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2023

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2023 Annual General Meeting
Tuesday, June 13, 2023

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alPHa
Association of Local PUBLIC HEALTH Agencies

RESOLUTION A23-01

TITLE: **Constitutional Amendment on Voting Delegates Allocation**

SPONSOR: **alPHa Board of Directors**

WHEREAS article 8.5 of the Constitution of the Association of Local Public Health Agencies specifies the total number of voting delegates based upon the population served by the member local official health agency as follows: *under 200,000* – **4**; *200,000 - 300,000* – **5**; *300,001 - 400,000* – **6**; *over 400,000* – **7**; *Toronto* **20**; and

WHEREAS the most recent change to this allocation was the passage of an amendment to the alPHa Constitution in 1998 to assign 20 delegates to the newly amalgamated City of Toronto, which incorporated former municipalities of East York, Etobicoke, North York, Scarborough and York; and

WHEREAS further amalgamations, public health unit mergers, and population growth have substantially altered the distribution and size of the population of Ontario since that time; and

WHEREAS the composition of the alPHa membership has changed substantially as a result, with the number of public health units reduced from 44 to a current total of 34; and

WHEREAS according to the 2021 Census, 34 public health units are serving over 3 million more Ontarians in total than 44 were serving in 1998; and

WHEREAS the data on population sorted by health region from the 2021 Canada Census of Population have been published; and

WHEREAS these data show that populations have changed sufficiently that four public health units have moved into a higher vote allocation category; and

WHEREAS these data show that populations have changed sufficiently that three public health units categorized in the “more than 400,000” allocation category now have populations in excess of 1 million;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies approve the creation of a new allocation category, namely “Population More Than 1,000,000”;

AND FURTHER that each member public health unit in this category be allocated a total of eight (8) voting delegates, as follows:

POPULATION VOTING DELEGATES

Under 200,000	4	Over 400,000	7
200,000 - 300,000	5	Over 1,000,000	8
300,001 - 400,000	6	Toronto	20

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Allocation of Votes: alPHa Resolutions

Health Unit	Population	Voting Delegates
TORONTO	2,794,356	**20**
POPULATION OVER 1,000,000		
Ottawa	1,017,449	**8**
Peel	1,451,022	
York	1,173,334	
POPULATION OVER 400,000		
Durham	696,992	**7**
Halton	596,637	
Hamilton	569,353	
Middlesex-London	500,563	
Niagara	477,941	
Simcoe-Muskoka	599,843	
Waterloo (587,165)	587,165	
Windsor Essex – moved up from >300K	422,860	
POPULATION OVER 300,000		
Wellington-Dufferin-Guelph	307,283	**6**
POPULATION OVER 200,000		
Eastern Ontario	210,276	**5**
Kingston, Frontenac, Lennox and Addington	206,962	
Southwestern	216,533	
Sudbury	202,431	
POPULATION UNDER 200,000		
Algoma	112,764	**4**
Brant	144,937	
Chatham-Kent	104,316	
Grey Bruce	174,301	
Haldimand-Norfolk	116,706	
Haliburton, Kawartha, Pine-Ridge	189,183	
Hastings-Prince Edward	171,450	
Huron Perth	142,931	
Lambton	128,154	
Leeds, Grenville and Lanark	179,830	
North Bay-Parry Sound	129,362	
Northwestern	77,338	
Peterborough	147,681	
Porcupine	81,188	
Renfrew	107,522	
Thunder Bay	152,885	
Timiskaming	32,394	

Association of Local PUBLIC HEALTH Agencies

RESOLUTION A23-02

TITLE: **Toward a Renewed Smoking, Vaping, and Nicotine Strategy in Ontario**

SPONSOR: **Simcoe Muskoka District Health Unit (SMDHU)**

WHEREAS commercial tobacco use remains the leading preventable cause of death and disease in Ontario and Canada; and

WHEREAS the direct and indirect financial costs of tobacco smoking are substantial and were estimated at $7 billion in Cancer Care Ontario and Public Health Ontario's 2019 report The Burden of Chronic Diseases in Ontario; and

WHEREAS the prevalence of cigarette smoking among Ontarians aged 15 years and older in 2020 was 9.9%, amounting to 1,222,000 people; and

WHEREAS the commercial tobacco control landscape has become more complex with the rapid rise of vaping among youth, as well as the concerning prevalence of waterpipe and cannabis smoking; and

WHEREAS the membership previously carried resolution A21-1 proposing policy measures to address youth vaping for implementation at the provincial and federal levels, several of which have yet to be implemented; and

WHEREAS the membership previously carried resolution A17-5 recommending that the provincial tobacco control strategy be aligned with the tobacco endgame in Canada; and

WHEREAS Ontario and Canada have made great strides in commercial tobacco control in Ontario, which are now endangered by the lack of a provincial strategy and infrastructure to support its continuation; and

WHEREAS disproportionate commercial tobacco and nicotine use and associated health burdens exist among certain priority populations;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies write to the Ontario Minister of Health recommending that a renewed and comprehensive smoking, vaping, and nicotine strategy be developed with the support of a multidisciplinary panel of experts, local public health, and people with lived experience;

AND FURTHER that the Association of Local Public Health Agencies recommend that, in the development of a target for such a provincial strategy, the expert panel examine the sufficiency and inclusiveness of Canada's Tobacco Strategy target of less than 5% commercial tobacco use by 2035 with respect to all nicotine delivery products;

AND FURTHER that the Association of Local Public Health Agencies recommend that the pursuit of health equity be foundational to such a provincial strategy;

AND FURTHER that a copy be sent to the Chief Medical Officer of Health of Ontario.

BACKGROUND:

TOWARD A RENEWED COMMERCIAL TOBACCO AND NICOTINE STRATEGY IN ONTARIO

1. Commercial Tobacco

Canada has made great strides in commercial tobacco[1] control, and Ontario has until recent years been a leader among our provinces and territories, having made tremendous progress in decreasing smoking rates and in turn the negative health outcomes of smoking. Smoking prevalence among Canadians and Ontarians 15 years and older have dropped from 25% and 23%, respectively, in 1999 down to around 10% in 2020.[1] This decrease is representative of a remarkable downward trend nationally and provincially that appear to be on track to reach the endgame goal of less than 5% tobacco use by 2035, a target adopted by the federal government in Canada's Tobacco Strategy[2] and previously recommended for adoption in Ontario[3]. The recent Report of the First Legislative Review of the *Tobacco and Vaping Products Act* elaborates on this trend, noting that "declines in the number of young persons who smoke played an important role in declining prevalence rates overall; smoking rates among Canadians aged 15-19 are currently at an all-time low."[4]

However, it is crucial to note that this progress was achieved over decades, with explicit commercial tobacco control strategies in place to guide tobacco control research, policy development, and policy implementation; all this work was also undergirded by a robust infrastructure. Recent examples of progress in the federal policy arena include the implementation of policies around plain and standardized packaging for commercial tobacco products and enhanced package health warnings, as well as a ban on flavours in cigarettes and most cigars. Provincially, Ontario has strengthened its commercial tobacco contraband measures.

While Canada retains a strategy, Ontario is now operating without one—and there is still much work to be done: Tobacco use remains the leading preventable cause of death and disability in Canada,[5,6] killing approximately 48,000 Canadians each year,[2] of which nearly 17,000 are Ontarians.[7] The Ontario Public Health Standards' *Tobacco, Vapour and Smoke Guideline, 2021* states that "[e]very day tobacco kills more Ontarians than alcohol, illegal drugs, accidents, suicides and homicides combined. People who use tobacco are more likely to go to the hospital and stay longer. They are also likely to die younger."[8] The economic burden is similarly immense: While updated data on the economic burden of tobacco use is needed, 2017 data indicated health care costs of $6.1 billion and overall costs of $12.3 billion nationally.[9] In Ontario, a separate report determined the overall annual economic burden of tobacco smoking to be around $7 billion, exceeding that of alcohol consumption, physical inactivity, or unhealthy eating, taken separately.[10]

2. Vaping

The landscape of commercial tobacco and nicotine products has become more complex with the advent of vaping products containing nicotine, which includes electronic cigarettes (e-cigarettes), the primary users of which are youth. Vaping is the "act of inhaling and exhaling an aerosol produced by a vaping product, such as an electronic cigarette."[11] Most vaping devices use electrical power from a battery to heat a liquid solution to produce an aerosol that is breathed in by the user through the mouthpiece. Most vaping liquids contain nicotine, the levels of which range from very low to more than what is found in a typical tobacco cigarette, together with flavouring compounds that are dissolved in a liquid mixture

[1] Commercial tobacco is distinct from traditional or ceremonial use of tobacco by Indigenous peoples. In the implementation and enforcement of the *Smoke-Free Ontario Act, 2017*, the Ministry of Health protects the use of tobacco by Indigenous peoples and communities when used for traditional or ceremonial purposes.

composed typically of propylene glycol and/or glycerol (i.e., vegetable glycerin).[11] Some vaping liquids also contain cannabis.[12]

National data from 2021 indicates that 13% of adolescents aged 15 to 19 years and 17% of young adults aged 20 to 24 years in Canada reported having vaped at least once during the 30-day period before the survey, compared with 4% of adults aged 25 or older.[13] Provincially, there has been a meteoric rise in youth vaping rates in recent years: According to the Ontario Student Drug and Health Survey, grade 7–12 students who reported used vaping products in the past year doubled from 11% in 2017 to 23% in 2019, with 13%—representing approximately 105,600 students—vaping weekly or daily.[14] These rates are particularly alarming among students in higher grades: The 2019 survey indicated that 35% of students in grade 12 vaped in the past year, of which 21% were vaping weekly or daily.[14] Moreover, among students who vaped in the past year, those who reported using a nicotine-containing product doubled from 28% in 2017 to 56% in 2019.[14] The more recent 2021 survey noted a decrease of past-year vaping among students to 15%. However, those who reported using a nicotine-containing product increased further to 84%, implying that the overall percentage of students vaping nicotine-containing products remained approximately the same as in 2019. There are several challenges to interpretation of the 2021 survey results. For example, the change to an online mode of questionnaire delivery for 2021 led to dramatically decreased response rates that may impact the provincial representativeness of the results.[15] The report also indicates that "because of the significant changes to the methodology in 2021, caution is warranted when comparing these estimates with those from previous OSDUHS cycles."[15] More broadly, both the COVID-19 pandemic as well as changes to the federal and provincial regulatory and policy environments since 2019 have likely impacted the prevalence of youth vaping; however, longitudinal assessments have been disrupted by the pandemic and therefore the extent of impacts is unknown. Further monitoring, data collection and evaluation is needed to understand the impact of these changes and events on adolescent vaping initiation, escalation, and overall prevalence.

Regardless of the method of delivery, the highly addictive effects of nicotine are fundamentally the same, and may have particularly insidious effects on the developing brains of youth.[16,17] Although vaping products have been advertised in part as a harm reduction and smoking cessation product that may reduce health risks and possibly save lives for people who smoke, with some evidence to support this claim,[18,19] there has been no discernible population-level change in smoking cessation rates since vaping products entered the market.[20] Therefore, any individual-level efficacy of vaping products as a smoking cessation tool does not appear to translate to population-level impact. Furthermore, the vast majority of uptake has been among youth without a smoking history. In fact, among those who reported having vaped in the past 30 days, a majority (61%) of youth aged 15 to 19 and more than one-quarter (27%) of young adults aged 20 to 24 had never tried a tobacco cigarette in their life, which suggests that the majority of youth are not using vaping devices to reduce or quit smoking.[13] Therefore, the current evidence around the benefits of vaping products for the purpose of smoking cessation, while still evolving, is not of relevance to youth. In contrast, the evidence to date around the harms of vaping is becoming increasingly clear; in particular, people who vape but do not smoke are on average around three times more likely than those who do not vape to initiate cigarette smoking,[21,22] lending credence to the concern of a gateway effect. Additional evidence of harms from vaping includes the following:

- A variety of substances known to be toxic, carcinogenic, or cause disease have been identified in vaping products.[23]
- Intentional or accidental exposure to nicotine e-liquids can lead to poisoning, which can be lethal, with a significant number of accidental poisonings occurring in children under the age of six.[21]
- Vaping can cause burns and injuries, which can be lethal.[21]
- Vaping can cause respiratory disease in the form of E-cigarette or Vaping Use-Associated Lung Injury (EVALI).[21]
- Vaping can lead to seizures.[21]

- Vaping products contribute to environmental waste.[21]

Moreover, there are differences between vaping and smoking dependence that may impact attempts to quit, including the greater variability in vaping products compared to cigarettes, the discreteness and convenience of vaping, and the greater social acceptability of vaping among youth.[24] To address the rise of vaping, Ontario has required retail registration with local public health units for sale of flavoured vaping products (except mint-menthol or tobacco flavours), restricted sale of flavoured products (except mint-menthol and tobacco flavours) to specialty vape stores, banned sale of vaping products in several public premises, and banned their use in most public premises, though with notable exceptions such as post-secondary institutions. There are also several promising local and regional campaigns such as "Not an Experiment"[25] aiming to raise awareness among youth, parents, and educators about the risks of vaping. However, more control measures and interventions, as well as evaluation of their effectiveness, are needed to protect youth from the harms of both vaping as well as all future commercial nicotine delivery products.

3. Waterpipe smoking

Also referred to as "shisha" or "hookah", waterpipe smoking involves smoking a heated tobacco or non-tobacco "herbal" product.[26] Its increase in prevalence globally may be explained in part by misconceptions of lesser harm relative to other forms of tobacco smoking, its social nature, and the availability of various flavours and nicotine-free products.[26] However, waterpipe smoking of both tobacco and non-tobacco products results in inhalation of various carcinogens and toxins, and results in similar negative health effects to cigarette smoking.[26] Moreover, while the *Smoke-Free Ontario Act, 2017* prohibits the use of tobacco in waterpipes in restaurants and bar patios, the use of non-tobacco products in waterpipes is still permitted, impacting not only waterpipe smokers but also the public through secondhand and thirdhand smoke.[26]

4. Cannabis smoking

Cannabis, which can be consumed by various means including smoking, vaping, and ingestion, refers to all products derived from the *Cannabis sativa* plant, and can consist of up to approximately 540 different chemical substances, among which the main psychoactive constituent is tetrahydrocannabinol (THC).[27] The federal *Cannabis Act* came into force in October 2018, resulting in legalization and regulation of production, distribution, sale, import, export, and possession of cannabis for adults of legal age.[28] The 2021 Canadian Cannabis Survey indicates that approximately 25% of Canadians have reported using cannabis in the past 12 months, of whom 74% reported smoking as one method of cannabis consumption.[12] In addition to an array of health effects associated with cannabis consumption, smoked cannabis in particular can increase risk of bronchitis, lung infections, and chronic cough.[29] The *Smoke-Free Ontario Act, 2017* prohibits the smoking of cannabis in enclosed workplaces, enclosed public places, and other designated places.

5. Ontario's commercial tobacco and nicotine control landscape

Despite concerted efforts through research and reports providing evidence-informed recommendations towards a "tobacco endgame" culminating in the *Smoke-Free Ontario Modernization* report in 2017,[3] there has been limited incorporation of these recommendations into the province's approach to commercial tobacco and nicotine control.[30] For example, actions to increase the cost of commercial tobacco products through tax and other pricing policies have been limited; Ontario continues to have the second lowest retail price and total tobacco tax for tobacco products in Canada.[31,32] Moreover, among the many programs and services that have been lost during the COVID-19 pandemic, commercial tobacco and nicotine prevention, protection, and cessation programs have been significantly impacted. Indeed, the

broader commercial tobacco control infrastructure in Ontario has declined substantially both before and during the pandemic, a decline that is closely tied to the loss of a provincial strategy. With the loss of the Smoke-Free Ontario Strategy, the following crucial infrastructure has been lost: the Smoking and Health Action Foundation, the Leave the Pack Behind program, the Youth Advocacy Training Institute as well as the associated youth advocacy programming, the Program Training and Consultation Centre, funding to public health units for youth and young adults as staff, Smokers' Helpline telephone counselling, Registered Nurses Association of Ontario special projects for tobacco control, Heart & Stroke Foundation of Ontario mass media campaigns, and provincial mass media campaigns. In addition, provincial funding has been reduced for monitoring, research, and evaluation, which has impacted the activities of organizations such as the Ontario Tobacco Research Unit. Funding from other sources such as NGOs has also been lost for organizations such as the Ontario Campaign for Action on Tobacco. Furthermore, many stakeholder engagement opportunities at the provincial level, such as through the Tobacco Control System Committee, the Youth Prevention Task Force, the Communications and Marketing Advisory Committee, the Protection and Enforcement Task Force, the Research and Evaluation Task Force, the Capacity Building and Training Task Force, and monthly calls between Tobacco Control Area Networks and Ministry staff, have been discontinued. Finally, organizations such as Public Health Ontario have had a reduced focus on commercial tobacco and nicotine as an inevitable consequence of the significant resources that have been committed to combatting the COVID-19 pandemic, although their recent re-engagement in this area is inspiring.

These setbacks are compounded by ongoing inequities in the health impacts of tobacco and nicotine use among certain populations. Smoking is a socioeconomically stratified behaviour, as evidenced by decreasing prevalence rates with increasing education.[33] Disproportionate commercial tobacco and nicotine use and associated health burdens exist among Indigenous populations, members of the LGBTQ2S+ community, low-income populations, people with less formal education, people working in certain occupations (e.g., trades), individuals with mental health needs, individuals who use other substances, and incarcerated individuals.[2,9,31,34] Moreover, while reaching less than 5% tobacco use by 2035 may be possible with current strategies, such a target on its own does not sufficiently address this disproportionate burden among these populations. When addressing such health inequities among Indigenous peoples, it is also important to take a culturally safe approach that distinguishes between commercial tobacco use and traditional or ceremonial use of tobacco.

6. Examining the policy options

In late 2022, the Simcoe Muskoka District Health Unit (SMDHU) performed a brief jurisdictional scan focusing on recently implemented commercial tobacco and nicotine control policies (see Appendix A) and explored the grey literature to both identify existing policies at the federal and provincial levels, as well as determine some of the priority areas for action for a renewed smoking and nicotine strategy. SMDHU also conducted a conversation with key informants, the key points of which were summarized through the lens of an adapted version of the World Health Organization's MPOWER framework[2] (see Appendix B).[36]

Given the relative recency of vaping as a phenomenon, evidence is emerging related to the effectiveness of interventions to reduce vaping[23,37–41] as well the cost-effectiveness of doing so.[42] Lessons learned from interventions used to combat commercial tobacco use may also be applied to address vaping.[40] However, evaluation will be needed to confirm effectiveness. There have already been a variety of effective

[2] The World Health Organization Framework Convention on Tobacco Control (FCTC) is a legally binding international health treaty on tobacco control, which 182 countries including Canada have ratified.[35] To help countries reduce demand for tobacco, the WHO developed the MPOWER measures: Monitor tobacco use and prevention policies; Protect people from tobacco smoke; Offer help to quit tobacco use; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion and sponsorship; and Raise taxes on tobacco.[36]

commercial tobacco and nicotine control interventions implemented in Ontario and other Canadian jurisdictions over the years, but a coordinated, comprehensive, multi-level, evidence-informed, and enduring strategy is needed to achieve the target of less than 5% tobacco use by 2035. Such a strategy would continue to be informed by evidence and focus on the traditional pillars of prevention, cessation, and protection, as well as industry denormalization and engagement of disproportionately impacted groups such as First Nations, Inuit and Métis (FNIM) organizations and communities.[3,9,34,43,44] However, for such a strategy to work, there must be provincial and federal commitments to strong regulations around all alternative methods of nicotine delivery. In particular, the Council of the Chief Medical Officers of Health has recommended a "broad regulatory approach to all alternative methods of nicotine delivery (i.e. other than tobacco products) that offers strong youth protection while allowing appropriate access for adult who smoke to products if they are proven effective in decreasing or stopping the use of all nicotine-containing products."[45]

7. Conclusion

Despite significant progress in commercial tobacco control, the health and economic burdens of tobacco-related disease in Canada remain unconscionably high. Moreover, vaping, waterpipe smoking, and cannabis smoking have added further complexity to the smoking and nicotine control landscape that risks undoing the tremendous progress that has been made. A coordinated, comprehensive, and enduring provincial smoking and nicotine control strategy is needed to save lives, protect young minds, reduce health inequities, and save money.

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Appendix A: Jurisdictional Scan of Tobacco and Nicotine Control Policies in Canada

Summary: A jurisdictional scan of Canadian federal, provincial, and territorial tobacco and nicotine control strategies was performed. An array of pre-existing documents[32,46–48] (environmental scans, briefing notes, etc.) produced by Physicians for a Smoke-Free Canada (PSC) cover similar objectives, and therefore constitute a major contribution to this scan. Overall, strategies have continued to focus on efforts surrounding the four pillars of prevention, cessation, protection and denormalization, with varying degrees of emphasis on each. However, the last few years have seen a deceleration in commercial tobacco control efforts, while vaping products have taken the spotlight, particularly following the amendment of the *Tobacco Act* in 2018 to become the *Tobacco and Vaping Products Act* (TVPA).

With respect to commercial tobacco control, the following recent changes have occurred at the federal, provincial, and/or territorial levels:

- plain and standardized packaging
- enhanced package health warnings
- ban on flavours in cigarettes and most cigars including menthol and cloves
- additional contraband measures in some jurisdictions

With respect to vaping control, the following recent changes have occurred at the federal, provincial, and/or territorial levels:

- taxes on vaping products
- retail licensing/registration
- minimum age restrictions
- requiring proof of age in stores
- display bans in stores
- restriction to sale in specialty vape stores
- bans on internet sales
- bans on incentives to retailers
- bans on non-tobacco flavours
- bans on various forms of advertisement
- restrictions on nicotine content
- health warnings

There are also plans at the federal level for implementing "reporting requirements that would require vaping product manufacturers to submit information to Health Canada about sales and ingredients used in vaping products."[4]

Limitations: While such a scan would be most useful if it summarized the implementation of the jurisdictional strategies that were identified (in addition to effects of implementation, technical feasibility, political viability, alignment with the Canadian regulatory landscape, etc.), the scan was largely limited to information that could be gleaned from web-based searches of the grey literature. Furthermore, jurisdictions outside of Canada such as New Zealand,[49] Australia,[50,51] Finland[52] and California[53] may provide further insights into tobacco and nicotine control, but were not covered in this scan.

Table A1: Jurisdictional Scan Results

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
Fed	Canada's Tobacco Strategy[2] (2018)	• Supports endgame goal of less than 5% by 2035. • Note: In 2020/2021, Health Canada changed its progress indicator from "percentage of Canadians (aged 15+) who have used any tobacco product in the last 30 days" to "Percentage of Canadians (aged 15+) who are current cigarette smokers."[54]	• Vaping products: ban on ads in stores (except age-restricted stores), display ban, ban on broadcast ads, ban on billboards/outdoor signs, ban on lifestyle ads, ban on sponsorships, ban on youth-appealing ads, health warnings / labelling requirements, restriction on nicotine content (max 20 mg/mL), excise tax, plan to ban all flavours except tobacco and mint-menthol, plan to impose vaping product reporting requirements, compliance and enforcement activities • Tobacco products: Plain and standardized packaging, enhanced package health warnings, ban on flavours in cigarettes and most cigars including menthol and cloves
BC	BC's Tobacco Control Strategy: targeting our efforts[55]	• No endorsement of endgame goal • BC's 2013 Guiding Framework for Public Health[56] targets a reduction of smoking to 10% by 2023. • In the 2018 report First to 5% by 2035[57], the Clean Air Coalition of BC recommended that BC be the first jurisdiction to achieve 5% by 2035, but there is no evidence of endorsement by government.	• Vaping products: tax, retail notification and reporting requirement, sale of flavoured products restricted to specialty vape stores, ban on sale and use in some public premises • Tobacco products: subsidized nicotine replacement therapy (NRT) to all residents, second highest level of overall taxation on cigarettes ($15.30 for a 20-pack), highly regarded stop-smoking service model, some exemplary practices in Indigenous stewardship
AB	Creating Tobacco-free Futures: Alberta's Strategy to Prevent and Reduce Tobacco Use 2012-2022[58]	• No endorsement of endgame goal • 10-year targets set for 2022: - Albertans ages 15 and over: 12 % - Albertans ages 12 to 19: 6% - Albertans ages 20 to 24: 20% - Pregnant women in Alberta: 11%	• Vaping products: ban on possession below minimum legal age, ban on sale in some public premises, ban on use in most public premises including outdoor cultural events

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
		- Reduce estimated per capita tobacco sales by 50 per cent to 745 units in 2022.	
SK	No strategic document identified. Public-facing Information available on their Tobacco and Vapour Products webpage.	• No endorsement of endgame goal • The Saskatchewan Coalition for Tobacco Reduction produced a report entitled Protecting our Future: Recommendations to reduce tobacco use in Saskatchewan, but this document does not appear to have been endorsement by government.	• Vaping products: tax, ban on sale and use in some public premises
MB	No strategic document identified. Public-facing information available on their Smoking, Vaping Control & Cessation webpage.	• No endorsement of endgame goal	• Vaping products: ban on sale and use in some public premises
ON	Smoke-Free Ontario: The Next Chapter - 2018[30] Note: This strategy was neither adopted nor implemented by the present government.	• No endorsement of endgame goal • Reduce smoking to 10% by 2023 • Reduce the number of smoking-related deaths by 5,000 each year. • Reduce exposure to the harmful effects of tobacco and the potentially harmful effects of other inhaled substances and emerging products (including medical cannabis).	• Vaping products: retail registration with local public health unit required for sale of flavoured products (not tobacco or mint-menthol), sale of flavoured products (except tobacco and menthol) restricted to specialty vape stores, ban on sale in several public premises, ban on use in most public premises (post-secondary institutions excluded) • Tobacco products: additional contraband measures
QC	Stratégie pour un Québec sans tabac 2020-2025[59] (see Appendix A for summary English translation)	• No endorsement of endgame goal • Reduce smoking to 10% by 2025.	• Vaping products: retail notification requirement, ban on internet sale and on incentives to vaping product retailers, ban on sale in most public premises, ban on use in many public premises • Tobacco products: subsidized nicotine replacement therapy (NRT) to all residents
NB	New Brunswick's Tobacco-Free	• **Supports endgame goal of less than 5% by 2035.**	• Vaping products: retail licensing/registration, ban on all

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
	Living Strategy: A Tobacco and Smoke-Free Province for All[60] (2019-2023) was produced by the NB Anti-Tobacco Coalition, funded by the Government of NB.		flavours except tobacco, ban on use in most public premises
NS	Moving toward a Tobacco-Free Nova Scotia: Comprehensive Tobacco Control Strategy for Nova Scotia[61] (2011) Public-facing information available on their Tobacco Free Nova Scotia webpage.	• No endorsement of endgame goal • Decrease tobacco use rates individuals aged 15-19 years to 10%, 20-24 years to 20%, and 25 years and older to 15%.	• Vaping products: retail licensing/registration, tax, ban on all flavours except tobacco, ban on sale and use in most public premises (post-secondary institutions included)
PEI	No strategic document specific to tobacco control identified. Tobacco control is addressed in PEI's Wellness Strategy[62] (2015-2018)	• No endorsement of endgame goal	• Vaping products: Sale restricted to age 21 years and above and only in specialty stores, ban on all flavours except tobacco, ban on sale in many public premises, ban on use in several public premises (post-secondary institutions included)
NL	Tobacco and Vaping Reduction Strategy[63] (2021) produced by the Newfoundland and Labrador Alliance for the Control of Tobacco, which is an alliance of government and non-government partners.	• No endorsement of endgame goal Action areas: • Community capacity building • Education and awareness • Healthy public policy • Cessation and treatment services • Research, monitoring and evaluation	• Vaping products: retail licensing/registration, tax, ban on sale in many public premises, ban on use in several public premises (post-secondary institutions included) • Highest level of overall taxation on cigarettes ($15.71 for a 20-pack)
YT	No strategic document identified. Public-facing information available on	• No endorsement of endgame goal	• Vaping products: ban on use in many public premises

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
	government webpage.		
NWT	No strategic document identified. Public-facing information available on Tobacco Control webpage.	• No endorsement of endgame goal	• Vaping products: ban on all flavours except tobacco, ban on possession below minimum legal age, ban on sale in some public premises, ban on use in many public premises
NU	Nunavut Tobacco Reduction Framework for Action[64] (2011-2016)	• No endorsement of endgame goal • Guiding principles draw from Inuit culture and practices. • Supports a coordinated communications plan using a range of media tools and using both universal and targeted approaches (including youth, pregnant women and their partners, and parents and Elders). • Younger age group is targeted through school and community youth programs because youth initiate tobacco use largely between 8 and 16 years of age.	• Vaping products (per Tobacco and Smoking Act[65], which received Assent on June 8, 2021, but is not anticipated to come into force until 2023): plan to consider vaping product price restrictions, plan to ban incentives to vaping product retailers, plan to ban sale and use in most public premises, plan to ban all flavours except tobacco and any product designed for use as flavouring for any smoking product, plan to make all publicly funding housing smoke-free, plan for biennial reporting requirements for vape retailers

Appendix B: Priorities for a Provincial Smoking and Nicotine Strategy — Key Informant Conversation Summary

To inform the call for a renewed and comprehensive provincial commercial tobacco and nicotine strategy, the Simcoe Muskoka District Health Unit (SMDHU) conducted a conversation on November 17, 2022, with a panel of key informants with extensive experience in commercial tobacco control in Ontario and Canada, in addition to following up individually upon request from some key informants for further discussion. The meeting was framed as an informal discussion around commercial tobacco and nicotine control, using past strategies and reports as a springboard to identify provincial priorities for a renewed commercial tobacco and nicotine strategy, as well as federal priorities to address relevant policy gaps.

Participants included:

- John Atkinson, Executive Director, Ontario Public Health Association
- Cindy Baker-Barill, Smoke-Free Program Manager, Smoke-Free Program and Central East Tobacco Control Area Network, Environmental Health Department, SMDHU
- Hillary Buchan-Terrell, Advocacy Manager (Ontario), Canadian Cancer Society
- Cynthia Callard, Executive Director, Physicians for a Smoke-Free Canada
- Vito Chiefari, Manager, Health Protection, Community & Health Services Dept, York Region
- Rob Cunningham, Senior Policy Analyst, Canadian Cancer Society
- Dr. Charles Gardner, Medical Officer of Health and Chief Executive Officer, SMDHU
- Dr. Lesley James, Director, Health Policy & Systems, Heart & Stroke Foundation
- David Neeson, Supervisor, Tobacco and Electronic Cigarette Control Team, Health Protection Division, Community and Health Services, York Region
- Michael Perley, former Director, Ontario Campaign for Action on Tobacco
- Dr. Emil Prikryl, Public Health and Preventive Medicine Resident, NOSM University
- Dr. Steven Rebellato, Vice President, Environmental Health Department, SMDHU
- Dr. Robert Schwartz, Executive Director, Ontario Tobacco Research Unit and Professor, Dalla Lana School of Public Health
- Linda Stobo, Program Manager, Substance Use Program, Healthy Living Division, Middlesex-London Health Unit
- Melissa van Zandvoort, Health Promotion Specialist, Smoke-Free Program and Central East Tobacco Control Area Network, Environmental Health Department, SMDHU

While it is our recommendation that the development of a renewed strategy be supported by a multidisciplinary panel of experts, Table B1 frames the priorities identified during the key informant conversation through the lens of an expanded version of the World Health Organization's MPOWER framework (i.e., MPOWER+):

Table B1: Priorities within the MPOWER+ Framework

MPOWER+ Measure	Priorities
Monitor tobacco and vaping use and prevention, cessation and protection/enforcement programs and policies.	• Re-invest in research/monitoring and evaluation to ensure practice and policy decisions are based on evidence. • Continue to explore age restrictions for smoking and vaping.
Protect people from tobacco smoke and e-cigarette aerosol.	• Further expand smoke- and vape-free public places. • Continue to increase access to smoke- and vape-free housing. • Direct focus towards consumer rights to be protected from marketing of nicotine products.
Offer help to quit smoking and vaping.	• Increase subsidization of smoking cessation pharmacotherapy for all residents.
Warn about the dangers of commercial tobacco and vaping products.	• Implement mass media and social marketing campaigns of greater intensity and duration targeted at youth and young adults addressing the real and potential harms of vaping such as its impacts on mental health, addiction, and environmental waste. • Implement mass media and social marketing campaigns of greater intensity and duration targeted at high-risk populations addressing the harms of smoking and the benefits of quitting.
Enforce bans on commercial tobacco and vaping product advertising, promotion and sponsorship.	• Return the focus of nicotine control efforts to the industry through activities such as leveraging litigation opportunities to further denormalize the industry and hold industry accountable for past and future harms to society. • Ban all flavours except tobacco flavour (if not achieved federally). • Restrict availability in brick-and-mortar settings and online access. • Strengthen retail registration and licensing requirements. • Further regulate vaping product design (e.g., plain and standardized packaging for vaping, health warnings). • Intensify tobacco and vaping product advertising promotion and sponsorship bans.

MPOWER+ Measure	Priorities
	• Ensure continued funding for enforcement through the *Smoke-Free Ontario Act, 2017*.
Raise taxes on commercial tobacco and vaping products.	• Implement a tax on vaping products, as well as regulatory fees as a means of cost recovery. • Further increase taxes on combustible tobacco products.
+ **Add** a strong health equity lens by linking commercial tobacco and nicotine control approaches to broader objectives addressing health inequities. **Add** bold interventions as indicated by evidence to further reduce the supply, demand, and access of all current and future industry nicotine delivery systems.	• Address the disproportionate use of commercial tobacco and nicotine use and associated health burdens among Indigenous populations, members of the LGBTQ2S+ community, youth, low-income populations, people with less formal education, people working in certain occupations (e.g., trades), individuals with mental health needs, individuals who use other substances, and incarcerated individuals. • Implement recommendations from the Council of Chief Medical Officers of Health to develop a "broad regulatory approach to all alternative methods of nicotine delivery (i.e. other than tobacco products) that offers strong youth protection while allowing appropriate access for adult smokers to products if they are proven effective in decreasing or stopping the use of all nicotine-containing products."[45]

alPHa
Association of Local PUBLIC HEALTH Agencies

RESOLUTION A23-03

TITLE: **Improving Indoor Air Quality to Prevent Infections and Promote Respiratory Health**

SPONSOR: **Niagara Region Public Health, Peterborough Public Health**

WHEREAS The Association of Local Public Health Agencies (alPHa) previously resolved on June 12, 2001 (Resolution A01-12) to petition the Province of Ontario to establish indoor air quality standards to protect the respiratory health of students.

WHEREAS The intense scientific inquiry conducted during the COVID-19 pandemic has discovered that COVID-19 can spread through the airborne route, and that new understanding around the role of aerosols in infection transmission has made it much more probable that other respiratory infections have a larger airborne transmission component than previously understood.

WHEREAS Canadians spend 90% of their time indoors, and indoor public settings such as food premises, meeting halls, athletics facilities, and congregate living settings have been some of the highest risk settings for COVID-19 transmission during the pandemic.

WHEREAS COVID-19 has emerged as the third leading cause of death in Canada, so measures that can reduce its transmission could have sizable impacts on health.

WHEREAS Improved indoor air quality would have additional positive benefits in terms of preventing lung disease, asthma attacks, and cancers.

WHEREAS Retrofitting indoor air handling equipment to improve air quality would also be an opportunity to move to more efficient air handling systems which would support environmental sustainability which would have its own health benefits.

WHEREAS The current Ontario Building Code includes only a requirement for minimum number of air exchanges, but not more detailed air quality standards, and no standards designed to protect individuals from infection risk.

WHEREAS Improved indoor air quality presents an opportunity for a universal, policy-driven, systems-level intervention to prevent respiratory infections, rather than reliance on individual behaviours within inequitable contexts.

WHEREAS Improved indoor air quality has been associated with improved academic performance in school, and improved productivity in workplaces.

WHEREAS Certain indoor air quality improvement strategies may require investments, however, others including natural ventilation strategies can be no or low cost.

WHEREAS Investments in indoor air quality are likely to achieve substantial economic savings through reducing infections, enhancing workplace/public safety, preventing absenteeism, and keeping the Ontario economy open for business.

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) calls on the Federal and Provincial governments to update building codes by incorporating higher standards of air quality such that respiratory diseases, especially COVID-19 and other emerging infections, can be sustainably mitigated in all new buildings, with regular updates to these building codes as best available evidence evolves;

AND FURTHER that alPHa encourages Municipal governments and First Nations governments to consider policy levers to improve indoor air quality in their regions, and particularly to assess and improve of indoor air quality in their own public facilities;

AND FURTHER that alPHa calls on the Federal and Provincial governments to create funds, incentives, and educational campaigns to support small businesses and other organizations in upgrading their HVAC systems, and/or otherwise improving their indoor air quality by using best practices and implementing technological advancements so that clean air becomes the norm in these spaces;

AND FURTHER that alPHa encourages members to liaise with other sectors (e.g. environmental engineers, municipal building departments, the business community, etc.) to fully understand how changes could be implemented in indoor public and residential settings and explore opportunities for improvement.

alPHa
Association of Local PUBLIC HEALTH Agencies

RESOLUTION A23-04

TITLE: **Ending Underhousing and Homelessness in Ontario**

SPONSOR: **alPHa Boards of Health Section**

WHEREAS housing is recognized as a human right in Canada under the International Covenant on Economic, Social and Cultural Rights [1]; and

WHEREAS the goal of Public Health is to reduce health inequities and improve the health of the whole population; and

WHEREAS housing is widely accepted as a key determinant of health, with the health of a population directly linked with the availability of adequate, affordable housing; and

WHEREAS the negative impacts of housing insecurity and homelessness include poor mental health, higher risk of infectious diseases, higher risk of chronic diseases, and higher risk of injuries among others [2]; and

WHEREAS ending underhousing and homelessness requires a range of housing, social service, and health solutions from a range of stakeholders; and

WHEREAS leadership and urgent action is needed from the provincial government on an emergency basis to develop, resource, and implement a comprehensive plan to prevent, reduce and ultimately end underhousing and homelessness in Ontario; and

WHEREAS The Association of Municipalities of Ontario, a strategic partner of alPHa has asked that their partners support their *Call to Action on Housing and Homelessness;*

THEREFORE BE IT RESOLVED THAT alPHa support AMO's *Call to Action on Housing and Homelessness*;

AND FURTHER THAT alPHa call on the Provincial Government to:

- acknowledge that housing is a social determinant of health and a human right.
- acknowledge that homelessness in Ontario is a social, economic, and health crisis.
- commit to the goal of ending underhousing and homelessness in Ontario.
- work with alPHa, AMO and a broad range of community, health, Indigenous and economic partners to develop, resource, and implement an action plan to achieve this goal.

AND FURTHER THAT the Association of Municipalities of Ontario and the Ministers of Health; Municipal Affairs and Housing; Ministry of Finance; the Premier's office; relevant ministries of the Federal Government; and Children, Community and Social Services be so advised.

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[1] Third report of Canada, International Covenant on Economic, Social and Cultural Rights : article 11 : housing : background report, https://publications.gc.ca/site/eng/9.847859/publication.html, retrieved April 20, 2023

[2] Public Health Ontario Evidence Brief: Homelessness and Health Outcomes: What are the associations? https://www.publichealthontario.ca/-/media/documents/E/2019/eb-homelessness-health.pdf

alPHa
Association of Local PUBLIC HEALTH Agencies

RESOLUTION A23-05

TITLE: **Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates**

SPONSOR: **Ontario Dietitians in Public Health**

WHEREAS the Population Health Assessment and Surveillance Protocol (2018) of the Ontario Public Health Standards require public health units (PHUs) to monitor food affordability, as well as assess and report on the health of local populations, describing the existence and impact of health inequities;

WHEREAS it is well documented that food insecurity has detrimental impacts on physical and mental health leading to increased healthcare utilization and greater healthcare costs;

WHEREAS adequate income is an important social determinant of health that greatly impacts household food security status;

WHEREAS results of monitoring food affordability in Ontario in 2022 highlight the inadequacy of both Ontario Works (OW) and the Ontario Disability Support Program (ODSP);

WHEREAS 67% of households in Ontario that rely on ODSP and OW as their main source of income experience food insecurity;

WHEREAS prices for food purchased from stores rose 10.6% from February 2022 to February 2023, the fastest pace since 1981;

WHEREAS ODSP rates were increased by 5% in 2022 and will be indexed to inflation going forward; however, current ODSP rates are not based on the costs of living. Further, OW has not been increased since 2018 and is not indexed to inflation; and

WHEREAS Previous alPHa resolutions A05-18 (Adequate Nutrition for Ontario Works and Ontario Disability Support Program Participants and Low Wage Earners), A15-04 (Basic Income Guarantee), and A18-02 (Minimum Wage that is a Living Wage) have underscored the need for income-based responses to poverty and food insecurity.

NOW THEREFORE BE IT RESOLVED that alPHa call on the Province of Ontario to utilize food affordability monitoring results from PHUs in determining the adequacy of social assistance rates to reflect the current costs of living and to index Ontario Works rates to inflation going forward;

AND FURTHER that alPHa call on the Province of Ontario to acknowledge the impact of rising food costs, particularly for individuals living on social assistance incomes, and legislate targets for reduction of food insecurity as part of Ontario's plan for poverty reduction.

BACKGROUNDER: Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates

SPONSOR: Ontario Dietitians in Public Health

Food insecurity, inadequate or insecure access to food due to household financial constraints, continues to be a serious and pervasive public health problem. Physical and mental health are tightly linked to individuals' household food security status.[1] The health consequences of food insecurity are a large burden on our healthcare system and are costly for public health care budgets.[1] The most current data indicate approximately one in six households in Ontario experience some level of food insecurity.[2]

Social assistance recipients, including those reliant on Ontario Works (OW) and the Ontario Disability Support Program (ODSP), are at extremely high risk of food insecurity. In 2021, approximately 67% of households in Ontario receiving social assistance experienced food insecurity.[2] The situation has undoubtedly worsened since then with extraordinary food inflation over the past year. The price of food purchased from stores from February 2022 to February 2023 increased by 10.6%, rising at a rate not seen since the early 1980s.[3]

Food affordability monitoring conducted by local Public Health Units (PHUs) in May/June 2022 substantiates that individuals receiving social assistance experience extremely dire financial situations, particularly single adults without children. Table 1 illustrates that for a sample of PHUs across all Ontario regions, monthly OW rates in addition to all potential tax credits (assuming individuals file income tax returns) fall short of covering only the cost of a bachelor apartment and food by a range of -$132 in Chatham-Kent to -$752 in Toronto. Other basic costs of living (e.g., clothing, personal care, transportation, phone, etc.) are not included. These data clearly indicate the extreme inadequacy of OW rates which have been frozen since 2018.[4]

Table 1: Single Adult receiving ONTARIO WORKS (OW)

Public Health Unit	Monthly income (OW[a] + tax credits[b])	Monthly cost of food[c]	Monthly cost of a bachelor apartment[d]	Remainder/ Shortfall
Chatham-Kent	$863	$381	$614	- $132
North Bay Parry Sound District	$876	$404	$650	-$178
Northwestern	$876	$466	$602	- $192
Ottawa	$863	$392	$1059	- $588
Peterborough	$863	$381	$805	- $323
Toronto	$865	$392	$1225	- $752
Wellington-Dufferin-Guelph	$863	$425	$936	-$498

[a] includes Basic Allowance ($343) + Maximum Shelter Allowance ($390)
[b] includes GST/HST tax credit, Ontario Trillium Benefit, and Climate Action Incentive Payment
[c] cost of the Ontario Nutritious Food Basket, collected by Public Health Unit in May/June 2022
[d] cost of market rental rates obtained from CMHC data tables (October 2021) or from municipal housing authorities; may or may not include utilities

Table 2 shows the monthly funds remaining or shortfall of ODSP and available tax credits after rent for a one-bedroom apartment and cost of food are deducted. Again, other basic costs of living are not included. The monthly funds remaining for ODSP recipients range from $121 in Chatham-Kent to a shortfall of -$525 in Toronto. Despite an increase of 5% to ODSP in September 2022, an increase from $200 per month to $1000 per month on employment earning cap, and an adjustment for inflation beginning in July 2023[1,4,5,6], ODSP falls well below the actual costs of living.

Table 2: Single Adult receiving ONTARIO DISABILITY SUPPORT PROGRAM (ODSP)

Public Health Unit	Monthly income (ODSP[a] + tax credits[b])	Monthly cost of food[c]	Monthly cost of a 1 bedroom apartment[d]	Remainder/ Shortfall
Chatham-Kent	$1309	$381	$807	$121
North Bay Parry Sound District	$1322	$404	$862	$56
Northwestern	$1322	$466	$814	$42
Ottawa	$1309	$392	$1280	- $363
Peterborough	$1309	$381	$1049	-$121
Toronto	$1313	$392	$1446	- $525
Wellington-Dufferin-Guelph	$1309	$425	$1277	-$393

[a] includes Basic Allowance ($343) + Maximum Shelter Allowance ($390)
[b] includes GST/HST tax credit, Ontario Trillium Benefit, and Climate Action Incentive Payment
[c] cost of the Ontario Nutritious Food Basket, collected by Public Health Unit in May/June 2022
[d] cost of market rental rates obtained from CMHC data tables (October 2021) or from municipal housing authorities; may or may not include utilities

Ontario's poverty reduction plan, Building a Strong Foundation for Success: Reducing Poverty in Ontario (2020-2025) includes various indicators (e.g., poverty rate, employment rate, graduation rate); however, it does not include an indicator or provincial targets for the reduction of household food insecurity (HFI). HFI is a highly sensitive measure of material deprivation that is strongly associated with health outcomes and health care utilization. Food insecurity data collected in the Canadian Community Health Survey and the Canadian Income Survey should be utilized to implement and evaluate effective policy interventions for alleviating food insecurity.[7]

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alPHa
Association of Local PUBLIC HEALTH Agencies

RESOLUTION A23-06

TITLE: **Advocating for a National School Food Program in Canada.**

SPONSOR: **Kingston, Frontenac and Lennox & Addington Board of Health**

WHEREAS children attending school hungry or undernourished have their energy levels, memory, problem-solving skills, creativity, concentration, and other cognitive functions negatively impacted[1,2]; and

WHEREAS over the past two years, rising costs of food and higher program uptake have significantly outpaced provincial school food programs (SFPs) funding[3]. In 2023, some programs have had to place limitations on the amount of food served or pause all operations for the school year due to insufficient financial support. Many SFPs are also projecting budget shortfalls for the 2023-24 school year and beyond which will have a significant negative impact on children who rely on these programs to meet their nutritional needs; and

WHEREAS providing children with adequate access to healthy food to grow, learn and thrive is important for achieving optimal child development outcomes and well-being[4]; and

WHEREAS children consume one third of their daily food at school[5], making it the ideal environment to support having nutritious food choices and improve food literacy; and

WHEREAS SFPs provide universally accessible school breakfast, lunch, and snack programs to students, and play a fundamental role in improving the diet of children and youth by providing access to nutritious food[6,7]; and

WHEREAS SFPs have been associated with reductions in behavioural and emotional problems, bullying, aggression, anxiety, and depression[8,9]; and

WHEREAS in Canada, only 35% of schools have some form of SFP that is funded, in part, by provincial and territorial governments[10,11,12]; and

WHEREAS this current patchwork of food programming varies greatly in scope, consistency, and quality, reaching a small percentage of the over 5 million students in Canada[10,11,12]; and

WHEREAS the lack of coordinated structure and adequate resources inhibits universal program access for all K-12 students, and results in an unsustainable delivery model that relies heavily on teacher and parent volunteers from the school community[7]; and

WHEREAS federal government action is required to establish an accessible, equitable, and sustainable nutritious SFP as a critical element of school food policy in Canada.

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) call on the Federal Government to:

- Follow through on its commitment from 2021 and allocate $1 billion over five years in Budget 2024 to establish a National School Nutritious Meal Program as a key element of the evolving Food Policy for Canada, with $200 million per year to contribute to provinces, territories and First Nations, Métis, and Inuit partners to fund their school programs[10,13].

- Enter discissions with Indigenous leaders to negotiate agreements for the creation and/or enhancement of permanent independent distinctions based First Nation, Métis and Inuit school meal programs[10,13].

- Create a dedicated school food infrastructure to enhance food production and preparation equipment and facilities so they can reliably and efficiently serve healthy food in adequate volumes[10,13].

AND FURTHER that alPHa endorse the work of the Coalition for Healthy School Food; a non-partisan network of more than 260 non-profit organizations advocating for public investment in a universal cost shared nutritious SFP, with consistent national standards[13].

Backgrounder: A National School Food Program in Canada
Sponsor: Kingston, Frontenac and Lennox and Addington Board of Health

Background:

An important part of promoting health is ensuring equitable access to nutritious food. Internationally, School Food Programs (SFPs) are widely implemented, and are a successful driver of improved health and education[14]. Healthy students are better prepared to learn, yet in Canada one third of students in elementary schools and two thirds of students in secondary schools do not eat a nutritious breakfast before school[15]. When children attend school hungry or undernourished their energy levels, memory, problem-solving skills, creativity, concentration, and other cognitive functions are negatively impacted[1,2]. SFPs provide students with snacks or meals while at school and are common throughout the world. These programs can play a fundamental role in improving the diet of children and youth and addressing health disparities[7,16]. SFPs have been associated with reductions in behavioural and emotional problems, bullying, aggression, anxiety, and depression[8,9]. Increased student enrollment, retention and school performance have also been observed alongside SFPs[17]. Given that children consume 1/3 of their daily food at school[5], it is the ideal environment to support nutritious food choices and improve food literacy.

In Canada, only 35% of schools have some form of SFP that is funded, in part, by provincial and territorial governments[10,11,12]. In the 2018/2019 school year, provincial and territorial funding for these programs equated to $0.48 per participating student per day, with remaining funds provided by donors, private funders, and other sources depending on the region[11]. This current patchwork of food programming varies greatly in scope, consistency, and quality, reaching a small percentage of the over 5 million students in Canada[10,11,12]. The lack of coordinated structure and adequate resources inhibits universal program access for all K-12 students, and results in an unsustainable delivery model that relies heavily on teacher and parent volunteers from the school community[7]. Federal government action is required to establish an accessible, equitable, and sustainable nutritious SFP as a critical element of school food policy in Canada.

Current Status:

International Level

A national SFP is an opportunity for more than just food provision. Many programs in leading countries integrate other aspects of food literacy, food quality, sourcing, and policy into their program[10,17]. Ninety-one percent of schools surveyed in the Global Child Nutrition Foundation (GCNF) report incorporate nutrition education into their SFPs, and 78% paired their food programs with school gardens[17]. Food programs in Italy and Brazil include a strong focus on local food sourcing, with the latter stipulating that 30% of all school program foods be purchased from small family run farms[18,19]. In Japan and England, programs feature a strong emphasis on food systems, with funding allocated for sensory gardens and gardens designated for growing fruits and vegetables[20,21]. Food programs in the United States have focused on investment in school food preparation infrastructure and staffing[22].

Federal Level

In December 2021, mandate letters were released to cabinet and marked the first-ever commitment to a national SFP. These mandate letters, addressed to the Minister of Agriculture and Agri-Food (Marie-Claude Bibeau) and the Minister of Families, Children and Social Development (Karina Gould) included directives to work with provinces, territories, municipalities, Indigenous partners, and stakeholders to

develop a national program[23,24]. Accompanying these mandate letters was a commitment of $1 billion of funding over five years.

The Coalition for Healthy School Food (CHSF) is a Canada-wide, non-partisan network of more than 260 non-profit organizations advocating for public investment in a universal cost-shared nutritious SFP, with consistent standards[10]. The *#NourishKidsNow* campaign has encouraged member and endorsing organizations to engage with Ministers of Parliament to advance the government's commitment to a national, nutritious SFP. In fall 2022, the CHSF submitted two key documents to the federal government: (1) a set of proposals, strongly recommending that the federal government develop a National School Nutritious Meal Program as a key element of the evolving Food Policy for Canada, and (2) a written submission for the pre-budget consultations in advance of the 2023 budget.

Despite advocacy efforts, the federal government did not include funding for a National School Nutritious Meal Program in Budget 2023[25]. Over the next year, the CHSF will continue advocacy efforts; urging the Government of Canada to develop a National School Food Policy and an implementation plan to ensure successful rollout of a School Food Program for Canada as pledged in two federal election platforms in 2021 and as included in two Ministerial mandate letters.

Provincial & Local Level

In 2004, Ontario launched the Student Nutrition Ontario (SNO) program. SNO is made up of representatives from 14 Lead Agencies who distribute provincial funds from the Ministry of Children, Community and Social Services. These funds contribute up to 15% of program costs to help develop and implement healthy breakfasts, snacks, and lunch programs across the province. These 14 Lead Agencies work with over 39 community partnerships across the province. These community partnerships engage school boards, public health units, communities, and parents to support school programs at the local level[26].

Supporting Documents:

- The Coalition for Healthy School Food: Proposals for a National School Nutritious Meal Program
- The Coalition for Healthy School Food – Written Submission for the Pre-Budget Consultations in Advance of the 2023 Budget

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