaccination strategy. Other Community Health Centers will be informed and assist with vaccine promotion and can get onboarded to provide vaccines
Long-Term Care Homes and Retirement Homes	Get onboarded to COVaxON and provide vaccines
Primary Care Providers	Stay informed, address vaccine hesitancy, assess and manage adverse events following immunization, encourage patients to attend clinics and provide vaccines
Pharmacies	Stay informed, address vaccine hesitancy and provide vaccines
Community agencies serving marginalized groups	Encourage community members to be vaccinated as prioritized Host mobile clinics as deemed appropriate by the MLHU
Police	Contribute to security assessments and planning. Consult on security resource requirements.
Government	
Provincial Government	Provide direction and oversight over the vaccine distribution Provide vaccine supply
Federal Government	Procure vaccines and distributes to the province

Appendix B – Mass immunization sites

Name	Location	Number of vaccinator tables (max)	Number of registration tables (max)	Max number of vaccines given/day	Pros of site	Cons of site
Agriplex – New space as of March 2022	845 Florence St, London, ON N5W 6G6	18	10	2,000	Very large Central Room for expansion	Parking became an issue when hockey tournaments occur
Agriplex – Old space	845 Florence St, London,	40	20	3,000	Very large Central	Parking became an issue when hockey tournaments occur

	ON N5W 6G6				Room for expansion	
Mt Brydges	565 Lions Park Dr, Mount Brydges, ON N0L 1W0	7	4	500	Ensure County access; Lots of parking	Can get congested at higher levels No room for expansion
Citi Plaza	355 Wellington St, London, ON N6A 3N7	6	3	500	MLHU owned	Parking for clients No room for expansion
Earl Nichols	799 Homeview Rd, London, ON N6C 5J4	15	8	1,200	Good parking during the day	Parking in the evening is an issue if recreation center is open Entrance/Exit is cold in the winter City Owned – need agreement
North London Optimist Community Center	1345 Cheapside St, London, ON N5V 3N9	18	12	1,500	Good location	Parking lot is too small (limited to 1,500) Staff had to park offsite – bus was needed City Owned – need agreement

Appendix C - Staff positions at mass immunization clinic

Position	Role	Description
Leaders	Associate Manager, VPD	Oversees the full clinic operations Clinic Operations Accountability - Performance management of immunizers and Team Leads Monitoring the reconstitution, vaccination and post care areas Clinical guidance to immunizers and Team Leads including orientation; implements and monitors practice changes Vaccine monitoring, cold chain, inventory and data reporting to informatics Complex client communication when consulted by immunizers or Team Leads
	Supervisor, VPD	Total Site Operations Accountability – site flow, building issues, ice, security, client incident

		<p>Performance manage/supervise program assistants and support staff with complex issues and clients</p> <p>Provide Supervision to the phone line staff, screeners, navigators, registration clerks and check out clerks</p> <p>Liaison with MLHU logistics, IT, informatics, community partners and/or subcontracted parties</p> <p>Monitoring supplies, inventory and oversee ordering</p>
	Team Leader, VPD	<p>Knowledge support for the immunizers and other staff (no performance management)</p> <p>Support immunizers and other staff by answering questions and problem-solving difficult practice/client situations</p> <p>Provide guidance on clinical practice and clinical support to immunizers and other staff as needed</p> <p>Collaborate with the Associate Manager-Clinical to maintain clinic practices, cold chain, supplies and inventory</p> <p>Identify areas for improvement</p>
Program Assistants	Phone Line staff, VPD	Monitor booking line and confirm eligibility
	Screeners	Confirming absence of COVID-19 signs and symptoms and verify eligibility to receive the vaccine
	Registration Clerks	Register client for vaccination in COVaxON system and confirming consent to share personal data and receive the vaccine
	Check-out clerks	Provide documented confirmation of receipt of vaccine
	Client navigators	Facilitate client flow through clinic, ensuring efficient throughput
Nurse or other health care professional	Vaccinator	Confirms consent, administers the vaccine, and provides post-vaccine instructions
	Re-constituters	Prepare vaccines for the immunizer
	Vaccine runner	Replenish immunizers vaccine supply
	Post-vaccine monitoring	Monitor clients following vaccination for any adverse events
	Security	Monitor crowds and vaccine storage; assess safety risks
	IT Support	Maintain critical IT infrastructure



TO: Chair and Members of the Board of Health

FROM: Alexander Summers, Medical Officer of Health

DATE: 2022 April 21

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR MARCH

Recommendation

It is recommended that the Board of Health receive Report No. 25-22, re: “Medical Officer of Health Activity Report for March” for information.

The following report presents activities of the Medical Officer of Health (MOH) for the period of March 4 – April 7, 2022. As of March 30, the formal Minister of Health’s appointment of Dr. Alexander Summers as Medical Officer of Health is pending.

The Medical Officer of Health participates in external and internal pandemic-related meetings with municipal and provincial stakeholders, along with liaising with community partners during the pandemic. The MOH in partnership with MLHU’s Communications Team hosts a weekly virtual media briefing for COVID-19 matters, and includes the Mayor of London, the Warden of Middlesex County and a representative from London Health Sciences Centre.

The Medical Officer of Health, along with other team members, continues to host a weekly Middlesex-London Health Unit (MLHU) Staff Town Hall (Friday) and presents on many topics, including COVID-19. The MOH also hosts weekly (Tuesday) healthcare provider outreach and community stakeholder webinars with information regarding COVID-19.

The Medical Officer of Health also attended the following meetings:

Client and Community Impact – *These meeting(s) reflect the MOH’s representation of the Health Unit in the community and media:*

- March 4** Interview with Jen Bieman (London Free Press) on mask mandates.
- March 9** Participated in an in-person news conference, regarding his appointment as Medical Officer of Health.
Attended Council of Medical Officers of Health (COMOH) Weekly Forum.
- March 10** Participated in West Region IMS meeting.
Interview with Rebecca Zandbergen (CBC London) on mask mandates and Dr. Summers’ appointment.
Participated in Ministry of Health COVID-19 Operations and Planning call.
- March 11** Interview with Mike Stubbs (AM980) on the second anniversary of the COVID-19 pandemic.
- March 14** Participated in Middlesex County IMS meeting.

- March 15** Attended City of London IMS/Policy Group meeting.
Participated in Ministry of Health COVID-19 Public Health Coordination call.
- March 21** Appeared on Craig Needles' Podcast to discuss Section 22 orders under the *Health Protection and Promotion Act*.
- March 22** Participated in Southwest Medical Officers of Health Monthly meeting hosted by Chatham-Kent.
Worked evening Sexually Transmitted Infection (STI) clinic shift.
- March 23** Interview with Marek Sutherland (CTV London) on COVID-19 positive wastewater rates in London.
- March 28** Participated in Middlesex County IMS meeting.
- March 29** Interview with Jaclyn Carbone (AM980) on rapid testing.
Attended City of London IMS/Policy Group meeting.
- March 31** With the Chief Executive Officer, met with City of London representatives, Maureen Cassidy and Kapil Lakhota to discuss plans regarding a London mental health hub.
With the Chief Executive Officer, met with Dr. Wajid Ahmed (Associate Chief Medical Officer of Health, Ontario) to discuss public health matters locally.
- April 1** Interview with Jen Bieman (London Free Press) on current opioid situation.
Interview with Jane Sims (London Free Press) on PCR testing.
- April 6** Attended Western Regional Integrated Vaccination meeting with Dr. Daniel Warshafsky (MOH).
Interview with Mike Stubbs (Global News) and Jen Bieman (London Free Press) on fourth doses.
Worked evening Sexually Transmitted Infection (STI) clinic shift.
- April 7** Interview with Ken Eastwood and Loreena Dickson (Newstalk CJBK) on COVID-19 matters locally.

Employee Engagement and Learning – *These meeting(s) reflect on how the MOH influences the Health Unit's organizational capacity, climate and culture and the contributions made to enable engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning:*

- March 4** Led Senior Leadership Team Retreat with the Chief Executive Officer.
- March 7** Led Senior Leadership Team Retreat with the Chief Executive Officer.
- March 8** Attended MLHU Leadership Team meeting.
- March 9** Led Office of the Medical Officer of Health (OMOH) Management meeting
- March 10** Attended Infectious Disease Control (IDC) Program meeting.
- March 23** Led Office of the Medical Officer of Health (OMOH) Management meeting

Attended webinar/forum on public health priorities, hosted by the Council of Medical Officers of Health (COMOH).

- March 24** Attended webinar hosted by Dr. Dirk Huyer (Chief Coroner, Ontario) and Matthew Anderson (CEO and President, Ontario Health) on “The Opioid Overdose Crisis as a Public Health Emergency”.
- March 28** Led Senior Leadership Team Retreat with the Chief Executive Officer.
- March 31** Attended Environmental Health and Infectious Disease division meeting. With the Chief Nursing Officer, met with stakeholders with the Canadian Institutes of Health Research (CIHR) to discuss funding proposals specific to responding to the Chief Public Health Officer’s (CPHO)’s 2021 report on the state of public health in Canada.
- April 1** Attended Program Evaluation meeting.
- April 5** Attended webinar hosted by the Public Health Association of British Columbia on “Our Planet, Our Health, Our Public Health Responsibility” in honour of Canadian Public Health Week.
- April 6** Attended MLHU Leadership Team session on “Joy in Work”.
- Governance** – *This meeting(s) reflect on how the MOH influences the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU’s mission and vision. This also reflects on the MOH’s responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health:*
- March 7** Participated in a meeting with the Chief Executive Officer to discuss program proposals and operational plans for the Vaccine Preventable Disease program
Attended Special Board of Health meeting
- March 11** Meeting with the Acting Managers of Population Health Assessment and Surveillance (PHAS) and Program Planning and Evaluation (PPE) on future projects needing PHAS/PPE support.
- March 17** Attended Board of Health meeting.
- March 22** Attended a Special Meeting of the City of London’s Strategic Projects and Policy Committee (SPPC).
- March 24** Attended Western Ontario Health Team (WOHT)’s Coordinating Council meeting.
- March 31** Attended the MLHU Anti-Black Racism Advisory Group meeting.
- April 4** Meeting with Mike McMahon (Ontario Health Team) on OHT and MLHU collaboration.
- April 7** Attended Finance and Facilities Committee meeting.

This report was prepared by the Medical Officer of Health.

A handwritten signature in black ink that reads "Alexander T. Summers". The signature is written in a cursive style with a long horizontal flourish at the end.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health



TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer

DATE: 2022 April 21

CHIEF EXECUTIVE OFFICER ACTIVITY REPORT FOR MARCH

Recommendation

It is recommended that the Board of Health receive Report No. 26-22, re: “Chief Executive Officer Activity Report for March” for information.

The following report highlights activities of the Chief Executive Officer for the period of March 4, 2022 – March 31, 2022.

Standing meetings include weekly Healthy Organization leadership team meetings, SLT (Senior Leadership Team), Logistics and R3 (Repatriation, Redeployment and Recruitment), Virtual Staff Town Hall meetings and C3 (COVID Collaborative Committee) meetings.

The Chief Executive Officer also attended the following meetings:

Client and Community Impact – *These meeting(s) reflect the CEO’s representation of the Health Unit in the community:*

March 8 The CEO attended the Middlesex County Council Budget meeting to present MLHU’s 2022 budget.

March 10 The CEO met with Mosaic Medical to discuss staffing options for future vaccine planning efforts.

The CEO met with MLHU’s IT service provider, Stronghold IT Services, to discuss updates.

March 22 The CEO met with Reg Ash from the Western Fair District to discuss the Agriplex Mass Vaccination Clinic lease agreement.

March 2 The CEO met with Cindy Howard from the Middlesex County to discuss the MLHU Budget.

March 31 The CEO, with the MOH, met with City of London representatives, Maureen Cassidy and Kapil Lakhotia to discuss plans regarding a London mental health hub.

Employee Engagement and Learning – *These meeting(s) reflect on how the CEO influences the Health Unit’s organizational capacity, climate and culture and the contributions made to enable engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning:*

March 4 The CEO chaired and participated in Day One of the SLT Retreat.

- March 7** The CEO chaired and participated in Day Two of the SLT Retreat.
- As part of the Healthy Living Division review project, the CEO met with the MOH and Healthy Living Director to discuss the project charter.
- The CEO met with Environmental Health and Infectious Diseases leadership to discuss the Vaccine Preventable Diseases team proposals development.
- March 8** The CEO attended the MLT (MLHU Leadership Team) meeting.
- March 10** The CEO attended a meeting with HR staff to discuss organizational plans for a leadership development program.
- March 21** The CEO participated in the HR interviews for the Program Planning and Evaluation Manager role.
- March 23** The CEO participated in the HR interviews for the Program Planning and Evaluation Manager role.
- March 28** The CEO chaired and participated in Day Three of the SLT Retreat.
- The CEO met with Kelly Gillis from Ahria Consulting to discuss MLHU leadership development.
- March 28-31** As part of the new MLHU on-call leadership system, the CEO provided on-call coverage in the evening.
- March 31** The CEO attended a follow up meeting with HR staff to discuss next steps for the organizational leadership development program.
- Personal Development** – *These meeting(s) reflect on how the CEO develops their leadership, skills and growth to define their vision and goals for the Health Unit.*
- March 31** As part of the CEO's McCormick Care Board membership, the CEO attended the McCormick Care Board of Directors Committee meeting.

Governance – *This meeting(s) reflect on how the CEO influences the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This also reflects on the CEO's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health:*

- March 7** The CEO attended the Special Meeting of the Board of Health.
- March 9** The CEO attended the MLHU Board of Health March Agenda Review and Executive meeting with the Board Chair and Vice-Chair.
- The CEO participated in an in-person news conference, announcing Dr. Summers' Medical Officer of Health appointment.

- March 18** The CEO attended the Board of Health meeting.
- March 23** The CEO attended the Association of Ontario Public Health Business Administrators (AOPHBA) webinar regarding remote work.
- March 30** The CEO met with Board Chair as part of their monthly update.
- March 31** The CEO, with the MOH, met with Dr. Wajid Ahmed, Ontario Associate Chief Medical Officer of Health to discuss public health matters locally.

This report was prepared by the Chief Executive Officer.

A handwritten signature in cursive script that reads "EWilliams". The signature is written in black ink on a light-colored, slightly textured background.

Emily Williams, BscN, RN, MBA, CHE
Chief Executive Officer

CORRESPONDENCE – April 2022

a) **Date:** March 15, 2022

Topic: COMO H motion of support OPHA statement, Health and Racial Equity: Denouncing Acts and Symbols of Hate

From: Dr. Charles Gardner, Medical Officer of Health/Chief Executive Officer, Simcoe-Muskoka District Health Unit and Chair, COMO H

To: Medical Officers of Health in Ontario

Background:

On February 23, 2022, Dr. Penny Sutcliffe wrote to Dr. Paul Roumeliotis to notify ALPHa that the Sudbury and District Board of Health passed a motion at their February 17, 2022 Board of Health meeting to denounce hateful acts, symbols of hate and discrimination in public health. Dr. Sutcliffe presented to the Council of Medical Officers of Health (COMOH) on February 25 the OPHA Statement on Health and Racial Equity, which has been supported by many health units in the province, including Middlesex-London. Dr. Gardner notes the importance of health equity work in public health and encouraged this to be supported by other boards of health. The Board of Health endorsed this on March 17th.

Recommendation: Receive.

b) **Date:** March 16, 2022

Topic: Response to the Opioid Crisis in Simcoe Muskoka and Ontario-wide

From: Anita Dubeau, Chair, Simcoe-Muskoka District Health Unit

To: The Hon. Christine Elliott, Minister of Health for Ontario

Background:

On March 16, 2022, Chair Anita Dubeau wrote to Hon. Christine Elliott, requesting that the government take action on the opioid crisis locally and province wide. These actions include: a opioid taskforce, expand access to evidence informed harm reduction programs, exploring revisions to the current Consumption and Treatment Service model, expand access to opioid agonist therapy for opioid use disorder, provide a long-term financial commitment to create more affordable and supportive housing, address the structural stigma and harms that discriminate against people who use drugs, increase investments in evidence-informed substance use prevention and mental health promotion initiatives, and fund a fulltime position of a Drug Strategy Coordinator/Lead for the Simcoe Muskoka Opioid Strategy

Recommendation: Endorse.

c) **Date:** March 30, 2022

Topic: Health and Racial Equity: Denouncing Acts and Symbols of Hate

From: Gary McNamara, Chair, Windsor-Essex Board of Health

To: The Hon. Christine Elliott, Minister of Health for Ontario

Background:

On March 24, 2022 at a regular meeting of the Windsor-Essex County Board of Health, the Board considered a letter from Sudbury & Districts Public Health to Dr. Paul Roumeliotis, President of alPHa, encouraging other Ontario Boards of Health and the Association of Local Public Health Agencies (alPHa), to endorse the January 31, 2022 statement of the Ontario Public Health Association Denouncing Acts and Symbols of Hate.

Recommendation: Receive.

d) **Date:** March 30, 2022

Topic: Ontario Regulation 116/20, Work Deployment Measures for Boards of Health

From: Gary McNamara, Chair, Windsor-Essex Board of Health

To: The Hon. Christine Elliott, Minister of Health for Ontario

Background:

On March 24, 2022 at a regular meeting of the Windsor-Essex County Board of Health, the Board considered a letter from Cynthia St. John, President of the Association of Ontario Public Health Business Administrators (AOPHBA) to Dr. Kieran Moore, CMOH, requesting that Dr. Moore consider extending Ontario Regulation 116/20 Work Deployment Measures for Boards of Health for the duration of public health units' response to the COVID-19 pandemic. The work of health units is still crucial, even in the nearing end of the pandemic.

Recommendation: Endorse.

From: COMOHO <comoh-bounces@lists.alphaweb.org> **On Behalf Of** Gardner, Charles
Sent: Tuesday, March 15, 2022 10:49 AM
To: COMOHO <comoh@lists.alphaweb.org>
Subject: [COMOH] COMOHO motion of support OPHA statement, Health and Racial Equity: Denouncing Acts and Symbols of Hate

Hello COMOHO members. In follow up to our general meeting on February 25th I am forwarding to you the following citation from our draft minutes asking that you consider communicating to your board of health:

4.4. OPHA Statement

[PHSD Motion](#)

P. Sutcliffe presented the OPHA statement, *Health and Racial Equity: Denouncing Acts and Symbols of Hate*, as endorsed by her board in the linked correspondence. She then made a MOTION that COMOHO endorse the statement, which was SECONDED by M. Klassen and CARRIED.

ACTION: C. Gardner to refer this item to the COMOHO Executive for follow-up.

The COMOHO Executive meeting scheduled for last week has been postpone to a date to be determined. This motion will be considered at our meeting.

Thank you.

Sincerely,

Dr. Charles Gardner, MD, CCFP, MHSc, FRCPC

Medical Officer of Health and Chief Executive Officer

t: 705-721-7520 or 1-877-721-7520 x: 7219

e: Charles.Gardner@smdhu.org

March 16, 2022

The Honourable Christine Elliott
Minister of Health
House of Commons
Ottawa, ON K1A 0A6

Dear Minister Elliott:

Re: Response to the Opioid Crisis in Simcoe Muskoka and Ontario-wide

On March 16, 2022, the Simcoe Muskoka District Health Unit (SMDHU) Board of Health endorsed a set of provincial recommendations to help address the ongoing and escalating opioid crisis experienced within Simcoe Muskoka and province-wide. Despite regional activities in response to the opioid crisis, there remains an urgent need for heightened provincial attention and action to promptly and adequately address the extensive burden of opioid-related deaths being experienced by those who use substances.

In the 19 months of available data since the start of the pandemic (March 2020 to September 2021) there have been 245 opioid-related deaths in Simcoe Muskoka. This is nearly 70% higher than the 145 opioid-related deaths in the 19 months prior to the start of the pandemic (August 2018 to February 2020), when our communities were already struggling in the face of this crisis. The first nine months of 2021 saw an opioid-related death rate more than 33% higher than the first nine months of 2020, suggesting the situation has not yet stabilized.

As such, the SMDHU Board of Health urges your government to take the following actions:

1. Create a multisectoral task force to guide the development of a robust provincial opioid response plan that will ensure necessary resourcing, policy change, and health and social system coordination.
2. Expand access to evidence informed harm reduction programs and practices including lifting the provincial cap of 21 Consumption and Treatment Service (CTS) Sites, funding Urgent Public Health Needs Sites (UPHNS) and scaling up safer opioid supply options.
3. Explore revisions to the current CTS model to address the growing trends of opioid poisoning amongst those who are using inhalation methods.
4. Expand access to opioid agonist therapy for opioid use disorder through a range of settings (e.g. mobile outreach, primary care, emergency departments), and a variety of medication options.
5. Provide a long-term financial commitment to create more affordable and supportive housing for people in need, including people with substance use disorders.
6. Address the structural stigma and harms that discriminate against people who use drugs, through provincial support and advocacy to the Federal government to decriminalize personal use and possession of substances and ensure increased investments in health and social services at all levels.

□ **Barrie:**
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□ **Collingwood:**
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Collingwood, ON
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705-445-0804
FAX: 705-445-6498

□ **Cookstown:**
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L0L 1L0
705-458-1103
FAX: 705-458-0105

□ **Gravenhurst:**
2-5 Pineridge Gate
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P1P 1Z3
705-684-9090
FAX: 705-684-9887

□ **Huntsville:**
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FAX: 705-789-7245

□ **Midland:**
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Midland, ON
L4R 1X8
705-526-9324
FAX: 705-526-1513

□ **Orillia:**
120-169 Front St. S.
Orillia, ON
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705-325-9565
FAX: 705-325-2091

7. Increase investments in evidence-informed substance use prevention and mental health promotion initiatives, that provide foundational support for the health, safety and well-being of individuals, families, and neighbourhoods, beginning from early childhood.
8. Fund a fulltime position of a Drug Strategy Coordinator/Lead for the Simcoe Muskoka Opioid Strategy.

The SMDHU Board of Health has endorsed these recommendations based on the well-demonstrated need for a coordinated, multi-sectoral approach that addresses the social determinants of health and recognizes the value of harm reduction strategies alongside substance use disorder treatment strategies, as part of the larger opioid crisis response. Evidence has shown that harm reduction strategies can prevent overdoses, save lives, and connect people with treatment and social services. Further, there is an urgent need to change the current Canadian drug policy to allow a public health response to substance use, through decriminalization of personal use and possession paired with avenues towards health and social services, as our Board called for in 2018. These recommendations collectively promote effective public health and safety measures to address the social and health harms associated with substance use.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Board of Health Chair
Simcoe Muskoka District Health Unit

cc: Associate Minister of Mental Health and Addictions
Attorney General of Ontario
Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Health
Ontario Boards of Health
Members of Parliament in Simcoe Muskoka
Members of Provincial Parliament in Simcoe Muskoka
Mayors and Municipal Councils in Simcoe Muskoka

March 30, 2022

The Honourable Christine Elliott
Minister of Health and Deputy Premier
Ministry of Health
College Park 5th Floor, 777 Bay St
Toronto, ON M7A 2J3

Dear Minister Elliott:

Letter of Support – Health and Racial Equity: Denouncing Acts and Symbols of Hate

On March 24, 2022 at a regular meeting of the Windsor-Essex County Board of Health, the Board considered a letter from Sudbury & Districts Public Health to Dr. Paul Roumeliotis, President of alPHa, encouraging other Ontario Boards of Health and the Association of Local Public Health Agencies (alPHa), to endorse the January 31, 2022 statement of the Ontario Public Health Association **Denouncing Acts and Symbols of Hate**.

The following motion was passed:

Motion: That the WECHU Board of Health support the letter from Sudbury & Districts Public Health to Dr. Paul Roumeliotis, President, Association of Local Public Health Agencies (alPHa), endorsing the January 31, 2022 statement of the Ontario Public Health Association Denouncing Acts and Symbols of Hate

The Windsor-Essex County Health Unit fully supports the above recommendation, and thanks you for your consideration.

Sincerely,



Gary McNamara, Chair
Windsor-Essex County Board of Health

c: Nicole Dupuis, CEO, WECHU
Loretta Ryan, Executive Director, alPHa
Ontario Boards of Health
Doug Ford, Premier of Ontario
Parm Gill, Minister of Citizenship and Multiculturalism
Sean Fraser, Minister of immigration, Refugee and Citizenship, Government of Canada



February 23, 2022

VIA ELECTRONIC MAIL

Dr. Paul Roumeliotis
President
Association of Local Public Health Agencies
480 University Avenue, Suite 300
Toronto, ON M5G 1V2

Dear Dr. Roumeliotis:

Re: Health and Racial Equity: Denouncing Acts and Symbols of Hate

At its meeting on February 17, 2022, the Board of Health for Public Health Sudbury & Districts carried the following resolution #08-22:

WHEREAS the reduction of health inequities is a goal of Ontario's public health programs and services as set out in the Ontario Public Health Standards (OPHS), health equity is a Foundational Standard of the OPHS, and programs and services must be implemented in accordance with the Health Equity Guideline which includes the requirement to apply anti racist, anti-oppressive, and culturally safe approaches to public health practice; and

WHEREAS the Vision of the Board of Health for Public Health Sudbury & Districts, Healthier communities for all, is further guided by its Mission and Strategic Plan, both of which prioritize action in support of health equity; and

WHEREAS the Board of Health for Public Health Sudbury & Districts is a leader among Ontario local public health agencies in their longstanding commitment to health and racial equity, including notably, the September 2019 endorsement of the Racial Equity Action Framework for Improved Health Equity; and

WHEREAS recent events in Ontario have included public displays of racism, anti-Semitism and discrimination, all detrimental to optimal health for all and prompting the Ontario Public Health Association (OPHA) on January 31, 2022, to issue the following statement:

While the right to protest is a fundamental element of our democracy, OPHA is disturbed by the hate filled racist and white supremacist symbols and messages flowing from the demonstrations in Ottawa. We denounce all forms of hate, bigotry, racism, antisemitism, and discrimination. Acts and

Sudbury

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f: 705.522.5182

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t: 705.522.9200
f: 705.677.9611

Sudbury East / Sudbury-Est

1 rue King Street
Box / Boîte 58
St.-Charles ON POM 2W0
t: 705.222.9201
f: 705.867.0474

Espanola

800 rue Centre Street
Unit / Unité 100 C
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t: 705.222.9202
f: 705.869.5583

Île Manitoulin Island

6163 Highway / Route 542
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Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

Chapleau

34 rue Birch Street
Box / Boîte 485
Chapleau ON POM 1K0
t: 705.860.9200
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toll-free / sans frais

1.866.522.9200

phsd.ca



Re: Health and Racial Equity: Denouncing Acts and Symbols of Hate

February 23, 2022

Page 2

symbols of hate are unwelcome and should not be tolerated. Silence is not acceptable. We urge political leaders from all levels & parties to speak out against such hate and racism, and to promote the importance of vaccines and other public health measures that are protecting all of us, especially the most vulnerable, against illness, hospitalization, & death. Change can only happen when we stand up and speak out. Let's work together to build a society that values diversity, inclusion, and optimal health for all.

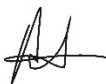
THEREFORE, BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts endorse the January 31, 2022, statement of the OPHA; and

FURTHER THAT the Board of Health encourage other Ontario boards of health and the Association of Local Public Health Agencies to do the same; and

FURTHER THAT that this resolution be shared with all boards of health, the Association of Local Public Health Agencies, area Honorable Members of Parliament and Provincial Parliament, the Ontario Public Health Association, the Association Municipalities of Ontario (AMO), among other stakeholders.

A reduction of health inequities is a goal of Ontario's public health programs and services as set out in the OPHS. Both ALPHA and local Boards of Health have a long-standing history of supporting various health equity measures (e.g., food security, Truth and Reconciliation Commission calls to action, living wage, low-income dental, use of a health equity lens, national pharmacare, extending the Ontario Pregnancy and Breastfeeding Nutritional Allowance). Thanks to efforts like these, public health addresses the social determinants of health and promotes health equity. There is still work to be done. Recent events in Ontario have included public displays of racism, anti-Semitism and discrimination, all detrimental to optimal health for all. In supporting health for all, it is important that public health not remain silent and instead state that acts and symbols of hate are unwelcome and should not be tolerated. Thank you for your consideration of this important matter.

Sincerely,



Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer

cc: All Ontario Boards of Health
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Pageen Walsh, Executive Director, Ontario Public Health Association
Jamie McGarvey, President, Association of Municipalities Ontario
Jamie West, Member of Provincial Parliament, Sudbury
France G elinas, Member of Provincial Parliament, Nickel Belt
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin
Paul Lefebvre, Member of Parliament, Sudbury
Marc Serr e, Member of Parliament, Nickel Belt
Carol Hugues, Member of Parliament, Algoma-Manitoulin-Kapuskasing

March 30, 2022

The Honourable Christine Elliott
Minister of Health and Deputy Premier
Ministry of Health
College Park 5th Floor, 777 Bay St
Toronto, ON M7A 2J3

Dear Minister Elliott:

Letter of Support – Ontario Regulation 116/20, Work Deployment Measures for Boards of Health

On March 24, 2022 at a regular meeting of the Windsor-Essex County Board of Health, the Board considered a letter from Cynthia St. John, President of the Association of Ontario Public Health Business Administrators (AOPHBA) to Dr. Kieran Moore, CMOH, requesting that Dr. Moore consider extending **Ontario Regulation 116/20 Work Deployment Measures for Boards of Health for the duration of public health units' response to the COVID-19 pandemic**. The following motion was passed:

Motion: **That the WECHU Board of Health support the letter from the AOPHBA to the CMOH, Dr. Kieran Moore, requesting that Work Deployment Measures for Boards of Health be extended for the duration of public health units' response to the COVID-19 pandemic.**
CARRIED

The Windsor-Essex County Health Unit fully supports the above recommendation, and thanks you for your consideration.

Sincerely,



Gary McNamara, Chair
Windsor-Essex County Board of Health

c: Nicole Dupuis, CEO, WECHU
 Loretta Ryan, Executive Director, alPha
 Ontario Boards of Health
 Dr. Kieran, Moore, CMOH
 Doug Ford, Premier of Ontario

Sent via email to: Kieran.moore1@ontario.ca

February 9, 2022

Dr. Kieran Moore
Chief Medical Officer of Health
Ministry of Health

RE: Ontario Regulation 116/20, Work Deployment Measures for Boards of Health

Dear Dr. Moore,

On behalf of the Association of Ontario Public Health Business Administrators (AOPHBA), I am writing to you concerning the Ontario Regulation 116/20, Work Deployment Measures for Boards of Health.

This Regulation, in place since April 2020, has proven invaluable in ensuring that public health units (PHUs) are able to effectively respond to the COVID-19 pandemic. Since April 2020, public health work has evolved and changed rapidly in response to both local and provincial directions and demands in areas such as case and contact management, outbreak management in our most vulnerable settings, the development and implementation of the vaccination program, and the continued support and leadership provided to community partners including businesses, municipalities, schools, health related agencies, etc.

It is the opinion of the Association Executive that public health units' continued response to the COVID-19 pandemic will be significantly negatively impacted if PHUs do not have the flexibility necessary to deploy staff how and where needed. PHUs have one or more unions within their employ and many of our members have noted that the restrictions of the various collective agreements often do not allow redeployment of PHU staff to different roles or different areas within the PHU, nor assignment of work on weekends, evenings, and holidays, all of which have been critical to vaccine clinics. The flexibility that this Ontario Regulation provides is critical to our ability to continue to plan and execute both local and provincial directives in line with our mandate, for the balance of 2022.

We respectfully ask that you consider extending Ontario Regulation 116/20 Work Deployment Measures for Boards of Health for the duration of public health units' response to the COVID-19 pandemic.

Sincerely,



Cynthia St. John
President
Association of Ontario Public Health Business Administrators (AOPHBA)

c. Brent Feeney, Manager, Funding and Oversight, Office of the CMOH, Ministry of Health
Teresa Bendo, Secretary, AOPHBA
Loretta Ryan, Executive Director, Association of Local Public Health Agencies (ALPHA)