BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
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AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, March 16, 2023 at 7 p.m.
Microsoft Teams (Virtual)

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

Matt Reid (Chair)
Michael Steele (Vice-Chair)
Peter Cuddy
Aina DeViet
Skylar Franke
Tino Kasi
Mike McGuire
Selomon Menghsha
Michelle Smibert
Dr. Alexander Summers (Medical Officer of Health, ex-officio member)
Emily Williams (Chief Executive Officer, ex-officio member)

SECRETARY

Emily Williams

TREASURER

Emily Williams

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

MINUTES

Approve: February 16, 2023 – Board of Health meeting

Receive: March 9, 2023 – Finance and Facilities Committee meeting

Item #	Delegation	Recommendatio	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Reports and Agenda Items						
1	X	X	X	Performance Appraisal Committee Meeting Summary (Verbal)	March 16, 2023 Agenda	To provide an update from the March 16, 2023 Performance Appraisal Committee meeting. Lead: To be determined
2		X	X	City of London Funding to Support Cannabis Programming (Report No. 17-23)	Appendix A Appendix B	To provide information on 2023 funding for cannabis education and programing, and enforcement activities by MLHU in 2022. Leads: Dr. Alexander Summers, Medical Officer of Health, and Linda Stobo, Manager, Substance Use Program Team
3		X	X	Burden of Health Attributable to Smoking and Alcohol Consumption in Middlesex-London (Report No. 18-23)	Appendix A	To provide local information on the burden of health conditions associated with smoking and alcohol in the region. Leads: Sarah Maaten, Acting Director, Office of the Medical Officer of Health and Linda Stobo, Manager, Substance Use Program Team
4		X	X	2022 Mpox Outbreak Summary (Report No. 19-23)		To provide an update on the 2022 Mpox outbreak. Leads: Mary Lou Albanese, Director, Environmental Health and Infectious Disease and Jordan Banninga, Manager, Infectious Disease Control

5		**X**	**X**	Current Public Health Issues (Verbal Update)		To provide an update on current public health issues in the Middlesex-London region. Lead: Dr. Alexander Summers, Medical Officer of Health
6		**X**	**X**	Medical Officer of Health Activity Report for February (Report No. 20-23)		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
7		**X**	**X**	Chief Executive Officer Activity Report for February (Report No. 21-23)		To provide an update on external and internal meetings attended by the Chief Executive Officer since the last Board of Health meeting. Lead: Emily Williams, Chief Executive Officer
8		**X**	**X**	Correspondence for March		To receive the following items for information: a) Public Health Sudbury & Districts re: *2022 COVID-19 Response by the Numbers and Recovery Progress Report* b) Public Health Sudbury & Districts re: *Community Engagement to Address Food Insecurity* c) Health Canada re: *response to August 2, 2022 consultation letter on the Tobacco and Vaping Products Act* d) March 2023 Middlesex-London Board of Health External Landscape e) Windsor-Essex County Health Unit re: *Letter of Support – Physical Literacy for Healthy Active Children* f) North Bay Parry Sound District Health Unit re: *Food Insecurity in Ontario*

						g) Chief Medical Officer of Health – 2022 Annual Report h) Association of Local Public Health Agencies re: in response to the *Chief Medical Officer of Health's 2022 Annual Report* To endorse the following items: i) Public Health Sudbury & Districts re: *Provincial Funding for Consumption and Treatment Services* j) Association of Local Public Health Agencies re: *Boards of Health – Order in Council Appointments* k) Association of Local Public Health Agencies re: *Pre Budget Submission*
9	**X**	**X**	**X**	Finance and Facilities Committee Meeting Summary (Report No. 22-23)	March 9, 2023 Agenda	To provide an update from the March 9, 2023 Finance and Facilities Committee meeting. Lead: Chair Mike Steele

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is on Thursday, April 20 at 7 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, February 16, 2023 at 7 p.m.
MLHU Board Room – Citi Plaza
355 Wellington St. London, ON, N6A 3L7

MEMBERS PRESENT:	Mike Steele (Vice-Chair) Selomon Menghsha (attended virtually) Skylar Franke Michelle Smibert Peter Cuddy Mike McGuire (attended virtually)
REGRETS:	Matt Reid Aina DeViet Tino Kasi
OTHERS PRESENT:	Stephanie Egelton, Executive Assistant to the Board of Health (recorder) Emily Williams, Chief Executive Officer Dr. Alexander Summers, Medical Officer of Health Sarah Maaten, Acting Director, Office of the Medical Officer of Health Amanda Harvey, Acting Manager, Program Planning and Evaluation Maureen MacCormick, Director, Healthy Living Julie Goverde, Acting Manager, Community Health Promotion Mary Lou Albanese, Director, Environmental Health and Infectious Disease Jennifer Proulx, Acting Director, Healthy Start David Jansseune, Assistant Director, Finance Dan Flaherty, Manager, Communications Alex Tyml, Online Communications Coordinator, Communications Parthiv Panchal, End User Support Analyst, Information Technology Morgan Lobzun, Communications Coordinator, Communications

Vice-Chair Mike Steele called the meeting to order at **7:01 p.m.**

DISCLOSURE OF CONFLICT OF INTEREST

Vice-Chair Steele inquired if there were any disclosures of conflicts of interest. None were declared.

APPROVAL OF AGENDA

The Vice-Chair noted that due to the cancellation of the February 16, 2023, Governance Committee meeting, that there were some time sensitive reports needing to be reviewed by the Board of Health that could not wait until the next Governance meeting.

It was moved by **P. Cuddy, seconded by M. Smibert**, *that the February 16, 2023 Board of Health meeting agenda be amended to include the Annual Privacy Program Update and the 2021-22 Provisional Plan Progress Update.*

Carried

It was moved by **S. Franke, seconded by M. Smibert**, *that the February 16, 2023 Board of Health meeting agenda be amended to remove the Governance Committee standing update.*

Carried

Vice-Chair Steele noted that the Board of Health had received a late item of correspondence from the Association of Local Public Health Agencies regarding provincial appointments. Vice-Chair Steele inquired if any Board members desired to make a motion to add this item of correspondence to the agenda. No motion was made, and the item was not added to the agenda.

It was moved by **S. Franke, seconded by P. Cuddy,** *that the **AGENDA** for the February 16, 2023 Board of Health meeting be approved as amended.*

Carried

APPROVAL OF MINUTES

It was moved **S. Franke, seconded by M. Smibert**, *that the **MINUTES** of the January 19, 2023 Board of Health meeting be approved.*

Carried

It was moved by **P. Cuddy, seconded by S. Franke,** *that the **MINUTES** of the January 24, 2023 Special Board of Health meeting be approved.*

Carried

It was moved by **M. Smibert, seconded by S. Menghsha,** *that the **MINUTES** of the February 2, 2023 Finance and Facilities meeting be received.*

Carried

NEW BUSINESS

Finance and Facilities Committee Meeting Summary (Report No. 10-23)

Mike Steele, Chair of the Finance and Facilities Committee introduced the summary for the February 2, 2023 Finance and Facilities Committee meeting. Chair Steele (in the capacity as Committee Chair) noted that the Committee recommended for the cadence of meetings to be adjusted to be in a two month on, one month off cadence along with being moved to the second Thursday of the meeting month to allow for more time and accuracy in compiling financial information for the Committee.

Chair (as the Committee Chair) Steele introduced Dave Jansseune, Assistant Director, Finance, to present the Q4 Financial Update, Financial Borrowing and Factual Certificate Update as it was presented at the Committee.

Shared Funded Programs

- Surplus of $2.1 million
- MLHU has $32.3 million in funding with $30.2 million in expenses.
- COVID-19 has resulted in a deficit of $2.1 million, with $17.9 million in funding and $20.0 million in expenses.

100% Funded Programs

- School Focused Nurses Initiative: funding of $1.6 million and expenditures totaling $1.1 million.
- Seniors Dental Program: funding of $2.2 million and expenditures totaling $1.8 million.
- Nurses Retention Incentive: funding of $1.2 million and expenditures totaling $1.1 million.
- CLIF – City of London Funding for Cannabis Legalization: funding of $416,000 and expenditures totaling $294,000. It is noted that the City of London approved carryover of these funds into 2023.
- Strathroy Capital for Seniors' Dental project is actively underway with $1 million available for funding.

Board Member Peter Cuddy inquired about CLIF funding and how the Health Unit uses these funds. Maureen MacCormick, Director, Healthy Living clarified that the CLIF funding was used to support education of cannabis retailers licensed under the *Cannabis Act* in the region.

P. Cuddy further inquired on the challenges in recruiting qualified nurses with School Focused Nurses Initiative funding. Dr. Alexander Summers, Medical Officer of Health, noted that these challenges were mainly to do with the temporary nature of these roles (due to the temporary nature of the funding) in a highly competitive job market for nurses.

Shared Funding – Variances

- Grants, user fees, and incomes are showing favourability of $1,127,000 due to Nurses Retention Incentive.
- Salaries and wages are showing favourability of $1,386,000 due to vacancies at the MLHU.
- Overtime hours are showing unfavourability of $128,000.
- Benefits are showing favourability of $749,000.
- General Expenses are showing favourability of $572,000 which includes:
    - Professional Services at $186,000;
    - Program Supplies at $257,000;
    - Travel at $181,000;
    - Equipment at $100,000;
    - Transfer to reserves at $361,000 unfavourability (which includes the previous transfers to the Employment Costs and Technology & Infrastructure reserves);
    - Other costs at $209,000.

Forecast

- Shared Funding Programs had forecasted a surplus of $2.3 million with an actual of $2.1 million. COVID-19 & School Focused Nursing Initiative forecasted expenditures at $22.1 million of actual at $21.1 million.
- This demonstrates highly accurate forecasting for the 2022 budget year.

Cashflow

- There is a potential for GIC investments to diversify cashflow and offset interest rate expenses.
- The bank balance as of December 31 was $4.2 million (positive).
- For borrowing, the fixed loan is at $3.05 million with $2.8 million owing and the variable loan is at $1.15 million with $1.035 million owing.
- In reserves, there is $287,000 in the Employment Cost Reserve and $250,000 in the Technology & Infrastructure Reserve.
- COVID-19 funding for Q4 was $3.4 million.
- Strathroy Capital (Seniors' Dental) funding for Q4 was $939,000, with scheduled construction beginning soon.

Board Member Skylar Franke inquired if MLHU can pay off all loans ahead of time due to inflationary costs and interest rates. D. Jansseune noted that the fixed rate loan had a specific pay term, and the variable loan has an interest rate of prime plus one. It was noted that in next year's budget, there is an

accelerated loan payment plan proposed. MLHU cannot pay off the entire portion of the loan due to Ministry of Health direction to redirect surplus funds from operating to COVID-19 expenses.

D. Jansseune noted that MLHU is continuing with year-end closing with minimal entries, preparing for the annual audit in March and April, preparing financial statements and the Ministry of Health Annual Reconciliation Report. It was added that any changes to numbers would be reported to the Board of Health, through the Finance and Facilities Committee.

It was moved by **S. Franke, seconded by P. Cuddy,** *that the Board of Health:*
1) Approve the 2023 Finance and Facilities Committee Reporting Calendar to include the timing change of meetings to the second Thursday of the meeting month;
2) Approve the Finance and Facilities Committee Terms of Reference as amended; and
3) Receive Report No. 02-23FFC re: "2022 Q4 Financial Update, Financial Borrowing and Factual Certificate" for information.

Carried

Public Sector Salary Disclosure Act – 2022 Record of Employees' Salaries and Benefits (Report No. 11-23)

E. Williams introduced the report regarding the Public Sector Salary Disclosure Act – 2022 Record of Employees' Salaries and Benefits. E. Williams noted that the MLHU is required as a public sector organization per the *Public Sector Salary Disclosure Act* to disclose the names, positions and salaries (over $100,000) of employees within the organization. In 2021, there were 99 individuals on the legislative record and this number in 2022 had decreased to 58 due to the decrease in COVID-19 pandemic overtime.

There was no discussion on this report.

It was moved by **M. Smibert, seconded by M. McGuire,** *that the Board of Health receive Report No. 11-23 re: "Public Sector Salary Disclosure Act – 2022 Record of Employees' Salaries and Benefits" for information.*

Carried

Annual Privacy Program Update (Report No. 15-23)

E. Williams provided the annual update on MLHU's Privacy Program. E. Williams noted that annual reporting of access requests under the *Municipal Freedom of Information and Protection Act* (MFIPPA), *the Personal Health Information and Protection Act* (PHIPA) and privacy breaches to the Information and Privacy Commissioner of Ontario is mandatory. March 1 is the reporting deadline for privacy breaches and March 31 is the deadline for access requests. All MLHU staff have taken mandatory privacy training.

E. Williams noted that all access requests were completed in mandated time periods. There were 14 MFIPPA requests, 5 PHIPA requests and 10 privacy breaches (9 were disclosures without authority) and appropriate actions were taken. Privacy breaches included paper records being accessed without authority and emails misdirected.

S. Franke inquired the comparison of privacy breaches to previous years. E. Williams noted that in 2021, there were 6 privacy breaches, with 5 being information disclosed without authority.

It was moved by **M. Smibert, seconded by S. Franke,** *that the Board of Health receive Report No. 15-23 re: "Annual Privacy Program Update" for information.*

Carried

2021-22 Provisional Plan Progress Update (Report No. 16-23)

Dr. Alexander Summers, Medical Officer of Health, introduced Amanda Harvey, Acting Manager, Program Planning and Evaluation, to provide an update on the Provisional Plan.

A. Harvey reminded the Board that in 2021, the Board of Health approved extending the timelines for phase two and three of the Provisional Plan by a minimum of three months, which extended the work of the phases and carries the Provisional Plan into Q2 2023. MLHU has made progress on 7 projects within the Provisional Plan:

- Employment Systems Review
- Implementation of the Anti-Black Racism Plan
- Onboarding and Enhancement of the Electronic Client Record (ECR)
- Transition to SharePoint
- Implementation of the Joy in Work Framework
- Return to Office
- Sociodemographic and Race-based Data Collection in Electronic Systems

It was moved by **S. Franke, seconded by P. Cuddy,** *that the Board of Health receive Report No. 16-23, re: "2021-22 Provisional Plan Progress Update" for information.*

Carried

Representation on the Middlesex-London Food Policy Council (Report No. 12-23)

M. MacCormick introduced Julie Goverde, Acting Manager, Community Health Promotion, to present the report on representation on the Middlesex-London Food Policy Council.

J. Goverde noted that the Middlesex-London Policy Food Policy Council is seeking a representative from the Board to sit on the council. Currently, there is an MLHU Dietician that sits on the council as a non-voting member. It is recommended that the Board of Health appoint a member representative to the Middlesex-London Food Policy Council as a voting member or direct the Medical Officer of Health to appoint a senior staff member to the Middlesex-London Food Policy Council as a voting member for a two (2) year term. The MLHU provides an important public health perspective for planning and decision-making and helps maintain the Middlesex-London Food Policy Council as a community organization anchored in health, with a commitment to food system sustainability.

Vice-Chair Steele inquired to the Board on the options at hand: appointing a member of the Board to sit on the Middlesex-London Food Policy Council or directing the Medical Officer of Health to appoint a senior staff member to the Middlesex-London Food Policy Council. The Board was in favour of directing the Medical Officer of Health to appoint a staff member to the Middlesex-London Food Policy Council.

It was moved by **S. Franke, seconded by M. Smibert,** *that the Board of Health:*
1) Direct the Medical Officer of Health to appoint a senior staff member to the Middlesex-London Food Policy Council as a voting member for a two (2) year term; and
2) Receive Report No. 12-23 re: Board of Health Representation on the Food Policy Council for information.

Carried

Current Public Health Issues (Verbal)

Dr. Alexander Summers, Medical Officer of Health, provided a verbal update on current public health issues within the region.

Health and Homelessness

There have been Health and Homelessness Summits last fall and in January and MLHU has been participating in these summits along with over 200 agencies locally. Significant trust has been built within the sector leading to the co-design of a new model being proposed to support 24/7 integrated hubs, with roll out to occur in 2023. There is an emphasis on creating places for people to go for wrap-around health services with an entry point to housing. Dr. Summers noted that the situation is not limited to the City of London but is also impacting the County of Middlesex.

Immunization of School Pupils Act

The Health Unit continues to proceed with enforcement of the *Immunization of School Pupils Act.* Suspensions have been proceeding and new learnings have been incorporated in each subsequent cohort. There are six cohorts from January to May, with the most recent suspension date on February 15, 2023. The MLHU continues to provide comprehensive support to keep students in school, including offering catch-up vaccines clinics.

COVID-19 and Influenza

COVID-19 and influenza are continuing to circulate in the community. Currently, the hospital system is not under threat. It is anticipated that additional COVID-19 boosters will be rolled out in spring to high-risk population, but the overall vaccination cadence for the general population is unclear at this time.

It was moved by **S. Franke, seconded by P. Cuddy,** *that the Board of Health receive the verbal report re: "Current Public Health Issues" for information.*

Carried

Medical Officer of Health Activity Report for January (Report No. 13-23)

Dr. Alexander Summers, Medical Officer of Health, presented the Medical Officer of Health activity report for January.

There was no discussion on this report.

It was moved by **M. Smibert, seconded by S. Franke,** *that the Board of Health receive Report No. 13-23 re: "Medical Officer of Health Activity Report for January" for information.*

Carried

Chief Executive Officer Activity Report for January (Report No. 14-23)

Emily Williams, Chief Executive Officer, presented the Chief Executive Officer activity report for January.

There was no discussion on this report.

It was moved by **M. McGuire, seconded by S. Menghsha,** *that the Board of Health receive Report No. 14-23 re: "Chief Executive Officer Activity Report for January" for information.*

Carried

CORRESPONDENCE

It was moved by **M. Smibert, seconded by S. Franke,** *that the Board of Health receive item a) for information.*

Carried

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is on Thursday, March 16, 2023 at 7 p.m.

CONFIDENTIAL

At **7:49 p.m.,** it was moved by **P. Cuddy, seconded by S. Franke,** *that the Board of Health will move in-camera to consider matters regarding labour relations or employee negotiations, an identifiable individual, including Board employees, litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board and to approve previous confidential Board of Health minutes.*

Carried

At **8:03 p.m.,** it was moved by **M. Smibert, seconded by P. Cuddy,** *that the Board of Health return to public session from closed session.*

Carried

ADJOURNMENT

At **8:03 p.m.,** it was moved by **S. Franke, seconded by P. Cuddy,** *that the meeting be adjourned.*

Carried

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MIKE STEELE
Vice-Chair

EMILY WILLIAMS
Secretary

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
FINANCE AND FACILITIES COMMITTEE

Thursday, March 9, 2023, 9:00 a.m.
Microsoft Teams

MEMBERS PRESENT: Mike Steele (Chair)
Matt Reid
Selomon Menghsha
Mike McGuire (joined at 9:10)

OTHERS PRESENT: Stephanie Egelton, Executive Assistant to the Board of Health (recorder)
Emily Williams, Chief Executive Officer
Dr. Alexander Summers, Medical Officer of Health
David Jansseune, Assistant Director, Finance
Sarah Maaten, Acting Director, Office of the Medical Officer of Health
Maureen MacCormick, Director, Healthy Living
Jennifer Proulx, Acting Director, Healthy Start/Chief Nursing Officer
Carolynne Gabriel, Executive Assistant to the Medical Officer of Health
Kaitlynn Van Diepen, Executive Assistant to the Chief Executive Officer
Dr. Joanne Kearon, Public Health Medical Resident

At **9:05 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 **M. Reid, seconded by S. Menghsha**, *that the **AGENDA** for the March 9, 2023 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by **S. Menghsha, seconded by M. Reid**, *that the **MINUTES** of the February 2, 2022 Finance & Facilities Committee meeting be approved.*

Carried

CONFIDENTIAL

At **9:06 a.m.,** it was moved by **M. Reid, seconded by S. Menghsha**, *that the Finance and Facilities Committee will move in-camera to consider matters regarding personal matters about identifiable individuals, including municipal or local board employees and matters regarding labour relations or employee negotiations.*

Carried

At **10:04 a.m.,** it was moved by **M. McGuire, seconded by S. Menghsha,** *that the Finance and Facilities Committee return to public session from closed session.*

Carried

NEW BUSINESS

Proposed Revised 2023 Budget (Report No. 04-23FFC)

Emily Williams, Chief Executive Officer provided an overview of the 2023 budget process during Fall 2022:

- Initial Funding assumptions
  - Flat provincial funding to 2022, with the Health Unit covering all inflationary pressures
  - Mitigation funding continuing for 2023
  - COVID-19 extraordinary funding will have the same process as 2022
- Inflationary pressures
  - Salary and benefits at $597,000
  - Corporate expenses at $300,000
- Additional pressures included a plan to bring gapping to 2021 levels ($330,000 pressure) and a plan to budget for an accelerated payment plan on the variable bank loan ($200,000).
- The total target was $1.2 million.

Current State and Changes to Funding

E. Williams explained the current state of funding. Funding from the provincial government remains unknown, with the budget anticipated on March 23, 2023. Currently, most public health units in Ontario are budgeting 1-2% increases - municipalities will bear these costs if provincial funding does not come through. Advocacy for public health funding through the Association of Local Public Health Agencies and the Association of Municipalities Ontario, as well as the Chief Medical Officer of Health, continues.

Budget Overview

Dave Jansseune, Assistant Director, Finance provided a budget overview.

Financial changes to the target include:

- Staffing inflation (initial estimate was $597,000 and revised to $478,470)
- Corporate inflation (initial estimate was $300,000 and revised to $306,184)
- OMERS pension increase for non-full-time staff (initial was unknown and revised to $199,452)
- Decrease to the gapping budget (initial was $300,000 and revised to $54,453)

The total target of savings is now $515,118. Salaries and benefit costs for 2023 is at $25,917,470, compared to $25,767,797 from 2022.

Disinvestments

Disinvestments have been discussed by the Senior Leadership Team in accordance to the public health pyramid and critical business infrastructure frameworks.

Pre-approved disinvestments by the Board of Health at the November 10, 2022 meeting include:

- General Expense reduction
- Cell phone reduction
- Student reductions

100% Funded – COVID-19, Seniors Dental and MLHU 2

COVID-19 funding supports the vaccine and case and contact management programs. For 2023, the total budget from the Ministry of Health is $10,655,019, which is a $17,413,875 decrease from 2022.

The Seniors' Dental program supports operating costs for the program only. For 2023, the total budget is $3,693,148. The budget request has increased to include staffing increases to support the expansion of the program, including the opening of the Strathroy operatories.

MLHU 2 includes Best Beginnings ($2,483,000), FoodNet ($116,000), Smart Start for Babies ($152,000) and Shared Library Services ($108,000).

Chair Steele inquired what a 1% increase in base funding represents to the health unit. D. Jansseune noted that this would be approximately $200,000.

It was moved by **M. McGuire, seconded by S. Menghsha,** *that the Finance & Facilities Committee recommend to the Board of Health to:*

1) *Receive Report No. 04-23FFC re: "Proposed Revised 2023 Budget" for information; and*
2) *Approve the disinvestments and investments as outlined in Report No. 04-23FFC.*

Carried

2022 Vendor and Visa Payments (Report No. 05-23FFC)

Emily Williams, Chief Executive Officer introduced Dave Jansseune, Assistant Director, Finance to present the 2022 Vendor and Visa Payments report.

D. Jansseune noted that this report detailed vendors whom the Health Unit paid over $100,000 in 2022 along with a summary of corporate credit card charges.

Board Member M. Reid inquired on the comparison of vendor and visa charges from 2021. D. Jansseune noted that corporate credit card usage was similar to 2021, with reductions for vendors from 2021 due to the reduction in COVID-19 vaccination clinics.

It was moved by **M. Reid, seconded by S. Menghsha**, *that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 05-23FFC re: "2022 Vendor and VISA Payments" for information.*

Carried

OTHER BUSINESS

The next meeting of the Finance and Facilities Committee will be held on Thursday, May 11, 2023 at 9 a.m.

ADJOURNMENT

At **10:21 a.m.,** it was moved by **M. McGuire, seconded by M. Reid,** *that the meeting be adjourned.*

Carried

MIKE STEELE	**EMILY WILLIAMS**
Chair	**Secretary**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 17-23

TO: Chair and Members of the Board of Health

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

DATE: 2023 March 16

CITY OF LONDON FUNDING TO SUPPORT CANNABIS PROGRAMMING

Recommendation

It is recommended that the Board of Health receive Report No. 17-23, re: "City of London Funding to Support Cannabis Programming" for information.

Key Points

- Every year since 2019, the City of London earmarked a portion of their Ontario Cannabis Legalization Implementation Fund (OCLIF) for the Middlesex-London Health Unit's cannabis program.
- Funding from the City of London is secured for 2023; however, no additional funding is anticipated for 2024 as the City's OCLIF funding will have been spent.
- Appendix A provides information on 2023 funding that has enabled the Health Unit to increase its Enforcement Officer capacity to fund two, temporary 1.0 FTE Enforcement Officers to respond to increased demands on enforcement, and to support the implementation of public education activities.
- Appendix B provides a summary of cannabis enforcement work from 2022.

Background – A Community Approach to the Legalization of Non-Medical Cannabis

In November 2017, the City of London convened the Cannabis Implementation Working Group (CIWG) to prepare for the implementation of a legalized non-medical cannabis supply system. The CIWG was comprised of City staff from planning, licensing, bylaw enforcement, fire prevention, and governmental/external relations, representatives from the London Police Service, and representatives from the Middlesex-London Health Unit. Collaboration between municipal, enforcement, health, education and community/social service partners was essential to locally respond and adapt to this complex policy change and protect public health and safety.

To support municipalities in their role of the implementation of a legalized non-medical cannabis system and to address activities within the illegal cannabis market, the Ontario Government created the Ontario Cannabis Legalization Implementation Fund (OCLIF). Between 2019 and 2021, municipalities across Ontario received funding, on a per household basis, to address implementation costs including: increased enforcement by public health, police, bylaw enforcement, and corresponding court administration; increased response to public inquiries; by-law and/or policy development (e.g. workplace health and safety policy); and public education. A full list of funding by municipality is archived online for reference.

Every year since 2019, the City of London earmarked a portion of OCLIF for the Health Unit's cannabis program. Public health work related to cannabis had historically been included within the broader program

area of "substance use"; however, with the legalization of non-medical cannabis, there are greater expectations and demands on public health to: monitor the trends and harms associated with cannabis use; provide public education and respond to inquiries from the public regarding potential health risks; field complaints and enforce the laws related to the consumption of non-medical and medical cannabis; and to work with municipalities and workplaces to support them in the development and enforcement of policies and bylaws. As outlined in Appendix A, this funding has enabled the Health Unit to increase its Enforcement Officer capacity from 3.2 FTE to 5.2 FTE (from 2021 to present) with the recruitment of two additional temporary full-time equivalents. The funding also increased the Health Unit's capacity to assess the burden of cannabis use and the impact in the community, public education, and health care provider outreach initiatives. Funding from the City of London is secured for 2023; however, no additional funding is anticipated for 2024 as the City's OCLIF funding earmarked for the Health Unit is anticipated to be spent by year-end.

Cannabis Use Trends

According to data collected by Statistics Canada (2022), 27% of Canadians aged 16 years and older reported using cannabis in the past year; an increase from 25% from the previous year. Cannabis use within the last twelve months is highest among young people, with 50% of young adults aged 20-24 and 37% of youth aged 16 to 19 reporting past year use. Twenty-four percent (24%) of those who used cannabis in the past 12 months reported an increase in their cannabis use during the COVID-19 pandemic. This change in use was reported primarily by youth and young adults, with stress, anxiety, boredom, loneliness and a lack of a routine or schedule as the most common reasons cited (Statistics Canada, 2022). Additionally, concerning trends regarding cannabis poisoning have also been observed over the last ten years. According to Public Health Ontario (2020), emergency department visits for cannabis poisonings in Middlesex-London increased significantly from 2013 to 2018 and were over two times higher than Ontario rates. In the two years following the legalization of cannabis edibles, oils, and extracts in 2019, researchers from Toronto SickKids hospital found that there was a four-fold increase in unintentional cannabis ingestion, a three-fold increase in intensive care admissions for severe cannabis poisonings, and nine times more emergency department visits per month for cannabis poisonings in young children across Ontario.

Public Education and Enforcement

The smoking and vaping of medical and non-medical cannabis is regulated provincially by the *Smoke-Free Ontario Act, 2017,* which is enforced by the Health Unit's Tobacco Enforcement Officers. While cannabis retail stores are licensed provincially by the Alcohol and Gaming Commission of Ontario, cannabis retail stores also sell vapour products, which are inspected by Health Unit Enforcement Officers. Appendix B provides a summary of cannabis enforcement work from 2022. In 2023, the Health Unit is using Poison Prevention Week, which runs from March 19th to March 25th, to encourage parents, guardians and caregivers to reduce cannabis poisonings in children through the roll-out of a social marketing campaign and the development of an adult caregiver outreach strategy. Given the concerns regarding early initiation of use by youth and young adults and impacts on mental health outcomes and brain development, the creation of a social marketing campaign targeted to older youth/young adults is planned for 2023.

Next Step

As OCLIF comes to an end in 2023, the Health Unit will continue to monitor the impacts of cannabis in the community and pursue opportunities to minimize harms associated with this substance.

This report was submitted by the Healthy Living Division.

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

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

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

January 30, 2023

Middlesex-London Health Unit – 2022//2023 Cannabis Program and Response to the Legalization of Non-Medical Cannabis
2022 City of London Reimbursement and 2023 Funding Proposal – Cannabis Legalization Implementation Fund (CLIF)

Cannabis for non-medical purposes became legal in Canada in October 2018. Public health work related to cannabis has historically been included within the broader program area of "substance use". With the legalization of non-medical cannabis in 2018 and the legalization of cannabis edibles, oils and extracts in October 2019, there is increased and dedicated attention to this topic required from both a health promotion, health harms and policy perspective.

New and emerging research indicates that much of the health-related harms of non-medical cannabis use fall into the following categories:

- Respiratory effects: smoking and negative respiratory symptoms from both smoking and vaping;
- Cannabis use disorder: problematic pattern of cannabis use leading to clinically significant impairment or distress;
- Mental health issues: increased risk of schizophrenia and psychosis;
- Cannabis and driving: increased risk of motor vehicle collision;
- Effects on the brain: long-term effects of cannabis on the brain can include an increased risk of addiction and harm to memory, concentration, intelligence, and decision-making. The effects on brain development are of particular concern for youth and young adults, since the brain is not fully developed until around the age of 25 years;
- Health effects on pregnancy and children: heavy use during pregnancy can lead to lower birth weights of the baby and has been associated with longer-term developmental effects in children and adolescents, such as decreased memory function and negative impacts on the ability to pay attention and problem-solve; and,
- Cannabis

Cannabis, like alcohol, are normative substances. Cannabis use has continued to increase, along with associated harms of use. During the COVID-19 pandemic, the sale of cannabis increased significantly compared to the years prior to the pandemic (Myran et al., 2021, Statistics Canada, 2021). During the COVID-19 pandemic, cannabis use increased among Canadian adults, and a significant increase in cannabis consumption was observed among those aged 15 to 35 who used cannabis compared to older age groups (Statistics Canada, 2021; Statistics Canada, October 2020). More Canadians aged 15 and older reported using cannabis daily or almost daily in late 2020 compared to the beginning of 2019 and 2020 (Rotermann, 2021). Since legalization, there has continued to be an increase in the number of legal cannabis retail outlets operating within the City of London; these retailers also sell vapour products that are used to consume cannabis. At the same time, with the relaxation of COVID-19-related restrictions on large outdoor gatherings, the number of inspections required at outdoor events has, and will continue to increase. MLHU COVID-19 recovery planning has identified that trends in substance use, including cannabis, have been negatively impacted during the pandemic. There are known risks related to increased use and over-reliance on cannabis use for stress relief (Canadian Centre on Substance Use and Addiction, 2020). From a youth/young adult perspective, alcohol and cannabis are in the top three most commonly used substances among grades 7 to 12 students in Ontario (OSDUHS, 2021). Evidence shows there are many short-term and long-term harms associated with alcohol and cannabis use especially among youth (Drug Free Kids Canada, 2019, Canadian Centre on Substance Use and Addiction, 2015).

The following are areas of focus of cannabis program work at the Middlesex-London Health Unit, with target populations/stakeholders including youth, young adults, parents, schools, healthcare providers, retailers, and operators of places of entertainment:

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

- The smoking and vaping of medical and non-medical cannabis is regulated provincially by the *Smoke-free Ontario Act, 2017*. The promotion and enforcement of the *Smoke-Free Ontario Act, 2017* and responding to complaints and inquiries about exposure to second-hand smoke and vapour from cannabis use is also a component of this program. Enforcement Officers, funded by the CLIF funding, continue to be required to respond to complaints and enforce cannabis consumption in public spaces (places of entertainment) and inside schools and on school grounds. Enforcement Officers also inspect cannabis retail outlets for their compliance with vapour product sales' signage requirements and smoke-free/vape-free provisions in London.

- Funding is required to support the development and implementation of a tailored public education and social marketing campaign targeting older youth/young adults and evidence-informed messages related to substance use and mental health and well-being. Funding from CLIF will be supplemented by funds from the Health Unit's Substance Use Program Team.

- The age-standardized rate for emergency department (ED) room visits related to cannabis poisonings was significantly higher in Middlesex-London compared to Ontario (Public Health Ontario, 2020). An Ontario study found many ED visits/hospitalizations related to cannabis poisonings involved children under the age of 10 with the average age of those affected being three years and nine months old (Myran DT, Cantor N, Finkelstein Y, et al., 2022). Several studies in Ontario have found cannabis poisonings have been increasing, are more severe and are seeing more intensive care admissions since the legalization of cannabis edibles. Ontario saw nine times more emergency department visits per month for cannabis poisonings in young children after Canada legalized non-medical cannabis (Ibid.; Sick Kids, 2021; Ontario Poison Control (n.d.)). Funding from CLIF will support the development and implementation of tailored messaging for parents to address this growing concern. CLIF funding will be supplemented by funds from the Health Unit's Substance Use Program Team.

Table 1. Middlesex-London Health Unit Cannabis Funding Request for 2022 Expense Reimbursement & 2023 Funding Proposal - Cannabis Legalization Implementation Fund

City of London Cannabis Funding	2022 Funding Request	2022 Actual Jan 1 - Dec 31	2022 Variance from requested	2023 Funding Request	COMMENTS
Staffing Costs					*In 2022, only 1.0 FTE Health Promoter position was filled due to reduced capacity in 2022 from ongoing pandemic response and recovery. Approved at mid-year report to allocate this funding line to public education and material development. Research completed, but unable to implement in 2022. Plans to develop/implement in 2023 (see above).
Tobacco Enforcement Officers - 2.0 FTE	171,262.00	124,012.62	47,249.38	117,620.67	
Health Promoter - 2.0 FTE*	167,416.00	87,638.06	79,777.94	[redacted]	
Program Assistant - 0.5 FTE	33,729.00	39,427.23	-5,698.23		
Program Supplies					
Signage (SFO)	5,000.00	6,713.63	-1,713.63	2,500.00	** Phase 1): YouNeedtoKnow Cannabis campaign July 2022 to Sept 2022 was implemented. Research initiated in 2022 to inform an older youth/young adult campaign. Plans to develop/implement in 2023 (see above). An emphasis for 2023 will be an expansion on messaging related to unintentional cannabis poisonings by children that was initiated in Q4 of 2022.
Public Education and Material Development **	40,000.00	30,328.23	9,671.77	3,746.80	
Travel					
Travel	6,000.00	6,419.76	-419.76	5,000.00	
	$423,407.00	**$294,539.53**	$128,867.47	**$128,867.47**	

The total amount for reimbursement from the City of London for 2022 CLIF-related expenses is $294,539.53. Proposed funding request for 2023 is $128,867.47.

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

CANNABIS ENFORCEMENT SUMMARY 2022
Smoke-Free Ontario Act, 2017 (SFOA, 2017)

Cannabis Retail Stores in Middlesex-London Region		
April 2019	**December 2022**	**Pending Licensing Approval**
3	66	3

Promotion, Education and Enforcement Activities - CANNABIS		
Description of Activity	**# of Warnings**	**# of Charges**
Provide education to Cannabis Retailers re: obligations under the *SFOA, 2017*: • No sale or supply of vapour products or cannabis to persons under the age of 19 years; • No sale or supply of vapour products or cannabis to persons who appear to be under the age of 25 years unless government-issued photo identification has been requested and the seller is satisfied that the person is at least 19 years old; • No person under the age of 19 years to be permitted entry to the store; • No display or promotion of vapour products visible from outside the place of business; • Vapour product retailers must post mandatory health warning and government ID signage; • No smoking or vaping inside all areas of the store (as an enclosed workplace and an enclosed public place); • Proprietors/owners of public places and workplaces must ensure that there are no ashtrays, and they must post "no smoking and no vaping" signage; and, • Proprietors/owners must ensure that anybody who smokes or vapes is not permitted to remain. * All new cannabis retailers are inspected at time of opening to ensure retailers are aware of their obligations under the *SFOA, 2017*.	10	2
Provide education and enforcement support to elementary and secondary school administration to ensure no smoking and vaping tobacco or cannabis in schools, on school property, and within 20 metres of school property. *Total # of **elementary and secondary school presentations = 11**	8	2
Provide education and enforcement to owners/proprietors of workplaces and **public places, hospitals, legions, restaurants** and **bars, long-term care homes, special events, playgrounds** and **sports fields,** and **multi-unit housing**.** ** There are different rules/regulations regarding smoking and or vaping tobacco or cannabis at different types of facilities/spaces.	59	11
Total # of collaboration referrals with Health Canada = 3 (cannabis promotion at special events). The promotion of cannabis is regulated federally under the *Cannabis Act, 2018*.		

Under the Tobacco, Vapour and Smoke Protocol, 2021 and the Ontario Public Health Standards, the Health Unit is mandated to respond to all inquiries and complaints received. The Health Unit employs a **progressive enforcement approach** with efforts focused on **education** first, progressing to **warnings** and then **charges** if non-compliance continues.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 18-23

TO: Chair and Members of the Board of Health

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

DATE: 2023 March 16

BURDEN OF HEALTH ATTRIBUTABLE TO SMOKING AND ALCOHOL CONSUMPTION IN MIDDLESEX-LONDON

Recommendation

It is recommended that the Board of Health receive Report No. 18-23, re: "Burden of Health Attributable to Smoking and Alcohol Consumption in Middlesex-London" for information.

Key Points

- It is estimated that smoking contributed to 597 or 16.3% of all deaths, 2082 or 7.9% of hospitalizations, and 3917 or 3.2% of emergency department visits in an average year, amongst those older than 35 years of age in Middlesex-London.
- Alcohol consumption is estimated to contribute to 154 or 4.1% of all deaths, 842 or 2.4% of hospitalizations and 6,968 or 3.8% of emergency department visits in an average year, amongst those older than 15 years of age in Middlesex-London.
- Full findings are found in the Executive Summary as Appendix A.

The Burden of Health from Tobacco and Alcohol - Summary of the Findings

On February 7, 2023, Public Health Ontario (PHO) and Ontario Health (OH) co-released the report "*Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit*" to highlight the prevalence of smoking and alcohol consumption along with their attributable health conditions and harms, including emergency department (ED) visits, hospitalizations, and deaths.

Between 2015 and 2017, the prevalence of people in the Middlesex-London region 20 years of age and older who reported that they smoke cigarettes daily or occasionally was 18.1%. The OH and PHO report showed that annually there was an estimated 597 (16.3%) deaths, 2,082 (7.9%) hospitalizations, and 3,917 (3.2%) ED visits among Middlesex-London residents age 35 and older that were attributable to smoking. It was also reported that between 2015 and 2017, the prevalence of current alcohol consumption for people aged 15 and older among Middlesex-London residents was 78.9%, while 36.5% of those 19 and older drink two or more drinks per week. OH and PHO estimated that in an average year in the Middlesex-London region, there were 154 (4.1%) deaths, 842 (2.4%) hospitalizations and 6,968 (3.8%) ED visits among residents age 15 and older attributable to alcohol consumption. These and other Middlesex-London region findings from the report are summarized in Appendix A.

Beyond the direct health costs outlined in the report, the economic and societal costs associated with tobacco and alcohol is substantial, including lost productivity from illness, injury and premature death, costs associated with the criminal justice system, and impacts related to motor vehicle collisions, violence, family discord and mental health challenges. According to the Canadian Centre on Substance Use and Addiction (CCSA), in 2017, substance use in Ontario cost more than $17 billion, or $1,235/person. Tobacco accounts for 28% of those costs ($4.8 billion) and alcohol, 35% ($6.2 billion) of the costs. To address the burden of tobacco and alcohol, Health Unit staff develop and implement public health interventions, including public education and skill-building, partnerships and collective community action, advocacy and healthy public policy, and enforcement.

Addressing the Burden of Tobacco Through Collective Action

The province is divided into seven public health unit regions (Tobacco Control Area Networks - TCANs), each with a coordinating public health unit. As the coordinating public health unit for the Southwest Tobacco Control Area Network (SW TCAN), Health Unit staff work collaboratively with the six other health units in southwestern Ontario, the seven coordinating public health units across Ontario, and provincial non-governmental organizations to develop, implement and evaluate public health interventions to reduce the burden of illness from tobacco and vapour product use. In 2022, TCAN staff conducted a needs assessment which identified potential provincial priorities for collective public health action in 2023:

- Cigarettes continue to be the most used nicotine product by adults, and therefore, cessation supports and resources for adults who smoke remains a priority.
- Vaping is the primary mode of nicotine consumption among youth, and common among never smokers, and therefore, youth vaping is a priority for collective action.

To address some of these priorities, the Southwest TCAN's @DogandTom Instagram social marketing strategy uses a Sunday comic strip style to engage with young adults on Instagram to promote a tobacco- and vape-free lifestyle. NotanExperiment.ca is a provincial website, with an inventory of complementary tools and resources for youth, parents and educators to prevent youth vaping and to promote vaping cessation.

Reducing the Harms from Alcohol

Alcohol is considered a normative substance in our community, yet alcohol is "no ordinary commodity" as a leading cause of preventable death, disability, and societal problems. The Health Unit's alcohol program uses a comprehensive health promotion approach to decrease alcohol-related harms and to create a culture of alcohol moderation. In January 2023, the CCSA released *Canada's Guidance on Alcohol and Health* and Infographic to replace the 2011 Canada's Low-Risk Alcohol Drinking Guidelines. This updated guidance is designed to help people make informed decisions about alcohol consumption and their health, by introducing a risk continuum:

- **No Risk** for those who consume **0 drinks** per week;
- **Low** for individuals who consume **one to two standard drinks** per week;
- **Moderate** for those who consume between **three and six standard drinks** per week; and
- **Increasingly high** for those who consume **seven standard drinks or more** per week.

Health Unit staff are working locally, regionally through the Southwest Polysubstance Working Group, and provincially through OPHA's Alcohol Policy Working Group to operationalize the new guidance, promoting the risks associated with alcohol use and supporting the development of healthier public policies. The Health Unit is involved in a multi-Health Unit social marketing campaign called "Before the Floor" that promotes tips to young adults on how to reduce harms when drinking. Plans are also underway to translate Canada's Guidance on Alcohol and Health into the creation and distribution of tangible messages and tools.

This report was submitted by the Healthy Living Division and the Office of the Medical Officer of Health.

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

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

2023

Summary of harms related to smoking and alcohol consumption in the Middlesex-London region

A SUMMARY OF THE ONTARIO HEALTH AND PUBLIC HEALTH ONTARIO REPORT: BURDEN OF HEALTH CONDITIONS ATTRIBUTABLE TO SMOKING AND ALCOHOL BY PUBLIC HEALTH UNIT IN ONTARIO

POPULATION HEALTH ASSESSMENT & SURVEILLANCE TEAM

MIDDLESEX-LONDON HEALTH UNIT | Office of the Medical Officer of Health

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Executive Summary:

From a recent report from Ontario Health (OH) and Public Health Ontario (PHO), smoking and alcohol attributable harms and injuries present a considerable burden on the health care system in Ontario and the Middlesex-London region. Between 2015 and 2017, the prevalence of people in the Middlesex-London region 20 years of age and older who reported that they smoke cigarettes daily or occasionally was 18.1%. The report showed that annually there was an estimated 597 (16.3%) deaths, 2,082 (7.9%) hospitalizations, and 3,917 (3.2%) emergency department (ED) visits among Middlesex-London residents age 35 and older that were attributable to smoking (Summary Table). Smoking attributable harms were higher for males compared to females for both Ontario and the Middlesex-London region.

OH and PHO also reported that between 2015 and 2017, the prevalence of current alcohol consumption for people age 19 and older who consumed more than two drinks per week among Middlesex-London residents was 36.5%, which is considered risk beyond a low level according to the new Canadian Guidelines. It was estimated that in an average year in the Middlesex-London region, there were 154 (4.1%) deaths, 842 (2.4%) hospitalizations and 6,968 (3.8%) ED visits among residents age 15 and older attributable to alcohol consumption (Summary Table). Alcohol attributable harms were approximately three times higher for males compared to females for both Ontario and the Middlesex-London region. These and other Middlesex-London region findings from the OH and PHO report, both for smoking and alcohol consumption, are summarized in this report.

Summary Table: A summary of prevalence and estimated annual health outcomes attributable to smoking and alcohol consumption, Middlesex-London

Consumption	Prevalence of use[a,b] (2015-2017)	Emergency department visits Estimated count (% of all visits)	Hospitalizations Estimated count (% of all hospitalizations)	Deaths Estimated count (% of all deaths)
Smoking	18.1%	3917 (3.2%)	2082 (7.9%)	597 (16.3%)
Alcohol	36.5%	6968 (3.8%)	842 (2.4%)	154 (4.1%)

[a] Respondents 20 years of age and older who are daily or occasional smokers.
[b] Respondents 19 years of age and older who have had more than two drinks per week.

Purpose:

The new report released by Ontario Health (OH) and Public Health Ontario (PHO), *Burden of Health Conditions Attributable to Smoking and Alcohol*, provides estimates of prevalence of smoking and alcohol consumption and the attributable harms to illustrate the burden of disease and injury. In Canada, smoking is the leading cause of disability and death, while alcohol is the sixth leading cause. OH and PHO reported that in 2017, alcohol and smoking contributed to approximately 89% of all substance use health care costs in Canada. Preventing and reducing smoking and alcohol attributable harms and injuries can reduce the substantial burden on the health care system locally and across the province. This document summarizes findings from the report that are relevant for the Middlesex-London region.

Traditional tobacco use is a sacred and cultural practice for many Indigenous peoples in Canada. For the purposes of this data summary, when tobacco is named, it references commercial tobacco products and related harms.

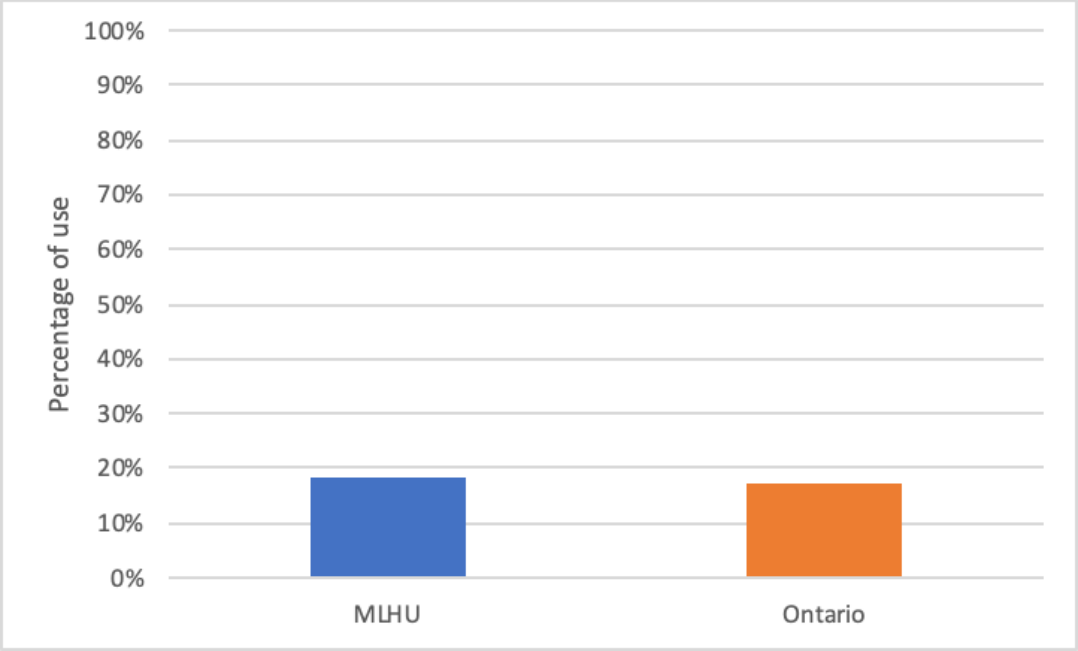
Prevalence of smoking and alcohol consumption:

Smoking

OH and PHO used the 2015 to 2017 Canadian Community Health Survey (CCHS) to estimate the prevalence of current smoking for residents of Ontario public health units. Smoking was defined as daily or occasional smoking of cigarettes only and does not include any other forms of tobacco, such as chew, waterpipe or vaping. It does not include smoking non-tobacco products, such as cannabis, nor does the data address health harms associated with environmental tobacco smoke exposure by individuals who are not daily or occasional smokers. As such, these estimates are conservative. The prevalence and harms described in this report are only associated with commercial tobacco use for recreational purposes and are not associated with the sacred and traditional uses of tobacco.

OH and PHO found that during the 2015 to 2017 period, 17.5% of people in Ontario ages 20 and older reported that they currently smoke cigarettes every day or occasionally. The prevalence of current smoking among residents of Ontario's 34 public health units ranged from 12.3% to 28.0%. The prevalence of current smoking for Middlesex-London residents was 18.1%, which was comparable to the province overall **(Figure 1).**

Figure 1: Prevalence of current smoking among people age 20 and older, Middlesex-London and Ontario, 2015-2017



Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario. Toronto: King's Printer for Ontario; 2023.

Canadian Community Health Survey, cycles 2015 to 2017, Statistics Canada, Ontario Share File, Distributed by Ontario Ministry of Health.

Alcohol consumption

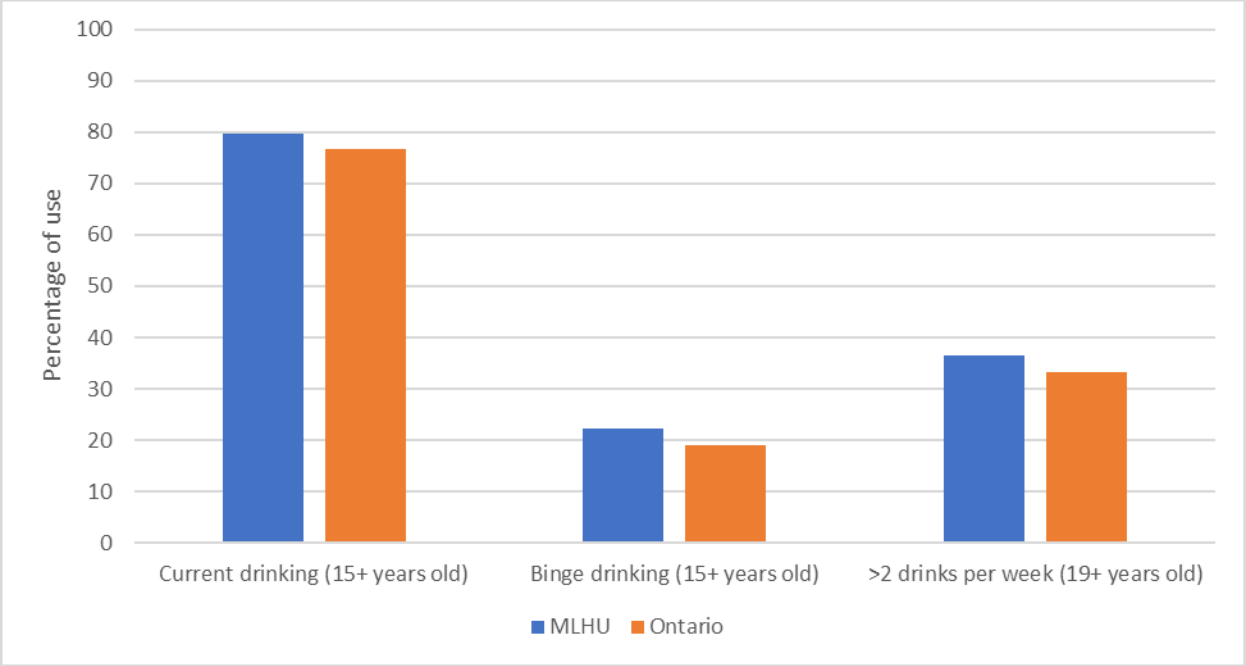
Using the most recently available self-reported data from the Canadian Community Health Survey (CCHS; 2015 to 2017), OH and PHO estimated the proportion of the population reporting current drinking, binge drinking and consuming more than two drinks of alcohol in past week. These were defined as:

- Current drinking: has had a drink of alcohol in their lifetime and has had a drink in the past 12 months, among people age 15 and older.
- Binge drinking: has consumed five or more (for males), or four or more (for females) drinks of alcohol on one occasion at least once a month in the past 12 months, among people age 15 and older.
- > 2 drinks per week: consumption in excess of two drinks of alcohol in the past week, among people age 19 and older who were not pregnant or breastfeeding.

During the 2015 to 2017 period, over three-quarters (76.8%) of people in Ontario age 15 and older reported that they currently drink alcohol. The prevalence of current drinking among

residents of Ontario's 34 public health units ranged from a low of 63.2% to a high of 83.7%. Similar to Ontario, the prevalence of current drinking for Middlesex-London Health Unit is 79.8% **(Figure 2)**.

Figure 2: Prevalence of alcohol consumption among people age 15 and older and 19 and older, Middlesex-London and Ontario, 2015-2017



Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario. Toronto: King's Printer for Ontario; 2023.

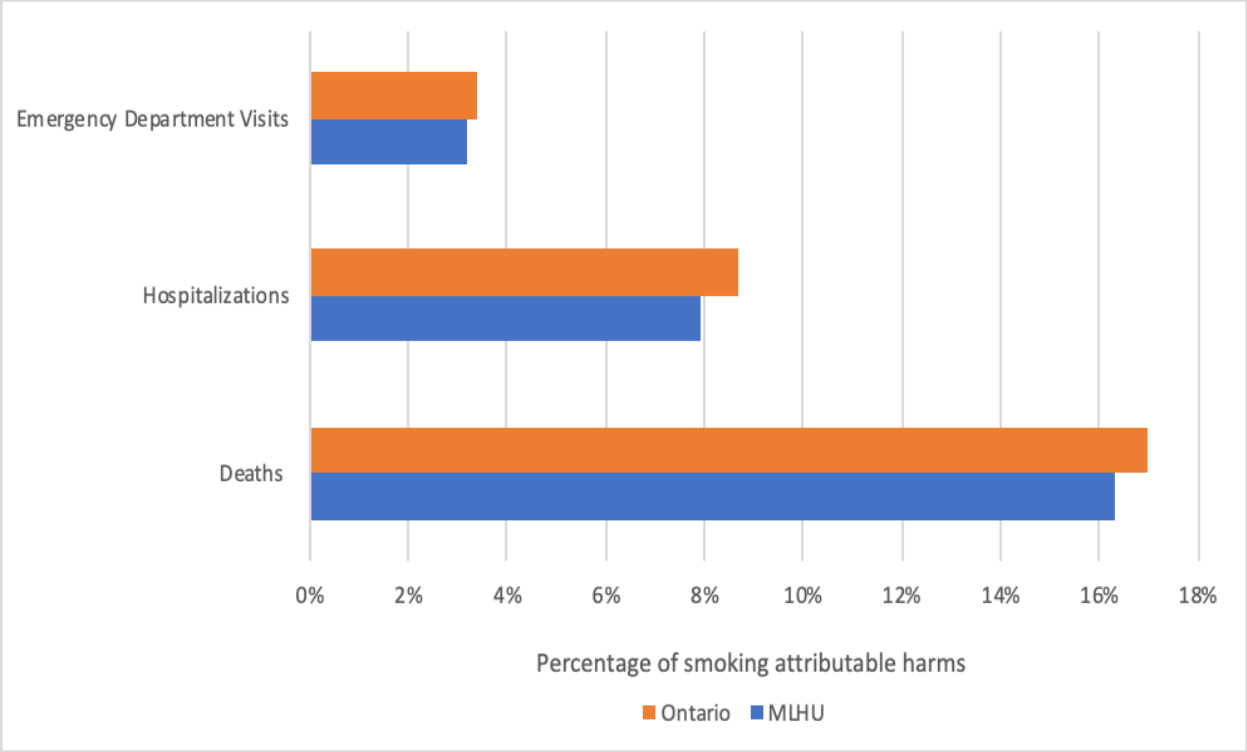
Canadian Community Health Survey, cycles 2015 to 2017, Statistics Canada, Ontario Share File, Distributed by Ontario Ministry of Health.

Smoking and alcohol attributable harms:

Smoking
Smoking attributable harms pose a substantial burden on the health care system. OH and PHO found that in Ontario, an estimated 16,673 (17.0%) deaths, 68,046 (8.7%) hospitalizations and 125,384 (3.4%) emergency department (ED) visits were attributable to smoking in people age 35 and older in an average year **(Figure 3).**

For the Middlesex-London region in an average year, there was an estimated 597 (16.3%) deaths, 2082 (7.9%) hospitalizations and 3917 (3.2%) emergency department visits that were attributable to smoking among people ages 35 and older **(Figure 3)**.

Figure 3: Smoking attributable harms relative to all causes among people age 35 and older, Middlesex-London and Ontario, annual average 2015-2019 (hospitalizations and emergency department visits) and 2014-2018 (deaths)



Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

Deaths from Vital Statistics – Death, 2014 to 2018, Office of the Registrar General. Hospitalizations from Discharge Abstract Database 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

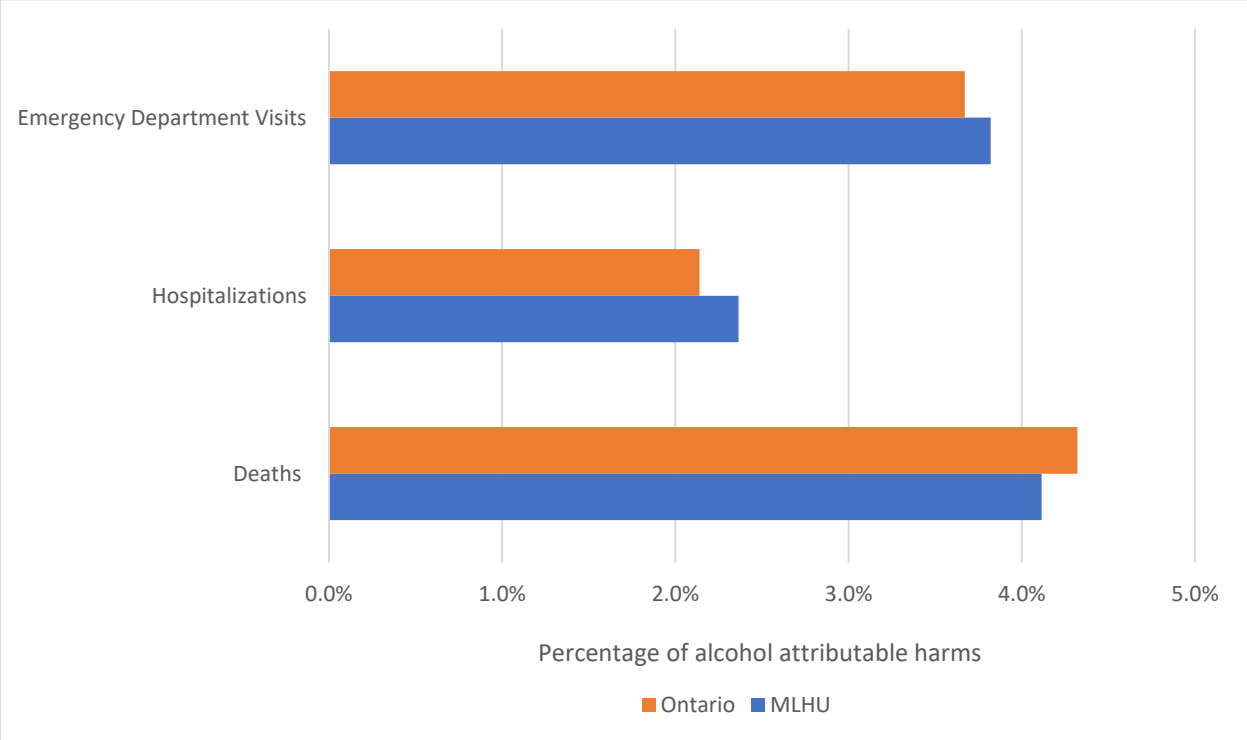
Emergency department visits from National Ambulatory Care Reporting System 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

Alcohol consumption

Alcohol attributable harms and injuries also present a considerable burden on the health care system. OH and PHO estimated that in Ontario, alcohol attributed health conditions caused an average of 4,330 deaths, 22,009 hospitalizations and 194,692 emergency department (ED) visits in people ages 15 and older. This represented 4.3% of deaths, 2.1% of hospitalizations and 3.7% of ED visits from all causes **(Figure 4).**

For the Middlesex-London region in an average year, there was an estimated 154 (4.1%) deaths, 842 (2.4%) hospitalizations and 6,968 (3.8%) emergency department visits that were attributable to alcohol consumption among people ages 15 and older **(Figure 4)**.

Figure 4: Alcohol attributable harms relative to all causes for people age 15 and older, Middlesex-London and Ontario, annual average 2015-2019 (hospitalization and emergency department visits) and 2014-2018 (deaths)



Data Sources:
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Deaths from Vital Statistics – Death, 2014 to 2018, Office of the Registrar General.

Hospitalizations from Discharge Abstract Database 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

Emergency department visits from National Ambulatory Care Reporting System 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

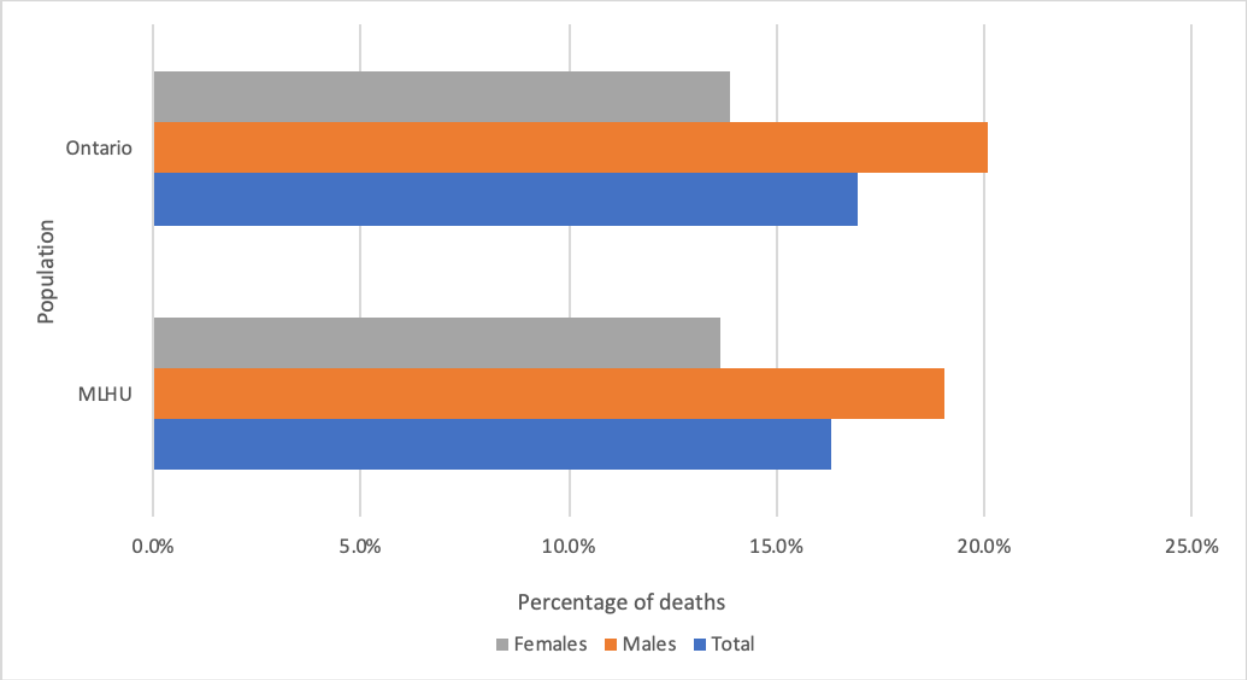
Smoking and alcohol attributable deaths:

Smoking

The OH and PHO report found that for Ontario and the Middlesex-London region, the highest number of smoking attributable deaths was from cardiovascular conditions and cancer. Smoking attributable deaths from all causes were higher for males compared to females for both Ontario and the Middlesex-London region **(Figure 5, Table 1)**.

In the Middlesex-London region, smoking contributed to nearly one in every six deaths. For males specifically in the Middlesex-London region this represented one in every five deaths. For females in the Middlesex-London region, this represented more than one in every eight deaths.

Figure 5: Estimates of smoking attributable deaths by sex for people age 35 and older, Middlesex-London and Ontario, annual average 2014-2018



Data Sources:

Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

Deaths from Vital Statistics – Death, 2014 to 2018, Office of the Registrar General.

Table 1: Estimates of smoking attributable deaths by sex for people age 35 and older, Middlesex-London and Ontario, annual average 2014-2018

Population	Sex	Total deaths from all causes	Total smoking attributable deaths	Percent of total deaths from all causes attributable to smoking
MLHU	Total	3,663	597	16.3%
	Males	1,797	343	19.1%
	Females	1,865	254	13.6%
Ontario	Total	98,293	16,673	17.0%
	Males	49,164	9,880	20.1%
	Females	48,917	6,793	13.9%

Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

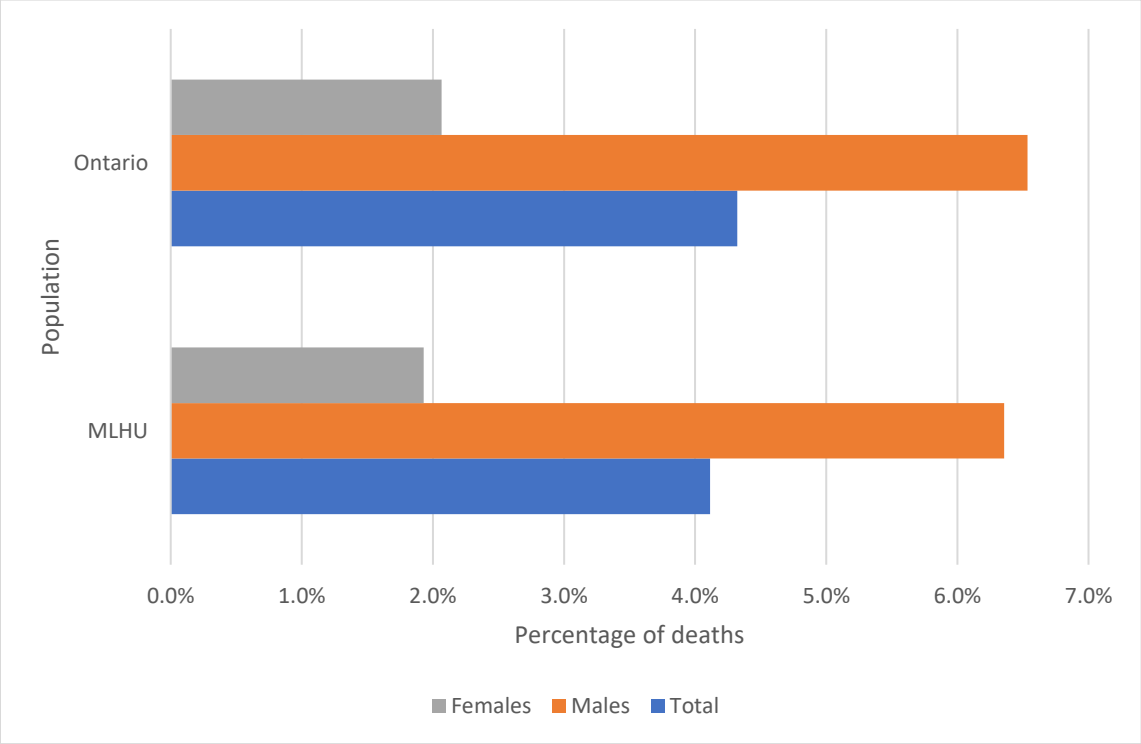
Deaths from Vital Statistics – Death, 2014 to 2018, Office of the Registrar General.

Alcohol consumption

The OH and PHO analysis found that for Ontario, the highest number of alcohol attributable deaths was from cancer, followed by cardiovascular conditions. For the Middlesex-London region, cancer was the leading cause, then digestive conditions (conditions that affect the gastrointestinal tract, liver, pancreas). Alcohol attributable deaths from all causes were approximately three times higher for males compared to females for both Ontario and the Middlesex-London region **(Figure 6, Table 2).**

In the Middlesex-London region, alcohol contributed to nearly one in every 24 deaths. For males specifically in the Middlesex-London region this represented one in every 16 deaths. For females in the Middlesex-London region, this represented more than one in every 52 deaths.

Figure 6: Estimates of alcohol attributable deaths by sex for people age 15 and older, Middlesex-London and Ontario, annual average 2014-2018



Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

Deaths from Vital Statistics – Death, 2014 to 2018, Office of the Registrar General.

Table 2: Estimates of alcohol attributable deaths by sex for people age 15 and older, Middlesex-London and Ontario, annual average 2014-2018

Population	Sex	Total deaths from all causes	Total alcohol attributable deaths	Percent of total deaths from all causes attributable to alcohol
MLHU	Total	3,737	154	4.1%
	Males	1,844	117	6.4%
	Females	1,893	37	1.9%
Ontario	Total	100,181	4,330	4.3%
	Males	50,572	3,305	6.5%
	Females	49,608	1,025	2.1%

Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

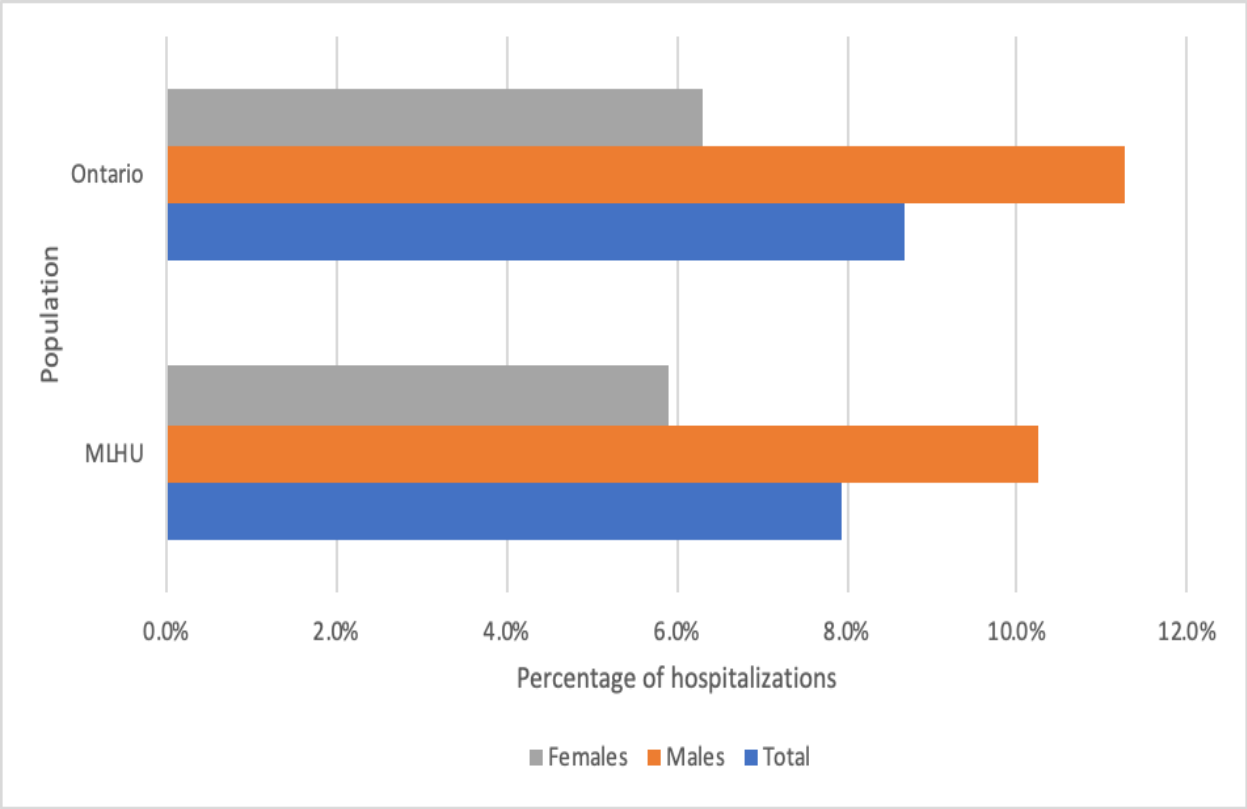
Deaths from Vital Statistics – Death, 2014 to 2018, Office of the Registrar General.

Smoking and alcohol attributable hospitalizations:

Smoking
The OH and PHO report showed that the largest number of smoking attributable hospitalizations was from respiratory conditions and cardiovascular diseases for both Ontario and the Middlesex-London region. Smoking attributable hospitalizations were higher for males compared to females for both Ontario and MLHU **(Figure 7, Table 3).**

In the Middlesex-London region, smoking contributed to nearly one in every 12 hospitalizations. For males specifically in the Middlesex-London region this represented one in every 10 hospitalizations. For females in the Middlesex-London region, this represented approximately one in every 16 hospitalizations.

Figure 7: Estimates of smoking attributable hospitalizations by sex for people age 35 and older, Middlesex-London and Ontario, annual average 2015-2019



Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

Hospitalizations from Discharge Abstract Database 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

Table 3: Estimates of smoking attributable hospitalizations by sex for people age 35 and older, Middlesex-London and Ontario, annual average 2015-2019

Population	Sex	Total hospitalizations from all causes	Total smoking attributable hospitalizations	Percent of total hospitalizations from all causes attributable to smoking
MLHU	Total	26,224	2,082	7.9%
	Males	12,294	1,260	10.2%
	Females	13,930	823	5.9%
Ontario	Total	785,564	68,046	8.7%
	Males	374,405	42,154	11.3%
	Females	411,159	25,892	6.3%

Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

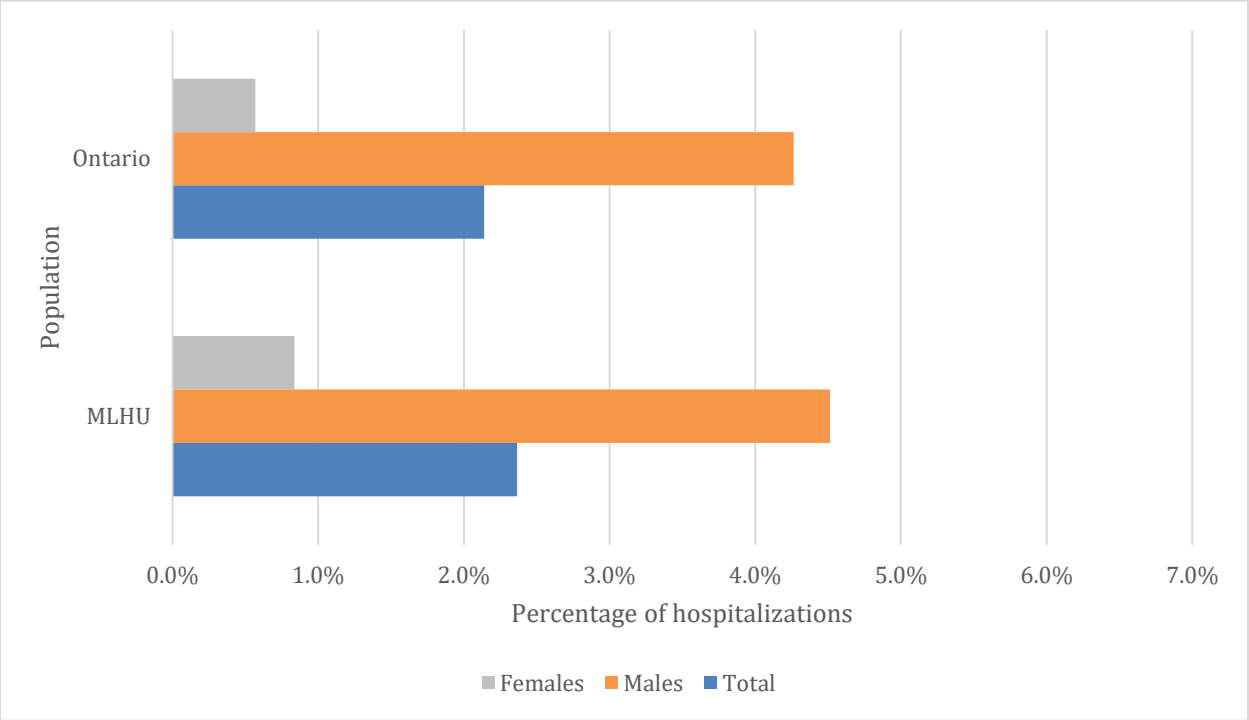
Hospitalizations from Discharge Abstract Database 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

Alcohol consumption

According to OH and PHO estimates, the largest number of alcohol attributable hospitalizations was from neuro-psychiatric conditions (mental, neurologic, substance use conditions) followed by unintended injuries (falls, drowning, poisoning). Alcohol attributable hospitalizations were approximately three times higher for males compared to females for both Ontario and Middlesex-London residents **(Figure 8, Table 4).**

In the Middlesex-London region, alcohol contributed to nearly one in every 41 hospitalizations. For males specifically in the Middlesex-London region this represented approximately one in every 22 hospitalizations. For females in the Middlesex-London region, this represented approximately one in every 120 hospitalizations.

Figure 8: Estimates of alcohol attributable hospitalizations by sex for people age 15 and older, Middlesex-London and Ontario, annual average 2015-2019



Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

Hospitalizations from Discharge Abstract Database 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

Table 4. Estimates of alcohol attributable hospitalizations by sex for people age 15 and older, Middlesex-London and Ontario, annual average 2015-2019

Population	Sex	Total hospitalizations from all causes	Total alcohol attributable hospitalizations	Percent of total hospitalizations from all causes attributable to alcohol
MLHU	Total	35,611	842	2.4%
	Males	14,812	668	4.5%
	Females	20,799	174	0.8%
Ontario	Total	1,028,338	22,009	2.1%
	Males	437,397	18,645	4.3%
	Females	590,942	3,364	0.6%

Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

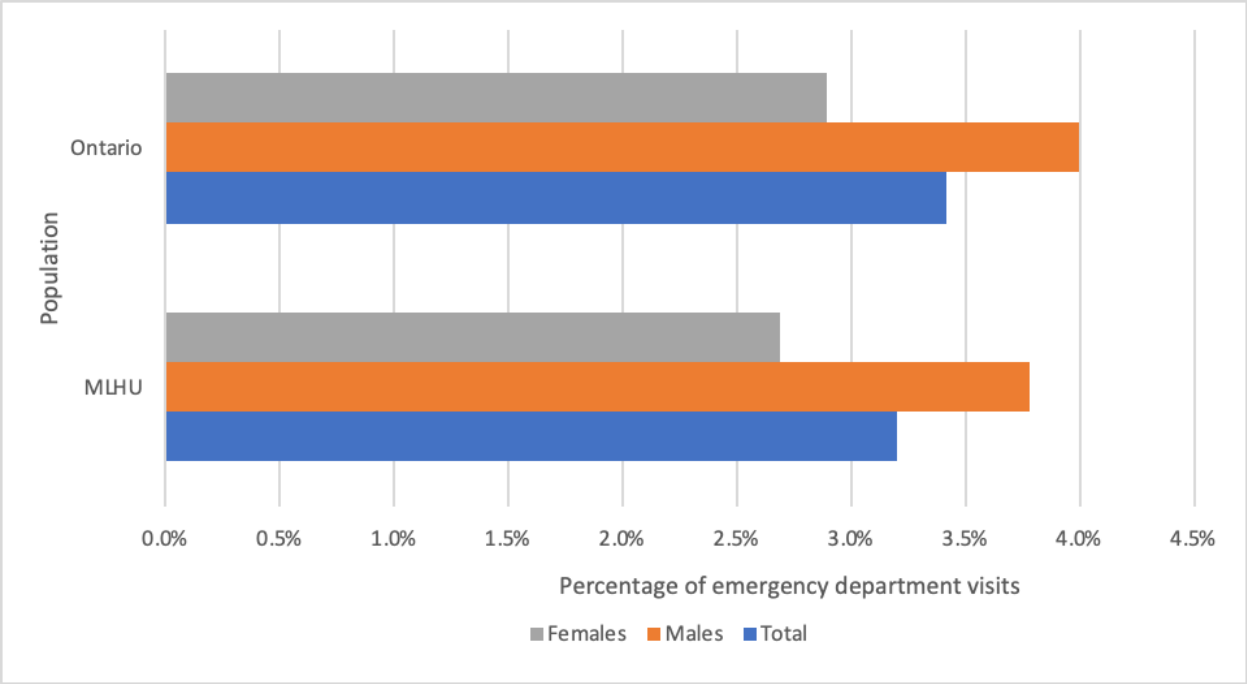
Hospitalizations from Discharge Abstract Database 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

Smoking and alcohol attributable emergency department visits:

Smoking
Smoking attributable emergency department (ED) visits for Ontario and the Middlesex-London region were highest for respiratory conditions, followed by cardiovascular diseases. Smoking attributable ED visits were higher for males compared to females for Middlesex-London residents and in Ontario overall **(Figure 9, Table 5).**

In the Middlesex-London region, smoking contributed to nearly one in every 30 emergency department visits. For males specifically in the Middlesex-London region this represented approximately one in every 26 emergency department visits. For females in the Middlesex-London region, this represents approximately one in every 37 emergency department visits.

Figure 9: Estimates of smoking attributable emergency department visits by sex for people age 35 and older, Middlesex-London and Ontario, annual average 2015-2019



Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

Emergency department visits from National Ambulatory Care Reporting System 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

Table 5. Estimates of smoking attributable emergency department visits by sex for people age 35 and older, Middlesex-London and Ontario, annual average 2015-2019

Population	Sex	Total emergency department visits from all causes	Total smoking attributable emergency department visits	Percent of total emergency department visits from all causes attributable to smoking
MLHU	Total	122,337	3,917	3.2%
	Males	57,203	2,165	3.8%
	Females	65,134	1,752	2.7%
Ontario	Total	3,671,804	125,384	3.4%
	Males	1,729,284	69,200	4.0%
	Females	1,942,520	56,184	2.9%

Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

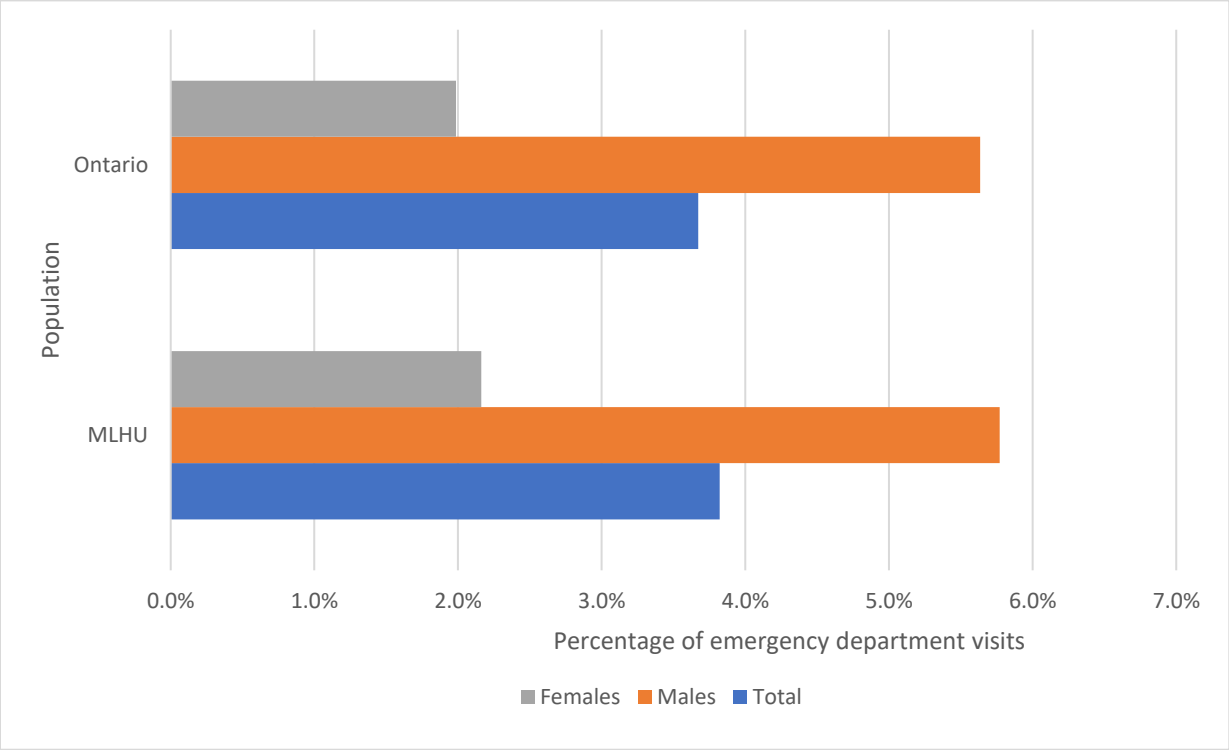
Emergency department visits from National Ambulatory Care Reporting System 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

Alcohol consumption

Alcohol attributable emergency department (ED) visits for Ontario and the Middlesex-London region were highest for unintended injuries (falls, drowning, poisoning) followed by neuro-psychiatric conditions (mental, neurologic, substance use conditions). Alcohol attributable ED visits were approximately three times higher for males compared to females for Middlesex-London residents and in Ontario overall **(Figure 10, Table 6).**

In the Middlesex-London region, alcohol contributed to nearly one in every 26 ED visits. For males specifically in the Middlesex-London region this represented approximately one in every 17 emergency department visits. For females in the Middlesex-London region, this represented approximately one in every 42 emergency department visits.

Figure 10: Estimates of alcohol attributable emergency department visits by sex for people age 15 and older, Middlesex-London and Ontario, annual average 2015-2019



Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

Emergency department visits from National Ambulatory Care Reporting System 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

Table 6: Estimates of alcohol attributable emergency department visits by sex for people age 15 and older, Middlesex-London and Ontario, annual average 2015-2019

Population	Sex	Total emergency department visits from all causes	Total alcohol attributable emergency department visits	Percent of total emergency department visits from all causes attributable to alcohol
MLHU	Total	182,384	6,968	3.8%
	Males	83,840	4,839	5.8%
	Females	98,544	2,130	2.2%
Ontario	Total	5,302,338	194,692	3.7%
	Males	2,449,671	138,056	5.6%
	Females	2,852,667	56,637	2.0%

Data Sources:
Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario: Supplementary Tables. Toronto: Queen's Printer for Ontario; 2023.

Emergency department visits from National Ambulatory Care Reporting System 2015 to 2019, Ontario Ministry of Health, IntelliHEALTH ONTARIO, Extracted November 2021.

Data Caveats:

- Smoking is defined as daily or occasional smoking cigarettes only and does not include any other forms of tobacco, such as chew, waterpipe or vaping. It does not include smoking non-tobacco products, such as cannabis, nor does the data address health harms associated with environmental tobacco smoke exposure by individuals who are not daily or occasional smokers. As such, these estimates are conservative. The harms described in this report are only associated with commercial tobacco use for recreational purposes and are not associated with the sacred and traditional uses of tobacco.

- Only harms partially or fully attributable to smoking and alcohol were included in this report. Only primary cause of death or primary diagnosis was counted for each harm. For example, deaths may be recorded as other conditions and not directly attributed to smoking or alcohol use. This may result in an underestimate of the true burden of harms associated with smoking and alcohol consumption.

- An examination of the impact of COVID-19 on smoking and alcohol attributable harms was not possible in this report because data were only available up to 2019 at the time of analysis.

- Due to limitations of the data available, the analysis was not able to incorporate socioeconomic differences that may impact the effect of smoking and alcohol on various harms.

- The terms used to refer to sex in this report (male, female, men and women) come from the report's data sources and do not represent the full gender diversity found in Ontario's population.

- This report does not quantify the synergistic impacts created when smoking and alcohol are combined. The increase in risk of disease becomes much greater when someone smokes cigarettes and drinks alcohol together, compared to the sum of the risks from smoking and drinking separately. Therefore, the risk estimates are likely an underestimate of these harms since the combined synergistic risk is not quantified.

- Smoking and alcohol consumption were self-reported and therefore prone to biases recall bias and social desirability bias. There is also the potential for measurement bias because people may transition from current smoking or drinking to former smoking or drinking, which would not be reflected in the estimates provided.

- For alcohol and smoking, there may be a lag between exposure and health outcomes, which was not accounted for in the analysis, given the inconsistency in lag time between different exposures and health outcomes.

- The methods used to calculate smoking and alcohol population attributable fractions were different and therefore cannot be directly compared.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 19-23

TO: Chair and Members of the Board of Health

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

DATE: 2023 March 16

2022 MPOX OUTBREAK SUMMARY

Recommendation

It is recommended that Report No. 19-23 re: "2022 Mpox Outbreak Summary" be received for information.

Key Points

- A significant Mpox outbreak occurred internationally in 2022, with 15 confirmed cases identified and responded to locally.
- The local Mpox response required extensive collaboration amongst teams at the Health Unit and with external partners in the community – most specifically agencies providing support to men who have sex with men.
- At this time, there is very low transmission in Ontario, with no cases recently reported in Middlesex-London, and procedures have been established to ensure continued coordinated response in the event of new cases being identified.

Background

Mpox is a viral illness that causes a rash or lesions on a person's body that can be in a single location (e.g., genital area, mouth) or all over the body. Other symptoms that can happen before or after the rash include fever/chills, fatigue, swollen lymph nodes, headache, muscle aches, and sore throat (Public Health Ontario, 2022-10-28). In 2022, there was a worldwide Mpox outbreak with 86,231 confirmed cases, 100 deaths and 110 countries reporting cases (World Health Organization, 2023-02-28).

Provincially, there were 691 confirmed cases of Mpox as of December 13, 2022. Of these cases, key highlights include:

- The first confirmed case was reported in May 2022.
- 505/691 (73.1%) confirmed cases were reported by Toronto Public Health (see Table 3 for confirmed cases by public health unit).
- 685/691 (99.1%) confirmed cases were male and 6/691 (0.9%) are female.
- The average age of confirmed cases was 36.6 years (range: <20 – 74 years).
- The commonly reported symptoms included rash, oral/genital lesions, swollen lymph nodes, headache, fever, chills, myalgia and fatigue.
- 20/691 (2.9%) of confirmed cases have been hospitalized, and 2/691 (0.3%) have been in the intensive care unit (ICU); no deaths have been reported in Ontario.

At the time of the first reporting of cases in Ontario, there was uncertainty regarding the nature of Mpox transmission and the outbreak was treated with a high degree of caution to protect the community from the spread of the disease. The response to Mpox was coordinated locally between many teams in the Health Unit and with local stakeholders.

Case and Contact Management in Middlesex-London

The first confirmed case of Mpox was reported locally on June 13, 2022. Investigators on the Infectious Disease Control Team were responsible for the intake, investigation, and reporting of all suspect, probable and confirmed cases within the region. From June 13 to November 11, 2022, the team investigated 33 reports of Mpox with 15 confirmed cases, and 18 cases that did not meet case definition.

Across Ontario, most of the cases identified were amongst men who report sexual or intimate contact with other men. Additionally, the most reported risk factor included intimate contact with new and/or more than one partner. Other less common risk factors included travel, being immunocompromised, or having close contact with someone outside of the province.

The Role of the Sexual Health Team

The Sexual Health Team connected with community partners who support the target population to share promotional materials and Mpox vaccine clinic dates and locations. During Pride 2022, Mpox promotional material was displayed at booths as an education opportunity for clients. Clients who attended the sexual health clinic presenting with suspect or probable Mpox were tested, told to isolate immediately and then referred to the Infectious Disease Team for case management.

The Role of the Vaccine Preventable Diseases Team

Mpox vaccine clinics were offered starting in June 2022 at MLHU Citi Plaza site, the Pride London events and in other community venues. By the end of February 2023, 865 first doses and over 90 second doses were administered. With new cases emerging in the Toronto area, there has been a recommendation from the Province to ramp up efforts for clients to receive a second dose. Efforts to connect with clients who require a second dose is now underway including individual reminder calls to clients and the offering of additional vaccination opportunities.

Communications

An Mpox education awareness campaign was launched for one month in August 2022 using social media avenues such as Advances AI Ads, premium display advertising, and targeted dating apps. Posters were developed by the Gay Men's Sexual Health Alliance, with support from the Regional HIV/AIDS Connection, Middlesex London Health Unit and Southwestern Health Unit, and shared with other community agencies.

Next Steps

The local response to Mpox was highly coordinated across the Health Unit and resulted in the effective control of ongoing transmission. Initial concerns about widespread Mpox transmission have been mitigated due to the engagement of priority populations and community partners. Mpox processes and procedures were created during the initial outbreak and will be reviewed and revised as necessary to respond to the possibility of new cases in the future.

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

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

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 20-23

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health

DATE: 2023 March 16

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR FEBRUARY

Recommendation

It is recommended that the Board of Health receive Report No. 20-23, re: Medical Officer of Health Activity Report for February for information.

The following report highlights activities of the Medical Officer of Health for the period of February 2, 2023 – February 27, 2023.

The Medical Officer of Health provides oversight of all public health programs at the Middlesex-London Health Uni, and co-chairs the Senior Leadership Team. The Medical Officer of Health participates in a wide range of external and internal meetings, along with liaising with community partners and municipal and provincial stakeholders.

The Medical Officer of Health, along with other team members, continues to host a weekly Middlesex-London Health Unit (MLHU) Staff Town Hall.

The Medical Officer of Health also participated in the following meetings:

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

February 2 Interview with Jennifer Bieman (London Free Press) regarding suspension letters as part of implementing the *Immunization of School Pupils Act*.

February 3 Attended a meeting with a ministry official to discuss pharmacies providing HPV vaccinations.

February 7 Attended a meeting with local First Nations Communities to discuss communicable disease management.

February 8 Attended a meeting regarding the Health and Homelessness Summit, organized by the City of London.

February 10 Attended the annual Youth Opportunities Unlimited breakfast.

Attended the COMOH Executive meeting.

February 13 Attended a meeting with Public Health Ontario providing information regarding Legionella outbreaks and management.

Attended a meeting at London City Hall regarding the Health and Homelessness Summit.

February 14 Attended a media event regarding the Health and Homelessness Summit.

February 15 Met with City Councilor McAlister regarding school suspensions under the *Immunization of School Pupils Act.*

Met with Dr. Rod Lim, Director, Paediatric Emergency Department at Children's Hospital, LHSC.

Attended a meeting regarding draft metrics for the City of London Strategic Plan.

Attended a meeting regarding the alPHa Winter Symposium for speaker and moderators.

Attended a meeting reviewing the draft systems review from the Health and Homelessness Summit.

February 16 Interview with Andrew Graham (Global News Radio 980 CFPL) regarding the opening of the permanent CarePoint Consumption and Treatment site.

Met with Scott Courtice, Executive Director, London InterCommunity Health Centre.

February 18 Interview with Jennifer Bieman (London Free Press) regarding the reported measles case.

February 20 Interview with Kate Dubinski (CBC London) regarding the reported measles case.

February 21 Interview with Loreena Dickson (NewsTalk 1290 CJBK) regarding the reported measles case and the CarePoint Consumption and Treatment Site.

Presented the Healthcare Provider Outreach webinar.

Attended Ministry of Health COVID-19 Public Health coordination call.

February 22 Presented at the alPHa EA/AA Conference.

Attended the media walk through of the permanent CarePoint Consumption and Treatment Site.

Participated in a call with Dr. Natalie Bocking, Medical Officer of Health, Haliburton, Kawartha, Pine Ridge District Health Unit.

February 23 Attended the alPHa Board Meeting.

Participated in a call with Dr. Elizabeth Richardson, Medical Officer of Health, Hamilton Public Health Services.

February 24 Presented at the alPHa Winter Symposium.

Attended the COMOH section of the alPHa Winter Symposium

February 27 Attended a COMOH Workgroup meeting on the relationship between Ontario Health Teams and local public health units.

With the CEO, met with the Cathy Burghardt-Jesson, Warden, Middlesex County and Cindy Howard, General Manager, Finance and Community Services at the County of Middlesex.

Attended the monthly Southwest Ontario Medical Officer of Health / Associate Medical Officer of Health meeting.

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:*

February 3 Attended a meeting to discuss cross-divisional shared programming.

February 6 Attended the weekly Provisional Plan Sponsor update meeting.

February 13 Attended the Vaccine Operations Committee meeting.

February 14 Attended a confidential meeting regarding labour relations.

Attended a meeting with the Director, Healthy Living and Manager, Community Health Promotion and Injury Prevention regarding the Community Drug and Alcohol Strategy.

February 16 Attended a meeting with the recruiter regarding interviews for an Associate Medical Officer of Health.

Attended the monthly surveillance meeting regarding communicable diseases.

Attended an update meeting regarding the enforcement of the *Immunization of School Pupils Act*.

Participated in the quarterly touch-base meeting with CUPE.

February 17 Attended a meeting regarding a reported case of measles.

February 20 Attended a meeting with Public Health Ontario regarding the reported measles case.

February 21 Participated in interviews recruiting into the Associate Medical Officer of Health position.

Met with MLHU Occupational Health and Safety to discuss internal TB Skin Testing regarding internal policies.

Met with the CEO, Finance, and HR regarding zero-based budgeting.

February 23 Attended a meeting regarding harmonized clinics in MLHU.

Attended a meeting regarding staffing for the dental operatories opening in the Strathroy dental clinic.

February 27 Met with the CEO and Director, Healthy Living to discuss cross-divisional processes.

Personal Development – *These meeting(s) reflect on how the MOH develops their leadership, skills and growth to define their vision and goals for the Health Unit.*

February 23 Attended the Public Health Ontario Rounds: Health Conditions Attributable to Smoking and Alcohol.

February 24 Attended the alPHa Winter Symposium.

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:*

February 2 Attended the February, inaugural meeting of the Finance and Facilities Committee.

February 6 Attended the February Board of Health agenda review and executive meeting.

February 8 Attended the monthly touch-base meeting with the Board chair.

February 16 Attended the February Board of Health meeting.

This report was prepared by the Medical Officer of Health.

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

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 21-23

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer

DATE: 2023 March 16

CHIEF EXECUTIVE OFFICER ACTIVITY REPORT FOR FEBRUARY

Recommendation

It is recommended that the Board of Health receive Report No. 21-23, re: Chief Executive Officer Activity Report for February for information.

The following report highlights activities of the Chief Executive Officer for the period of February 2, 2023 – February 27, 2023.

Standing meetings include weekly Healthy Organization leadership team meetings, SLT (Senior Leadership Team) meetings, MLT (MLHU Leadership Team) meetings, Virtual Staff Town Hall meetings, bi-weekly R3 meetings, and weekly check ins with the Healthy Organization managers and the MOH.

As part of the MLHU on-call leadership system, the CEO provided on-call coverage from February 20 to February 26.

The CEO also attended the following meetings:

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

February 8 The CEO attended a meeting regarding the Health and Homelessness Summit, organized by the City of London.

February 10 The CEO attended the annual Youth Opportunities Unlimited breakfast.

February 13 The CEO attended a meeting organized by the City of London, regarding draft metrics for its Strategic Plan.

February 15 The CEO attended a community partners discussion group for the London Health Sciences Centre Accreditation Canada process.

February 23 The CEO participated in the monthly meeting of the Middlesex-London Ontario Health Team Coordinating Council.

February 27 The CEO with the Medical Officer of Health, met with Cathy Burghardt-Jesson, Warden, Middlesex County and Cindy Howard, General Manager, Finance and Community Services at the County of Middlesex.

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:*

February 2 The CEO participated in interviews for the position of Executive Assistant to the Chief Executive Officer.

February 6 The CEO participated in a meeting to discuss Requests for Proposals regarding an Information Technology digital content developer contract.

The CEO attended a meeting of the Leadership On-Call Working Group.

The CEO attended a meeting regarding team business rules.

February 8 The CEO attended a meeting to plan for a review of office spaces and material storage.

February 9 The CEO attended the quarterly meeting with Stronghold Inc., MLHU's IT service provider.

The CEO attended a confidential meeting regarding labour relations.

February 10 The CEO attended an internal meeting regarding funding for the Ontario Seniors Dental Program.

February 13 The CEO attended the monthly Strathroy Dental Steering Committee.

The CEO attended a meeting reviewing a performance management module in the Human Resources Information System for potential implementation.

February 16 The CEO attended a meeting with the recruiter regarding interviews for an Associate Medical Officer of Health.

The CEO, with the Medical Officer of Health and Manager, Human Resources, attended the quarterly touch-base meeting with CUPE.

February 21 The CEO participated in interviews for the Associate Medical Officer of Health position.

The CEO attended the monthly Employee Systems Review (ESR) Steering Committee meeting.

The CEO met with the Medical Officer of Health, Finance, and Human Resources to conduct a zero-based budgeting review of staffing resources provided by the MLHU leadership team.

February 23 The CEO attended a meeting regarding harmonized clinics in the MLHU.

The CEO attended a meeting regarding staffing for the dental operatories opening in the Strathroy dental clinic.

February 27 The CEO attended a meeting regarding recruitment for the Manager, Privacy, Risk, and Client Relations job posting.

The CEO, with the Medical Officer of Health, and Director, Healthy Living division attended a meeting to discuss cross-divisional communication processes.

The CEO attended a meeting to discuss the MLHU Leadership Development Framework.

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.*

February 9 As part of the CEO's McCormick Care Board membership, the CEO attended the McCormick Executive Committee meeting.

February 15 As part of the CEO's McCormick Care Board membership, the CEO chaired the McCormick Quality Committee meeting.

February 22 The CEO participated in Crucial Conversations refresh training.

February 24 The CEO attended the alPHa Winter Symposium and Board of Health section 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:*

February 2 The CEO attended the February inaugural meeting of the Finance and Facilities Committee.

The CEO attended the monthly provincial call regarding funding updates.

February 6 The CEO attended the February Board of Health meeting agenda review and executive meeting.

The CEO attended the weekly Provisional Plan Sponsor update meeting.

February 7 The CEO met with the Board Chair for a monthly touch-base meeting.

February 13 The CEO attended a meeting with the Ministry of Health Funding and Oversight Branch and Ministry of Health Public Health Programs Branch regarding funding for operating expenses for the Ontario Seniors Dental Program.

February 16 The CEO attended the February Board of Health meeting.

This report was prepared by the Chief Executive Officer.

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

2022 COVID-19 Response by the Numbers & Recovery Progress Report

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Background

Public Health Sudbury & Districts (Public Health) has been focused on responding to the COVID-19 pandemic since the beginning of 2020. As a result of this intense effort, established programs and services were adapted, and many were reduced or paused all together throughout 2020 and 2021.

2022 marked the beginning of Public Health's journey toward recovery and resumption of some programs and services. During this time, the pandemic continued to demand leadership and resources from the public health sector, and Public Health Sudbury & Districts looked to concentrate efforts on the impacts of the pandemic on local communities and on its own workforce. As such, the agency directed resources to assess and address ongoing and emerging health needs that require public health intervention.

As a result, in March 2022 Public Health launched *Public Health Sudbury & Districts and the COVID-19 pandemic: From risk to recovery and resilience plan*. The *risk, recovery, and resilience plan* focuses on public health priorities that emerged from the COVID-19 pandemic—with an overall goal to resume the full scope of public health programs and services in the future.

This *COVID-19 Response by the Numbers and Recovery Progress Report* highlights achievements of our ongoing COVID-19 response as well as accomplishments from our continued recovery efforts.

How this report is organized

The **first section** of this report focuses on the COVID-19 response. Data and explanatory notes are presented in table format for indicators in the following categories: overall COVID-19 program supports; case, contact, and outbreak management; COVID-19 vaccine program; and health and human resource capacity and financial impact.

The **second section** of this report presents the progress on recovery planning. This section presents an update on Public Health's four overarching community-focused priorities – getting children back on track; levelling up opportunities for health; fostering mental health gains; and supporting safe spaces–along with one operational priority–people and processes–which identifies work required to support staff to deliver on our overall programs and services. Within each priority area, Public Health's key initiatives are highlighted and a summary on progress to date is provided.

COVID-19 Response by the Numbers

Public Health's response activities were wide ranging and included case, contact, and outbreak management; the COVID-19 vaccination program; COVID-19 prevention and behaviour change; school and COVID-19 programming; ongoing quality and monitoring; and evaluation of public health services, regular reporting, and communication. This was all supported by the essential work of data analysis and epidemiological reviews, stakeholder engagement, human resources, and information technology supports.

The data in this section demonstrate the agency's ongoing responsibilities and transparency to stakeholders, clients, and community members by showcasing key activities and indicators of success pertaining to Public Health's 2022 COVID-19 response. Key indicators were selected based on their ability to showcase the scope of Public Health's leadership in various categories of the local COVID-19 response in 2022.

Overall COVID-19 program supports

Data	Indicator
68 185	**Total calls processed by the COVID-19 vaccination booking line and call centres** (operated by Public Health from April 6, 2022, to December 31, 2022, with support from the City of Greater Sudbury from January to April 5, 2022)**.**
	City of Greater Sudbury-led COVID-19 booking call centre (up to April 5, 2022)
10 320	*Inbound calls*
2 433	*Outbound calls*
	Public Health-led COVID-19 booking call centre (from April 6, 2022)
47 075	*Inbound calls*
8 357	*Outbound calls*

Overall COVID-19 program supports (continued)

Data	Indicator
84	Public service announcements and news releases related to COVID-19 response issued.

- Topics ranging from promoting COVID-19 vaccination opportunities, public health precautions, and key public health updates.

Data	Indicator
23	Advisory Alerts supporting COVID-19 response issued to local health system partners and primary care providers.

- Topics included, for example, COVID-19 vaccination updates and guidance, service disruption and resumption of programming, case and contact management, and co-circulation of COVID-19 and influenza viruses.

Data	Indicator
4 472 637	People reached and impressions[1] on social media.
172 924	Engagements[2] on social media.
970 828	Unique COVID-19 pageviews[3] on our English and French websites.
220	Media requests and responses.
14	Debrief sessions hosted with community partners to reflect on local COVID-19 response.

- Debrief sessions were held with partners from 11 different sectors, for example, education, municipal, healthcare, and First Nation and urban Indigenous sectors.

[1] Total number of people reached and impressions on our English and French Facebook, Twitter, and YouTube channels, all content.

[2] Total number of engagements (for example, likes, shares, retweets, link clicks, or time watched for videos) on our English and French Facebook, Twitter, and YouTube channels, all content.

[3] A unique pageview represents the number of sessions during which a page was viewed one or more times.

Overall COVID-19 program supports (continued)

Data	Indicator
16	Debrief sessions hosted with staff to reflect on internal COVID-19 response (across 7 different response functions).
6	COVID-19-related surveys and evaluations conducted to help guide and plan Public Health's COVID-19 response activities.

- Surveys and evaluations were conducted internally and externally to inform ongoing planning. Information was gathered from primary care providers, pharmacies, health centres, community partners, staff, and members of the general public on overall COVID-19 response, COVID-19 vaccines, and program supports.

Case, contact, and outbreak management

Data	Indicator
15 343	**Confirmed COVID-19 cases among residents of Sudbury and districts in 2022.**
71.4%	*Of the COVID-19 cases reported from the start of the pandemic until December 31, 2022, occurred in 2022.*

- As of December 31, 2021, eligibility for publicly funded PCR testing is limited to people who are associated with highest risk settings or who are at high risk of severe health outcomes if they become infected. Therefore, counts of new and active cases underestimate the true number of people with COVID-19 in Sudbury and districts.

Data	Indicator
187	**COVID-19-related deaths among residents of Sudbury and districts in 2022.**
78.9%	*Of the COVID-19 deaths reported from the start of the pandemic until December 31, 2022, occurred in 2022.*

COVID-19 vaccine program

Data	Indicator
132 811	**Doses administered throughout the entire service area** (including Public Health-led clinics, other provider clinics, and pharmacy clinics) **in 2022.**
25.7%	*COVID-19 doses administered since the beginning of the vaccine program in January 2021, that were administered in 2022.*
78 943	**Doses administered in Public Health-led clinics in 2022.**
59.4%	*Percentage of all doses administered in 2022 that were provided exclusively by Public Health-led clinics.*
21.7%	*Percentage of all doses administered by Public Health-led clinics since the beginning of the vaccine program (January 2021) that were provided in 2022.*

- Public Health-led clinics include mass immunization clinics, pop-up clinics, mobile bus clinics, retirement home-based clinics, school-based clinics, homebound clinics, select Indigenous clinics, and partner clinics co-led with Public Health staff. These do not include primary care, long-term care, and pharmacy offerings.

Data	Indicator
2 283	**Total doses administered in Chapleau in 2022.**
2 132	*Doses administered in Public Health-led clinics in Chapleau in 2022.*
93.4%	*Percentage of total doses that were administered in Public Health-led clinics in Chapleau in 2022.*
106 417	**Total doses administered in Greater Sudbury in 2022.**
62 644	*Doses administered in Public Health-led clinics in Greater Sudbury in 2022.*
58.9%	*Percentage of total doses that were administered in Public Health-led clinics in Greater Sudbury in 2022.*
6 432	**Total doses administered in Lacloche Foothills in 2022.**
4 837	*Doses administered in Public Health-led clinics in Lacloche Foothills in 2022.*
75.2%	*Percentage of total doses that were administered in Public Health-led clinics in Lacloche Foothills in 2022.*
9 934	**Total doses administered on Manitoulin Island in 2022.**
5 906	*Doses administered in Public Health-led clinics on Manitoulin Island in 2022.*
59.5%	*Percentage of total doses that were administered in Public Health-led clinics on Manitoulin Island in 2022.*

COVID-19 vaccine program (continued)

Data	Indicator
3 768	**Total doses administered in Sudbury East in 2022.**
1 735	*Doses administered in Public Health-led clinics in Sudbury East in 2022.*
46.0%	*Percentage of total doses that were administered in Public Health-led clinics in Sudbury East in 2022.*
1 090	**Total Public Health-led vaccination events throughout the entire service area in 2022.**
65	*In Chapleau*
834	*In Greater Sudbury*
68	*In Lacloche Foothills*
98	*On Manitoulin Island*
25	*In Sudbury East*

- Vaccination event types include mass immunization clinics held in large arenas, churches, or community centres; mobile vaccination teams attending targeted locations such retirement homes; pop-up clinics held in strategic locations such as shopping malls, Samaritan centres, or tied to local events; vaccine-to-client offerings at client homes; and mobile bus clinics to reach targeted populations.

Data	Indicator
5 470	*Residents* (6 months and older) received their first doses in 2022.
10 331	*Residents* (6 months and older) received their second doses in 2022.
118 827	Booster doses were administered to *residents 5 years of age and older* in Sudbury and districts.
9.5%	Percentage of doses wasted at Public Health-led vaccination events, of all doses provided.
22.9%	Percentage of doses wasted at other provider vaccination events, of all doses provided (includes primary care, long-term care, and select partner-led clinics).
12 659	Doses wasted as a result of storage, handling, and supply constraints (for example, due to travel time, expiration dates, and additional shipments beyond orders).

COVID-19 vaccine program (continued)

Data	Indicator
23	**Total adverse events following immunization (using all federally approved vaccines).**
17.3	*Adverse events following immunization per 100 000 doses administered.*

- The majority of clients who reported an adverse event following immunization (n=14), experienced mild reactions such as rashes, enlarged lymph nodes, dizziness, shortness of breath, and chest pain post vaccination.

Health and human resource capacity and financial impact

Data	Indicator
$ 14,369,689	**Projected costs of COVID-19-related expenditures in 2022.**
46.5%	*Of projected COVID-19 costs financed by additional provincial COVID-19 extraordinary funds.*
27.5%	*Of base Public Health cost-shared[4] budget redirected to COVID-19 activities.*
500	**Staff employed by Public Health Sudbury & Districts on December 31, 2022**
255	*Positions in 2022 budget (including full-time, part-time and casual).*
245	*Staff over baseline complement (combination of full-time, part-time, and casual roles).*
39	Students who supported COVID-19 response activities.
33	Volunteers who supported COVID-19 response activities.

[4] Projected COVID-19 program extraordinary funding is the amount of additional expenditures on COVID related activities over and above what is being expensed through the cost-shared budget.

Recovery Planning Progress Report

As a result of Public Health's COVID-19 focused work, there is a growing backlog of unmet community needs tied to non-COVID-19-related public health programs and services. New and intensified public health concerns have also arisen during the pandemic. In response, the agency created a Recovery Plan to guide Public Health's work with area communities to move forward from risk, to recovery, to resilience.

Throughout 2022, Public Health began working toward recovery. As priorities shifted from pandemic response to core programs and services, achievements and outcomes were monitored. The September to December 2022 recovery planning data and narratives featured below are a follow-up to the *Public Health Sudbury & Districts Recovery Plan Progress Report: March – August 2022* published in September 2022. The progress updates highlight the next phase of recovery efforts linked to the four community recovery priorities– getting children back on track, levelling up opportunities for health, fostering mental health gains, and supporting safe spaces. The progress report also includes an update on people and processes as a critical internal recovery priority to support staff.

Getting Children Back on Track

Public Health Sudbury & Districts is helping *Children Get Back on Track*. Recovery initiatives for children and families continue to be a top priority. The response that COVID-19 required resulted in a significant reduction of public health services and programming in communities and in schools. Gaps and growing needs have been identified and are starting to be addressed. Over the past year, Public Health continued to support children, families, and communities in their recovery through strong partnerships and an attention to rebuilding following the disruptions of the pandemic.

Oral health program

Indicator	Updates (from September to December 2022)
Dental screening.	⁍ 8 800 children screened. ⁍ 16 183 dental screenings completed throughout 2022.

Oral health program (continued)

Indicator	Updates (from September to December 2022)
Reassess dental program clients to ensure issues are addressed and cases are closed or referred.	⁍ 172 children previously noted as at risk for higher rates of tooth decay have been reassessed to determine the status of outstanding dental care. ⁍ 280 children reassessed in all of 2022. ⁍ 516 cases management files were addressed and closed. ⁍ 1 035 case management files addressed and closed throughout 2022.
Promote Healthy Smiles Ontario (HSO) and encourage the resumption of dental checkups	⁍ Promoted the availability of the HSO program and encourage dental checkups.

Vaccine preventable diseases program

Indicator	Updates
Address backlogged vaccination records.	⁍ Completed the final data entry of approximately 2 000 backlogged records. ⁍ Continuation of auditing records for quality assurance of data entry.
Vaccinate overdue Grade 7 and 8 students.	⁍ Prioritized in-house clinics and school vaccination clinics to catch students up on their Grade 7 vaccines. ⁍ Resumed school vaccination clinics for current Grade 7 students with 48 school clinics offered, including invitations to Grade 8 students with overdue vaccinations.

Vaccine preventable diseases program (continued)

Indicator	Updates
Vaccinate overdue Grade 7 and 8 students.	⁍ 259 students received a hepatitis B vaccine. ⁍ 275 students received the HPV-9 vaccine ⁍ 139 students received the meningococcal C-ACYW-135 vaccine. ⁍ 5 980 students remain overdue for their Grade 7 vaccinations. Clinics continue to be available to support these individuals.
Vaccinate overdue children under the *Child Care and Early Years Act (CCEYA)* and *the Immunization of School Pupils Act (ISPA)*.	⁍ 111 CCEYA vaccines were provided to children ages 1 to 4 years + 8 months enrolled in licensed child care settings. ⁍ Prioritized in-house clinics for those overdue for ISPA vaccines[5], required for school attendance. ⁍ 166 ISPA vaccines were provided to individuals aged 0 to 17. ⁍ Implemented a phased approach to enforcing the ISPA due to pandemic disruptions in service. ⁍ Continue to provide education on importance of vaccination. ⁍ Continue expanding opportunities for immunization for overdue children (ISPA specific).
Engage with health care providers for vaccination catch-up.	⁍ Issued two Advisory Alerts to support vaccination efforts for the influenza program. ⁍ Provided communication materials and updates on vaccines required for school attendance under the ISPA.

[5] ISPA vaccines required for school attendance include vaccines for these designated diseases: meningococcal disease, pertussis, varicella (for children born in 2010 or later), diphtheria, tetanus, poliomyelitis, measles, mumps, and rubella.

Vaccine preventable diseases program (continued)

Indicator	Updates
Engage with school boards for vaccination catch-up.	⁃ Collaborated with schools to book Fall Grade 7 immunization clinics. Grade 8 students who were missed the year before are also eligible. ⁃ Continue developing communications for directors of education regarding the ISPA program to share in 2023.
Develop and implement a media campaign targeting those overdue for vaccination.	⁃ Created social media posts to increase awareness of routine immunization schedules and ISPA requirements. ⁃ Updated the immunization webpage to promote and share the extended eligibility for Grade 7 vaccines for individuals who may have missed their opportunity under the publicly funded program during the COVID-19 pandemic. ⁃ Continued developing communication materials as needed.

School health

Indicator	Updates
Offer professional development opportunities on the topics of resiliency, mental health promotion, substance use, and sexual health to staff in all local school boards and licensed child care centres.	⁃ Delivered substance use workshops to educators at one local school board's professional development day. ⁃ Delivered naloxone training to principals in one school board and to Laurentian University nursing students. ⁃ Started developing naloxone pilot project targeting educators for 2023. ⁃ Continued offering presentations as needed through the academic school year.

School health (continued)

Indicator	Updates
Offer grade appropriate classroom chats in all school boards on resiliency, mental health promotion, substance use, and sexual health.	⁃ Delivered presentations to secondary school students on risky behaviours and substance use as part of a comprehensive strategy. ⁃ Started developing vaping and substance use toolkits for 2022–2023 school year.
Develop school community approach for *Reaching In Reaching Out (RIRO)* and *Bounce Back & Thrive (BBT).*	⁃ Completed staff training. ⁃ Continued promoting opportunities for RIRO/BBT in collaboration with Family Health programming.
Offer RIRO to all school staff and licensed child care centre staff.	⁃ Offered RIRO training to Early Years staff via meetings with leads from all school boards. ⁃ Delivered RIRO training to French nursing students at Laurentian University in October 2022. ⁃ Continued promotion of the RIRO program to target audiences.
Offer BBT to parents and guardians of children 0–8 years attending schools and early learning agencies.	⁃ Offered BBT training to Early Years staff via meetings with leads from all school boards. ⁃ Ongoing BBT training offered for parents in partnership with community partners as opportunities arise. ⁃ Promoted the BBT program to target audiences.

School health (continued)

Indicator	Updates
Communicate importance of school health promotion to overall community via community campaign.	▸ Prepared a back-to-school package including resources and information for educators on various health topics. ▸ Shared back-to-school social media messages targeting parents and community. ▸ Updated educator resources and curriculum resources on Public Health Sudbury & Districts' website. ▸ Presented Public Health services and opportunities for support to mental health leads, superintendents, directors of student services, and curriculum consultants. ▸ Launched *Caring Adults* campaign to emphasize the importance and role of having strong relationships with adult influencers.

Family health

Indicator	Updates
Address backlog in family health programming.	▸ 271 reminder postcards sent to promote 18-month well-baby visits. ▸ Reviewed monthly waiting list for the Healthy Babies Healthy Children program and identified 7 new families awaiting services. ▸ 483 appointments (virtual and in-person) provided in the breastfeeding clinic. ▸ 199 expectant parents registered for online prenatal program. ▸ Assisted Our Children Our Future with facilitation of the *Creating Healthy Babies Canada Prenatal Nutrition Program* (CPNP). ▸ Developed new web content regarding infant safety and health after having a baby.

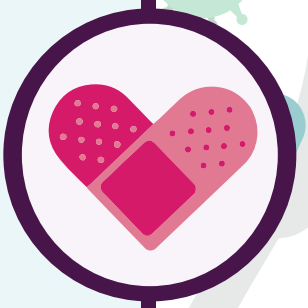
Family health (continued)

Indicator	Updates
Reinstate programming to address intensity of family needs in communities.	⁃ Disseminated social media and print resources on family health topics including the Period of Purple Crying and injury prevention. ⁃ Ran radio ads to promote the Health Information Line services. ⁃ Continued developing the *Preparation for Parenting* program. ⁃ Updated online prenatal programming to include a module on labour and delivery. ⁃ Prepared content for French version of the online prenatal program, set to launch in 2023.
Address increased volume of phone calls from community members.	⁃ 275 calls received to the Health Information Line for public health services or referrals to partnering agencies. ⁃ Promoted phsd.ca and parenting4me.com websites to help families in need.
Engage and consult with all local family health community partners and stakeholders to meet increased intensity of needs in community.	⁃ Delivered presentations to families regarding healthy growth and development and skill building for healthy eating. ⁃ Participated in the Parent Service Advisory Committee (Health Sciences North, Children Aid Society, Compass, Magic Triangle, Better Beginnings Better Futures, Our Children, Our Future, Manitoulin Family Resources, Jubilee Heritage Centre, Wordplay/Jeux de mots, Early ON) to facilitate scheduling and access to programming across the district.

Family health (continued)

Indicator	Updates
Implement programs with all local family health community partners and stakeholders to meet increased intensity of needs in community.	⁕ Promoted Public Health's online prenatal course. ⁕ Began implementing breastfeeding clinics in the Espanola and Manitoulin areas. ⁕ Prepared for the implementation of the *Bounce Back and Thrive*, *Triple P*, and *Preparation for Parenting* programs scheduled for 2023.
Offer the *Triple P Parenting* program to all parents and caregivers and frontline community service providers in local agencies.	⁕ 50 parents registered for in-person *Triple P* services and 12 parents received codes to complete *Triple P* online. ⁕ 10 parents attended *Triple P* primary session in Espanola.

Public Health Sudbury & Districts is making significant progress supporting the recovery of children and families in our communities. With the return of school, in-person learning, and extracurricular activities, additional programs and services for children will resume. New and pre-existing community supports for parents and caregivers continue to be initiated and delivered. Partnerships in all sectors—municipal, education, health, and non-profit—remain critical for building the momentum of this recovery priority.



Levelling Up Opportunities for Health

The COVID-19 pandemic negatively impacted priority populations. *Levelling Up Opportunities for Health* is an important priority for Public Health Sudbury & Districts through regular programming and recovery initiatives. Engaging with those most affected by the pandemic is an important part of recovery. Partners have been meeting, planning, and implementing programs and services to address community needs and provide direct supports exceeding pre-pandemic levels to catch up and recover.

Health and racial equity

Indicator	Updates
Engage with marginalized and other priority populations and partners who serve them across Sudbury and districts. This includes racialized persons, individuals experiencing homelessness, and Indigenous and 2SLGBTQ+ persons.	⁃ Engaged with Black community organizations, associations, informal networks, and groups that support Black peoples, to learn more about their mandates, activities, and gaps or challenges, to identify a potential role for public health support. ⁃ Gathered information to update an engagement plan to better understand experiences and priorities of Black communities. ⁃ Worked with partners to identify and coordinate opportunities for health-related needs of newcomers. Examples include providing support to people displaced by the current war in Ukraine and families in Sudbury, the Sudbury Rural and Northern Immigration Pilot Project, and the Northern Ontario Francophone Immigration Support Network. ⁃ Engagement continues with area First Nations and Urban Indigenous partners to understand experiences and inform agency planning. ⁃ Hosted two meetings with the Public Health Indigenous Engagement Network, and representatives from 11 Ontario public health units. ⁃ Connected with Greater Sudbury's homelessness sector partners to discuss how to better support homeless and precariously housed populations. ⁃ Supported community partners with the creation of a Client Navigator position with the City of Greater Sudbury and the By-Name List initiatives.

Health and racial equity (continued)

Indicator	Updates
Engage with marginalized and other priority populations and partners who serve them across Sudbury and districts. This includes racialized persons, individuals experiencing homelessness, and Indigenous and 2SLGBTQ+ persons.	⁃ Worked with the City of Greater Sudbury to secure temporary shelter for precariously housed individuals who were exposed to monkeypox or COVID-19 to help prevent the spread. ⁃ Hosted a community launch event to showcase 13 digital stories from the 2SLGBTQ+ community health study report in October. ⁃ Hosted a meeting with community partners in December to share results from the *Invisible No More 2SLGBTQ+* community health study and to identify opportunities to collectively support 2SLGBTQ+ community members. ⁃ Developed website content to raise awareness on the experiences of the 2SLGBTQ+ community.
Develop an understanding of the impacts of the pandemic and the needs compounded by the pandemic for First Nation and Indigenous communities, individuals experiencing homelessness, and the 2SLGBTQ+ community.	⁃ Provided tailored cultural competency training to frontline staff who support COVID-19 clinics and recovery programming for Indigenous persons. ⁃ Delivered Land Acknowledgement workshops to agency staff and additional workshops at team levels. ⁃ Supported planning for COVID-19 vaccination clinics to increase uptake of boosters in the fall among individuals experiencing homelessness. ⁃ Hosted vaccination clinics tailored to the needs of individuals experiencing homelessness and completed mobile clinics at residences with individuals who are homeless or at risk of homelessness. ⁃ Engaged regularly with the Local Immigration Partnership to provide updates about agency services and vaccination opportunities.

Health and racial equity (continued)

Indicator	Updates
Develop an understanding of the impacts of the pandemic and the needs compounded by the pandemic for First Nation and Indigenous communities, individuals experiencing homelessness, and the 2SLGBTQ+ community.	⁃ Held a community and provider consultation session to discuss local stories of trauma, resilience, and hope for safe spaces and programs and services that are inclusive and accepting of the Queer population.
Develop and disseminate media campaigns amplifying the voices of those with lived and living experiences of discrimination and racism and marginalized groups disproportionately affected by the pandemic. This includes the 2SLGBTQ+ community as well as newcomer and racialized populations.	⁃ Updated website content to include the 2SLGBTQ+ community health study report, titled, *Invisible No More: Voices of the Queer Community*, and corresponding digital stories. ⁃ Organized a mandatory staff development initiative to increase capacity among all staff about 2SLGBTQ+ inclusion in equitable health services. ⁃ Continued planning for a more applied interactive training initiative provided by Rainbow Health Ontario for select staff to be available in early 2023. ⁃ Created internal knowledge translation materials and community social media content in honour of the National Day of Truth and Reconciliation and Treaties Recognition week. ⁃ Coordinated a keynote address about Truth and Reconciliation in Public Health with Dr. Marcia Anderson. ⁃ Participated in the City of Greater Sudbury's *Greater Together Forum: Building a More Welcoming Community* that sought to built collaborative work with community institutions and organizations on the needs of newcomers and immigrants in the city.

Health and racial equity (continued)

Indicator	Updates
Implement allyship training for Public Health staff.	⁕ Reviewed and analysed agency-wide survey results to determine baseline knowledge, comfort, experiences, and perceptions related to racial equity. ⁕ Utilized results to inform next steps and recommendations for staff development opportunities beyond allyship training.
Implement food literacy initiatives targeting priority groups and informed by local partners and community members.	⁕ Continued to engage with community partners for planning and implementing food literacy initiatives. ⁕ Reunite food literacy and food affordability work into the resumption of regular programming.

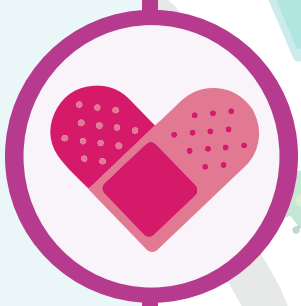
Municipal and Indigenous leadership engagement

Indicator	Updates
Increase collaboration and engagement with municipal partners and contribute to Community Safety and Well-being plans (Population Health and Well-being) and associated recovery plans in all communities in Sudbury and districts (includes First Nation partner participation).	⁕ Monitored local developments following municipal elections to inform collaborations and planning with municipal partners. ⁕ Produced District Office Snapshot reports which include demographic data and details of local public health efforts for launch in 2023. ⁕ Continued developing a public health orientation for municipal partners.
Increase understanding of unmet community needs resulting from the pandemic and develop plans and implement actions to address these needs.	⁕ Gathered input from community and Indigenous agency leadership to support community voices. ⁕ Continued to plan engagement approaches with health directors and host monthly meetings with municipal partners, N'Swakamok Native Friendship Centre (NNFC), and BBBF.

Municipal and Indigenous leadership engagement (continued)

Indicator	Updates
Increase understanding of unmet community needs resulting from the pandemic and develop plans and implement actions to address these needs.	⁃ Collaborated with the City of Greater Sudbury and staff from N'Swakamok and BBBF to host a public virtual keynote speaker event in honour of the National Day for Truth and Reconciliation. ⁃ Supported Indigenous communities with COVID-19 vaccination clinics upon community request.
Improve population health initiatives overall to address health of community members.	⁃ Participated in project meetings to support the NOSM University-led Indigenous youth vaccine hesitancy study. ⁃ Collaborated with Indigenous Communities to host COVID-19 clinics as needed. ⁃ Participated in working groups to support applications for Ontario Health Teams in Sudbury, Espanola, Manitoulin, and Elliot Lake. ⁃ Developed and distributed a municipal election primer to election candidates and members of the general public via social media platforms and website.

Issues leading to inequitable opportunities for health are firmly rooted in our social and structural systems, and there are no easy or quick solutions for recovery, especially as longstanding issues continue to be exacerbated by the pandemic. However, the work to *Level Up Opportunities for Health* is ongoing. Significant work on this priority has been completed. Engagement at all levels and with multiple sectors will continue to be critical as planning evolves and new initiatives get underway. Persons with lived experience will continue to be important partners to ensure programs and services are reaching and supporting those most impacted.



Fostering Mental Health Gains

Public Health Sudbury & Districts recognizes the impacts of the COVID-19 pandemic on mental health. Everyone has been affected either directly or indirectly. Through planning and engagement with community partners and persons with lived experience, strides are being made toward recovery with continued efforts underway.

Community engagement

Indicator	Updates
Re-engage local partners and local planning tables and committees to determine priority mental health needs in Sudbury and districts and to develop action plans to address increasing needs due to the pandemic.	⁃ Participated in internal and external committees and planning tables, such as the System Priority Table and Public Mental Health Steering Committee.
Amplify the voices of people with lived and living experience with mental health and use to understand community needs resulting from the pandemic and empower them to share pandemic impacts with other service providers in the community.	⁃ Supported the *Honouring Voices Initiative* (previously known as the *Empowerment Council*), in collaboration with *Northern Initiative for Social Action (NISA)*, to facilitate contributions from people with lived and living experience. ⁃ Drafted applications for peer recruitment.
Strengthen community actions to create equitable access to spaces that are safe and inclusive for all residents including Indigenous and racialized individuals living with mental illness.	⁃ Continued to support the work of the Youth Hub, Suicide Safer Network (SSN), Honouring Voices Initiative, and Indigenous engagement.

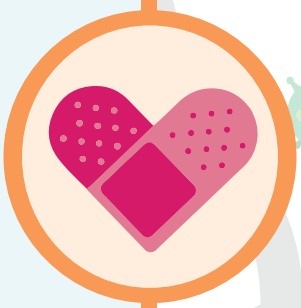
Community engagement (continued)

Indicator	Updates
Create meaningful relationships with Indigenous communities to assist with implementing recovery-related interventions and strategies for mental health and substance use.	⁃ Allocated needle kiosk bins and harm reduction supplied to Indigenous communities. ⁃ Engaged with Indigenous partners across the districts to determine their interest in partnering in harm reduction expansion. Two agreements have been signed, and three others are pending. ⁃ Continued to engage with Indigenous communities in Chapleau regarding the development of the Chapleau Community Substance Use Survey and community research protocols.
Use population health data to fully understand the scope of local needs related to mental health and substance use.	⁃ Determined best practice interventions and emerging needs using The Centre for Addiction and Mental Health's (CAMH) Evidence Exchange Network (EENet). ⁃ Continued with regular reviews of reports from the National Ambulatory Care Reporting System (NACRS), Canadian Institute for Health (CIHI), and the Office of the Chief Coroner for Ontario. ⁃ Reviewed monthly reports from the Sudbury Supervised Consumption Site (SCS) following its opening in September 2022.
Offer anti-stigma training related to mental health to staff and community partners.	⁃ Drafted internal mental health literacy and stigma and harm reduction principles training plans.

Partner engagement

Indicator	Updates
Establish an external community of practice to support the development of strategies to address the impact of the pandemic on mental health and substance use amongst youth and young adults.	⁃ Co-chaired the Mental Health Promotion in Public Health Community of Practice (through CAMH). ⁃ Engaged with partners through the use of CAMH's Evidence Exchange Network (EENet) to share resources and information.
Increase understanding of best practice to prevent and address children's mental health and substance use issues as a result of the pandemic.	⁃ Conducted presentations for school staff on character strengths, brain architecture, and mental health resources. ⁃ Led a presentation to the School of Education (Laurentian University) regarding mental health resources. ⁃ Provided ongoing support to school boards for substance use including naloxone training. ⁃ Began the development of toolkits to support schools in addressing vaping and substance use.
Provide support for the initiation of a local children's mental health youth hub.	⁃ Continued co-leading the development of a Youth Wellness Hub for Greater Sudbury youth aged 12 to 25 in collaboration with Compass. ⁃ Secured temporary site location, hired youth ambassadors, and began recruiting for a program coordinator.

Fostering mental health gains will take time. Progress is underway and next steps will require further action and implementation. Mental health is an identified priority for many sectors and agencies in Ontario including Ontario Health, social services, education, local municipal governments. Collective action is critical as recovery in this priority area cannot be achieved in silos. Partners and stakeholders throughout Sudbury and districts are collectively working to support and enhance community mental health in the wake of the pandemic and Public Health is ready to continue supporting where we can.



Supporting Safe Spaces

The pandemic hindered access to public and communal spaces enjoyed for leisure and used for programs and services. Public Health Sudbury & Districts has an important role to *Support Safe Spaces* throughout its service area. Much of this work is guided by public health legislation; however, locally, work involves identifying community needs and working with partners to find local solutions. The pandemic exacerbated existing issues resulting in the need for creative recovery planning.

Fixed premises inspections

Indicator	Updates
Resume inspection of food premise facilities in accordance with Ontario Public Health Standards (OPHS) frequency and timelines.	⁍ 1589 active food premises in the service area in December 2022 compared to 1422 at the end of August. ⁍ 77% (1225 premises) were inspected at least once with the remaining premises primarily categorized as low-risk. ⁍ 92% of high-risk food premises (130 premises) were inspected twice, 5% (7 premises) were inspected once, as they were not active for the whole year, and 3.5% (5 premises) were inspected only once. ⁍ 92% of year-round medium-risk facilities (541 total) were inspected twice; 3.2% (19 premises) were inspected once as they were not active for the whole year; and, 5% (29 premises) were inspected only once. ⁍ 51.1% of low-risk food premise (309 premises) inspections were completed. ⁍ Paused low-risk food premise inspections in June 2022 to respond to public health inspector vacancies and limitations.

Fixed premises inspections (continued)

Indicator	Updates
Resume inspection of personal service settings in accordance with OPHS frequency and timelines.	⁍ 94.5% of personal service settings (294 settings) were inspected. Remaining settings were temporarily closed for parts of 2022 and not available for inspection.
Resume inspection of recreational water facilities in accordance with OPHS frequency and timelines.	⁍ 93% of the year-round public pools and spas (22 facilities) had 1 routine compliance inspection every 3 months during operation. The remaining 3 were inactive for parts of 2022, but inspected at least once. ⁍ 100% of Class C recreational water facilities (that is, 19 low-risk splash pads) active during the bathing season were inspected once.
Resume inspection of licensed child care settings as outlined in the OPHS (excluding food premises located within the facility).	⁍ 98% of all licensed child care settings (86 settings) were inspected. Remaining 2 settings were inactive for parts of 2022 and closed when attempts were made.
Routine inspections of facilities for health hazards including but not limited to arenas, work camps in unorganized territories, migrant farm worker housing, recreational camps, funeral homes, and residential facilities.	⁍ 25% of arenas were inspected for health hazards and air quality. ⁍ Released a report on *Climate Change in Sudbury and Districts: Assessing Health Risks and Planning Adaptations Together* and shared with municipalities, First Nations Communities, and the public.

Harm reduction

Indicator	Updates
Engage community partners in Sudbury and districts, including the Community Drug Strategy partners (harm reduction, prevention, and treatment pillars), to address the increase in opioid overdoses and deaths in the service area during the pandemic; this includes collaboration on the establishment of a supervised consumption and treatment service in Greater Sudbury and mobilization of a partnership to explore service needs in the districts.	⁃ Co-led the City of Greater Sudbury Community Drug Strategy and Supervised Consumption Site Steering Committees. The current focus is on to addressing the status of opioid overdoses and deaths in Greater Sudbury. ⁃ Continued supporting the Supervised Consumption Site Stakeholder Committee, which provides regular progress updates to stakeholders in the community. ⁃ Continued the development of a *Sudbury and Districts Opioid Poisoning Response Plan* with partners. ⁃ Participated in regular meetings for the Northern Opioid Community of Practice. ⁃ Supported training and onboarding of organizations for the use of naloxone kits.
Onboard additional partners for needle distribution to address increased intensity of need.	⁃ Engaged with community partners to address the intensity of need for harm reduction supplies and expansion of the needle exchange program. ⁃ Supported one new agreement for needle disposal kiosks (Township of Sables-Spanish Rivers) and two new agreements for harm reduction supplies (Supervised Consumption Site and the pharmacy in Chapleau).
Complete an assessment and evaluation of best practices for public health prevention interventions to address the opioid crisis.	⁃ Drafted an initial version of the Chapleau Community Substance Use Survey and submitted a Research Ethics Review Application. ⁃ Engaged with the Canadian Research Initiative in Substance Misuse (CRISM) Ontario Node who visited the Supervised Consumption Site in Sudbury to administer a survey which will inform future direction.

Harm reduction (continued)

Indicator	Updates
Develop and implement a media campaign to address opioid use, stigma, and services offered.	⁍ Issued a "Plan Ahead—Safe Ride Home" radio campaign to remind community members to plan ahead and avoid driving while impaired by drugs or alcohol. ⁍ Shared monthly overdose prevention messages via social media platforms. ⁍ Supported ongoing development of media campaigns focusing on stigma and harm reduction.

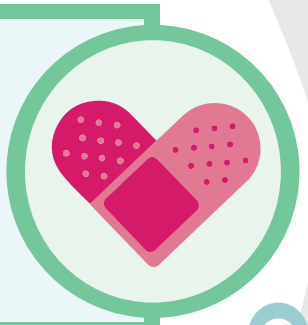
Sexual health

Indicator	Updates
Address needs of priority populations seeking sexual health services, including addressing the backlog of needs resulting from a reduction in services during the pandemic.	⁍ Resumed physician-led clinics and drop-in visits for urgent matters effective September 6, 2022, at our Elm Place location. ⁍ Resumed all district office sexual health services in addition to on-site COVID-19 clinics. ⁍ 134 drop-in clients received services for urgent matters such as the emergency contraception pill (ECP), Herpes simplex virus (HSV) testing, and treatment at our Elm Place location. ⁍ Began planning for sexually transmitted and blood-borne infections (STBBI) testing at the Sudbury East location for 2023. ⁍ Updated presentation and workshop materials for partner and community outreach. ⁍ Shared a series of campaigns through social media on topics such as syphilis awareness, physician clinic advertisement, abortion, and World AIDS Day. ⁍ Continued developing the Syphilis Prevention Initiative in response to local needs.

Sexual health (continued)

Indicator	Updates
Address backlog of sexually transmitted infection (STI) follow-ups.	⁕ Addressed all backlogged follow-ups. Up to date with current client load.
Ensure resources are in place to address increasing intensity of support needs of individuals experiencing blood-borne infections.	⁕ Supported continuing education and professional development for health care providers and other relevant partners. ⁕ Provided telephone consults to health care providers. ⁕ Distributed free condoms to locations servicing high-risk populations.

Recovery to *Support Safe Spaces* continues to make significant strides forward and the majority of sexual health services have fully resumed. Public Health Sudbury & Districts will continue to meet with partners to implement new and creative delivery models that support service options for clients. Ongoing work will be underway for the resumption of all regular programming to *Support Safe Spaces*.



People and Processes

Operational responsibilities, including roles performed to support the operation of the agency and staff, were not immune to the effects of the pandemic. Backlog accumulated as public health resources were diverted to pandemic response efforts. The *People and Processes* recovery priority reflects the efforts necessary to ensure the organization has the required human resources that can optimally perform their roles safely and in accordance with organizational and legislative expectation. It includes functions related to policies, procedures, human resources, staff development, and staff recovery within Public Health. Work continues to move this priority further toward recovery.

Indicator	Updates
Address staff recovery, including staff mental health, corporate culture, and change management.	⁃ Delivered two key programs (*Mindfulness on the Rocks: Fearless at Work* and *Solution-Focused Approach to Mental Health and Well-being* workshops) in collaboration with the Psychological Health and Wellness Committee. ⁃ Offered six workshops and six reflective circles to management and staff between October and December. Workshops and reflective circles focused on self-care and building resilience during difficult and unpredictable times. ⁃ Collaborated with United Way to host internal wellness activities that supported the United Way and promoted well-being. ⁃ Invested additional resources to support overall psychological health and well-being.
Address the backlog of human resource legislative and policy requirements.	⁃ Allocated additional staffing resources to complete Ministry of Labour requirements. ⁃ Hosted staff training outlining responsibilities as per the *Occupational Health and Safety Act*. ⁃ Reviewed and updated fire safety plans and Workplace Hazardous Materials Information System. ⁃ Provided management training on *Human Rights at Work* and *Managing in a Unionized Environment*.
Address backlog with agency policies and procedures.	⁃ Developed and updated workplace policies, including the Workplace Violence Harassment and Discrimination Prevention policy, Health and Safety policy, and the new policy related to Bill 88 Electronic Monitoring, and Disconnect from Work policy. ⁃ Reviewed, updated, and distributed staff and division orientation modules.

Indicator	Updates
Address backlog with agency policies and procedures.	⁍ Provided annual training refreshers for health and safety, violence harassment and discrimination prevention, privacy, and emergency preparedness. ⁍ Completed compliance checks for annual training, re-certifications for CPR and first aid, and police record checks or declarations. ⁍ Reviewed and updated General Administrative Policies including staff immunizations and new hybrid work policy.
Address the backlog with asset management system, software upgrades, security training and compliance, and records management.	⁍ Returned to work at the Paris Street location in September 2022. ⁍ Launched a SharePoint Online pilot program in November. ⁍ Upgraded or purchased software, such as Microsoft 365 and Collab Space, to support staff.

As we continue to move from recovery to resilience, Public Health will continue to invest in the mental health and resiliency of its employees. We will also continue to update processes and structures to ensure we are ready for future public health emergencies.

Next steps and future reporting

While the COVID-19 response continues, Public Health is making substantial strides regarding recovery, with the resumption of core Public Health business having started in the latter half of 2022. Recovery initiatives focused on actions that had an impact for individuals and groups facing the highest disadvantage as well as the reintroduction of core public health programs and services. Our recovery efforts and resumption of services put us back on track to optimally support communities through the full scope of public health practice. Over the course of the coming months, local communities will continue to benefit as we move toward the normalization of COVID-19 programming and the evolution of regular programs and services. As part of ongoing recovery efforts, routine monitoring and reporting will also be re-established through customary channels, including up-to-date reports on Public Health's website at phsd.ca. Our resiliency and renewed focus will allow us to take on new challenges alongside our community partners in an effort to prevent illness and promote and protect the health of the communities we serve.

Public Health
Santé publique
SUDBURY & DISTRICTS

February 24, 2023

VIA ELECTRONIC MAIL

The Honourable Doug Ford
Premier of Ontario
Legislative Building
Queen's Park
Toronto ON M7A 1A1

Dear Premier Ford:

Re: Community Engagement to Address Food Insecurity

At is meeting on February 16, 2023, the Board of Health carried the following resolution #08-23:

> *BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts, in recognition of the root causes of food insecurity, call on the provincial government to incorporate local food affordability findings in determining adequacy of social assistance levels; and*
>
> *THAT the Board of Health reaffirm its support for the Association of Local Public Health Agencies (alPHa) resolutions A18-02 (Minimum Wage that is a Living Wage) and A15-04 (Basic Income Guarantee); and*
>
> *THAT the Board of Health intensify its work with relevant area agencies and community groups, and municipalities to shift the focus of food insecurity initiatives from food charity to income-based solutions, including but not limited to the sharing of data and evidence-based income solutions; and*
>
> *FURTHER THAT the Board of Health for Public Health Sudbury & Districts Board share this motion with area partners, Ontario boards of health, alPHa, and the relevant provincial government ministers.*

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phsd.ca

The health consequences of food insecurity have serious adverse effects on people's physical and mental health and the ability to lead productive lives. Ontarians living with food insecurity are at greater risk for numerous chronic conditions including mental health disorders, non-communicable diseases (e.g., diabetes, hypertension and cardiovascular disease), and infections.[1] People who have chronic conditions and are food insecure are more likely to have negative disease outcomes, be hospitalized, or die prematurely.[2]

The health consequences of food insecurity are a significant burden on our province's healthcare and social service system. Adults in food insecure households are more likely to be admitted to acute care; they also may stay in hospital for a longer period and are more likely to be readmitted.[3] Income-based policies that effectively reduce food insecurity offset considerable public expenditures on healthcare and social services in Ontario by reducing demands on these services and reducing costs.

Thank you for your attention to this important issue – the solutions for which will not only help many Ontarians in need but also protect the sustainability of our critical health and social services resources.

Sincerely,

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

cc: Dr. Kieran Moore, Chief Medical Officer of Health
Honourable Sylvia Jones, Deputy Premier and Minister of Health
Honourable Merrilee Fullerton, Minister of Children, Community and Social Services
Honourable Steve Clark, Minister of Municipal Affairs and Housing
France Gélinas, Member of Provincial Parliament, Nickel Belt
Jamie West, Member of Provincial Parliament, Sudbury
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin
All Ontario Boards of Health
Constituent Municipalities

[1] Tarasuk V, Li T, Fafard St-Germain AA. (2022). Household food insecurity in Canada, 2021. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved 15 February 2023 from https://proof.utoronto.ca/.
[2] Tarasuk V, Li T, Fafard St-Germain AA. (2022). Household food insecurity in Canada, 2021. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved 16 February 2023 from https://proof.utoronto.ca/.
[3] Tarasuk V. Implications of a basic income guarantee for household food insecurity. Northern Policy Institute – Research Paper No. 24. Retrieved 16 February 2023 from: https://proof.utoronto.ca/wp-content/uploads/2017/06/Paper-Tarasuk-BIG-EN-17.06.13-1712.pdf

Health Canada Santé Canada

February 27, 2022

Middlesex-London Board of Health
Citi Plaza 110-355 Wellington Street
London, ON N6A 3N7

Dear Matt Reid and Dr. Alexander Summers,

Thank you for the letter from the Middlesex-London Board of Health of August 2, 2022, addressed to the Honourable Carolyn Bennett, Minister of Mental Health and Addictions, concerning youth vaping. I have been asked to respond on the Minister's behalf, and I apologize for the delay in responding.

Through Canada's Tobacco Strategy, the Government of Canada is taking focussed action to help Canadians quit smoking, including groups with the highest rates of tobacco use. It is also continuing to focus on protecting young people and non-tobacco users from the negative consequences of nicotine addiction. While vaping has risks, for people who are unable to quit smoking using approved quit aids like nicotine patches or nicotine gum, switching completely to vaping is a less harmful option than continuing to smoke. There are short-term general health improvements if one completely switches from smoking cigarettes to vaping products, as it reduces their exposure to harmful chemicals. Non-smokers and young people should not vape.

Vaping rates among Canadian youth have stabilized, according to a recent survey, yet remain relatively high Health Canada has made extensive investments in public education, increased compliance and enforcement of existing rules and advanced regulations to put in place more regulatory controls that aim to reduce youth access and the appeal of vaping products to youth.

As you may be aware, regulations now prohibit the promotion and advertising of vaping products anywhere they can be seen or heard by youth. Regulations are also now in force setting a maximum nicotine concentration for all vaping products.

On December 9, 2022, the final report of the first *Tobacco and Vaping Products Act* (TVPA) legislative review was tabled in Parliament. The review identifies areas for potential action including: examining access to vaping products by youth; communicating the potential benefits of vaping as a less harmful source of nicotine for people who smoke as well as health hazards; strengthening compliance and enforcement; and addressing scientific and product uncertainty to better understand the vaping product market and health impacts of vaping. The report is available on Canada.ca.

Health Canada Santé Canada

We recognize and appreciate the important work of the Middlesex-London Board of Health and your contribution to our collective efforts. Please be assured that your recommendations about further restricting vaping products will be taken into consideration as we continue to take action to protect the health of Canadians. For more information on our approach to regulating vaping products, their risks and potential benefits, please visit Canada.ca/vaping.

Again, thank you for taking the time to write about this important issue.

Yours sincerely,

Sonia Johnson, Director General
Tobacco Control Directorate
Controlled Substances and Cannabis Branch
Health Canada

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Middlesex-London Board of Health
External Landscape Review – March 2023

The purpose of this briefing note is to inform the MLHU Board of Health members about what is happening in the world of public health and impacts to the work of the MLHU and Board. This includes governance and legislative changes, news from other local public units, external reports on important public health matters, learning opportunities and MLHU events. **Please note that items listed on this correspondence are to inform Board members and are not necessarily an endorsement.**

National, Provincial and Local Public Health Advocacy

Official opening of Carepoint Consumption and Treatment Centre in London

On February 28, 2023, Regional HIV/AIDS Connection (RHAC), along with partners London Intercommunity Health Centre (LIHC) and the Middlesex-London Health Unit (MLHU) were pleased to share the opening of the Carepoint Consumption and Treatment Centre at 446 York Street in London.

Photos taken by Middlesex-London Health Unit's Communications Team

Carepoint has been operating out of a temporary trailer on the property front at 446 York since end of June 2022. This transition has helped to orient service users to the intended long-term location of the program which has continued to run from 9:00 a.m. to 9:00 p.m., seven days a week, including statutory holidays. The Carepoint program has seen the demand for its services continue throughout the pandemic. The program is a vital lifesaving service and wraparound support for many of London's most marginalized citizens and remains a critical part of the care continuum in our community.

To learn more about Carepoint, visit both RHAC's website and MLHU's website.

Impact to MLHU Board of Health
The Board first supported the Temporary Overdose Prevention site in 2018, and with the support of community partners, there is now a permanent site. This site provides an essential service to reduce harms associated with drug use, including opioid-related overdoses. The Board has continued to support MLHU and its partners in creating safe spaces and education for people who use drugs.

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

COMMUNITY SUMMIT:

HEALTH AND HOMELESSNESS

Health and Homelessness Summits

MLHU along with over 200 community partners have been participating in Health and Homelessness Summits, which are working to support a new model of integrated hubs around London and Middlesex County. These hubs are being designed across multiple sectors to support those seeking a healthy lifestyle who are also experiencing homelessness. There will be 12-15 hubs, with 600 housing support opportunities being created over a 3-year period.

City of London staff brought a recommendation for implementation for these integrated hubs to the Strategic Priorities and Policy Committee in this report on **February 28, 2023** and will be further discussed at City of London's council meeting on **March 7, 2023**.

Impact to MLHU Board of Health
Homelessness is a crisis that is being faced in Middlesex-London with significant impact on the health of the community. The Health Unit continues to support community-driven collaborative solutions to address the immediate crisis and underlying causes.

City of London Strategic Plan

Every four years, the City of London prepares a Strategic Plan that identifies the shared vision, mission and priorities that will guide the City's next four years. The Strategic Plan reflects the needs and expectations of the community and drives decision-making through the Multi-Year Budget and the City's Technology Investment Strategy.

Council will be reviewing the draft Strategic Plan at the March 28, 2023 Council meeting.

For more information, visit the Strategic Plan website and take the Strategic Plan survey to share your thoughts.

Impact to MLHU Board of Health
The MLHU has been actively engaged by the City of London to review areas of focus, expected results, strategies, draft metrics and order of magnitude costing for the City of London 2023-2027 Strategic Plan. This is an opportunity for public health to support future activities within the City's Strategic Plan to promote health, wellness and plan for services within the community.

Local Public Health Unit News

Renfrew County and District Health Unit
"Optimal Health for All in Renfrew County and District"

New Medical Officer of Health in Renfrew County and District

The Board of Health for Renfrew County and District Health Unit (RCDHU) has announced that **Dr. Jason Morgenstern, MD MPH FRCPC**, has been appointed as permanent, full-time Medical Officer of Health for Renfrew County and District Health Unit, effective April 3, 2023.

To read the media release from February 28, 2023, please visit Renfrew County and District Health Unit's website.

Impact to MLHU Board of Health
The Board supports collaboration and connection with other public health units in the province, and encourages the MLHU's Medical Officer of Health to work with other Medical Officers of Health as necessary for advocacy and idea sharing.

WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | wechu.org |

1005 Ouellette Avenue, Windsor, ON N9A 4J8 | 33 Princess Street, Leamington, ON N8H 5C5

February 28, 2023

sylvia.jones@ontario.ca

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

Dear Minister Jones:

Letter of Support – Physical Literacy for Healthy Active Children

On February 16, 2023 at a regular meeting of the Windsor-Essex County Board of Health, the Board considered a letter from Sudbury & Districts Public Health to Directors of Education, Local School Boards, Sports and Recreation Organizations and Early Learning Centres, encouraging them to work to improve physical activity levels among children and youth, including agencies that provide comprehensive physical literacy training to teachers, coaches, recreation providers and early childhood educators.

The following motion was passed:

Motion: **That the WECHU Board of Health support the letter from Sudbury & Districts Public Health to Directors of Education, Local School Boards, Sports and Recreation Organizations and Early Learning Centres, encouraging them to work to improve physical activity levels among children and youth.**

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

Sincerely,

F. Costante

Fabio Costante, Chair
Windsor-Essex County Board of Health

c: Kenneth Blanchette, CEO, WECHU
Windsor-Essex County Directors of Education
Loretta Ryan, Executive Director, alPHa
Ontario Boards of Health
Lisa Gretzky, MPP Windsor-West
Andrew Dowie, MPP Windsor-Tecumseh
Anthony Leardi, MPP Essex
Trevor Jones, MPP Chatham-Kent

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound

March 3, 2023

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Room 281
Queens Park
Toronto, ON M7A 1A1

The Honourable Sylvia Jones
Minister of Health / Deputy Premier
777 Bay Street, College Park, 5th Floor
Toronto, ON M7A 2J3

The Honourable Merrilee Fullerton
438 University Avenue, 7th Floor
Toronto, ON M5G 2K8

Dear Premier Ford, Minister Jones, and Minister Fullerton:

RE: Food Insecurity in Ontario

On behalf of the Board of Health (Board) and staff of the North Bay Parry Sound District Health Unit (Health Unit), we are expressing our concerns about the high rates of food insecurity in Ontario. Most recent estimates show that one in six households experience food insecurity, and one in five children live in a food insecure household. This is not acceptable. The magnitude of the problem, paired with the severe health consequences associated with experiencing food insecurity, make this an important and pressing public health issue that requires attention from all levels of government.

Food insecurity means a household has inadequate or insecure access to food due to financial constraints. Not being able to afford food has profound adverse effects on people's physical and mental health, and their ability to lead productive lives. The health consequences of food insecurity are also a large burden on our healthcare system.

As per the Ontario Public Health Standards, health units are required to monitor food affordability. We recently released our local 2022 Cost of Eating Well report, which draws attention to the inadequacy of current social assistance rates. It highlights that households with social assistance as their main income do not have enough money for the costs of living, including food. An excerpt from the report is included as **Appendix A.** It is important to note the scenarios presented include very modest estimates of both food costs and rent. Local data from the Canadian Mortgage and Housing Corporation is used for rent estimates which may or may not include utilities. Food costs are based on the Nutritious Food Basket (NFB). Grocery stores are surveyed locally to determine the cost of the NFB, which provides an estimate of the cost of following Canada's Food Guide. Examining food costs and rent rates alongside household income scenarios determines if food is affordable. For those receiving social assistance, it is clear they do not have enough money for the costs of living.

.../2

As record high food inflation rates persist, there is no doubt the financial situation is increasingly dire for these households. While the Ontario Disability Support Program (ODSP) was increased by 5% in 2022 and will be indexed to inflation going forward, the current rates are not based on the costs of living. Further, Ontario Works (OW) has not been increased since 2018 and is not indexed to inflation.
Last week, our Board passed a series of motions demonstrating collective support from Health Unit staff, leadership, and Board members, to call on the province for income-based policy action to reduce food insecurity. The complete list of resolutions and motions are attached as **Appendix B**. To summarize, our Board is urging the Province of Ontario to:

- Legislate targets for the reduction of food insecurity as part of the Ontario Poverty Reduction Strategy.
- Increase social assistance rates to reflect the costs of living, and to index Ontario Works rates to inflation going forward.
- Resume investigating the feasibility of creating a guaranteed living wage (basic income) in the Province of Ontario.

Income is an important social determinant of health (SDOH) that greatly impacts other SDOHs, including food security. Income support programs are recognized globally as important and effective population health interventions, meaning they can impact the health of the whole population. Ensuring low-income households have enough money to meet their basic needs is essential for health.

Food insecurity in Canada is a persistent and highly prevalent problem that has not improved since systematic monitoring began in 2005. Our Health Unit has been vocal in the past about the importance of adequate income to reduce food insecurity. Most recently, we called on the federal government to consider the importance of a basic income program for all in light of COVID-19 pandemic response benefits, and we called on the province to establish a Social Assistance Research Commission to advise on strengthening social assistance in Ontario. We will continue to monitor food affordability and follow the evidence on this issue, as health units are required to 'assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective strategies that decrease health inequities.'

The Province of Ontario holds the power to reduce food insecurity and extreme poverty among households receiving social assistance. From a public health perspective, our Board urges you to take action. Please consider the motions our Board passed on this important issue and thank you for reviewing this information.

Sincerely yours,

Rick Champagne
Chairperson, Board of Health

James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

Carol Zimbalatti, M.D., CCFP, MPH
Associate Medical Officer of Health

/sb

Enclosures (2) – Appendix A and B

Copy to:
Vic Fedeli, MPP, Nipissing
Graydon Smith, MPP, Parry Sound-Muskoka
John Vanthof, MPP, Timiskaming-Cochrane
Hon. Anthony Rota, MP, Nipissing-Timiskaming
Hon. Scott Aitchison, MP, Parry Sound-Muskoka
Hon. Marc Serre, MP, Nickel Belt
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)
Association of Municipalities of Ontario (AMO)
Federation of Canadian Municipalities (FCM)
Health Unit Member Municipalities

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Appendix A

Single man receiving Ontario Works

This person does not have enough money to cover rent and food in a month, or their other costs of living. Current social assistance rates in Ontario are not based on the real costs of living. There are few income supports in place for working aged adults without children, leaving them in extreme poverty should they be unemployed.

**Income is based on OW basic allowance and maximum shelter allowance, GST/HST credit, Ontario Trillium Benefit, and the Ontario Climate Action Incentive Payment.*

Monthly income:*	$876
Rent (bachelor apartment):	$650
Food:	$404
	-$178

Single woman with 2 kids receiving Ontario Works

It is highly unlikely that the $688 remaining after paying for rent and food will be enough to cover this family's monthly expenses. Parents in Canada are eligible for the Canada/Ontario Child Benefit (CCB), which provides a seemingly significant amount of money monthly for low-income households. Yet, 1 in 5 children in Ontario live in a food insecure household, suggesting the CCB does not provide enough money to protect against food insecurity.

**Income is based on Ontario Works basic allowance for one recipient and two dependents and maximum shelter allowance for a family size of three, Canada and Ontario Child Benefit, GST/HST credit, Ontario Trillium Benefit, and the Climate Action Incentive Payment.*

Monthly income:*	$2548
Rent (2 bedroom apartment):	$1032
Food:	$828
	$688

Appendix B

Board of Health Motion: #BOH/2023/02/04 – February 22, 2023
Moved by: Marianne Stickland **Seconded by: Jamie McGarvey**

***Whereas,** the Ontario Public Health Standards require public health units 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 a detrimental impact on physical and mental health;*

***Whereas,** adequate income is an important social determinant of health that greatly impacts food security;*

***Whereas,** 67% of households in Ontario with social assistance as their main source of income experience food insecurity;*

***Whereas,** the 2022 Nutritious Food Basket Survey results show that households reliant on social assistance do not have enough money for the costs of living, including food;*

***Therefore Be It Resolved,** That the Board of Health for the North Bay Parry Sound District Health Unit continue to support the efforts of staff and community stakeholders to raise awareness about, and work to reduce, health inequities, including food insecurity; and*

***Furthermore Be It Resolved,** That the Board of Health call on the Province of Ontario to legislate targets for the reduction of food insecurity as part of the Ontario Poverty Reduction Strategy; and*

***Furthermore Be It Resolved,** That the Board of Health call on the Province of Ontario to increase social assistance rates to reflect the costs of living, and to index Ontario Works rates to inflation going forward; and*

***Furthermore Be It Resolved,** That the Board of Health urge the province to resume investigating the feasibility of creating a guaranteed living wage (basic income) in the Province of Ontario; and*

***Furthermore Be It Resolved,** That the Board of Health provide correspondence of these resolutions to district municipalities, Ontario Boards of Health, Victor Fedeli, MPP (Nipissing), Graydon Smith, MPP (Parry Sound-Muskoka), John Vanthof, MPP (Timiskaming-Cochrane), the Honourable Doug Ford (Premier), the Honourable Merrilee Fullerton (Minister of Children, Community and Social Services), the Honourable Sylvia Jones (Minister of Health) and the Association of Local Public Health Agencies (alPHa), MP Anthony Rota, MP Scott Aitchison, MP Marc Serre, the Association of Municipalities of Ontario (AMO), and the Federation of Canadian Municipalities (FCM).*

BEING READY

Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics

Ontario

2022 ANNUAL REPORT

Of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario

Land Acknowledgement

We wish to acknowledge the land on which we are working. For thousands of years it has been the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today this place is still home to many Indigenous people from across Turtle Island, and we are grateful to have the opportunity to work on this land.

Dear Speaker,

I am pleased to provide you with my 2022 Annual Report, *Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics,* in accordance with the provision of section 81.(4) of the *Health Protection and Promotion Act*.

Three years of COVID-19 have reinforced the devastating impact of pandemics on individuals, communities, and societies. We have lost too many loved ones. Ontarians are still experiencing the acute and ongoing, long-term effects of the virus itself, as well as the unintended consequences of some measures used to control the virus. The province also faces new infectious disease risks such as MPOX, re-emerging pathogens like poliomyelitis and tuberculosis, and the return of annual seasonal epidemics such as influenza and respiratory syncytial virus (RSV). Now, more than ever, we must be able to rapidly identify and respond to infectious disease outbreaks and pandemics so we can limit their impact, save lives, and safeguard Ontarians' health and well-being.

Being Ready is a call to learn from the past and ensure Ontario is ready for the next outbreak or pandemic, whenever it may occur. It calls for an end to the "boom and bust" cycle of funding that left Ontario less prepared than it should have been for COVID-19. It also calls for sustained investment in pandemic preparedness over time, so Ontario maintains a steady state of readiness. As Ontario's Long-Term Care COVID-19 Commission noted: "Pandemic planning is most effective when it is completed and tested before an emergency hits."

This report stresses the need for ongoing investment in public health sector and health system readiness: the relationships, workforce, scientific expertise, technologies, systems, supplies, and other resources required to detect and manage outbreaks. It also makes the case for investing in community and societal readiness: healthier, more equitable communities that will be more resilient during outbreaks; and an informed society that understands how and why decisions are made and has the information and supports it needs to protect itself.

As with previous Chief Medical Officer of Health (CMOH) reports, *Being Ready* advocates for the routine collection of sociodemographic data and community-based efforts to reduce health inequities which, as COVID-19 has proven, can help ensure more equitable outbreak and pandemic responses.

Thank you to all Ontarians who made sacrifices and endured through these very challenging times. And my condolences to all those who lost loved ones. We must learn from this experience to ensure Ontario continues to be ready, I will be assessing and reporting on the state of Ontario's pandemic preparedness in future CMOH reports.

Yours truly,

Dr. Kieran Moore

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Executive Summary

Three years after the first case of COVID-19 was diagnosed, the world is still struggling to adapt to and recover from this disease. While still in the midst of this pandemic, we have to ask the hard questions. If another infectious pathogen emerges in the near future, will Ontario be ready? What about in five, 10 or 20 years from now?

History tells us that, once an event like SARS, H1N1, or COVID-19 passes, complacency often sets in, funding is redirected, and readiness wanes.

Yet the risk of serious disease outbreaks and another pandemic is real and growing. Population growth, land use practices, climate change, the growing international wildlife trade, and global travel are making it more likely for zoonotic diseases, like COVID-19, to spread from wildlife to people. At the same time, we are seeing the re-emergence, globally and locally, of previously controlled pathogens, such as polio, tuberculosis, and measles, as well as an increase in antimicrobial resistant organisms, and the potential for an accidental or deliberate release of engineered or natural pathogens.

What does it mean to be ready for infectious disease outbreaks?

The duration and severity of COVID-19 drove home the challenges of containing a fast-spreading virus and making ethical decisions in a world competing for scarce resources. It highlighted the critical importance of the public health sector:

- maintaining the people, expertise, technology, systems, supplies, and other tools to track and contain infectious diseases
- knowing their communities and settings – who is most of risk of infection and severe illness – and adapting services to meet their needs
- having the support of an informed and engaged public who knows why and how to protect themselves and others.

The experience with COVID-19 demonstrated that the only way to slow or stop outbreaks and pandemics is through collective action.

Preparedness is a process that requires sustained investment in a wide range of relationships, skills, technologies, infrastructure, and capacities.

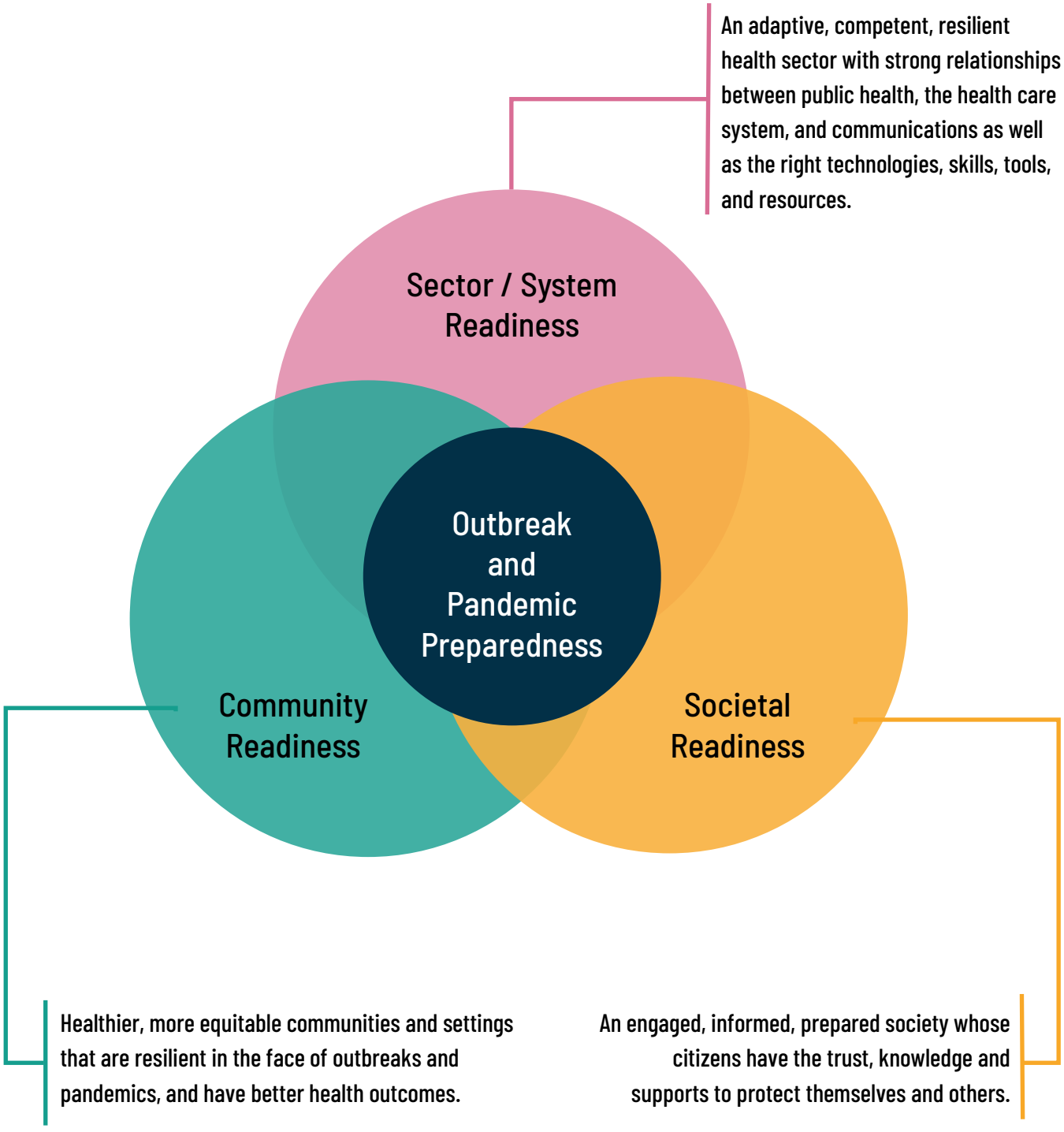
While Ontario's public health sector is responsible for leading pandemic preparedness and response in the province, preparedness is a team effort. During an infectious disease outbreak, public health must work closely with the broader health care system and other organizations responsible for health, including Indigenous health authorities and leaders, as well as communities, schools, workplaces, families, individuals, and all levels of government to:

- increase resilience
- achieve shared objectives, such as equitably minimizing morbidity, mortality, and social disruption.

> "Pandemic planning is most effective when it is completed and tested before a public health emergency hits.
>
> Final Report, Ontario's Long-Term Care COVID-19 Commission, 2021

To be ready for the next outbreak, Ontario's public health sector must take a collective, forward-thinking approach to pandemic planning. It must make sustained investments in strengthening sector and system[1], community, and societal readiness.

Figure 1: A big picture of readiness



[1] In this report, the term "sector" refers to the public health sector and the term "system" refers to the broader health system.

Where should we focus our attention and investment in the next 1-2 years?

Sector and System Readiness

Relationships Strengthen **collaborative networks** across the health care system, including with Indigenous health service providers, and develop the governance structures to support those networks.

People Build a skilled, adaptable resilient **public health workforce**, cross-trained in public health core competencies (e.g. vaccination, infection control, epidemiology, and outbreak management), with the surge capacity to respond to outbreaks, pandemics, and other emergencies while maintaining essential public health services.

Testing capacity and expertise Strengthen Ontario's lab network capacity - people**, infrastructure, and technologies** - including Public Health Ontario (PHO) Laboratory's capacity, so that the network can deliver high volume testing during a pandemic while continuing to provide routine health testing, and contribute to global efforts to detect and monitor emerging infectious diseases.

Surveillance and scientific expertise Strengthen the public health surveillance and scientific infrastructure so the sector can: provide **comprehensive real-time information** (e.g. laboratory results, cases, severity, immunizations, and sociodemographic data) to inform the public health response; adopt One Health Surveillance approaches; and coordinate the work done by scientific experts to create knowledge and inform decision-making.

Critical response resources Maintain timely access to the critical resources required in most outbreaks:

- **Infection prevention and control** (IPAC) interventions and expertise in both health care and non-health care settings - including primary care, schools, workplaces, and congregate living settings (e.g. long-term care homes, retirement homes, shelters).
- **Personal protective equipment** (PPE) - including the capacity to produce PPE, resilient supply chains, and a reliable rolling provincial stockpile
- **Vaccines and therapeutics** – partnerships with the health care system, including pharmacists, to deliver vaccines and therapeutics, as they become available.

Community Readiness

Community partnerships Build enduring collaborative partnerships with **communities that face health inequities and systematic racism and discrimination** as well as settings that may be at increased risk, such as congregate living settings. Work with them to: adapt public health and other health services to meet their needs; co-design and advocate for upstream interventions to reduce health inequities and risks; and co-develop and test outbreak plans.

Data to address inequities Develop the provincial capacity to routinely collect **social, economic, health outcome, and sociodemographic data**, including information on race, ethnicity, and language, that can be used to identify communities at risk and work with them to reduce health inequities.

Societal Readiness

Social trust and ethical preparedness Build social trust and **engage society in conversations** about the ethics and values that guide public health decisions.

Clear and transparent communications Use evidence-based methods to increase **health literacy** and improve communications, provide credible, trusted and transparent information, and **counter misinformation**.

There are many competing demands for health and public health resources across the health system. The province must take a balanced approach to managing the health care needs of today and preparing for the disease threats of tomorrow. It is more efficient and more effective to invest in preparedness than to pay the much higher and heavier costs of being unprepared: more illness and death, mental health problems, social disruption, and economic losses.

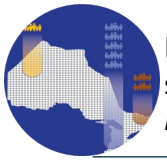
To enhance the province's preparedness and its capacity to respond to future outbreaks and pandemics, Ontario must sustain its investments in public health over time.

Investments in preparedness can cut the health and economic costs of pandemics.

When jurisdictions are prepared and respond quickly to outbreaks, they can reduce illnesses and deaths. They can also avoid more stringent public health measures (e.g. stay-at-home orders, mask mandates), or reduce the negative impacts of those measures.

Preparedness is an ongoing process, not an end state.

Ontario's public health sector knows what to do to improve health now **and** be ready for the next outbreak or pandemic. Many recommendations in this report echo those in past Chief Medical Officer of Health (CMOH) reports – because they are the right way to improve health both before and during outbreaks, including:



Develop information systems to help public health agencies gather health, economic and sociodemographic data on their communities and identify populations at risk (**2015 report** *Mapping Wellness: Ontario's Route to Healthier Communities)*

Reduce health inequities to improve health, and lower health and social costs (**2016 report** *Improving the Odds: Championing Health Equity in Ontario)*

Build public confidence in vaccines (**2014 report** *Vaccines: the Best Medicine)*

Encourage strong social connections as a way to reduce stress, improve health, and make individuals and communities more resilient (**2017 report** *Connected Communities: Healthier Together)*

Improve health literacy and help people distinguish between credible scientific evidence and misinformation (**2013 report** *Old Foes and New Threats, Ontario's Readiness for Infectious Diseases)*

This report also aligns with recommendations made by Ontario's Long-Term Care COVID-19 Commission (2021), which called on the province to develop pandemic plans that are "updated, tested, drilled" and reported on "annually to the legislature".

There is no specific checklist that Ontario can use to guarantee it will be ready for the next outbreak or pandemic. However, the Office of the Chief Medical Officer of Health will adapt existing frameworks and indicators for pandemic preparedness to regularly assess and report on the public health sector's progress in sustaining, strengthening, and developing its capacity to be ready for the next outbreak or pandemic.

Learning from the Past

COVID-19 caught the world off guard.

No one was ready for a pandemic that would last years, cause more than 6.5 million deaths worldwide (Coronavirus Resource Center, 2022) – 14,724 in Ontario as of October 29, 2022 – overwhelm hospitals, send millions of people into long lockdowns, close businesses, schools, and daycares, halt global travel, and cause social rifts over whether to follow public health measures. Nor was the world prepared for global supply chain issues and the competition over limited supplies, including hand sanitizer, masks, respirators, and vaccines.

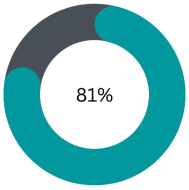
Compared to other countries that took a similar approach to COVID-19 (i.e. they did ***not*** take a zero-COVID approach[2]), Canada had relatively low mortality and high vaccination rates. (Ogden et al, 2022; Razak et al, 2022).

> Simply put, we were not adequately prepared to face an emergency of the scale and magnitude of COVID-19. We must do better for the future.
>
> *A vision to Transform Canada's Public Health System, The Chief Public Health Officer of Canada's Report on the State of Public Health in Canada, 2021*

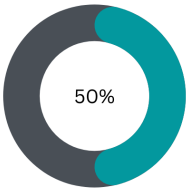
Figure 2: Cumulative deaths per 100,000 population and percentage of the population vaccinated with two doses as of April 20, 2022

Country	Cumulative deaths per 100,000 population	Percent of the adult population vaccinated with two doses
Canada	101.3	82%
Denmark	103.7	82%
Germany	159.3	77%
Sweden	183.1	75%
France	214.6	78%
United Kingdom	259.8	73%
Belgium	268.7	79%
United States	291.9	66%

Ontario also did well in preventing COVID-related hospitalizations and deaths, and vaccinating its population (all ages). (Public Health Ontario data as of November 19, 2022)

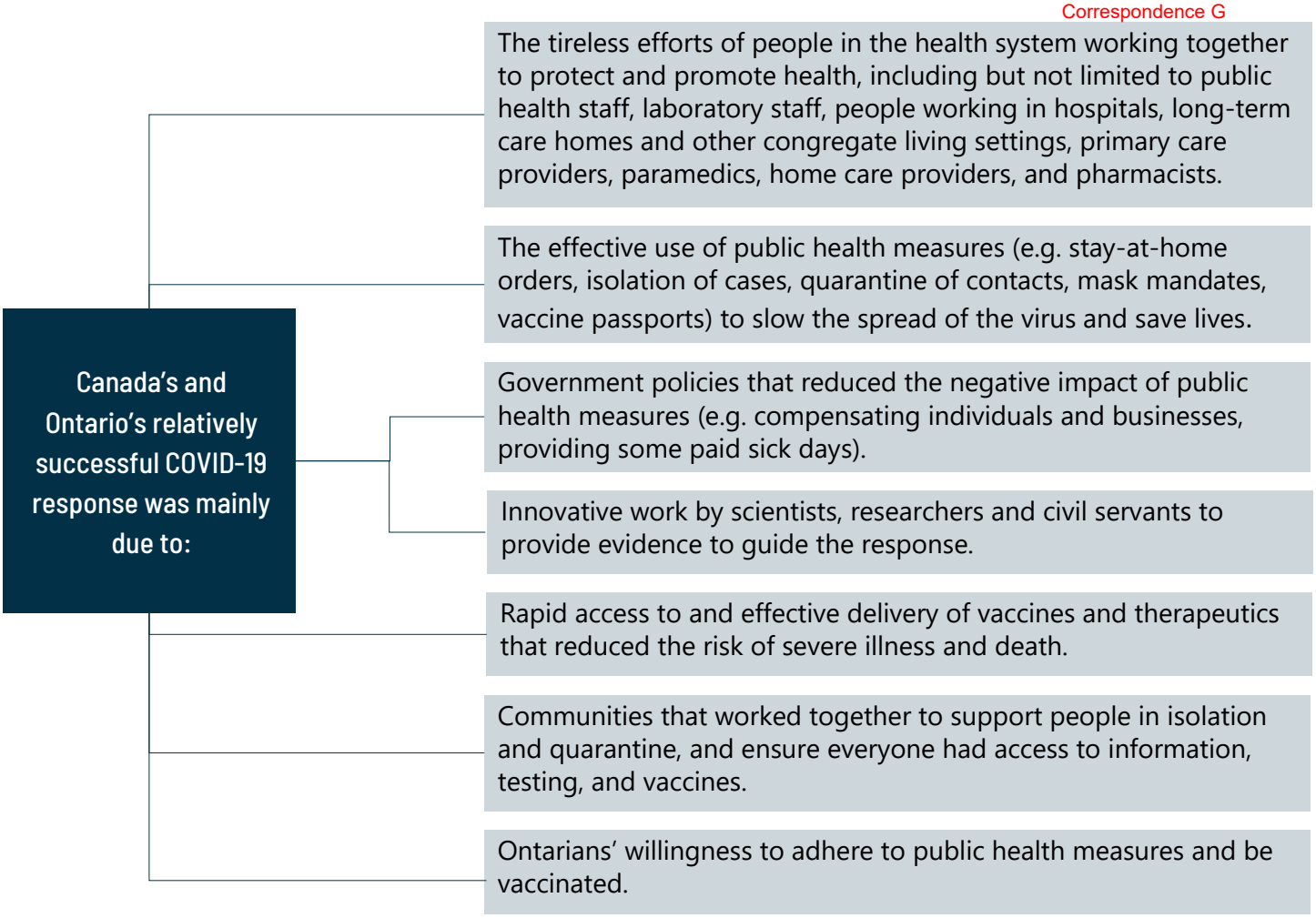


Ontarians are fully vaccinated with two shots



Ontarians have had a third dose

[2] Note: a small number of countries did adopt a zero-COVID approach, including New Zealand, Singapore, Australia, and South Korea. Those countries had lower death rates (between 11.7 and 42.2 per 100,000 population) and higher vaccination rates (between 80% and 90%) than countries, like Canada, that did *not* adopt that approach nationally.



While Ontario has done well overall, the response required sacrifices by individuals, families, society, and the health care system. In addition to the direct effects on health, including deaths, hospitalizations, acute illness, and long-term illness, the pandemic isolated people from family and friends, exacerbated health inequities (i.e. some populations experienced worse outcomes), limited access to other essential health services (e.g. surgeries, cancer care), had a negative effect on mental health and well-being, caused burnout and stress in all parts of the health system, and had a severe economic impact on many individuals, businesses, and industries.

Almost three years since the first case of COVID-19 was diagnosed in Canada, we are still experiencing the impacts of the pandemic. We will be weighing its toll for years to come.

If another virus similar to COVID-19 emerges in the future, will Ontario be ready?

Although the health system is dealing with capacity and health human resources issues, Ontario is more ready now than we were when the COVID-19 pandemic started in 2020. The province proved that in its response to the global MPOX (formerly monkeypox) outbreak in the spring of 2022. Within three weeks of the province's first confirmed case, the public health sector had established testing, determined who was most at risk, worked with those communities to reduce risk, educated health care providers to recognize and manage the illness, accessed vaccines and therapeutics from the federal government, provided immunization clinics, and connected infected individuals with specialty care.

The effective rapid response to MPOX was possible because the public health sector was ready. Learning from COVID-19, the public health sector had in place the skills, capacity, experience, infrastructure, and relationships to manage another disease threat.

What about three, five, 10 or 20 years from now?

History tells us that, once a disease threat passes, the sense of urgency drops, investments in preparedness are redirected, and readiness wanes.

Despite lessons learned from outbreaks here and in other parts of the world over the past 20 years – including SARS (Severe Acute Respiratory Syndrome), pandemic influenza H1N1, Zika virus, MERS (Middle Eastern Respiratory Syndrome), and Ebola – **Ontario did not maintain its investment in preparedness** before COVID-19 hit.

In recent reports, Ontario's Office of the Auditor General (2020, 2021) highlighted the lack of ongoing investment in:

- public health surge capacity to meet the demand for testing, and case and contact tracing in the event of a pandemic
- public health testing infrastructure and laboratory capacity to respond to public health threats
- stockpiles of personal protective equipment established post SARS
- staffing and infection prevention and control capacity in long-term care homes
- hospital surge and ICU capacity.

How do we learn from the past so the next time is different?

This report is not an assessment of Ontario's response to the COVID-19 pandemic, nor is it specific to COVID-19. It is a call to learn from the past and invest in preparedness so Ontario is ready for the next outbreak or pandemic, whenever it may occur.

While all parts of the health system and other sectors must prepare for any emergency or disaster that can affect their operations and communities, the public health sector is responsible for leading preparedness and response for infectious disease emergencies in Ontario.

> "Public health faces "boom and bust" funding cycles that leave us ill-prepared for new emergencies. As we have seen in the past, public health resources are often scaled back after health emergencies as governments move to address other priorities. This places public health systems at a disadvantage at the onset of each crisis since the capacity and networks required for a rapid response are not there. We need to invest in public health up front and consistently. This investment will be cost saving and provide many long-term social and economic benefits.
>
> *A vision to Transform Canada's Public Health System, The Chief Public Health Officer of Canada's Report on the State of Public Health in Canada, 2021*

> "When COVID-19 hit, Ontario experienced the same problems with laboratory capacity as it had during SARS: "the provincial laboratory in Toronto quickly became swamped with specimens. Like other parts of the health care system, it lacked surge capacity …"
>
> *COVID-19 Preparedness and Management Special Report on Laboratory Testing, Case Management and Contact Tracing, Office of the Auditor General of Ontario, November, 2020*

Outbreaks are inevitable. Preparedness allows us to respond early and decisively, blunting the impact of outbreaks when they occur.

Each year, outbreaks of influenza and other respiratory viruses provide opportunities to work together purposefully to practice and sustain preparedness.

Figure 3: Ontario's public health sector - the "three-legged stool" of
(i) Ministry of Health / Chief Medical Officer of Health; (II) Public Health Ontario; and (iii) Local Public Health Agencies

- Provides leadership and expertise
- Sets policy directions and public health standards for the province

- Provides scientific evidence and technical advice to the Ministry of Health, Chief Medical Officer of Health and local public health agencies
- Provides laboratory testing services
- Is responsible for disease surveillance and monitoring

- Deliver public health programs and services
- Lead health promotion and health protection/ disease prevention services
- Work to improve the health of their populations and reduce health inequities

This report focuses specifically on how to enhance the capacity of Ontario's public health sector to fulfill its lead role in preparedness planning. It:

- lays out the case for ongoing investments in preparedness for infectious disease emergencies
- argues for a more collective "big picture" approach to outbreak preparedness that builds sector and system, community, and societal readiness
- highlights the priorities for outbreak and pandemic preparedness that must be **sustained**, **strengthened** and/or **developed** over the next one to two years.

The Case for Sustained Investment in Outbreak Preparedness

There are compelling social, ethical, and financial reasons why Ontario must invest in being prepared and resilient in the face of outbreaks:

- The risk of serious outbreaks and another pandemic is real and growing.
- The human and economic costs of *not* being ready are too high.
- The burden disproportionately affects populations already facing health inequities.

> Resilience is the capacity of a system, community or society to adapt to disturbances resulting from hazards by persevering, recuperating or changing to reach and maintain an acceptable level of functioning. Resilient capacity is built through a process of empowering citizens, responders, organizations, communities, governments, systems and society to share the responsibility to keep hazards from becoming disasters.
>
> Emergency management strategy for Canada: toward a resilient 2030, Public Safety Canada, 2019

1. The risk of other outbreaks and another pandemic is real and growing

It is not a question of "if", but "when".

Novel pathogens are emerging more rapidly than in the past. In the last 20 years alone, the world has seen more frequent disease threats and serious outbreaks. Most have been caused by zoonotic viruses that spread from wildlife to humans.

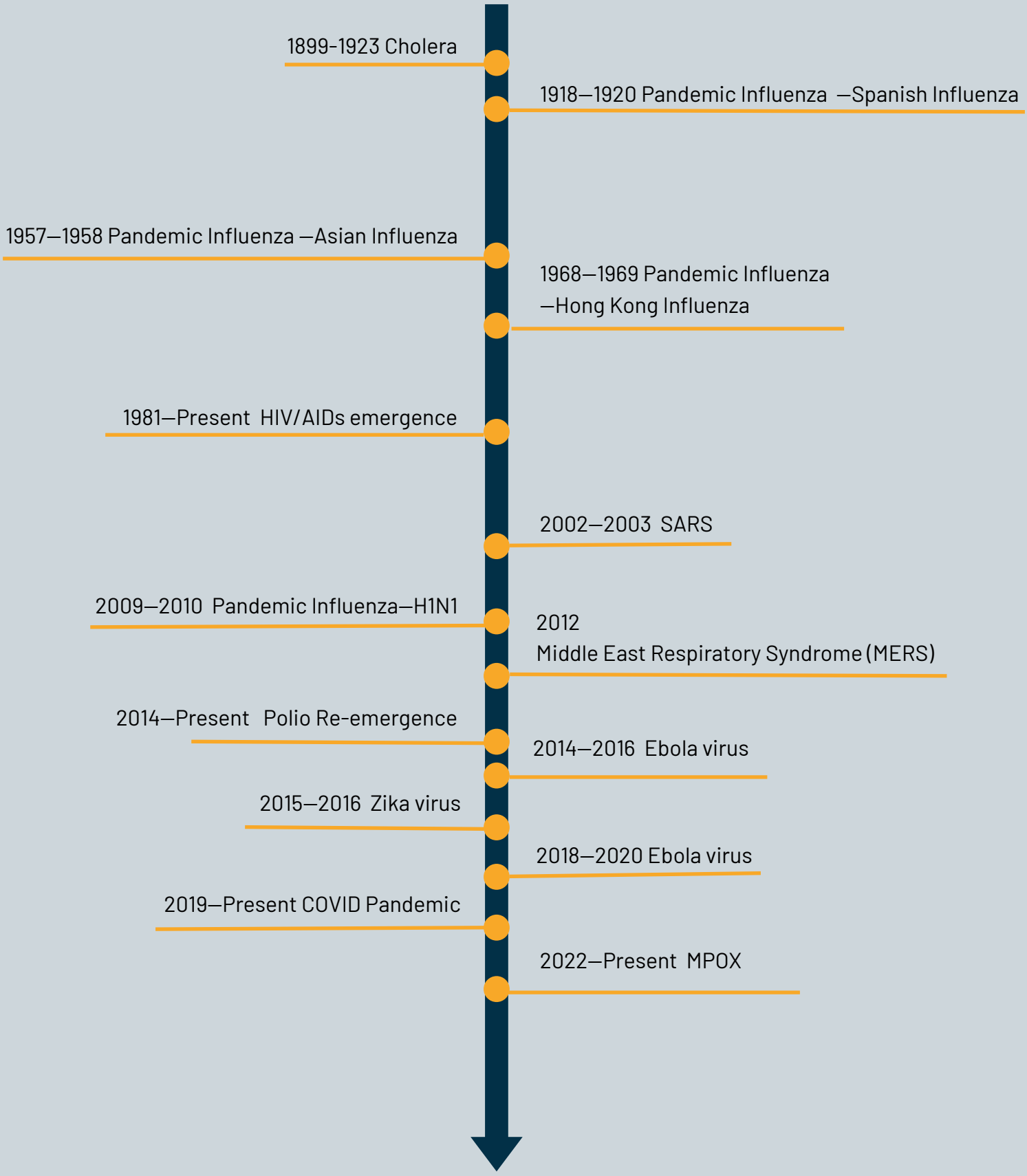
The increasing risk of zoonotic diseases is driven by: human and domestic animal population growth, climate change pushing land use and livestock production into areas inhabited by wild animals, the growing international wildlife trade, industrial-level farming and transportation of wild animals, and human behaviour and travel. As people move into wildlife habitats and animals relocate to more hospitable ecosystems, viruses carried by wild animals have more opportunity to infect domestic animals and humans. (Keusch et al, 2022; The Independent Panel for Pandemic Preparedness and Response, 2021).

> Detecting and stopping the spread of zoonotic diseases requires a One Health approach, which recognizes that human and animal health are closely connected, and brings together experts in human, animal and environmental health as well as other relevant disciplines to learn how diseases spread among people, animals, plants, and the environment.
>
> The One Health approach has the potential to prevent outbreaks in animals and people, improve food safety, reduce antibiotic resistance and protect global health security.
>
> One Health Basics, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention. 2022

There are also growing risks from:

- the resurgence of previously controlled pathogens, such as polio, tuberculosis, and measles
- rapid global spread of emerging infectious diseases, such as MPOX
- antimicrobial resistant organisms
- the accidental or deliberate release of engineered or natural pathogens.

Figure 4: Timeline of major outbreaks over the past 100 years.



The risk of an outbreak becoming a pandemic is exacerbated by our connectedness: diseases that emerge in one part of the globe do not stay there. They travel quickly to other parts of the world – often before the threat has been identified. Geopolitical forces, such as war and economic instability, affect a country's ability to maintain public health programs or respond to emerging diseases, making it more likely they will spread in that country and beyond its borders.

As a society, we know the value of being ready in case of an external threat or disaster.

Countries maintain an intelligence and defense system in case of attack or war. Provinces maintain capacities to respond to wildfires and storms. Municipalities support a network of fire stations and equipment. Individuals install smoke and carbon monoxide detectors in their homes. These investments are a form of insurance and readiness for uncommon events so that we can respond quickly in the event of an emergency. Societies must make the same kind of ongoing investment in the competencies and capacity required to respond to outbreaks and pandemics.

Maintaining and strengthening public health's capacity to plan for outbreaks and pandemics is good risk management. It's a form of insurance that will cost significantly less than another unplanned-for pandemic.

Protecting Ontarians from the threats of tomorrow will improve health today.

Strengthening Ontario's capacity to detect emerging diseases and respond to a pandemic will also enhance our ability to manage less serious or widespread outbreaks. For example, the same rapid, high volume genomic sequencing that allowed Ontario to identify and track the spread of different COVID-19 variants can be used to investigate and link cases of food-borne or other illnesses provincially, nationally – even internationally – and identify the cause of outbreaks.

2. The human and economic costs of not being ready are too high

The personal, health, social/emotional, and economic costs of a pandemic are unacceptably high.

Ontarians are still experiencing the impact of COVID-19 on their lives and health. As of September 2022, COVID-19 had resulted in:

- **>55,000** Ontarians being hospitalized[3]
- **>14,000** deaths
- **thousands** who have experienced long COVID or post-COVID-19 conditions.

What Would have Happened Without Public Health Measures?

As devastating as COVID-19 was in Ontario and Canada, without public health measures such as closures, travel restrictions, contact tracing, masking, and social distancing, and without high rates of vaccination, the toll would have been much worse.

Ogden et al (2022) estimate that, in Canada, there would have been:

up to 34 million vs 3.3 million cases

up to 2 million vs 150,602 hospitalizations

up to 800,000 vs 38,783 deaths

[3]Public Health Ontario. Ontario COVID-19 Data Tool. Numbers as of September 17, 2022. https://www.publichealthontario.ca/en/data-and-analysis/infectious-disease/covid-19-data-surveillance/covid-19-data-tool?tab=summary. Accessed September 24, 2022.

In terms of mental health, Ontarians have had to cope with stresses related both to the direct impacts of COVID-19 and the public health measures adopted to protect people from illness and death, including, but not limited to:

- grief and loss caused by COVID-19 illnesses and deaths
- stress and burnout from caring for people with COVID-19
- fear and anxiety about the virus and feeling that you do not have the capacity to protect yourself and your family
  - ◊ particularly for essential workers who were at risk of getting infected on the job and bringing the virus back to their families and for people with co-morbid conditions who were at high risk
- isolation from family members and friends for months at a time
- caring full-time for children while working from home
- disruptions to children's lives, education, and social development from being out of school or learning remotely for months
- increases in alcohol and cannabis use
- increases in domestic and intimate partner violence
- inaccessible supports for those experiencing homelessness and substance use disorders
- anxiety and mental distress over loss of income
- mental distress over loss of housing due to evictions
- stress from lack of available medical and mental health care.

> "Between March 2020 and January 2022, schools in Ontario were closed for 27 weeks, longer than any other Canadian jurisdiction and most European countries.
>
> Ontario Returns to School: An Overview of the Science, Science Table: COVID-19 Advisory for Ontario, 2022

Economic costs from pandemics are also high. The resulting illness, death, and disability due to COVID-19, and the indirect costs of caring for infected individuals took a toll on the economy. During COVID-19, hundreds of businesses closed and thousands of people were laid off. By February 2021, compared to other provinces, Statistics Canada (2021) reported that Ontario had the lowest percentage of active businesses, and the second lowest employment rate in the country (compared to pre-pandemic levels). Sectors most negatively affected at that time were: hospitality and food services; arts, entertainment, and recreation; and retail. While many sectors rebounded in 2022, the full economic impacts of COVID-19 are still unknown.

Investments in preparedness can cut the health and economic costs of pandemics

When jurisdictions are prepared and can respond quickly to outbreaks, they can reduce illness and deaths, and either avoid implementing stringent public health measures to protect health or reduce their negative impacts.

For example, early in the pandemic, South Korea was able to minimize COVID-19 spread without closing businesses or issuing stay-at-home orders. The country was able to avoid strict measures required in other countries because, after a MERS[4] outbreak in 2015 that resulted in 185 cases and 38 deaths (World Health Organization, Outbreaks and Emergencies), it invested heavily in people and systems to test, detect, and contain infectious diseases. Its preparedness initiatives included hiring more infection control staff, running more outbreak simulations, significantly increasing capacity to scale up testing as well as case and contact management, working with the private sector to ensure an adequate supply of tests, and purchasing personal protective equipment (PPE) centrally. As a result, in the first year of COVID-19, South Korea, a country with a population of 52 million, had fewer than 80,000 cases and 1,500 deaths, and the lowest percentage decrease in gross domestic product of all 37 members of the Organization for Economic Cooperation and Development (OECD) (Kim JH et al., 2021).

[4] Middle East Respiratory Syndrome

3. The burden disproportionately affects populations already facing health inequities.

Health and social inequities are exacerbated during an outbreak or pandemic.

Although Ontario had a comparatively good response to COVID-19, it was not equitable. Populations already experiencing health inequities – including Indigenous, Black, and other racialized, low-income, and newcomer communities – were disproportionately affected by COVID-19, and had more severe outcomes.

According to the Wellesley Institute's analysis of Ontario race-based data to mid-2021, Latino, South Asian, Middle Eastern, South East Asian, and Black populations were 4.6 to 7.1 times more likely to test positive for COVID-19 than white populations (Wellesley Institute, 2021). During the first waves of the pandemic, public health measures failed racialized neighbourhoods where people had fewer options to work from home or isolate if they got sick. Early vaccine rollout also favoured affluent neighbourhoods and provided fewer options for higher risk communities to access vaccine (Black Health Alliance, 2021).

> "While emergencies affect everyone, they disproportionately affect those who are the most vulnerable. The needs and rights of the poorest, as well as women, children, people with disabilities, older persons, migrants, refugees and displaced persons, and people with chronic diseases must be at the centre of our work.
>
> Health Emergency and Disaster Risk Management Framework, World Health Organization, 2019

People living in northern, rural, and remote regions, including First Nations communities, also experienced poorer outcomes. Because of inequities in access to the social determinants of health, many had underlying health conditions that increased their risk. The COVID-19 pandemic also reinforced long-standing geographic inequities in access to services in these parts of the province. For example, early in the pandemic, people in southern Ontario could get a COVID-19 test and their results within two days or less, while individuals in the north could wait as long as two weeks because of distance from laboratories and delays transporting samples. Over the course of the pandemic, the health system invested in laboratory equipment and point-of-care tests to improve access to testing in rural and remote areas, but underlying systemic health disparities were not so easily addressed.

Individuals at highest risk of COVID-19 included:

- essential workers who could not work from home
- people living in congregate settings, such as long-term care homes, as well as those in overcrowded housing that made it difficult for people to self-isolate when ill or exposed
- people with co-morbidities, such as cardiovascular diseases, diabetes, chronic respiratory disease, and cancer
- people and communities coping with long-standing social, economic, and cultural barriers to care and health, particularly those who had higher rates of chronic diseases and poorer health outcomes before COVID-19.

For some populations that experienced more severe COVID-19 outcomes, the risks were not biological. They were related to inequities in income, education and access to services, as well as the impacts of colonization, systemic racism, and discrimination.

The Link Between Poverty and Poor COVID-19 Outcomes

Over the first three waves, the number of COVID-19 cases was highest among people living in neighbourhoods with the highest levels of material deprivation – which refers to the inability of individuals and communities to access and attain their basic material needs. People in these neighbourhoods were also more likely to experience severe outcomes from COVID-19. Compared to people living in neighbourhoods with the lowest levels of material deprivation, they were 2.7 times more likely to be hospitalized and admitted to intensive care, and 2.9 times more likely to die. (Ontario Agency for Health Protection and Promotion, 2022).

It is difficult to address health inequities in the midst of an outbreak or pandemic.

Instead, that important work must be an integral part of outbreak or pandemic preparedness, as well as the ongoing work of the public health sector. The process of preparing for outbreaks includes developing and sustaining trusting partnerships with communities. It means working collaboratively with them to address the social determinants of health and reduce health inequities so communities can be healthier and more resilient during an outbreak. Pandemic responses work best when everyone is properly protected. If parts of society are left behind, the effectiveness of the response decreases for everyone.

Our existing systems are characterized by inequities. These challenges will only be exacerbated when a disease outbreak occurs. The more equitable our communities and health systems are before an outbreak, the more likely Ontario will have a better and more equitable outbreak response.

A Bigger Picture View of Readiness

Recent pandemics including SARS, H1N1, and COVID-19 have taught important lessons about preparedness. In particular, the duration and severity of COVID-19 drove home the challenges of containing a fast-spreading virus and making ethical decisions in a world competing for scarce resources. It also highlighted the critical importance of local public health agencies knowing their communities, and advocating for and delivering services to meet their needs. It is only through collective action – individuals, families, communities, schools, workplaces, the health care system, other sectors, and governments working together – that we can slow or stop outbreaks and pandemics.

While we have learned key lessons from past outbreaks, the next one may be different. To be ready, Ontario needs a supported, adaptive, resilient public health sector that continually learns from previous experiences **and** is ready to respond to new challenges that may require different solutions.

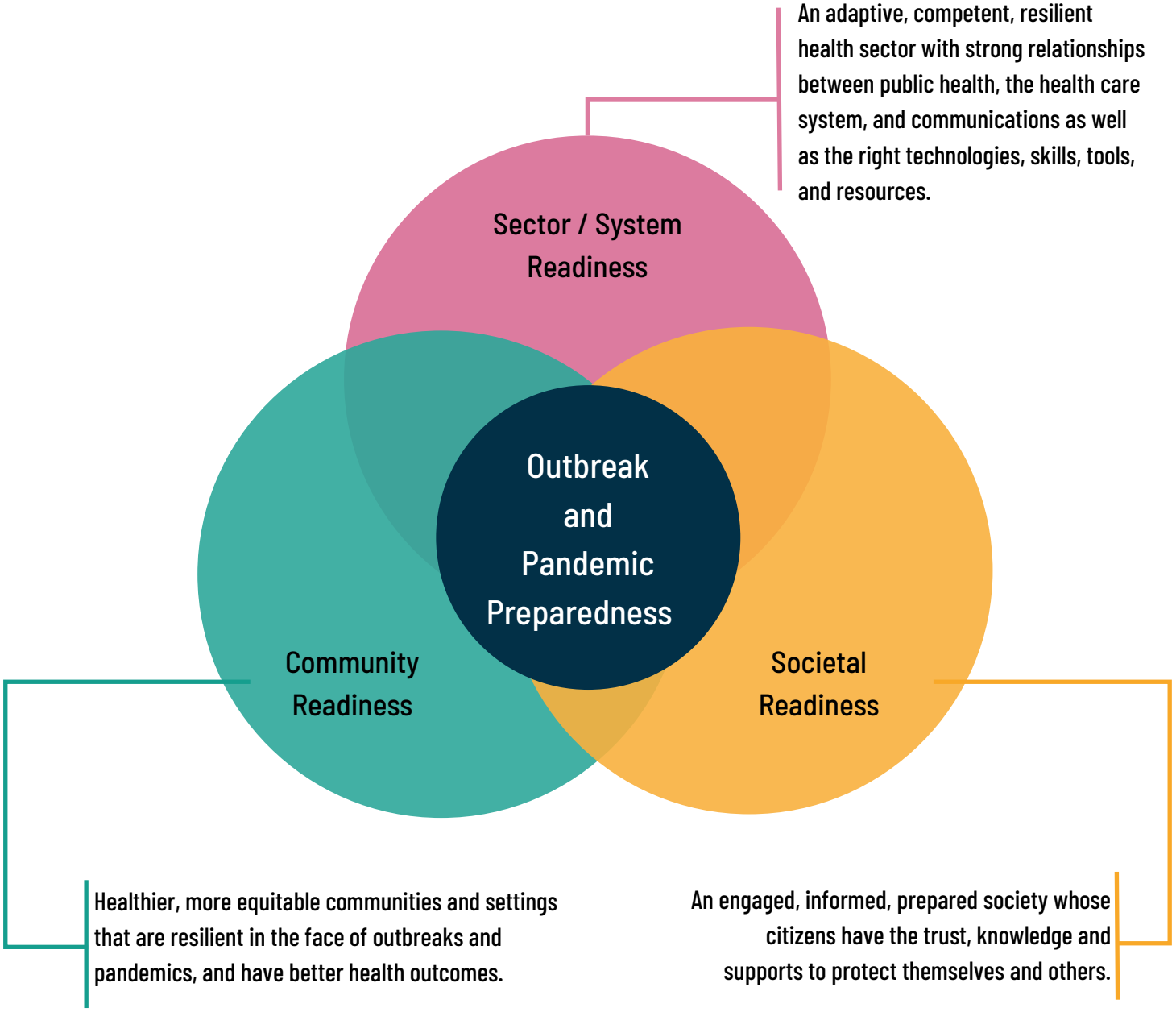
Ontario's public health sector must take a collective, forward-thinking approach to outbreak and pandemic planning that builds:

i) sector and system readiness,

ii) community readiness, and

iii) societal readiness.

Preparedness requires sustained investment in a wide range of relationships, skills, technologies, infrastructure, and capacities.



Sector and System Readiness

Sector readiness means having in place the relationships (networks), people (workforce), competencies and expertise, technologies, data systems, resources, structures, processes, and surge capacity that enable the public health sector and the broader health system to manage and contain an outbreak or pandemic - while continuing to provide other essential public health and health care services and, if necessary, respond to other emergencies that may occur during an outbreak.

Community Readiness

Planning only for sector and system readiness – the main focus of past preparedness efforts – does not address the facts that outbreaks start with people, people live in communities, and not all communities are equal. To reduce health inequities and improve health outcomes (before, during and after outbreaks and pandemics), local public health agencies must forge and maintain strong collaborative partnerships with their communities and, populations at risk, working with them, as well as with their governments and the health system, to improve health equity and resilience (O'Sullivan et al, 2014; O'Sullivan et al, 2013). They must also work closely with congregate living settings in the community, such as long-term care homes and shelters, where residents may be at greater risk.

Societal Readiness

To respond effectively to an emerging disease, Ontarians must trust public health leaders. They must be confident that governments and public health agencies will fulfill their responsibility to protect the health of the public and support Ontarians in their efforts to protect themselves and others. To prepare society for the types of difficult decisions that may have to be made during an outbreak – such as who will be first in line for scarce resources and what measures will be used to interrupt transmission (e.g., isolation, quarantine, closures) – the public health sector must engage an informed public in frank discussions about the ethical values guiding those decisions. Provincial and local public health agencies must also communicate clearly and transparently about the disease risk (i.e. what we do and do not know) and the reasons for implementing different public health measures. Society must be confident that the public health measures are based on best evidence, and reflect shared ethics and values. (Emanuel et al, 2022).

Measuring Preparedness: How Will We Know We are Ready?

The vision of readiness laid out in this report is based on the Public Health Emergency Framework and Indicators, work led by Public Health Ontario (Khan Y et al, 2018; Ontario Agency for Health Protection and Promotion, 2020) to guide planning for a broad range of public health emergencies. In this framework, ethics and values are at the centre of ten preparedness domains, and all domains rely on governance and leadership. The domains are interdependent, reflecting the complex adaptive system required to respond to public health emergencies, such as pandemics.

Figure 5: Resilience framework, adapted from Khan Y et al, 2018

Preparedness is an ongoing process, not an end state.

There is no specific checklist that Ontario can use to guarantee it will be ready for the next outbreak or pandemic. However, the Public Health Emergency Framework provides 67 indicators that public health agencies can use to monitor and assess their preparedness, and the National Collaborating Centres for Infectious Diseases and Determinants of Health (2020) have developed a resource that applies a health equity lens to assess these indicators. In addition, this report highlights some of the **Ontario Public Health Standards** that outline the local public health agencies' current accountabilities for emergency and pandemic preparedness.

Future CMOH reports will adapt and use the Public Health Emergency Framework indicators, as well as indicators from other pandemic preparedness frameworks and the Ontario Public Health Standards, to report regularly on the public health sector's progress in sustaining, strengthening, and developing the capacities required to be ready.

I. Sector/System Readiness

Ontario's public health sector – and the broader health system – must maintain the relationships, people, expertise, technologies, surge capacity, tool, processes, and resources required to quickly detect and respond to outbreaks.

During COVID-19, the public health sector and the health care system built extensive expertise, capacity, and tools to respond to and manage a pandemic. The sector and system have established a solid foundation for future readiness that must be sustained and strengthened.

To improve sector and system readiness for the next pandemic, the public health sector and its partners must focus on:

- Strong collaborative networks across the health system and other partners, including Indigenous health services
- A skilled, adaptable, resilient workforce
- Innovative, leading-edge testing and diagnostics
- Real-time surveillance systems and scientific expertise
- Critical response resources such as:
    - ◊ Infection prevention and control interventions and expertise in both health care and non-health care settings
    - ◊ Dependable supplies of personal protective equipment (PPE)
    - ◊ Timely access to vaccines and therapeutics

Strengthen Collaborative Networks

Pandemic preparedness is a team effort.

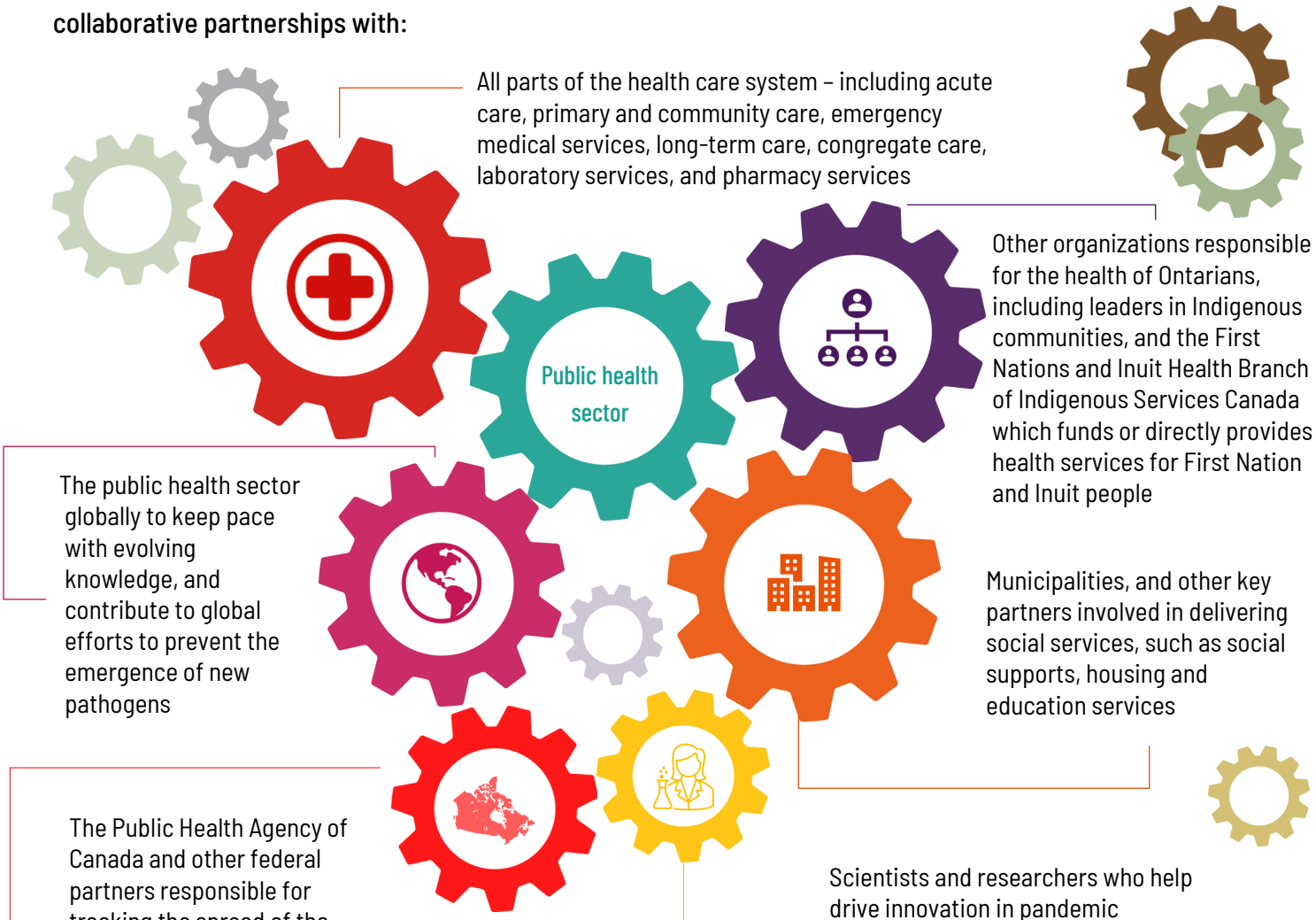
While the public health sector is responsible for leading outbreak planning and response, it relies heavily on other parts of the health care system and different levels of government to co-design and co-implement outbreak plans.

Relevant Ontario Public Health Standards

Conduct emergency planning in co-ordination with community partners and governmental bodies, including co-ordination and management of emergencies or disruptions.

Engage in relationships with Indigenous communities in a way that is meaningful for them.

Effective outbreak planning and response depends on Ontario's public health sector sustaining strong collaborative partnerships with:



These collaborative networks should be in place before an outbreak occurs and sustained over time. All partners should have a clear understanding of their roles, and work together to continually improve readiness.

Achievements and Challenges

Health System Networks

Over the course of the COVID-19 pandemic, the public health sector in some parts of the province was able to leverage existing collaborative relationships to improve access to services:

- With the creation of Ontario Health and Ontario Health Teams in 2019 (Ontario Ministry of Health, 2019), just before the pandemic, local public health agencies had opportunities to become part of new collaborative health care networks and forums to improve service co-ordination.
- Local public health agencies used their pre-existing relationships with long-term care homes, congregate living settings, and primary care, including community health centres, to improve access to testing and immunization particularly for people who are hard to reach.

- Pharmacies already trained to administer annual influenza shots were able to provide COVID-19 immunizations and tests, and can now prescribe and dispense Paxlovid®.
- Many public health agencies made innovative use of community paramedics to conduct health assessments, provide COVID-19 testing, and give immunizations – particularly in communities where it was difficult for people to travel to COVID-19 assessment centres or immunization clinics.
- Primary care physicians staffed mass immunization clinics, assessed and counselled patients, provided therapeutics, and supported local communities.

However, regions of the province with limited primary care and pharmacy services were unable to leverage these networks to the same extent, and a heavier responsibility for COVID-19 testing and immunizations fell on local public health agencies.

Forging Trusting Relationships with Indigenous Health Services

The roles and responsibilities of Ontario's public health sector in supporting the health of Indigenous communities is a long-standing issue, particularly in First Nations communities where the federal government is responsible for health care services. Some local public health agencies had already developed trusting relationships with Indigenous communities, including First Nation, Métis and Inuit communities, and were able to build on these relationships during COVID-19 (see box), but that was not the experience in all parts of the province.

In some cases, the lack of pre-existing partnerships with Indigenous leaders and communities led people to mistrust the services offered. Local public health agencies also experienced both successes and challenges co-ordinating public health services for Indigenous people living in urban and rural areas across the province.

Case Study: Collaboration with Indigenous Communities

Porcupine Health Unit serves a geographic area of more than 270,000 sq km. of northeastern Ontario from Timmins to Moosonee, shares lands with 10 diverse First Nations communities, and works closely with 12 municipalities that have large urban Indigenous populations. The public health unit respects each community's right to self-determination and is mindful in supporting their unique needs and concerns.

During the COVID-19 pandemic, the public health unit worked collaboratively with First Nations community leadership, the Weeneebayko Area Health Authority (WAHA), Tribal Councils, and Indigenous Services Canada to support the COVID-19 response in several First Nations communities. Public health staff attended regular (often weekly) meetings at the invitation of many communities, and provided the level of public health involvement guided by each community.

While public health's role was adapted to each community's needs, activities included: sharing information on the province's COVID-19 guidance and the science behind the guidance; providing advice on how that guidance could be implemented in each community; and being available to answer questions. The public health unit shared daily social media updates with First Nations Chiefs, health directors, hospitals and other health care partners, urban Indigenous partners, directors of education, and business associations. It also shared templates for communications that communities could adapt to meet their needs.

Collaborative Network Priorities

- Strengthen local public health agencies' collaborative networks with local and regional health system partners, including Indigenous leaders and Indigenous health service providers, and continue to clarify structures, roles and responsibilities during outbreaks and in pandemic planning.
- Sustain the province's collaborative networks with local, regional, and provincial forums for public health and health system partnerships.
- Integrate Indigenous models of community public health, and clarify the public health sector's role in supporting the health of Indigenous people and communities.

Build a Skilled, Adaptable, Resilient Workforce

The public health sector's ability to respond to an outbreak or pandemic depends on having a skilled, adaptable, resilient workforce.

The workforce must have the public health competencies, baseline capacity, and surge capacity to provide services at the scale and intensity required during outbreaks or a pandemic – while also being able to respond to other public health emergencies that may occur at the same time **and** maintain essential public health operations. The public health workforce must also have the capacity to provide leadership and expertise to support partner organizations assisting with the outbreak response.

Relevant Ontario Public Health Standards

Support a culture of excellence in professional practice and ensure a culture of quality and continuous organizational self-improvement.

Achievements and Challenges

COVID-19 was and continues to be a stress test of the public health workforce, and its ability to adapt.

The workforce responded, but at the cost of placing heavy demands on individuals, teams, and the public health sector:

- Local public health agencies reallocated staff from all parts of their operations to pandemic activities, such as case and contact management, and vaccinations. A number of local public health agencies had already cross-trained staff in the necessary public health skills as part of their outbreak planning, which made it easier to redeploy staff quickly.
- Local public health agency staff stepped into new roles to meet the needs of their communities, either providing services themselves and/or negotiating with community partners to provide them. For example, to support individuals in isolation or quarantine, local public health agencies coordinated places for them to isolate, delivered supplies, and arranged ways to look after dependents and pets. However, the public health sector's ability to redeploy people was limited by collective bargaining contracts and legislative requirements on health care provider scope of practice. Through the pandemic, these restrictions were eased to allow more effective use of human resources to meet demands.
- Faced with the increasing demand for case and contact management, the government gave local public health agencies additional resources to hire contract workers. Local public health agency staff rapidly recruited, trained, co-ordinated, and supervised a large number and wide variety of people, some with minimal public health or health experience. Hiring inexperienced people was challenging for public health staff who had to spend time training and supervising them, which meant they were less able to do their own jobs. In some parts of the province, there were not enough people to fill available positions.
- Like those working in other parts of the health care system, all public health staff across Ontario's public health sector were stretched extremely thin during the COVID-19 response, working long hours under great pressure, and struggling to recruit to fill vacancies. The ongoing demands affected work-life balance, and resulted in a significant increase in stress and burnout.

Lack of Surge Capacity Disrupted Other Public Health Services

In both 2020 and 2021, 74-78% of local public health agency resources were diverted to the COVID-19 response (alPHa, 2022). Almost all other public health services had to be stopped or scaled back.

Although all local public health agencies have business continuity plans, those plans did not take into account the need to adjust service levels and interrupt service delivery over such a long period of time (currently almost three years). While relatively little harm may be done when a local public health agency has to delay some activities for a few weeks, the longer an emergency continues or the more complex it is (i.e. several concurrent emergencies), the greater the negative impact of the disruption to other public health services.

Public health business continuity and contingency plans must be updated to reflect the resources and strategies required during a long-term disruption of normal business activities. The goal is to put in place plans and contingency measures that will allow the public health sector to respond to an outbreak or pandemic while still delivering other essential public health programs and services.

While the public health sector was able to respond to COVID-19, it was clear that, faced with a pandemic, the public health workforce does not have adequate surge capacity.

Examples of local public health agency services that were severely cut back or delayed during COVID-19:

- routine school immunizations
- children's health services, including Healthy Babies Healthy Children visits
- population health assessments
- upstream work on the social determinants of health
- sexual health services and sexually transmitted infection testing
- clinical and public health follow-up for sexually transmitted infections
- restaurant/food safety inspections
- delivery of substance use and injury prevention programs
- delivery of healthy eating and physical activity initiatives

The negative consequences of the delays in access to public health services may continue for years to come.

COVID-19 tested public health business continuity plans and highlighted the critical importance of planning for outbreaks or pandemics that last a long period of time.

Other Emergencies Don't Stop During a Pandemic

One of the most compelling arguments for investing in the public health workforce and surge capacity is that other public health emergencies and seasonal epidemics, such as influenza and respiratory syncytial virus, don't stop just because there is a pandemic.

One public health agency in northern Ontario reported that, during COVID-19, they were also responding to:

- clusters of tuberculosis
- an outbreak of blastomycosis
- flooding and fire-related community evacuations, including from First Nation communities
- the ongoing opioid epidemic and the need to increase harm reduction services including setting up consumption and treatment services.

Workforce Priorities

- Build a flexible, adaptable and resilient public health workforce within public health agencies locally, regionally, and at the provincial level (Ministry of Health and Public Health Ontario), that:
  - ◊ is cross trained in public health core competencies
  - ◊ has adaptive skills to respond to outbreaks and pandemics as well as other emergencies, while maintaining essential public health services
  - ◊ is supported by healthy work environments.
- Develop the surge capacity to quickly scale up the public health workforce and train additional responders in critical pandemic skills (e.g. vaccination, case and contact management, infection prevention and control).
- Strengthen public health agency continuity of operations plans to account for outbreaks of varying length, and identify the strategies and resources to maintain and restore public health services during prolonged disruptions.

Invest in Innovative, Leading-edge Testing and Diagnostics

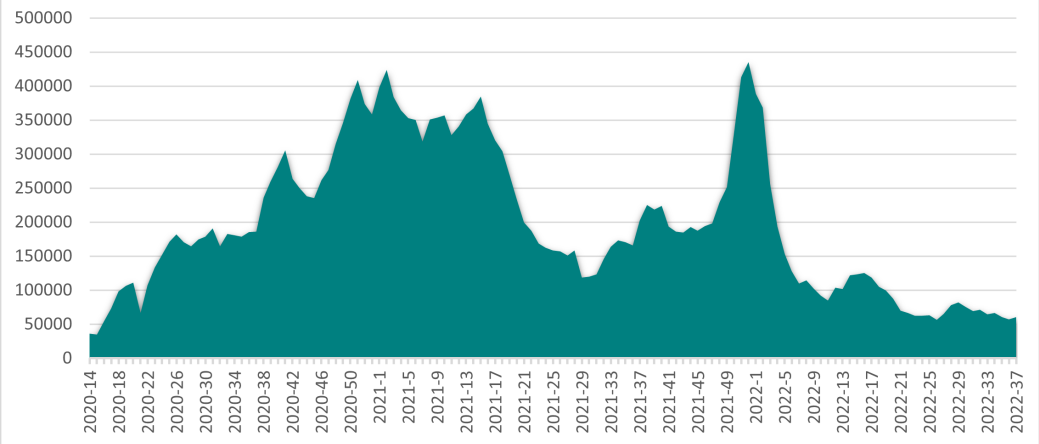
Testing capacity is essential for early detection and outbreak management.

The earlier that public health can pick up a new pathogen, the sooner it can act to contain it. Every early piece of diagnostic information buys time to understand the risk, assess whether a pathogen is emerging, spreading or mutating, and implement measures to slow or to stop its spread.

Achievements and Challenges

- As part of its collaboration with the Canadian Sentinel Practitioner Surveillance Network, Public Heath Ontario (PHO) uses community practitioners to test for influenza and other respiratory viruses to inform influenza epidemiology and vaccine effectiveness. This program allows the testing system to pick up cases early.
- When the COVID-19 pandemic began, the PHO laboratory had the capacity to process about 10,000 tests a day. Early in the pandemic, it significantly increased its capacity, and introduced new testing methodologies. To respond to increasing testing demands, the Provincial COVID-19 Testing Network, supported by Ontario Health, was formed as a network of 40 independent hospitals, public health and community laboratories. More than 170 assessment centres, over 200 pharmacies, and a number of mobile and pop-up facilities provided testing and sent samples to the laboratories in the network. At its peak, the Provincial Testing Network was processing over 100,000 COVID-19 PCR tests a day, and over 75% of people tested were getting their results within 48 hours.

Figure 6: Trends in the number of COVID-19 laboratory tests per week in Ontario over time (April 2020 to September 2022)



While the PHO Laboratory and other laboratories in the network were able to ramp up COVID-19 testing volumes, they didn't have the automated test requisition or reporting systems to support those volumes. Test requisitions were still being completed by hand, creating many person-hours of manual data entry at hospitals, long-term care homes, laboratories, and public health agencies. In the worst cases, these manual processes meant results were delayed or went missing, negatively affecting clinical care and the public health response.

The problem was highlighted in the final report of Ontario's Long-Term Care COVID-19 Commission, which recommended that Ontario "ensure laboratory surge capacity … [that prioritizes] long-term care in accessing effective testing and timely, efficient reporting of testing results, [including] ensuring long-term care homes have the technological capacity to receive electronic medical test results."

There were also geographic inequities related to accessing testing and results. The increases in provincial testing capacity mainly benefited Ontarians who lived in or near major city centres. Many people in rural and remote areas had to travel further to access a testing site, and wait longer for specimens to arrive at testing laboratories and to receive their results. These delays made it harder for public health agencies to identify and isolate people who were infected before the virus had a chance to spread. They also meant that:

- some individuals and their close contacts were in isolation longer than necessary while waiting for delayed test results
- outbreaks in long-term care homes and other settings could not be appropriately managed because of the time it took to identify individuals who were positive.

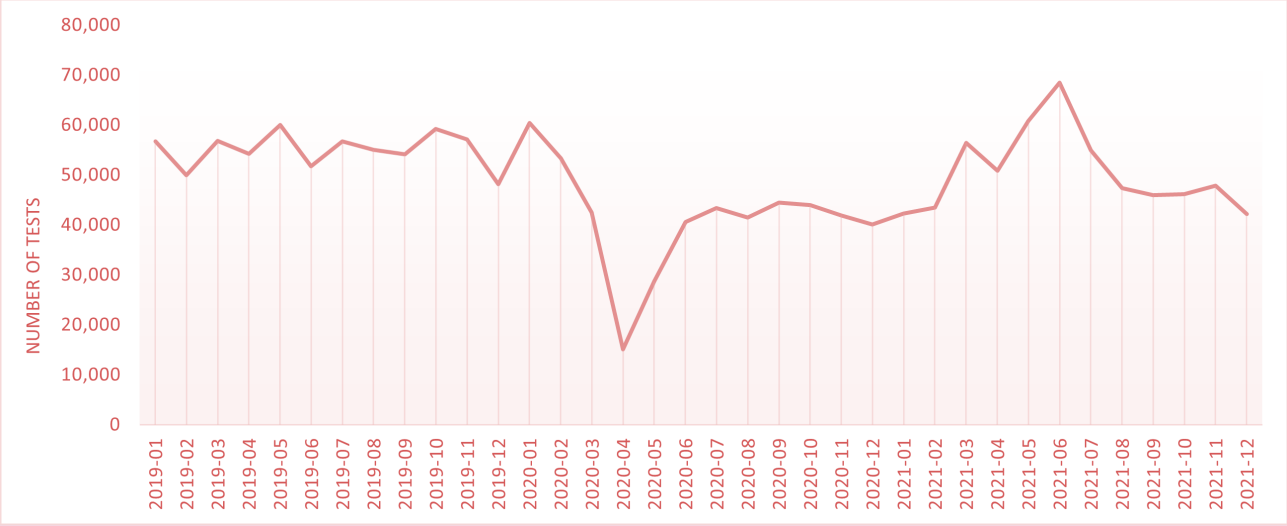
Ontario had to look for alternative strategies to provide more timely testing across the province, such as investing in rapid antigen testing kits, the introduction of ID Now testing (see box), and the use of self-collection of specimens to reduce demands on collection sites.

Lack of Laboratory Surge Capacity Limited Access to Other Testing

Ontario's rapid response to the need for COVID-19 testing came at the expense of other infectious disease testing usually done by Ontario's public health laboratories.

The combination of disruptions in clinical care and laboratory capacity issues meant people did not access the routine lab testing they would have normally received, which may have led to significant delays in diagnoses, and poor health outcomes. For example, in 2020, testing for HIV was down 26%.

Figure 7: Number of HIV diagnostic tests per week at Public Health Ontario Laboratory, January 2019 to December 2021



Outbreak planning should include strategies to ensure ongoing access to regular diagnostic testing as well as the capacity to ramp up testing for an emerging pathogen.

Case Study: ID Now Provides More Timely Testing in First Nations Communities

Northern Ontario had high COVID-19 case rates compared to the southern part of the province. Although people in the north were highly affected by COVID-19, they had less access to timely testing. To close that gap in First Nations communities, Ontario's public health sector worked closely with the Public Health Agency of Canada (PHAC) to implement the Abbott™ ID Now Analyzer: a machine that provides rapid point-of-care molecular test results. Analyzers were installed in 98 First Nations communities across Northern Ontario to provide point-of-care testing, which meant individuals in those communities no longer had to wait the days to weeks it could take to receive laboratory-based results.

Ontario worked with the communities, training local staff to conduct the tests and operate the ID Now analyzer. Challenges in implementing this testing included amending legislation to allow non-regulated health professionals to administer the testing, and finding ways to report test results to the public health agency, as part of provincial surveillance.

In the future, efforts to improve testing capacity should leverage the COVID-19 lessons on: how to provide more equitable access to testing across the province for all communities; and the health service capacities required to collect specimens in a timely and geographically equitable way. For example, providing testing resources in a variety of sites and modalities, such as primary care offices, pharmacies, community paramedics, assessment centres, mobile sites, and self-collected at home, can support rapid ramp-up of testing across the province, avoid unnecessary use of emergency departments as testing sites, and produce timely data to inform public health surveillance and response.

Testing Priorities

- Strengthen the end-to-end provincial testing infrastructure, including specimen collection and processing capacity, leading-edge testing technologies, and data systems that automate the test requisition process and reporting of results.
- Strengthen the provincial laboratory infrastructure to support high volume, province-wide testing during a pandemic while maintaining the capacity to support ongoing routine testing.
- Sustain the PHO Laboratory's capacity and expertise in the detection, monitoring, and genomics of emerging infectious diseases.

Strengthen Real-time Surveillance Systems and Scientific Expertise

Surveillance and monitoring are critical to infectious disease prevention, detection, and management.

Ontario needs timely, accurate, and detailed surveillance information as well as ready access to scientific expertise to: enhance its capacity to detect and monitor disease threats; and guide decisions about public health measures when a threat reaches a certain magnitude.

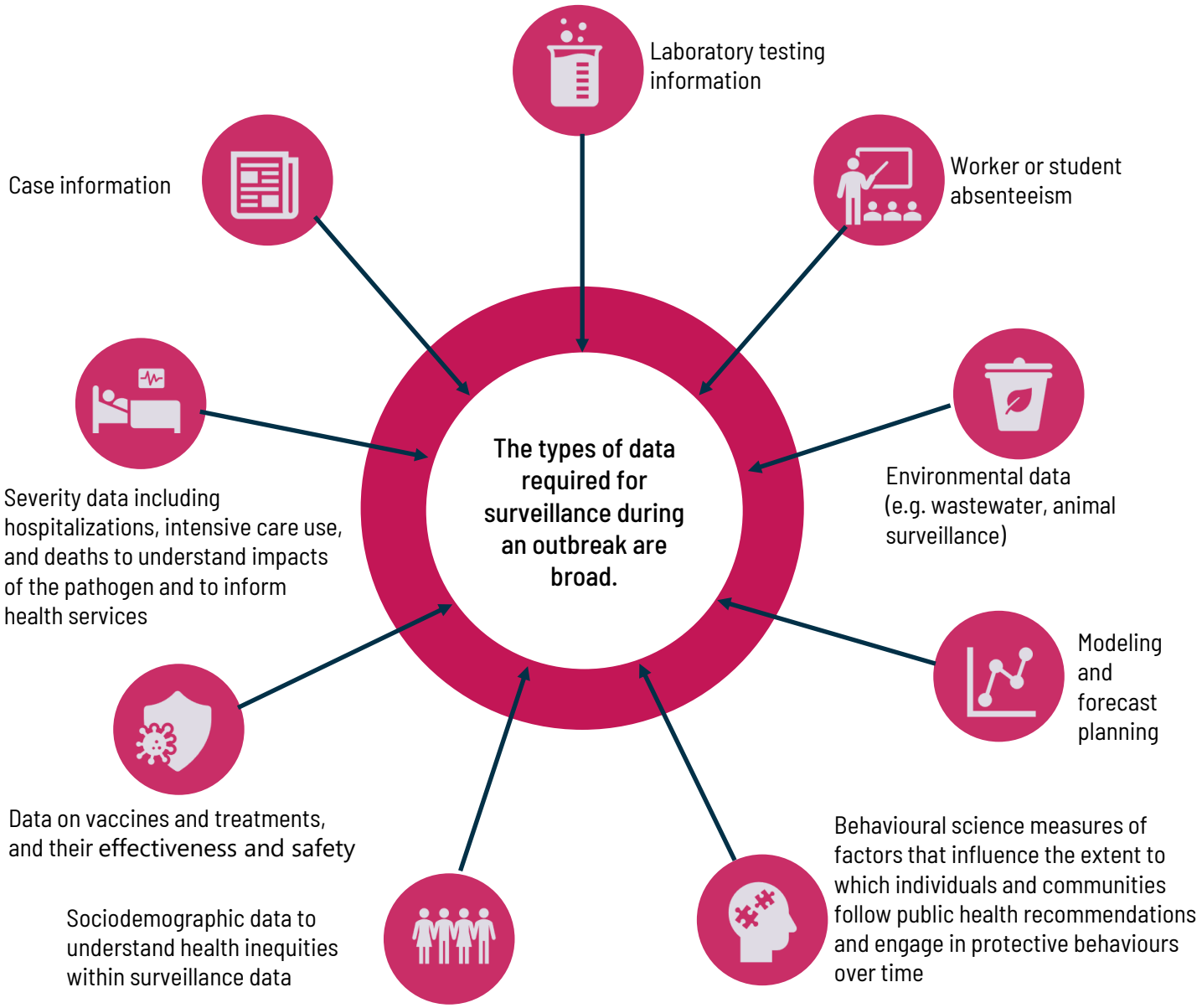
Surveillance is also key to health equity. Surveillance information is used to identify those at high risk of getting infected and/or suffering poor health outcomes, and to guide prevention and treatment. To be useful – particularly during an outbreak or pandemic – surveillance data must be collected, analyzed, synthesized, and shared quickly, preferably in real time, with those trying to understand and interrupt disease spread locally and beyond our borders.

Relevant Ontario Public Health Standards

Interpret and use surveillance data to communicate information on risks to relevant audiences.

Conduct population health assessment and surveillance regarding infectious and communicable diseases and their determinants.

Conduct surveillance and epidemiological analysis, including the monitoring of trends over time, emerging trends, and priority populations.



Achievements and Challenges

Ontario surveillance in action during COVID-19:

- Using local data showing that racially and ethnically diverse, newcomer, and low-income communities and neighbourhoods were disproportionately affected by COVID-19, the public health sector was able to target testing and immunization services to high-risk communities.
- Black, South Asian and other racialized populations were able to use local data on health disparities to advocate for and implement health services for their communities.
- Ontario used newly developed methodologies for testing municipal wastewater to help understand population-wide levels of virus within communities.
- Because of prior PHO Laboratory investments in genomic testing for foodborne illness outbreaks and human immunodeficiency virus (HIV), Ontario was a global leader in whole genome sequencing (WGS) for COVID-19. Ontario leveraged this capacity at the PHO Laboratory and other laboratories across the province to provide ongoing real-time assessments of the evolution of the virus to inform provincial, national, and global surveillance.
- COVAX – the centralized vaccination data collection system – made it possible to track uptake of COVID-19 vaccines across the province in real time. With a supportive data governance structure that made the province the health information custodian (HIC) for COVAX, Ontario had the information it needed to assess vaccine uptake and effectiveness in real time.
- PHO used surveillance data to develop a series of epidemiological reports and knowledge products synthesizing the emerging literature on COVID-19, which were used provincially and internationally.
- Ontario's open data initiatives made information about COVID-19 more transparent, and enabled researchers and scientists, including modelers, to develop analyses and models to support decision makers (Hillmer et al, 2021).
- The Ontario Science Advisory Table (now the Ontario Public Health Emergencies Science Advisory Committee of Public Health Ontario), a multidisciplinary group of researchers and scientists, analyzed provincial data and provided advice to the public health sector and government.

But there were still gaps and challenges. Ontario lacks key elements of surveillance and data system infrastructure, including data collection and use agreements to provide comprehensive and responsive data for decision-making. For example, although the greatest pandemic threat is from zoonotic viruses that spread from wildlife to people, there is a lack of integrated surveillance across human, animal, and environmental data to support a One Health approach to surveillance.

Ontario initially did not have the authority or capacity to collect data on the race, ethnicity, or other sociodemographic characteristics of COVID-19 cases to understand which populations were at greatest risk from COVID-19. It also did not have processes to ensure that the way data were collected and used respected Indigenous data sovereignty as well as the importance of responsible engagement, governance, access, and protection of race-based data.

Lack of Integrated Data Systems

Data systems used by public health agencies, hospitals, primary care, laboratories, and long-term care homes are not integrated and cannot talk to each other. Lack of information system integration results in unnecessary duplication of data collection and missing information. During COVID-19, some progress was made in integrating data to support case and contact management, and vaccination (i.e. COVAX), but those systems can currently only be used for COVID-19. They could not be adapted for MPOX when it emerged in 2022. Public health agencies had to revert to cumbersome, time-consuming manual processes for case and contact investigations and vaccinations, and MPOX case and vaccination data cannot be easily linked.

The province does not have systems that support automatic reporting of hospitalizations and deaths of individuals with diseases of public health significance. As a result, public health agencies had to use labour-intensive manual processes to assess the number of individuals with COVID-19 who had been hospitalized, were in the intensive care unit, or had died due to COVID-19.

The most effective use of scientific expertise relies on a diverse interdisciplinary range of expertise, including biomedical, social sciences, ethics, law, and history, organized to provide a pipeline of research, evidence and knowledge that integrates lessons learned from practice and provides timely, synthesized information for decision-making. During the COVID-19 pandemic, several scientific entities across the province, as well as nationally and internationally, produced similar summaries of the rapidly evolving literature. Lack of co-ordination among these scientific networks resulted in unnecessary duplication. Over the course of the pandemic, organizations in Ontario did establish an evidence synthesis infrastructure to provide rapid evidence syntheses across a range of topics to inform decision makers about the current state of the science. Approaches like this can help ensure more effective and efficient use of scientific expertise .

Case study: Recognizing Indigenous Data Sovereignty

Both the Calls to Action of the Truth and Reconciliation Commission (TRC) and the United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP) reinforce Indigenous Peoples' right to data sovereignty and self-determination.

During COVID-19, Ontario faced challenges ensuring that, when First Nations communities supported efforts to collect public health data on cases and vaccination, the data were collected, entered, and shared in a way that aligned with the OCAP® principles of Ownership, Access to, Control and Possession of First Nations data, OCAP principles for Metis, Inuit Qaujimatuqangit principles for Inuit, or other guiding data sovereignty structures in place, which are crucial to Indigenous data sovereignty and self-determination.

These principles and data sovereignty structures are not yet well established or integrated in Ontario's health care system, and it was difficult to address this gap in the midst of a global pandemic. As a result, it was challenging for First Nations communities, Indigenous Services Canada, Indigenous leaders, and public health agencies to access surveillance data that could inform and guide public health advice and responses.

The process of working with Indigenous communities to determine if and how their data will be collected, accessed, used, and managed in ways that respect their data sovereignty rights should be an integral part of ongoing outbreak and pandemic planning.

Surveillance Priorities

- Strengthen the province's capacity to conduct One Health surveillance of zoonotic viruses and environmental surveillance.
- Strengthen the provincial surveillance infrastructure to provide comprehensive real-time information on laboratory results, cases, severity, immunizations, and sociodemographic data that can be adapted quickly for use with any new or emerging pathogen.
- Develop data governance mechanisms that allow the province to access timely, relevant, local surveillance data during an outbreak or pandemic, including working respectfully with Indigenous, Black, and other racialized communities to determine how their data may be collected and responsibly used to address inequities.
- Develop proactive processes and platforms to co-ordinate the work done by scientific experts to generate evidence and knowledge products to inform public health decision-making.

Provide Critical Response Resources

Having access to the right resources in the right place at the right time is key to pandemic preparedness and response.

Maintaining access to critical response resources is particularly challenging during a global pandemic when there is fierce competition for limited resources and supply chains are disrupted. During COVID-19, jurisdictions that had invested in infection control expertise as well as stockpiles of personal protective equipment (PPE) – including masks, gloves, gowns, and hand sanitizer – as part of pandemic planning were in a much stronger position to respond than those that had not.

While future pandemics may create different resource needs (e.g., ventilators, acute care capacity, therapeutics), all will require logistical planning to ensure access as well as ethical frameworks for allocating resources during shortages. Three types of critical response resources are likely to be required during all outbreaks and pandemics:

- infection prevention and control interventions and expertise in both health care and non-health care congregate settings
- dependable supplies of personal protective equipment
- timely access to vaccines and therapeutics (if/when available).

Infection Prevention and Control Interventions and Expertise

Infection prevention and control (IPAC) interventions and expertise are a critical public health resource – and a key tool in preventing and managing outbreaks.

IPAC expertise has traditionally been focused on acute health care settings, but it is a first line of defence against infectious diseases in all settings where people congregate, including long-term care homes and retirement homes, workplaces, schools, post-secondary residences, correctional facilities, shelters – even our own homes. Effective IPAC interventions and practices can reduce the spread of seasonal illnesses and improve overall health and resilience; they can also help prevent the emergence of new pathogens.

Achievements and Challenges

Outbreaks are quick to find weaknesses in infection prevention and control.

In 2003, SARS revealed IPAC deficiencies in the acute care sector. As part of the post-SARS investment in pandemic preparedness, the health system made a substantial investment in IPAC programs and expertise, which focused on acute care settings and had limited resources to support other settings.

COVID-19 exposed IPAC deficiencies in other parts of the health care system, such as long-term care homes and retirement homes, and in other community settings, such as shelters and workplaces. Many non-acute care health settings did not have access to the IPAC resources and expertise they needed or the right practices consistently in place to prevent the spread of COVID-19. Community settings also faced significant challenges applying IPAC recommendations for health care facilities in their context.

Ontario does not have enough certified infection control practitioners to meet demand. The province also needs more evidence about how to help health care and non-health care settings as well as individuals consistently implement IPAC interventions and practices.

In an effort to address the IPAC gaps, Ontario took steps to improve the quality and consistency of infection control interventions and practices during COVID-19:

- It established regional IPAC hubs responsible for providing expertise and support to community-based congregate living settings funded and overseen by the Ministries of Health, Long -Term Care, Seniors and Accessibility, Municipal Affairs and Housing, and Children, Community and Social Services including: long-term care homes, retirement homes, shelters, supportive housing, and other residential settings.
- The hubs were supported by the Ministry of Health, public health agencies, Public Health Ontario, and Ontario Health, as well as local hospitals, which provided just-in-time advice and assistance on infection control issues. This expertise helped congregate-living settings build their internal IPAC capacity.

The average citizen and employer may also now have a better understanding of the layers of infection prevention and control measures that can help protect against the spread of respiratory pathogens, such as hand hygiene, staying home when sick, wearing a mask in public spaces, and improving indoor air quality and ventilation. Ontarians may be more likely to adopt these measures as part of their day-to-day lives, as well as during outbreaks and pandemics.

However, more must be done to be ready for the next outbreak. Ontario's Long-Term Care COVID-19 Commission (2021) recommended that public health "develop minimum standards, best practices, and principles related to IPAC capacity, training and certification for both IPAC leaders and staff in long-term care homes."

The Role of Policies and Environmental Changes in Infection Prevention and Control

The COVID-19 pandemic highlighted the potential for social policies, technologies, and environmental changes such as better ventilation to help prevent disease transmission. For example:

- The Ontario government compensated people for up to three COVID-19 related sick days so they could stay home when ill.
- Both the provincial and federal governments invested in improvements to ventilation and indoor air quality in a variety of settings, including hospitals and schools (Government of Ontario, 2021; Government of Ontario, 2022).
- Ontario provided direction for businesses, organizations, and individuals on how to reduce the risk of COVID-19 transmission by improving filtration and ventilation (Ontario Agency for Health Protection and Promotion, 2022; Siegel J, 2021).
- Many buildings installed touch-free doors, faucets and toilets, and many redesigned ventilation systems and installed air filtration systems to reduce the spread of respiratory viruses and bacteria.
- Long-term care homes now limit the number of residents sharing rooms and have redesigned rooms to help prevent transmission of infectious diseases.

These types of policy and environmental changes can make communities more resilient in the face of an outbreak, and should be part of the pandemic preparedness toolkit.

Dependable Supplies of Personal Protective Equipment

Although the type of personal protective equipment (PPE) needed for the next outbreak will depend on the pathogen, PPE will always play a role in reducing risk.

Early in the COVID-19 pandemic, Ontario's capacity to provide PPE was limited by both global and local factors, including: massive worldwide demand, supply chain issues, local stockpiles that had expired, competition among sites trying to purchase supplies, distribution challenges, and the lack of local companies producing PPE.

Achievements and Challenges

Over the course of the pandemic:

- The province negotiated agreements with domestic manufacturers to produce PPE to ensure the province would have a stable supply.
- The province co-ordinated the centralized purchasing and distribution of PPE supplies to ensure fair and timely access for health care settings across the province.
- Provincial guidance on the appropriate use of PPE was updated over time to reflect evolving evidence.

However, PPE was a challenge throughout the pandemic, mainly due to changing guidance on the use of PPE in non-health care settings, and the ability of those settings to get appropriate PPE for their staff. As Ontario's Long-Term Care COVID-19 Commission (2021) notes: "As part of its pandemic planning, the province should ensure that there is a central procurement process for personal protective equipment and other necessary supplies [and maintain] within the province of Ontario a capacity to manufacture PPE [and] a provincial pandemic stockpile including personal protective equipment and other necessary supplies."

Timely Equitable Access to Vaccines and Therapeutics

Vaccines, when available, are a critical tool in stopping or controlling the spread of communicable diseases or reducing the risk of severe illness.

In the early stages of an outbreak, there may be global competition for vaccine and, as was the case with COVID-19, demand may exceed supply. The federal government is responsible for vaccine supply, including negotiating contracts to purchase vaccine, and working with academic hubs and manufacturing facilities to develop the capacity to produce vaccines in Canada. However, it is up to the provinces and territories to establish vaccine priorities, manage distribution, and collaborate with academic partners to monitor vaccine effectiveness and safety.

Investing in Innovation

Ontario has a critical mass of scientists and researchers involved in vaccine and therapeutic research and development. Every effort should also be made to build the province's capacity to innovate and contribute to efforts to find better vaccines and treatments as well as more effective ways to detect and protect against emerging pathogens.

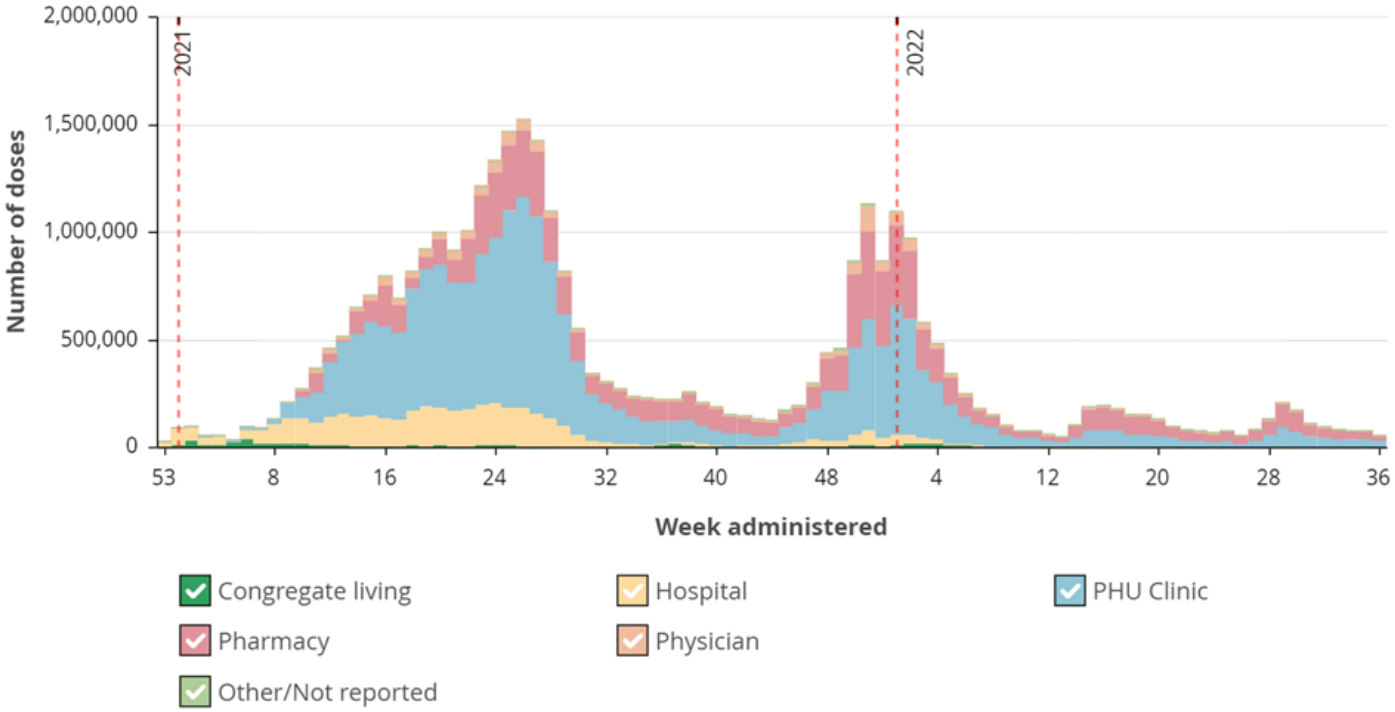
Achievements and Challenges

The world now has the expertise and technologies to rapidly develop highly effective, safe vaccines for some emerging pathogens. Ontario has also demonstrated through two outbreaks – H1N1 and COVID-19 – that it has the infrastructure and capacity to ramp up immunization services. Once a supply of COVID-19 vaccine was available in Canada, Ontario leveraged parts of the health care system to vaccinate the population quickly and efficiently:

- Ontario's public health agencies successfully used a combination of their own staff and other partners, such as hospitals, pharmacies, Indigenous agencies, and paramedics to deliver mass vaccination clinics.

- At the peak of its immunization drive, Ontario delivered over 1.5 million doses in a week.

Figure 8: Weekly number of COVID-19 vaccine doses administered in Ontario by vaccination setting



- Indigenous people were a priority for immunization because of the high risk of poor outcomes from COVID-19, particularly in remote communities that have few health services. To help protect those communities, Ontario launched Operation Remote Immunity. The program successfully delivered immunizations to 31 remote Indigenous communities and Moosonee. Indigenous and public health leaders, community members, and front-line providers worked together, with the support of Ornge, the air ambulance and critical care transport services and Indigenous Services Canada, to get people vaccinated. Community coordinators helped overcome vaccine hesitancy and organized vaccine clinics (Government of Ontario, 2021; Baifuzhiyeva D, 2022).
- The Black Physicians Association of Ontario and the Black Health Alliance worked with local public health agencies and health partners to address the disparities in early vaccine rollout, and increase coverage and protection for Black communities across the province (Black Health Alliance, 2022).
- As the COVID-19 vaccination program expanded and became more complex, public health and health system partners adapted quickly to changing guidance and implemented individual and population level recommendations, while maintaining high levels of vaccine distribution across the province.
- Ontario has also been successful in finding innovative ways to take immunization services to populations and groups who, because of personal health concerns, work schedules, distance from mass immunization clinic sites, lack of public transportation, problems accessing the online booking system, or vaccine hesitancy, may not have received their vaccines. Effective vaccination programs must be able to deliver mass immunization clinics as well as targeted vaccine programs to reach everyone possible.

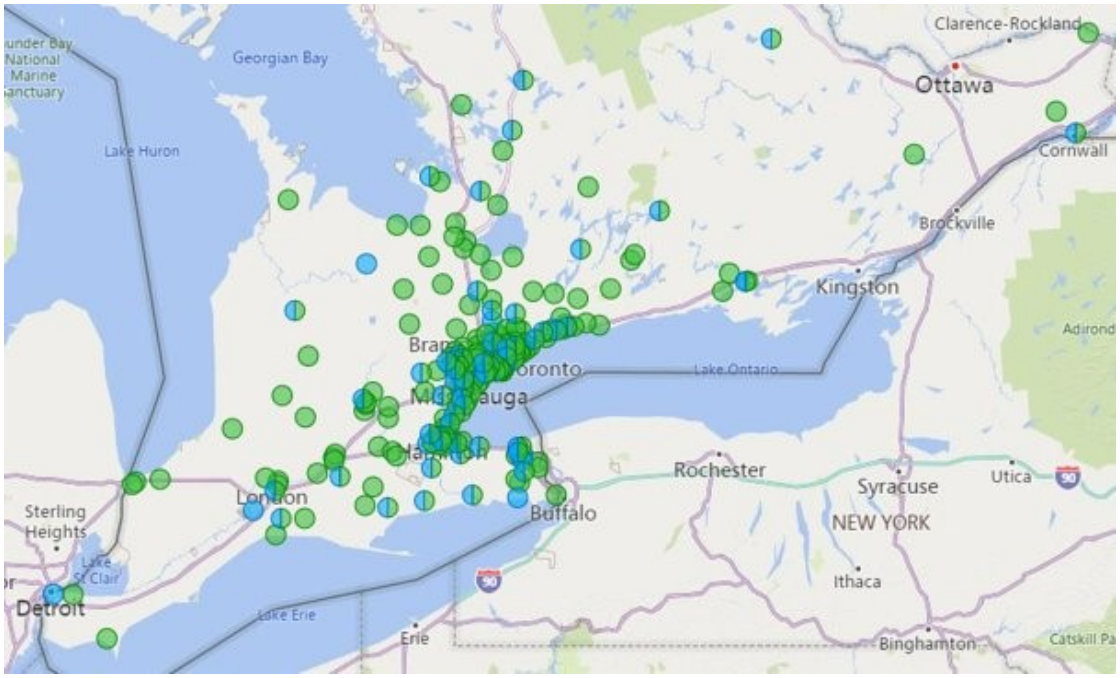
Ontario has been very successful in getting its population vaccinated: 81% of Ontarians are now fully immunized (two doses). However, only 50% have received a third (booster) dose, and vaccine uptake in children is lower than expected. These gaps are not due to lack of access to vaccines but to other factors, such as vaccine hesitancy, less sense of urgency as the number of hospitalizations and deaths drop, and/or the message that younger people are at less risk of serious illness.

Case Study: GO-VAXX Bus and Mobile Clinics Reach Under-vaccinated Groups

Between August 2021 and July 2022, the GO-VAXX Bus and Mobile Vaccine Clinics delivered almost 150,000 doses of COVID-19 vaccine to under-vaccinated groups in 26 of the province's 34 public health unit areas. The initiative, led by the Ministries of the Solicitor General and Health, worked with Metrolinx, local public health agencies, and other ministries and partners, to retrofit buses to serve as mobile vaccine clinics (GO-VAXX), and to operate pop-up clinics in indoor sites. The goal of these clinics was to reach Ontarians who might face barriers scheduling appointments at mass immunization clinics. The clinics set up in a range of settings including: shelters, homes for people with developmental disabilities, senior living facilities, community centres, shopping malls, sporting events, religious and cultural organizations, schools, and post-secondary institutions.

Part of the success of the GO-VAXX bus is that, for people who are anxious about or distrust the health system, it is not a traditional clinical environment. Although it is a fully functioning vaccine clinic, it has a non-clinical feel that makes it easier for people who are hesitant or nervous about getting their vaccines. The mobile vaccination clinics also tailor their approach to the community they are trying to reach: they work with community groups to plan the clinic and make special accommodations to meet community needs.

Figure 9: Sites of GO-VAXX bus and mobile vaccine clinics (August 2021–July 2022)



Access to Therapeutics

In future outbreaks and pandemics, effective treatments may be developed more quickly than vaccines, or there may be an urgent need for widespread delivery of therapeutics. As part of outbreak preparedness, the public health sector must co-ordinate with the broader health system to develop a plan and ethical framework for distributing treatments that may be in short supply. The plan should include strategies to ensure: equitable access across the province, ethical decision-making about how to prioritize groups for treatment, expert advice to develop and update clinical treatment guidelines, and research on the impact of novel therapies.

Priorities for Critical Response Resources

Infection Prevention and Control Expertise

- Develop the evidence, policies, procedures, minimum standards, best practices – including environmental changes, such as better ventilation, and expertise, such more certified infection control practitioners – to support appropriate use of IPAC interventions and practices in non-health care settings (e.g. congregate living settings, workplaces, schools).

- Strengthen Ontario's capacity to provide IPAC evidence, policies, procedures, minimum standards, best practices – including interventions for the built environment and IPAC expertise –– in all health care settings to reduce risks posed by emerging pathogens, particularly zoonotic diseases and antibiotic resistant organisms.

Personal Protective Equipment

- Sustain the local capacity to produce PPE, and establish, manage, and distribute a reliable rolling provincial stockpile of appropriate PPE that will avoid equipment expiring, and ensure sufficient supply to meet demand during a pandemic.

Vaccines and Therapeutics

- Sustain partnerships with the health care system, including with pharmacies, to manage the timely, equitable distribution and delivery of vaccines and therapeutics, using a variety of approaches (e.g. mass, mobile and pop-up clinics, and population-specific programs).

II. Community Readiness

Individuals and communities fare better during disease outbreaks when they are in good health and live in favourable social conditions.

People are healthier and more resilient when they:

- have supportive friends and family
- are educated
- are stably housed
- are employed in jobs where they earn a good living and have paid sick time
- live and work in safe physical environments, have easy access to health services
- healthy food and opportunities to be physically active
- have good coping skills
- do not face discrimination or racism.

While Ontarians are generally healthy, there are people in every community who do not have the same opportunities as their neighbours to enjoy good health. Because they experience inequities in factors such as income, employment, housing, education, and access to health services, and/or the impacts of systemic racism and colonialism, they have worse health outcomes. When outbreaks happen, these individuals and groups are again at higher risk of worse health outcomes.

To strengthen community readiness, the public health sector must work with populations facing health inequities to improve health and resilience before a new pathogen emerges. To do that, public health agencies must:

- Build enduring community partnerships
- Engage communities in co-creating and testing outbreak plans
- Improve health equity and resilience

Relevant Ontario Public Health Standards

Engage in multi-sectoral collaboration with municipalities and other relevant stakeholders in decreasing health inequities.

Engage with Indigenous communities and organizations, as well as with First Nation communities striving to reconcile jurisdictional issues, including fostering and creating meaningful relationships, starting with engagement through to collaborative partnerships.

Lead, support, and participate with other stakeholders in health equity analyses and policy development, and advance healthy public policies that decrease health inequities.

Build Enduring Community Partnerships

To improve health equity, the public health sector must build enduring, trusting partnerships with communities before the next threat occurs.

Collaborative partnerships respect and build on community strengths, including trusted community leaders who have an in-depth understanding of how their communities work, and the barriers they face. Community leaders can provide valuable advice to public health on the community's needs, how to adapt public health services to meet those needs, and how to communicate effectively with community members.

The process of building enduring partnerships must include opportunities to develop trust with communities that have not previously had strong working relationships with provincial public health agencies; and strategies to ensure partnerships are maintained over time (i.e. when the individuals involved in those partnerships change).

As Ontario learned during COVID-19, the process of working with communities must be deeper, more collaborative, and more sustainable than traditional approaches to community development.

True relationship building with First Nation communities must be reciprocal and go beyond "just one more consultation".

Achievements and Challenges

During COVID-19, there were many examples of local public health agencies collaborating with communities to improve health outcomes:

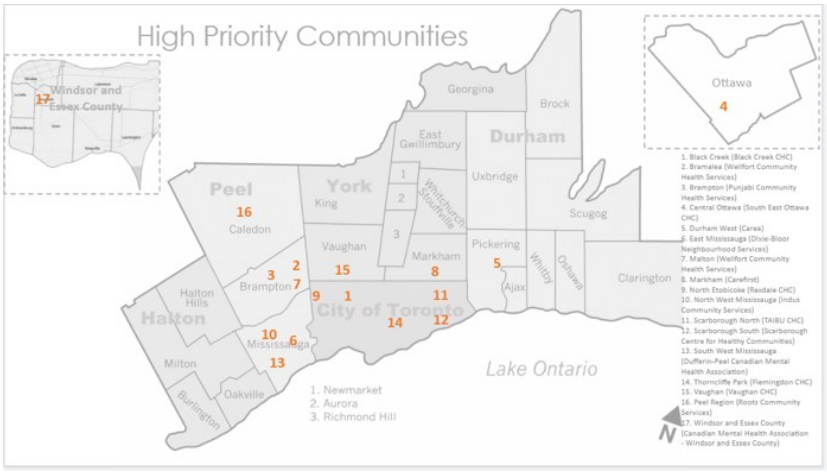
- The High Priority Communities Strategy (see below) was able to increase immunization rates significantly in communities at greater risk of COVID-19 infection and more severe outcomes. However, the strategy was limited to specific neighbourhoods, and not all communities that could have benefited from these supports received them.
- Special efforts were made to reach culturally and linguistically diverse communities. For example, local public health agencies located in areas designated under the French Language Services Act leveraged existing mechanisms and relationships to engage Francophone communities in planning and delivering services that would reach and meet the needs of Francophone Ontarians.
- Provincially funded local community ambassadors helped local public health and community health agencies connect with culturally and linguistically diverse communities with higher needs.
- In some cases, communities worked with local public health agencies to adapt public health guidance to reflect their living conditions, such as modifying hand hygiene recommendations for households without running water, or adapting isolation recommendations for people living in crowded housing conditions.
- Local public health agencies supported First Nations communities' sovereign authority to enact their own by-laws to, for example, close communities to outside people, and reopen borders, schools, and businesses on reserve.
- Some local public health agencies worked collaboratively with community leaders and services to develop strong partnerships to help people in isolation meet their basic needs (e.g. food, social supports, internet connectivity, phones).

The High Priority Communities Strategy: A Model for Greater Health Equity

When it became clear that certain communities were at greater risk of severe COVID-19 outcomes, the province and many local public health agencies worked with those communities to implement the **High Priority Communities Strategy** to reduce health risks and inequities.

The strategy used surveillance data to identify 17 high priority communities across the Greater Toronto Area, Windsor and Ottawa based on: prevalence of COVID-19, low testing and vaccination rates, and other factors (e.g. social determinants of health) that could affect access to health services (racial/ethnic diversity), and challenges meeting basic needs (material deprivation).

Figure 10: High priority communities



The provincial team collaborated with lead agencies in each community to plan and implement culturally and linguistically appropriate initiatives that would reduce barriers and improve access to community outreach and education, testing and vaccination, and wrap-around social supports. The communities developed targeted communications in relevant languages. They hired community ambassadors armed with information to promote COVID-related services and supports, and combat misinformation and myths. Testing and vaccination services were offered by trusted primary care providers in culturally safe settings and in relevant languages, and the clinics ran for longer hours and provided transportation. Each community also provided case management and referrals to other services, such as emotional support, access to PPE, isolation facilities, grocery shopping, food banks, and financial assistance.

Because of these initiatives, testing and first dose vaccination rates in high priority communities are now comparable to those in other parts of the province.

The High Priority Communities Strategy involved:

- focusing proactively on those at increased risk, based on community knowledge of the drivers of poor health outcomes
- engaging the community based on trust, and funding lead agencies, community leaders, and peers to deliver culturally responsive services
- making it a priority to bring health and social services together to solve disparities in access and outcomes
- establishing a sustainable network of partners to maintain relationships between communities and care teams
- developing an infrastructure for effective care management that directed resources where they were needed most.

Even strong community partnerships can be tested in pandemic situations, and those scenarios become more difficult when there is no pre-existing trusting relationship.

Local public health agencies reported that it was challenging to manage outbreaks and implement appropriate public health measures in congregate or crowded living settings, such as shelters (see box).

Case Study: Adapting Public Health Measures to Shelters

Early in the pandemic, outbreak measures for individuals living in shelters were highly restrictive. Every time a case of COVID-19 was diagnosed in a shelter, others using the services had to go into isolation or quarantine for extended periods of time. That meant they were unable to work or access support services. Some clients chose to stop using shelter services rather than live with these restrictions.

While many local public health agencies had strong relationships with local shelters and their clients, and they worked with community partners to support shelter clients, they could not meet all the needs. Staff of all the agencies involved found it very discouraging that efforts to protect vulnerable people from COVID-19 were having such a negative impact on their health and social well-being. In some regions, homeless shelters moved to different models of operation, such as using hotels – but that option wasn't available in all communities.

In some First Nation communities, a large proportion of the community could be in isolation or quarantine for long periods of time while ill individuals waited for test results. In other cases, communities opted to use additional measures to keep COVID-19 from entering their community. For example, members returning to the community had to be tested pre-arrival and then go into an extended quarantine. While these measures protected the community, they increased the stress on individuals and families, and affected people's mental health.

Engage Communities in Co-Creating and Testing Outbreak Plans

> **[P]andemic plans … must be reviewed, assessed and drilled annually. The province should set out a testing strategy that involves a review of the pandemic plans and full simulations that engage all key stakeholders involved in implementing the plan.**
>
> Ontario's Long-Term Care COVID-19 Commission, 2021

Outbreak planning is a process of ongoing learning and continuous quality improvement.

Tabletop and other full-scale simulation exercises are a key tool in emergency preparedness. They provide the opportunity to test assumptions, relationships, and plans, and identify and address problems or gaps.

Tabletop and simulation exercises usually involve people from different organizations collaboratively working through an outbreak or pandemic scenario. Because of the key role that community partners, including at-risk communities, play in outbreak response, they should be part of processes to co-create outbreak plans, exercises to test the plans, and ethical discussions about prioritizing access to scarce resources.

Relevant Public Health Standards

If no lived experience from disruptions or emergencies has occurred in the past 3 years, practice in whole or in part emergency plans and 24/7 notification procedures every three years.

Apply a self-assessment process to emergency management. This process may be applied to tests, exercises, simulations, and/or emergency plan activations and agency responses.

Planning for seasonal community-wide outbreaks, such as influenza, provides ongoing opportunities for local public health agencies to engage communities and the broader health system in tabletop and simulation exercises, assess readiness, and identify gaps and issues.

In addition to organizing tabletop and simulation exercises to test outbreak plans, the public health sector should document lessons learned from actual outbreak responses. What worked? What didn't? What could have been done differently? Evaluating real experiences is a critical part of the adaptive learning process.

Community Readiness Priorities

- Strengthen efforts to build enduring collaborative partnerships between local public health agencies and communities that face health inequities, systemic racism, and discrimination, and work with them to adapt public health services to meet their needs.
- Strengthen the public health sector's capacity to engage the broader health sector and community partners in co-creating and testing outbreak plans, and documenting and applying lessons learned from past outbreaks to emerging threats.
- Conduct regular exercises and simulations to test and improve outbreak plans.

Improve Health Equity and Resilience

The public health sector has a responsibility to assess the health of the population, identify health inequities, and work with partners and governments to implement interventions to reduce those inequities.

To identify individuals or groups coping with health inequities, local public health agencies need to routinely and responsibly gather information about their population's health, as well as the social, economic and demographic factors that can affect health, such as: age, sex, gender, sexual orientation, income, education, race, ethnicity, language, employment and unemployment rates, population growth, the number of seniors living alone, the number of lone-parent families, the number of newcomers, how many people own their own homes and how many rent, access to affordable housing experiences of racism or discrimination, access to healthy foods and physical activity, immunization rates, rates of preventable diseases and their impact on hospitalizations and deaths, and other factors that affect healthy growth and development.

Analyzed at the individual level, sociodemographic data can help the public health sector identify groups experiencing health inequities, and subsequently work with those groups - as well as with governments and other partners - to develop and advocate for upstream interventions that improve health equity and resilience.

Relevant Ontario Public Health Standards

Assess and report on the health of local populations, describing the existence and impact of health inequities and identifying effective local strategies that decrease health inequities.

Use population health, social determinants of health, health inequities, and other sources of information to assess the needs of the local population, including identifying populations at risk of negative health outcomes, to determine the groups that would benefit most from public health programs and services.

Achievements and Challenges

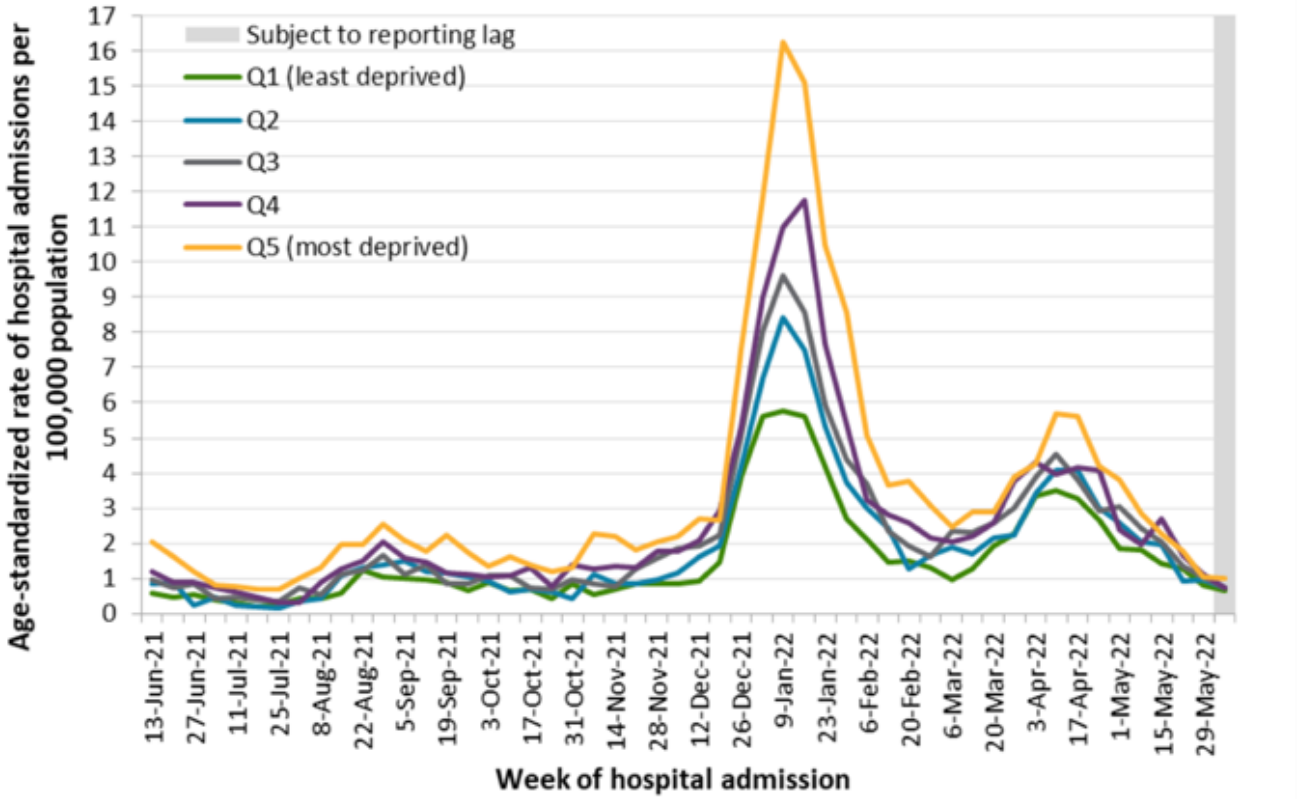
Some sociodemographic data became available as part of COVID-19 vaccine and case management. This information was extremely helpful in guiding initiatives like the High Priority Communities Strategy. However, the data were not complete or easy to collect.

At the current time, Ontario is not able to identify individuals or groups at risk of poor outcomes from future disease threats because it doesn't routinely collect sociodemographic information. To understand and address health inequities – both before and during an outbreak or pandemic – the province needs a more systematic way to routinely collect and update this information for all Ontarians, with the appropriate privacy, data safeguards, data sovereignty, and respect for Indigenous, Black and other racialized populations. Once developed, this capacity to identify groups at risk could be leveraged to improve health inequities beyond pandemics and across the health system.

During COVID-19, Ontario also experienced gaps in information about risk and the impacts of public health measures. For example:

- Local and international outbreak information indicated that some workplaces were at higher risk of having severe COVID-19 outbreaks; however, Ontario did not routinely collect information on the occupation and job type of people diagnosed with COVID-19. As a result, the public health sector was not able to assess the frequency of COVID-19 cases by occupation, understand workplace risks, or evaluate the effectiveness of workplace interventions (Buchan et al, 2022).
- Public health measures used during a pandemic can have unintended consequences for people's health and increase health inequities. For example, school closures have a more negative effect on children in families with low incomes, and families in communities with higher rates of COVID-19 – many of whom were lower income (see Figure 11) – were more likely to choose virtual school for their children even after the schools reopened (Chaabane et al, 2021).

Figure 11: Confirmed COVID-19 cases that were admitted to hospital (per 100,000 population), by quintile of neighbourhood material deprivation and hospital admission week, June 2021 to May 2022

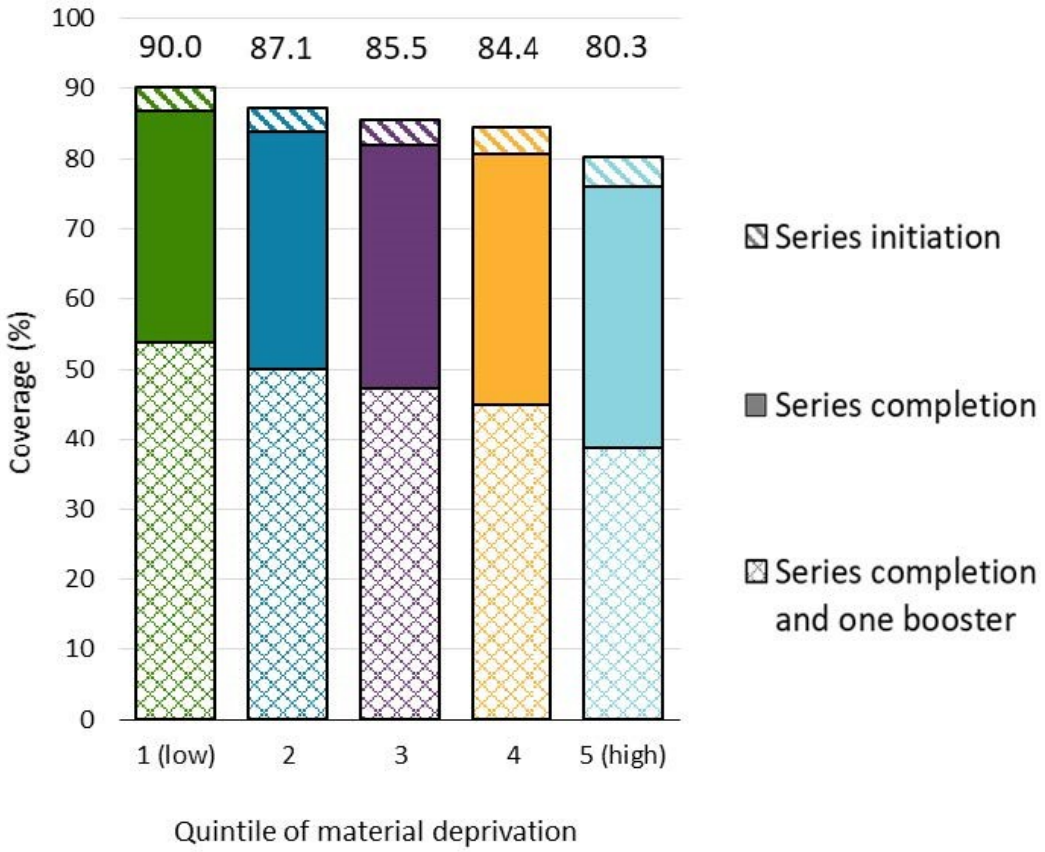


The Role of Sociodemographic Data in Identifying Health Inequities

Sociodemographic information that became available as part of case and vaccination data revealed that communities with a higher proportion of immigrants, Black and other racialized populations, and populations with low socio-economic status had a higher incidence of COVID-19 cases and deaths.

These same communities also faced barriers accessing vaccine (see Figure 12), and their residents were more likely to experience marginalization related to racism, discrimination, or other barriers to accessing resources (Ontario Agency for Health Protection and Promotion, 2022; Amberber et al, 2021).

Figure 12: Vaccination coverage for individuals aged 5 years and older by quintile of neighbourhood material deprivation: Ontario, December 14, 2020 to February 21, 2022



Health Equity Priorities

- Develop provincial systems to support the responsible and respectful collection, linkage, governance, and use of social, economic, health outcomes, and other sociodemographic data (including information on age, sex, gender, sexual orientation, race, ethnicity, language, preferred official language, income, occupation, access to services) to help the public health sector identify and address health inequities in their communities.
- Sustain the public health sector's efforts to work with populations at risk and leverage local innovation to co-design and advocate for upstream interventions that will reduce health inequities, build community strengths, and increase resilience.

III. Societal Readiness

The effective use of public health measures to prevent or manage outbreaks depends on a resilient, supportive society.

Outbreaks and pandemics raise difficult ethical questions that influence all aspects of preparedness and response, including how to allocate scarce resources, and whether or when to limit individual or societal freedoms. In a supportive, "ready" society, citizens are willing to act for the common good. They follow public health advice and recommendations, and they adhere to mandatory measures such as stay-at-home orders, mask mandates, and vaccine passports.

Measures adopted during an outbreak must be consistent with society's ethics and values, and must be clearly and transparently communicated. When people understand why certain decisions are made and have the necessary supports, they are more likely to adhere to public health recommendations.

However, to be ready and supportive, citizens must:

- Have relatively high levels of trust in government
- Understand and accept the ethics and values underlying public health decisions
- Understand and accept the government's and public health's legal authority to implement measures to protect the health of the population
- Have the information and supports they need to follow public health advice (e.g. the risks associated with the particular disease, the populations most affected, the evidence showing the measures are effective, easy access to masks and tests, places to isolate, and supports during isolation and quarantine)

To increase societal readiness for the next outbreak or pandemic, Ontario's public health sector must:

- Build social trust and ethical preparedness
- Communicate clearly and transparently with the public, and counter misinformation

Build Social Trust and Ethical Preparedness

The effectiveness of pandemic responses is related to social trust.

In countries where citizens had higher levels of trust in their government and in one another, infection rates were lower and vaccine coverage was higher (COVID-19 National Preparedness Collaborators, 2022)

Trust is closely correlated with people's sense that the government is doing the right thing: that is, making decisions that are in society's best interests, reflect shared social values, and achieve stated pandemic goals.

Who should be first in line for masks, vaccines, or treatments? How should vulnerable populations be protected or supported? What sectors should remain open? How do we prioritize pandemic health services while maintaining routine health services? When is it acceptable to make some public health measures mandatory? How should we navigate trade-offs between competing objectives or values?

Relevant Ontario Public Health Standards

Ensure a culture of quality and continuous organizational self-improvement that underpins programs and services and public health practice, and demonstrates transparency and accountability to clients, the public, and other stakeholders.

People are more likely to maintain trust in government when the answers to these questions reflect society's shared ethics and values. While it may not be possible to reach consensus on any of these difficult issues, it is incumbent on the public health sector to be transparent about its decisions, the decision -making process, and the rationale for those decisions. The sector must engage communities so that the ethics and values underpinning those decisions reflect the voice of the community, and be willing to revisit decisions at frequent intervals as well as when new information emerges.

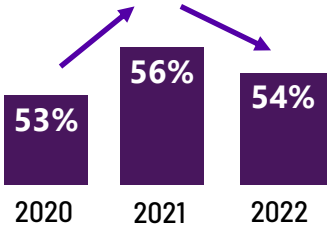
Trust is also closely correlated to reciprocity: individuals are more likely to adhere to public health measures if they have access to the supports and resources needed to follow those measures. For example, an individual who has to isolate for several days to avoid spreading illness to others is more likely to do so if they have a place to isolate and receive the physical, emotional, and financial supports they need while in isolation.

Frank public conversations about shared values, ethical frameworks and trade-offs should happen before an outbreak, as part of outbreak planning. These conversations should be revisited when an outbreak occurs to make sure that society still understands and shares the same values.

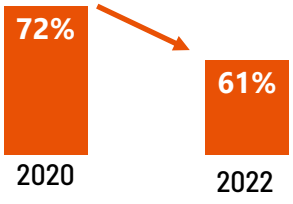
Achievements and Challenges

Measures of social trust have varied in Canada and Ontario over the past three years:

- According to the Edelman Trust Barometer (2022), an international survey assessing the general populations trust in democracies, Canadians have relatively 'neutral' levels of trust that rose and then fell during the pandemic: **53% in 2020, 56% in 2021**, **54% in 2022**. However, Canadians had higher levels of social trust than other comparable countries including the United States, Australia, Germany, and the United Kingdom.



- An Ipsos' international survey of social cohesion found a similar trend: between late 2020 and March 2022, the proportion of Canadians who trusted in other Canadians to "do what is in the best interest of the country" dropped from **72%** to **61%,** while trust in government to "do what is right" dropped from **58%** to **43%** (Sethi, 2022).



- During COVID-19, Ontario used data from behavioural measures surveys to understand where Ontarians were obtaining information, their trusted sources of information, and their awareness and compliance with recommended public health measures. Based on those surveys, Ontario experienced relatively high levels of public trust in government and adherence with public health measures, including high compliance with masking and high rates of immunization, particularly for the first two vaccine doses. There is also evidence that provincial and local medical officers of health were highly trusted and credible sources of information (Ontario Ministry of Health, 2022).
- Not all Ontarians agreed with all public health measures, and support for some measures dropped over time. Many public health officials became the targets of abuse and threats. Early public support for health care workers (e.g. going out each evening to bang pots) was replaced by anti-mask protests outside hospitals.

> Social cohesion can rise in the aftermath of natural disasters or mass tragedies, but this "coming together" is often short-lived. The early stages of the COVID-19 pandemic witnessed marked increases in kindness and social connection, but as months passed social tensions re-emerged or grew anew. Thus local authorities faced persistent and evolving challenges.
>
> The social cohesion investment: Communities that invested in integration programmes are showing greater social cohesion in the midst of the COVID-19 pandemic, Lalot et al, 2021

Ontario employed a variety of mechanisms to build social trust and ethical preparedness during COVID-19, including:

- The Public Health Measures Table, made up of Medical Officers of Health and Public Health Ontario, provided confidential advice to the Chief Medical Officer of Health on the type and timing of different public health measures throughout the pandemic.
- Ontario's COVID-19 Bioethics Table (2022), developed briefs and guidance on a range of ethical issues, including: priority-setting for personal protective equipment, paid sick leave, a framework for ramping down elective surgeries and other non-emergent activities, and ethical frameworks for drug shortages and vaccine distribution. The public health sector used these frameworks to integrate ethical issues (e.g. harms and benefits, fairness, legitimacy, trust) into the plans to distribute vaccines and therapeutics.

> There is broad agreement that, even in a crisis, doing the right thing must take account of fairness. … Doing the right thing also means taking proper account of individual rights … while recognizing that, at times and to the least degree possible, those rights may have to be limited for the safety and well-being of others. [It is a] difficult balancing act of reducing harm, tackling unfair health inequities and minimizing measures that are coercive.
>
> Ethical Preparedness
> Archaud, 2022

Because the process of developing ethical briefs and frameworks occurred in the midst of a pandemic, it was not possible to involve society as a whole in the conversations. It was also challenging to communicate to the public "why" certain decisions were made, and the steps that decision makers took to try to balance competing ethical principles and societal objectives.

Most of the briefs from the Bioethics Table focused on making decisions about health services. However, some of the most challenging ethical decisions during COVID-19 were about non-health services, such as public health measures that closed businesses and schools, the restrictions on visitors in long-term care settings, and the use of vaccine passports. Some of these decisions were less transparent: Ontarians did not necessarily understand the ethical values or trade-offs underlying them.

Unintended Negative Consequences of Public Health Measures

Another ethical challenge that should be considered as part of pandemic preparedness is the fact that many public health decisions and interventions required to control an outbreak can have significant unintended negative consequences for individuals, families, communities, and society. For example, during COVID:

- School closings affected parents' and children's mental health. A survey of Ontario parents found one in three had moderate to high levels of anxiety, 57% met the criteria for depression, and 40% reported their children's mood/behaviour had deteriorated. Children have also fallen far behind in their learning, and the education system will need to implement special strategies to help them recover (Gallagher-Mackay et al, 2021). School closures and the stresses associated with moving teaching online or working in hybrid models was also extremely stressful for educators.
- The decision to prioritize COVID-19 services in acute care settings kept many Ontarians who needed surgery or cancer care from getting that care. From delays in just the first three months of the pandemic, one modelling study suggested the province's surgical backlog would take 84 weeks to clear (Wang et al, 2022).
- Business closings hit those in the service, tourism, and arts and culture industries particularly hard. The full health, social and economic impact of job and business losses – although mitigated by federal and provincial income supports – is not known.

When deciding on and managing public health measures, the public health sector must weigh the potential negative unintended consequences, monitor their impact, and continually look for ways to minimize or mitigate them.

Weighing the Economic Impact of Lockdowns vs a High Number of Cases

An analysis by the International Monetary Fund, found that a very high number of COVID-19 cases caused as large a reduction in economic activity as a lockdown, except the reductions in economic activity due to high rates of illness last longer than those associated with lockdowns. Economies bounce back more quickly from the impact of lock-downs than high rates of illness, hospitalizations and deaths (International Monetary Fund, 2020).

Priorities for Ethical Preparedness

- Strengthen public health sector efforts to build and measure social trust, and involve society in conversations about the shared values and ethics that underlie pandemic decision-making, and the role of both government and society in protecting and promoting public health.
- Establish formal consistent mechanisms for the public health sector to access ethical expertise to guide public health decision-making during all phases of a pandemic (i.e. preparedness, response, recovery).

Improve Communication and Counter Misinformation

Clear communication, including effective risk communication, can help build social trust and societal readiness.

Because so much of outbreak response depends on individual and societal behaviour, the public health sector and government must be able to communicate clearly and transparently – in English, French and other languages – why public health measures are needed. It must also be able to assess public opinion and support, and quickly and effectively counter misinformation that can hinder the public health response.

The public health sector has long been a credible, trusted, non-political source of health information. During the COVID-19 pandemic, the sector had to compete in a noisy, demanding media and social media environment to communicate with the public. The World Health Organization (2022) describes that environment as an "infodemic": "too much information including false or misleading information in digital and physical environments during a disease outbreak."

Relevant Ontario Public Health Standards

Public health communication strategies reflect local needs and utilize a variety of communication modalities to ensure effective communication.

Use a variety of communication modalities, including social media, taking advantage of existing resources where possible, and complementing national/provincial health communications strategies.

> "An infodemic can cause confusion and risk-taking behaviours that harm health, lead to mistrust in health authorities, undermine the public health response, and intensify or lengthen outbreaks.
>
> Infodemic, World Health Organization, 2022

Achievements and Challenges

- Over the course of the COVID-19 pandemic, the Canadian public's trust in most information sources, particularly traditional media, declined. However, public trust remained relatively high in scientists and in leaders in their local communities (Edelman Trust Barometer, 2022). This trust in science creates opportunities for the public health sector to communicate accurate information and counter misinformation.
- COVID-19 vaccine uptake was a success in Ontario. Provincial resources and centralized telephone services, such as the Provincial Vaccine Contact Centre and the Hospital for Sick Children Vaccine Consult Service, helped providers communicate with individuals and families about the importance of immunization.
- The public health sector responded rapidly to the emergence of vaccine-related complications, such as vaccine-induced immune thrombotic thrombocytopenia and myocarditis (Science Table, 2021; Ontario Agency for Health Protection and Promotion, 2022). Communications with the public about evolving evidence were clear and transparent, building confidence in the province's strong programs for assessing vaccine safety.
- The public found it confusing when vaccine recommendations changed and became more nuanced over time (e.g. booster doses, new vaccine products), and when recommendations varied from one province or country to the next. This complex communications landscape increased vaccine hesitancy and uncertainty in individuals who readily received their first two doses.
- The public health sector was unable to keep pace with the speed at which information evolved. During the early days of the COVID-19 pandemic, the public's demand for information was insatiable, and public health struggled to produce and distribute culturally appropriate information in English, French, and other languages quickly enough to meet needs.

Countering Misinformation

It is no longer enough to put out accurate information. The public health sector must also actively counter misinformation.

In May 2021, the Center for Countering Digital Hate in the US published the results of an investigation, which showed that 12 people – the disinformation dozen – were responsible for 65% of the misleading claims and lies about COVID-19 vaccines on Facebook, Instagram, and Twitter. The social media companies took steps to reduce their influence, such as labelling posts as misleading, removing falsehoods, and banning people who repeatedly share debunked claims. However, it is relatively easy for people to start new accounts or find ways around the restrictions, and the misinformation continues. To be able to counter misinformation, Ontarians need public education in health literacy, including the skills to assess information and information sources.

Correspondence G

> Misinformation is one of the defining issues of our time. We have a growing body of evidence that tells us that misinformation is killing people.
>
> Too good to be true: Timothy Caulfield on misinformation and trust in health, Nicholson, 2022

Tackling the spread of harmful health information will require a multi-pronged approach, including:

Develop trusted, credible and diverse leaders – both within and outside government – who are strong communicators. In general, the more informed Canadians are, the more likely they are to trust their institutions (Edelman Trust Barometer, 2022).

Support a whole-of- society approach to developing digital strategies to counter infodemics. Health authorities, journalists, fact-checkers, civil society organizations, empowered citizens, and other relevant parties can all play an important role in debunking misinformation and building trust.

Help people develop the scientific literacy and critical thinking skills to be able to assess information and information sources. According to the Edelman survey, only 20% of Canadians have what is described as "good information hygiene", that is: they avoid information echo chambers (i.e. people only engage with information that reinforces their own opinions), verify information before they share it, and do not amplify unvetted information.

Strategies to effectively communicate public health guidance, focus on partnerships, and collaboration, and the importance of roles and relationship-building before public health incident occurs:

1. Anticipate
2. Invest in building relationships and networks
3. Establish liaison roles and redundancy
4. Active communication
5. Consider and respond to the target audience
6. Leverage networks for coordination
7. Acknowledge and address uncertainty

Khan et al, 2017.

Communication Priorities

Strengthen public health sector capacity to provide credible, trusted, transparent information that can counter infodemics and misinformation, and to use evidence-based methods to improve communications, in English, French and other languages.

Next Steps

Ontario's public health sector is committed to a bigger picture view of pandemic and outbreak readiness: one that ensures all the expertise, tools, and technologies are in place, and actively engages communities and society as a whole in pandemic preparedness.

Over the past three years, the province has demonstrated tremendous strength and resilience in terms of sector, community, and societal readiness. We have learned a great deal about how to be better prepared, and we have a clear picture of the challenges that remain as well as the efforts required to be ready for the next outbreak or pandemic.

It seems impossible that we could forget the hard lessons that COVID-19 taught us about the importance of being prepared. But history has often proved otherwise. Memories fade, life goes on, and societies become complacent about a theoretical future threat. But we no longer live in a time when future disease threats are theoretical. The emergence of new pathogens, and the resurgence of old ones mean we now live in a time when we must be constantly vigilant.

Invest in Preparedness

This report lays out the steps the public health sector and its partners must take over the next one to two years to be ready for infectious disease outbreaks. Preparedness is a process of continuous improvement. To get better at detecting and responding to emerging diseases – to reduce the impact of disease outbreaks, including illness, deaths, and social disruption – Ontario must sustain its investment in public health preparedness over time.

It is time to break the "boom and bust" funding cycles that characterized past outbreaks.

Strengthen Accountabilities

Many priorities recommended in this report are part of existing Ontario Public Health Standards. The public health sector and local public health agencies already have the mandate to address these aspects of preparedness. To help ensure accountability for outbreak preparedness and response, the Office of the Chief Medical Officer of Health will review the relevant Ontario Public Health Standards, including the *Emergency Management Guideline*, for opportunities to provide clearer direction about public health agencies' role in building and maintaining readiness.

Assess Progress

Risks and threats may change over time, and the skills, tools, resources, and capabilities to address those threats may also change. We will only know if Ontario is ready if we continue to highlight our successes, progress, challenges, and inequities in achieving system, community, and societal readiness.

The Office of the Chief Medical Officer of Health will adapt and use pandemic preparedness indicators to regularly assess and report on the public health sector's progress in outbreak and pandemic preparedness. The Office will also continue to recommend other ways to sustain, strengthen or develop key aspects of preparedness.

Improve the Health of Indigenous Peoples

Ontario's public health sector is committed to helping to improve the health of Indigenous people. We will continue to work with Indigenous leaders and health service providers, as well as federal partners including Indigenous Services Canada, to: reduce health inequities and improve community relationships; clarify the roles, responsibilities, and governance of health services; and improve data for Indigenous communities in ways that reflect the principles of Indigenous data sovereignty.

Improve the Health of Black and Other Racialized Populations

Ontario is also committed to improving the health of Black and other racialized populations, and reducing health inequities. The public health sector will work with these populations to improve the responsible and respectful collection and use of race-based data to address systemic racism and other health inequities.

Sustain Relationships

To ensure progress on the priorities identified in this report, the Office of the Chief Medical Officer of Health will strengthen partnerships within the public health sector, including with local public health agencies and Public Health Ontario, and with our health sector colleagues.

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And with thanks to the Ministry of Health Internal Advisory Committee

Appendix

Ontario Public Health Units with Vacant Medical Officer of Health (MOH) Positions* Filled by Acting MOHs as of December 15, 2022

Brant County Health Unit
Chatham-Kent Health Unit
Haldimand-Norfolk Health Unit
Niagara Region Public Health Department
Peel Public Health
Renfrew County & District Health Unit
Timiskaming Health Unit
Windsor-Essex County Health Unit
Total = 8 Public Health Units with MOH Vacancies

*Under 62. (1)(a) of the Health Protection and Promotion Act, every board of health shall appoint a full-time medical officer of health.

Ontario Public Health Units with Vacant Associate Medical Officer of Health (AMOH) Positions* as of December 15, 2022

Grey Bruce Health Unit
Halton Region Health Department**
City of Hamilton, Public Health
Middlesex-London Health Unit
Niagara Region Public Health Department
Ottawa Public Health**
Sudbury and District Health Unit**
Thunder Bay District Health Unit
Total = 8 Public Health Units with AMOH Vacancies

***Under 62. (1)(b) of the Health Protection and Promotion Act, every board of health may appoint one or more associate medical officers of health.

**Vacancies may include less than or more than one FTE position per health unit and positions filled by qualified physicians awaiting ministerial approval.

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Ontario Association of Public Health Nursing Leaders

Ontario Dietitians in Public Health

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Hon. Sylvia Jones
Minister of Health
College Park 5th Flr, 777 Bay St
Toronto, ON M7A 2J3

March 9, 2023

Dear Minister Jones,

Re: CMOH Annual Report 2022

On behalf of the Association of Local Public Health Agencies (alPHa) and its Council of Ontario Medical Officers of Health, Boards of Health Section and Affiliate Organizations, we are writing to congratulate the Chief Medical Officer of Health (CMOH) for the release of his 2022 Annual Report to the Legislative Assembly of Ontario, *Being Ready, Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics* and to reinforce the calls for investments in public health therein.

We could not agree more with the central theme of learning from the experiences of the past three years to put an end to the "boom and bust" cycle of funding and ensure sustained investment in preparedness. While the CMOH Report frames preparedness squarely in the context of future pandemics and outbreaks, we would observe that "preparedness" includes all aspects of the population-wide, upstream, prevention-focused approach to protecting and promoting health.

As you are aware, Ontario's locally-based public health agencies are subject to a detailed mandate under the Health Protection and Promotion Act (HPPA) and the Ontario Public Health Standards (OPHS) to support and protect the physical and mental health and well-being, resiliency and social connectedness of the population, through the core public health functions of assessment and surveillance; health promotion and policy development; health protection & disease prevention; and emergency management.

It is indeed illustrative that when the coronavirus began to sweep through Ontario in early 2020, our local public health agencies were able to pivot so quickly and completely to the last of these functions, doing exactly what they were designed and mandated to do in a public health emergency. Through case/contact management; data analysis; implementation and enforcement of public health measures; provision of advice to the public, community partners and decision makers; and leadership of outbreak control and vaccination campaigns; local public health agencies were the true "front line" of the pandemic response. As such, we are uniquely positioned to articulate lessons learned and provide specific advice on where investments in preparedness should be directed.

In this report, the CMOH identifies three interrelated domains for sustained investment, namely, "Sector and System Readiness", "Community Readiness", and "Societal Readiness". Local public health has foundational roles in each, and several priorities directly related to its activities are identified, including:

- Leadership in Infection prevention and control (IPAC) strategies and response.
- Leadership in vaccination promotion and delivery strategies.
- Forging collaborative partnerships with communities that face health inequities.
- Collecting sociodemographic data to address health inequities.
- Building social trust and engage society in conversations.
- Increasing health literacy through communication of credible, trusted, and transparent information, while countering misinformation.

None of these priorities is unique to pandemic preparedness, but rather foundational to many, if not all, of the health promotion and protection endeavours undertaken by Ontario's unique network of locally based public health agencies. Investing in this system is therefore by definition investing in preparedness.

Now that the acute phase of the response is in the past, our members are pivoting back to the routine OPHS-mandated programs and services that promote and protect health in every community every day. This work is often done in collaboration with local partners as well as the broader health sector, and results in a healthier population that in turn is the foundation of a stronger economy and key to the preservation of scarce health care resources.

As the CMOH critically observes, "It is more efficient and more effective to invest in preparedness than to pay the much higher and heavier costs of being unprepared: more illness and death, mental health problems, social disruption, and economic losses". This observation is as true for each of the population health-based activities our members are responsible for as it is for pandemic preparedness alone.

We hope you will take our perspectives on the CMOH Annual Report into careful consideration, and we look forward to collaborating to create a stronger, healthier, and more prepared Ontario.

We look forward to working with you and would like to request an opportunity to meet with you and your staff. To schedule a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 647-325-9594.

Sincerely,

Trudy Sachowski,
President

Copy: Dr. Kieran Moore, Chief Medical Officer of Health, Ontario
Elizabeth Walker, Executive Lead, Office of Chief Medical Officer of Health, Public Health

The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to Ontario's boards of health. alPHa represents all of Ontario's 34 boards of health, medical officers and associate medical officers of health, and senior public health managers in each of the public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology, and business administration. As public health leaders, alPHa advises and lends expertise to members on the governance, administration, and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective, and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario's communities.

Public Health
Santé publique
SUDBURY & DISTRICTS

February 24, 2023

VIA ELECTRONIC MAIL

The Honourable Doug Ford
Premier of Ontario
Legislative Building
Queen's Park
Toronto ON M7A 1A1

Dear Premier Ford:

Re: Provincial Funding for Consumption and Treatment Services

At its meeting on February 16, 2023, the Board of Health carried the following resolution #11-23:

> *WHEREAS as recognized by motion 14-21, Sudbury and districts continue to experience an opioid crisis with the second highest opioid-related death rate in Ontario; and*
>
> *WHEREAS the Ontario Public Health Standards require boards of health to collaborate with health and social service partners to develop programs and services to reduce the burdens associated with substance use; and*
>
> *WHEREAS evidence shows that supervised consumption sites, as a harm reduction strategy, reduce overdose deaths, increase access to treatment and other health and social services, reduce transmission of infectious diseases, including HIV and Hepatitis C, reduce public injection of drugs, and reduce publicly discarded hazardous syringes; and*
>
> *WHEREAS the provincial application for approval and funding for Sudbury's Consumption and Treatment Services was submitted in August 2021 and the application remains under review; and*
>
> *WHEREAS Réseau Access Network received the required federal exemption and has been operating Sudbury's supervised consumption services site since September 2022 with temporary operating funds provided by the City of Greater Sudbury; and*
>
> *WHEREAS there is uncertainty about the future of supervised consumption services in Sudbury given the temporary nature of current municipal funding and the outstanding provincial application;*

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> *THEREFORE BE IT RESOLVED THAT the Board of Health reaffirm motion 14-21, sounding the alarm on the local and regional opioid crisis – a crisis that has continued to intensify since 2021; and*
>
> *THAT the Board of Health urge the provincial government to immediately approve funding for the Sudbury supervised consumption services site, operating as a Consumption and Treatment Services site under the Ontario model; and*
>
> *FURTHER THAT this resolution be shared with relevant federal and provincial government ministers, area members of parliament and provincial parliament, local municipal leadership, the Chief Medical Officer of Health, and boards of health.*

The worsening drug poisoning crisis in our community requires concerted efforts on behalf of many partners. The Board of Health for Public Health Sudbury & Districts is looking to the provincial government as one of these key partners.

In addition to the primary goal of saving lives, Consumption and Treatment Services decrease health care pressures by reducing emergency services and hospital utilization and decreasing the transmission of infectious diseases such as HIV and Hepatitis C. They also facilitate referral to treatment for substance use and early treatment for other health concerns. Consumption and Treatment Services are an investment into the health of those that use the services and the health of our health care system.

The Board urges the provincial government to immediately approve and fund Sudbury's Consumption and Treatment Services site.

Thank you for your urgent and positive consideration of this request.

Sincerely,

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

cc: Dr. Kieran Moore, Chief Medical Officer of Health
Honourable Sylvia Jones, Deputy Premier, Minister of Health
Honourable Michael Tibollo, Associate Minister, Mental Health and Addictions
Honourable Jean-Yves Duclos, Minister of Health of Canada
Honourable Carolyn Bennett, Associate Minister, Mental Health and Addictions
Honourable Gwen Boniface, Order of Ontario, Senator
Viviane Lapointe, Member of Parliament, Sudbury
France Gélinas, Member of Provincial Parliament, Nickel Belt
Jamie West, Member of Provincial Parliament, Sudbury
Marc G. Serré, Member of Parliament, Nickel Belt
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin
Paul Lefebvre, Mayor, City of Greater Sudbury
All Ontario Boards of Health

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Correspondence ↓

Hon. Doug Ford
Premier of Ontario
Legislative Bldg Rm 281, Queen's Park
Toronto, ON M7A 1A1

February 10, 2023

Dear Premier,

Re: Boards of Health – Order in Council Appointments

On behalf of the Boards of Health Section of the Association of Local Public Health Agencies (alPHa), we are writing to you with regards to delays in Order-in-Council appointments to local boards of health under Section 49 of the *Health Protection and Promotion Act*.

Ontario's boards of health are at the forefront of the important decisions that are aimed at keeping people healthy throughout the province, and their success depends on stability and consistency within their membership. This is especially important in the immediate aftermath of municipal elections, which already have a significant destabilizing effect every four years.

24 out of 34 Ontario Boards of Health depend on provincial appointees to maintain their necessary complement, and the delays they are already reporting in securing these appointments are having a detrimental effect on their governance and accountability roles, as well as their engagements with their respective public health units, local councils, and community partners.

This is not the first time we have been faced with this issue, which we also raised with you via correspondence in June of 2020. At that time, several boards reported that their requests for appointments were not responded to, not approved, or approved for only a limited time. The uncertainty, interruption of continuity and simple depletion of the ranks compromised the capacity for sound decision-making on local public health matters in many areas, and we worry that this is being repeated.

We hope that provincial appointments will soon be announced. Should you wish to discuss this issue further, please have your staff contact Loretta Ryan, Executive Director, alPHa at 416-595-0006, x 222 or loretta@alphaweb.org.

Sincerely,

Carmen McGregor,
Chair, Boards of Health Section

Trudy Sachowski,
President, alPHa

COPY: Hon. Sylvia Jones, Minister of Health
Dr. Catherine Zahn, Deputy Minister, Ministry of Health
Dr. Kieran Moore, Chief Medical Officer of Health
Siobhan Corr, Manager (Acting), Public Appointments Secretariat

The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to the boards of health and public health units in Ontario. alPHa advises and lends expertise to members on the governance, administration and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario's communities.

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The Honourable Peter Bethlenfalvy, MPP
Minister of Finance
Frost Building North, 3rd floor
95 Grosvenor Street
Toronto ON M7A 1Z1

February 14, 2023

Dear Minister Bethlenfalvy,

Re: 2023 Pre-Budget Submission: Public Health Programs and Services

On behalf of the Association of Local Public Health Agencies (alPHa) and its Council of Ontario Medical Officers of Health, Boards of Health Section and Affiliate Organizations, we are writing to provide input on the financial requirements for a stable, locally based public health system as part of this year's pre-budget consultation.

We were pleased that the 2022 Speech from the Throne included commitments to actively engage with health-system partners to identify and implement actionable solutions to help ease pressures on the health care system, which, as you know, have been considerable as a trio of respiratory diseases surged in recent months.

Many of those solutions are inherent in what Ontario's public health professionals do every day and should thus be a major focus for the meaningful investments that you have pledged to contribute to a stronger, more resilient health system and prioritize the health of the population.

Local public health agencies provide programs and services that promote well-being, prevent disease and injury, and protect population health. Our work, done in collaboration with a wide range of partners both within and outside of the health care system, results in a healthier population and in so doing conserves costly and increasingly scarce health care resources.

Indeed, your commitment of $47 million through 2023 to public health units in addition to the increased provincial investments to support the public health sector's response to COVID-19 was a welcome demonstration of your support for public health stability, and we hope that this has set the stage for more permanent solutions.

alPHa published a detailed report in 2022 (*Public Health Resilience in Ontario*), the purpose of which is to demonstrate the need for additional investments in public health that will be required for ongoing pandemic response, clearing the backlog of public health services, and resuming routine activities mandated under the Ontario Public Health Standards. alPHa continues to stand strongly behind this document and its principles.

As we emerged further from the crisis phase of the COVID-19 response in the late spring of last year and the notion of returning to routine programming became more concrete, our leadership agreed that a more specific assessment of our members' local public health units' base budget requirements in the coming years would be advisable.

To this end, alPHa conducted a detailed survey of all 34 local public health units (June 2022) to assess the funding needs for the delivery of these programs and services, including specific base budgets and one-time funding allocations, for the 2023 year. Most of the questions focused on quantifying the gaps between amounts requested in Ontario health units' Annual Service Plans and amounts granted per the Ministry funding letters. In addition, we canvassed our members last month and invited them to share their own input to the pre-budget consultation to identify common priorities for amplification.

Key Findings

1. Overall, the current funding envelope for PHUs in Ontario is not sufficient to meet the provincially mandated standards. Though this has been the case for many years, our survey indicated that local public health units are projecting additional budget pressures from multiple sources in the coming years, including collective agreements, substantially increased inflationary pressures, the additional demands of the COVID-19 response, and the backlog of programs and services that has built up over nearly three full calendar years.

2. Effectively meeting the Ontario Public Health Standards, excluding the Healthy Babies Healthy Children program for 2023 will require an estimated $132M in total additional funding, representing an average increase of 11.8% across health units. This represents an increase of just 0.2% of the entire Ministry of Health budget.

3. Effectively meeting the requirements of the Healthy Babies Healthy Children program for 2023 will require an estimated $12.5M in total additional funding, representing an average increase of 13.8% across health units. This represents an increase of only 0.08% of the entire Ministry of Children, Community and Social Services budget.

4. There is an overreliance on mitigation and one-time funding to underwrite ongoing and predictable costs. It creates unnecessary uncertainty in the budget planning process and carries significant enough financial risk that it can result in the curtailment of important services. The absence of sufficient, predictable, and timely funding of public health through multi-year budgets and a consistent funding formula is a long-standing issue that can and should be easily resolved.

5. Changing the funding formula for public health will result in no net savings for the Ontario taxpayer but cause a disproportionate hardship for Ontario's municipalities. The provincial government has already recognized this by providing mitigation funding to offset this burden, so we reiterate our call to Immediately revert to the 75% / 25% provincial-municipal public health cost-sharing formula, along with a pledge to continue 100% funding for programs that have been traditionally underwritten by the Province.

6. COVID-19 has become society's third leading cause of death after cancer and heart disease, so it is reasonable to assume that related public health efforts such as vaccination and outbreak control will become routine. Language in the public health mandate (i.e., the Ontario Public Health Standards) and permanent funding to sustain these efforts will be required.

Investments in public health generate significant returns, including better health, lower health care costs, and a stronger economy. According to the 2018-19 Ministry of Health and Long-Term Care Expenditure Estimates, the operating estimate for the entire Population and Public Health Program (which includes internal Ministry expenses, funding for Public Health Ontario and the local grants) was

$1.267 billion, or about 2% of the total Ministry operating expenses. This demonstrates a tremendous return on investment given the significant benefit to the health of the people of Ontario.

To illustrate this, alPHa's latest infographic, Public Health Matters – Public Health Fall Vaccine Success, which builds upon the first, Public Health Matters infographic (A Public Health Primer), focuses on the success of recent local public health campaigns to increase coverage against a range of vaccine preventable diseases, including COVID-19, mPox, influenza, and those included in routine childhood immunizations. This is just one small example of how public health work can have an immediate impact within the broader health care system.

The Ontario Medical Association has identified strengthening of Public Health as one of its key pillars in its Prescription for Ontario: Doctors' 5-Point Plan for Better Health Care, which includes a recommendation to provide "a clear, adequate and predictable funding formula for local public health."

The Association of Municipalities of Ontario, in its August 26 submission entitled *Strengthening Public Health in Ontario: Now and for the Future*, has also made a clear call to reinforce public health resources, including continuing funding to cover COVID-19 response costs, new funding to address the backlog of routine public health services, and a legislated reversion to the 75%-25% cost-sharing arrangement between the Province and the municipalities. It also calls for an assessment of what is required to fully fund the delivery of services as mandated under the Ontario Public Health Standards as well as all COVID-related costs at the local level, and a strategy to address its own health human resource challenges.

As noted in more detail in our *Public Health Resilience in Ontario* paper (January 2022), none of the OPHS requirements were completed to pre-pandemic levels due to the extensive redeployment of staff required for the COVID-19 response. Service backlogs specifically related to children's health are a major concern, with oral health screening in schools effectively ceased, Healthy Babies Healthy Children activities severely curtailed and a significant backlog of required childhood immunizations built up.

In addition to these, mental health promotion, substance use and harm reduction, and health equity considerations were brought into sharp relief through the pandemic, and the OPHS requirements related to these are expected to become priorities for public health action for the foreseeable future. We are aware that many of our members, including individual boards of health and Affiliate organizations will be making their own submissions to this consultation that cover these and other public health priorities at the operational level. We strongly urge you to take these into equal consideration.

Ontario's unique, locally based public health system is designed to create healthy individuals and communities, which are in turn fundamental to a strong, vibrant, and economically prosperous Ontario. Investment in upstream, preventive local public health is therefore essential to achieving the goals articulated in the August Speech from the Throne. In those words, we are a key health system partner that is well positioned to identify urgent, actionable solutions to ease immediate pressures. Our fundamental purpose of keeping people healthy is also essential to a strong economy, as a strong economy is not possible without healthy people.

We certainly appreciate that the unprecedented spending throughout the pandemic has created fiscal challenges in Ontario that will require prudent economic management in the months and years to come. We acknowledge that this will require an incremental approach to meeting resource requirements

across sectors, and we are prepared to assist in setting priorities and sharing ideas for a longer-term plan to ensure that we are all well positioned to meet our shared objectives.

We look forward to working with you and would like to request an opportunity to meet with you and your staff to provide further details on our survey findings and discuss options to ensure a sustainable and resilient public health system. To arrange a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 647-325-9594.

Sincerely,

Trudy Sachowski,
President

Copy: Hon. Sylvia Jones, Minister of Health
Dr. Kieran Moore, Chief Medical Officer of Health, Ontario

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 22-23

TO: Chair and Members of the Board of Health

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

DATE: 2023 March 16

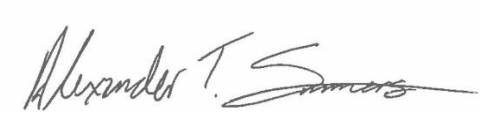
FINANCE AND FACILITIES COMMITTEE MEETING – March 9, 2023

The Finance and Facilities Committee (FFC) met at 9 a.m. on Thursday, March 9, 2023.

Reports	Recommendations for Information and Board of Health Consideration
Proposed Revised 2023 Budget **(Report No. 04-23FFC)**	It was moved by **M. McGuire, seconded by S. Menghsha,** *that the Finance & Facilities Committee recommend to the Board of Health to:* *1) Receive Report No. 04-23FFC re: "Proposed Revised 2023 Budget" for information; and* *2) Approve the disinvestments and investments as outlined in Report No. 04-23FFC.* Carried
2022 Vendor and Visa Payments **(Report No. 05-23FFC)**	It was moved by **M. Reid, seconded by S. Menghsha**, *that the Finance & Facilities Committee make a recommendation to the Board of Health to receive Report No. 05-23FFC re: "2022 Vendor and VISA Payments" for information.* Carried

This report was prepared by the Chief Executive Officer.

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



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Medical Officer of Health