Board of Health for
Peterborough Public Health
AGENDA
Board of Health Meeting
Wednesday, October 12, 2016 – 5:30 p.m.
Lower Hall, Administration Building
123 Paudash Street, Hiawatha First Nation

1. Call to Order

1.1. Opening Statement
Scott McDonald, Chair

We acknowledge that where we meet is the land and territory of the Anishnaabeg [Ah-nish-naw-beg] people, and that we gather with gratitude to our Mississauga neighbours. We say "meegwetch" to thank them and other Aboriginal peoples for taking care of this land from time immemorial and for sharing this land with those of us who are newcomers. Out of that gratitude, we are called to treat the land, its plants, animals, stories, and its Peoples with honour and respect. We are all Treaty people.

1.2. Acknowledgement of Service – Scott McDonald
Dr. Rosana Salvaterra, Medical Officer of Health

2. Confirmation of the Agenda

2.1. Confirm Agenda for October 12, 2016

2.2. Consent Items to be Considered Separately

Board Members: *Please identify which items you wish to consider separately for section 8, and advise the Chair when requested. For your convenience, circle the item(s) using the following list:* 8.1b 8.2a 8.2b 8.2c 8.2d 8.3a

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

4.1. Hiawatha First Nations Update
Julie Thompson, Health Assistant, L.I.F.E. Services Centre

5. Confirmation of the Minutes of the Previous Meeting

5.1. **September 14, 2016** (p. 4)

6. Business Arising From the Minutes

6.1. **Presentation: Vision and Mission Update**
Sarah Tanner, Manager, Oral Health, Facilities & Quality Improvement

6.2. **Presentation: Smoke Free Multi-Unit Housing Update** (p. 13)
Donna Churipuy, Manager, Healthy Living

6.3. **Staff Report: Promoting Food Literacy for Children, Youth and Educational Institutions** (p. 18)
Lauren Kennedy, MScFN, Registered Dietitian, Public Health Nutritionist

7. Staff Reports

8. Consent Items

8.1. **Correspondence**

a. **Correspondence for Direction (nil)**

b. **Correspondence for Information** (p. 46)

8.2. **Staff Reports**

a. **Staff Report: Health Care Worker Influenza Immunization 2015-16** (p. 65)
Edwina Dusome, Manager, Infectious Disease Programs and Emergency Preparedness

b. **Staff Report: Food Insecurity in Peterborough** (p. 72)
Carolyn Doris RD, Registered Dietitian

c. **Staff Report: Amended 2016 Budget Approval – Cost-Shared Budget from the Ministry of Health and Long-Term Care** (p. 81)
Dale Bolton, Manager, Finance

d. **Staff Report: Amended 2016 Budget Approval - 100% Funded Programs and One-Time Funding from the Ministry of Health and Long-Term Care** (p. 84)
Dale Bolton, Manager, Finance

8.3. **Committee Reports**

a. **First Nations Committee** (p. 88)
Chief Williams, Chair, First Nations Committee

9. New Business

10. In Camera to Discuss Confidential Matters

11. Motions for Open Session

12. Date, Time, and Place of the Next Meeting

Date: November 9, 2016
Time: 5:30 p.m.
Location: Dr. J. K. Edwards Board Room, 3rd Floor, Peterborough Public Health, Jackson Square, 185 King Street, Peterborough.

13. Adjournment

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Board of Health for
Peterborough Public Health
DRAFT MINUTES
Board of Health Meeting
Wednesday, September 14, 2016 – 5:30 p.m.
Dr. J.K. Edwards Board Room, 3rd Floor
Jackson Square, 185 King Street, Peterborough

In Attendance:

Board Members:	**Mr. Scott McDonald, Chair**
	Deputy Mayor John Fallis
	Ms. Kerri Davies
	Councillor Henry Clarke
	Councillor Gary Baldwin
	Councillor Lesley Parnell
	Mr. Andy Sharpe
	Mr. Gregory Connolley
Staff:	**Mr. Larry Stinson, Director of Operations**
	Ms. Natalie Garnett, Recorder
	Dr. Rosana Salvaterra, Medical Officer of Health
	Ms. Alida Tanna, Executive Assistant
	Ms. Patti Fitzgerald, Assistant Director, Chief Nursing and Privacy Officer
Regrets:	**Chief Phyllis Williams**
	Mayor Mary Smith, Vice Chair
	Mayor Rick Woodcock

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1. Call to Order

Mr. McDonald, Chair, called the meeting to order at 5:30 p.m.

1.2. **Membership Update**

Mr. McDonald advised that Councillor Vowles, the representative from Hiawatha First Nation, has had to resign from the Board of Health. Councillor Vowles was thanked for his contributions to the Board.

1.3. **Staff Introduction – Dale Bolton, Manager, Finance**

Larry Stinson, Director of Operations introduced Dale Bolton, the new Manager of Finance. Ms. Bolton was welcomed by the Board members.

2. **Confirmation of the Agenda**

MOTION:
That the agenda be approved as circulated.
Moved: Councillor Clarke
Seconded: Councillor Parnell
Motion carried. (M-2016-088)

3. **Declaration of Pecuniary Interest**

4. **Delegations and Presentations**

4.1. **Kawartha Truth and Reconciliation Support Group Quilt**

Marilyn Tudhope, member of the Kawartha Truth and Reconciliation Support Group provided information on the work of the group and provided information regarding the meaning of the quilt.

MOTION:
That the presentation on Kawartha Truth and Reconciliation Support Group Quilt be received for information.
Moved: Councillor Parnell
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-089)

5. **Confirmation of the Minutes of the Previous Meeting**

5.1. **June 8, 2016**

MOTION:
That the minutes of the Board of Health for the Peterborough Public Health meeting held on June 8, 2016, be approved as circulated.
Moved: Councillor Parnell
Seconded: Mr. Sharpe
Motion carried. (M-2016-090)

6. **Business Arising From the Minutes**

7. **Staff Reports**

7.1. **Presentation: Developing and Testing of Indicators to Guide Health Equity Work in Public Health**

Dr. Rosana Salvaterra, Medical Officer of Health, provided a presentation on "Developing and Testing of Indicators to Guide Health Equity Work in Public Health".

MOTION:
That the Staff Presentation "Developing and Testing of Indicators to Guide Health Equity Work in Public Health" be received for information.
Moved: Deputy Mayor Fallis
Seconded: Councillor Clarke
Motion carried. (M-2016-091)

7.2. **Presentation: Environmental Burden of Cancer in Ontario**

Dr. Rosana Salvaterra, Medical Officer of Health, provided a presentation on "Environmental Burden of Cancer in Ontario".

MOTION:
That the Staff Presentation "Environmental Burden of Cancer in Ontario" be received for information.
Moved: Councillor Baldwin
Seconded: Councillor Clarke
Motion carried. (M-2016-092)

7.3. **Presentation: Development of New Vision and Mission – 2018-2022 Strategic Plan Pre-Work**

Sarah Tanner, Manager, Oral Health, Faculties and Quality Improvement, provided a presentation on the preliminary steps involved in developing a new strategic work plan. The Board members discussed and provided input on the current Vision and Mission statements.

MOTION:
That the Staff Presentation "Development of New Vision and Mission – 2018-2022 Strategic Plan Pre-Work" be received for information.
Moved: Deputy Mayor Fallis
Seconded: Mr. Sharpe
Motion carried. (M-2016-093)

8. **Consent Items**

MOTION:
That items 8.1b, 8.2a, 8.2b, 8.2c, 8.3a and 8.3b, be approved as part of the Consent Agenda.
Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2016-094)

MOTION:
That the Board of Health for Peterborough Public Health receive the following for information:
- Letter dated May 25, 2016 from Minister Monsef to the former Board Chair regarding her original letter dated December 2, 2015, regarding food security and the transformation of social assistance in Ontario.
- Email received June 10, 2016 from the Association of Local Public Health Agencies (alPHa) regarding the disposition of resolutions from the June 2016 Annual General Meeting (AGM).
- Letter dated June 21, 2016 from the Board Chair to Minister Hoskins regarding Community Water Fluoridation.
- Email received June 30, 2016 from alPHa regarding conference proceedings from the June 2016 conference and AGM.
- E-newsletter dated July 13, 2016 from alPHa.
- Letter dated July 22, 2016 from Minister Hoskins to the Board Chair, in response to his original letter dated June 2, 2016, regarding Patients First.
- Letter dated August 2, 2016 to Ministers Bennett and Zimmer regarding safe drinking water on reserves.
- E-newsletter dated August 15, 2016 from alPHa.

- Updates from the Ministry of Health and Long-Term Care regarding the Modernization of the Ontario Public Health Standards:

a. Organizational Governance Committee (OGC) – Highlights #1
b. Accountability Committee (formerly OGC) – Highlights #2
c. Accountability Committee – Highlights #3
d. Executive Steering Committee – Highlights #1
e. Executive Steering Committee – Highlights #2
f. Executive Steering Committee – Highlights #3
g. Practice and Evidence Program Standards Advisory Committee – Highlights #1

- Letters/Resolutions from other local public health agencies:

<u>Basic Income Guarantee</u>
Haliburton Kawartha Pine Ridge
Simcoe Muskoka

Cannabis – Legalization/Public Health Approach
Lambton
Wellington Dufferin Guelph

International Code of Marketing of Breastmilk Substitute
Grey Bruce
Environmental Health Program Funding
Algoma

Patients First
Lambton

Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act
Windsor Essex

Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2016-094)

MOTION:
That the Board of Health for the Peterborough Public Health:
- receive the staff report, "Quarter 2 2016 Public Health Programs Report", for information.
Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2016-094)

MOTION:
That the Board of Health for the Peterborough Public Health:
- receive the staff report, "Quarter 2 2016 Corporate Services Report", for information.
Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2016-094)

MOTION:
That the Board of Health for the Peterborough Public Health:
- receive the staff report, "Toward the Legalization, Regulation and Restriction of Access to Marijuana: Submission to Federal Task Force", for information.
Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2016-094)

MOTION:
That the Board of Health for Peterborough Public Health:
- receive for information, meeting notes of the First Nations Committee for January 8 and April 14, 2016.
Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2016-094)

MOTION:
That the Board of Health for Peterborough Public Health:
- receive for information, meeting minutes of the Fundraising Committee for April 13, 2016; and
- dissolve the Fundraising Committee.
Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2016-094)

8.1.a **Correspondence for Direction**

MOTION:
That the Board of Health for Peterborough Public Health:

1. Receive the correspondence dated May 31, 2016 from Algoma Public Health regarding changes to the Human papillomavirus vaccine (HPV) program;
- endorse the resolution calling on the Province of Ontario to increase annual funding for the Vaccine Preventable Disease program in order to provide the staff resources to meet the newly expanded mandate; and,
- communicate this support to the Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care, with copies to the Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Executive Director, Ministry of Health and Long-Term Care, local MPPs, the Ontario Chief Medical Officer of Health, the Association of Local Public Health Agencies, and Ontario Boards of Health.

2. Receive correspondence from Thunder Bay District Health Unit regarding food security and a universal hot meal program;
- endorse the report and request calling for the Province of Ontario to develop and implement a universal hot meal program in elementary and secondary schools;
- further request for enhanced funding to better reflect program costs for existing universal student nutrition programs in elementary and secondary schools across the province; and

- communicate this support to the Hon. Mitzie Hunter, Minister of Education and the Hon. Helena Jaczek, Minister of Community and Social Services, with copies to local MPPs, the Ontario Chief Medical Officer of Health, the Association of Local Public Health Agencies, and Ontario Boards of Health.

3. Receive correspondence from Grey Bruce Health Unit (GBHU) and Niagara regarding Lyme Disease;
- endorse the resolutions put forward by GBHU and Niagara calling for:
- the Government of Canada to increase funding for research aimed to enhance the testing for Lyme disease and determine better treatment for long term outcomes of Lyme disease;
- the Province of Ontario to:
- increase funding for research aimed to enhance the testing for Lyme disease; o increase funding to enhance environmental surveillance for the tick;
- monitor the pattern of spread of the tick and the rate of tick infection in various areas of the province;
- develop control measures for the tick; and,
- increase the education to the population regarding personal protection, property management, testing and treatment.
- communicate this support to the Hon. Jane Philpott, Minister of Health, and the Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care, with copies to the Hon. Kathleen Wynne, Premier of Ontario, local MPs and MPPs, the Ontario Chief Medical Officer of Health, the Association of Local Public Health Agencies, and Ontario Boards of Health.

Moved: Councillor Parnell
Seconded: Mr. Sharpe
Motion carried. (M-2016-095)

8.3.c **Governance Committee**

MOTION:
That the Board of Health for Peterborough Public Health:
- receive for information, meeting minutes of the Governance Committee for May 3, 2016;
- receive for information, the staff report Stewardship Committee;
- approve 2-354, Terms of Reference, Stewardship Committee;
- approve 2-140 By-Law #5, Powers, Duties and Terms of Office of the Chairperson and Vice-Chairperson of the Board of Health (revised);
- approve Position Description, Medical Officer of Health (revised);
- receive 2-200 Duties and Responsibilities of Board Members (no changes); and,

- *receive 2-284 Correspondence (no changes).*
Moved: Ms. Davies
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-096)

9. **New Business**

9.1. **Association of Municipalities of Ontario Conference – Oral Update**

Councillor Parnell provided an update on the 2016 AMO conference.

MOTION:
That the Board of Health for Peterborough Public Health receive the Oral Report: Association of Municipalities of Ontario Conference, for information.
Moved: Councillor Baldwin
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-097)

9.2. **Board Member Skills Matrix Inventory**

Dr. Rosana Salvaterra, Medical Officer of Health, discussed the Board Member Skills Matrix Inventory provided to members. Committee members completed the form during the meeting and these were collected by staff.

Councillor Parnell raised the issue of food literacy and changes to the public school curriculum over the past years.

MOTION:
That the Board of Health for Peterborough Public Health advocate to the Province to reinstate family studies and Industrial Arts in public schools.
Moved: Councillor Parnell
Seconded: Councillor Clarke
Motion withdrawn.

Councillor Clarke left the meeting at 7:15 p.m.

MOTION:
That staff provide a report on family studies/breakfast programs and nutritional health in schools.
Moved: Councillor Parnell
Seconded: Councillor Baldwin
Motion carried. (M-2016-098)

10. **In Camera to Discuss Confidential Matters**

11. **Motions from In Camera for Open Session**

12. **Date, Time, and Place of the Next Meeting**

The next meeting will be held October 12, 2016 at the Administration Building, 123 Paudash Street, Hiawatha First Nation, 5:30 p.m.

13. **Adjournment**

MOTION:
That the meeting be adjourned.
Moved by: Mr. Sharpe
Seconded by: Deputy Mayor Fallis
Motion carried. (M-2016-099)

The meeting was adjourned at 7:33 p.m.

_____ _____

Chairperson Medical Officer of Health

Smoke-Free Multi-Unit Housing: Update

Presentation to: Board of Health

By: Donna Churipuy, Manager, Healthy Living

Date: October 12, 2016

Peterborough Public Health

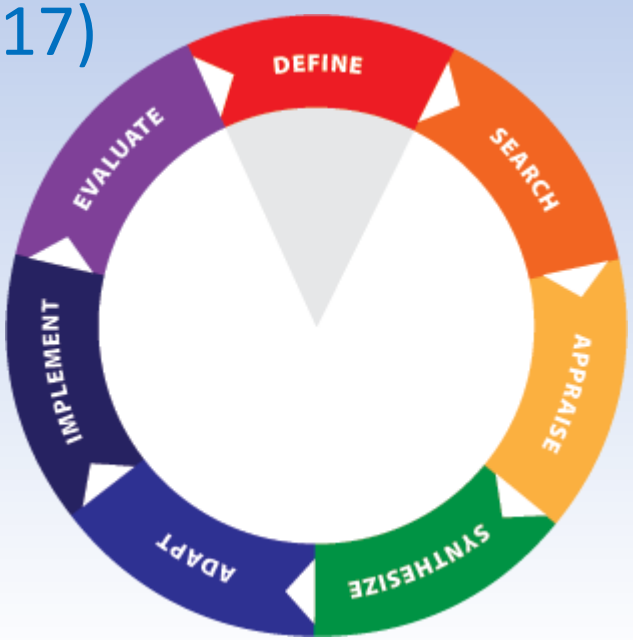
Peterborough Housing Corporation

- Staff continue to build a relationship with Peterborough Housing Corporation (PHC) staff
  - Sharing tobacco cessation resources
  - Sharing resources on smoke-free multi-unit housing
- **Bradburn House** (18 units)

  is smoke-free (2013)

Urban Planning and Smoke-Free Multi-Unit Housing

- Developing a multi-year plan in consultation with Healthy Promoter – Healthy Public Policy
  - Defining stage (Fall/Winter 2016-17)
    - best practice review, literature search, situational assessment and environmental scan
    - consultation with Non-Smokers Rights Association
    - consultation with City of Peterborough planners



Additional Activities

- Respond to complaints and opportunities
- Develop relationship with new Manager of Housing, City of Peterborough
- Active membership in provincial coalition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Peterborough Public Health

Staff Report

Promoting Food Literacy for Children, Youth and Educational Institutions

Date:	October 12, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Lauren Kennedy, MScFN, Registered Dietitian, Public Health Nutritionist

Proposed Recommendations

It is recommended that the Board of Health for Peterborough Public Health:

- receive the staff report, *Promoting Food Literacy for Children, Youth and Educational Institutions,* for information*;*
- support the petition initiated by Ontario Home Economics Association, urging the Government of Ontario to make at least one food and nutrition course compulsory in secondary schools; and
- send a letter to the Executive Steering Committee for the Standards Modernization, chaired by Dr. David Jones, supporting the Ontario Society of Nutrition Professionals in Public Health's (OSNPPH) position to include food literacy rather than food skills for priority populations in the revised Ontario Public Health Standards.

Financial Implications and Impact

There are no financial implications for the board of health arising from this report.

Decision History

The Board of Health has not previously made a decision with regards to food literacy. There has been longstanding support for Community Health programs focusing on food literacy,

including education and skill building programs such as supermarket tours, Collective Kitchens, Come Cook With Us, community gardens and JustFood boxes. The development of Myrtle's Kitchen as a site to hold food literacy programs is an asset for Peterborough Public Health (PPH).

Background

Boards of Health are mandated by the Ontario Public Health Standards (OPHS) to provide opportunities for skill development in the areas of food skills and healthy eating practices for priority populations.[1] Priority populations may include pregnant and postpartum women, individuals of low socio-economic status, First Nations, and youth.

Food skills are a component of food literacy, which is described in the document, "A Study of Food Literacy" (Attachment A). The Ontario Society of Nutrition Professionals in Public Health (OSNPPH) advocates for changing public health focus and language from food skills, to food literacy.[2] Attachment B prepared by the Ontario Society of Nutrition Professionals in Public Health (OSNPPH), entitled "Ontario Public Health Standards Modernization/ Review: Advocating for Food Literacy," outlines the definition and role of food literacy in public health, and steps public health can take to promote food literacy in collaboration with partners:

> ***Food Skills Definition*** (Taken from the OSNPPH briefing note, Attachment B):[3]
> In the Ministry of Health Promotion's Guidance Document: Healthy Eating, Physical Activity and Healthy Weights,[4] food skills is defined as a complex, interrelated, person-centered set of skills that are necessary to provide and prepare safe, nutritious, and culturally-acceptable meals for all members of one's household.[5] This definition encompasses five general categories:[6]
>
> - Knowledge (nutrition, label reading, food safety, food varieties, ingredients, substitution);
> - Planning (organizing meals, budgeting, food preparation, teaching food skills to children);
> - Conceptualizing food (creative thinking about leftovers, adjusting recipes);
> - Mechanical techniques (preparing meals, chopping/mixing, cooking, following recipes); and
> - Food perception (using your senses – texture, taste, when foods are cooked).[7]

Research also supports the ability to select healthy food as part of food skills.[8]

> ***Food Literacy Definition:***
> A locally driven collaborative project (LDCP) though OSNPPH was conducted from 2012 to 2014.[9] This study's findings produced a food literacy definition that surpassed the food skills definition developed by the Ministry of Health and Long-Term Care.[10] Food literacy was found to include not only personal factors, but also broader environmental factors.[11] In the results of this study, food literacy was described as follows: [12]

- Food literacy is a set of skills and attributes that help people sustain the daily preparation of healthy, tasty, affordable meals for themselves and their families;
- Food literacy builds resilience, because it includes food skills (techniques, knowledge and planning ability), the confidence to improvise and problem-solve, and the ability to access and share information; and
- Food literacy requires external support with healthy food access and living conditions, broad learning opportunities, and positive socio-cultural environments. [13]

This broadened definition of food literacy is supported by a body of research.[14] Food literacy also involves an understanding of where food comes from, and appreciation of environmental implications of food waste and disposal.[15]

Best practices in food literacy development in general populations

Food literacy programs that target cooking skills have been developed and used throughout Canada and abroad.[16] A review of literature identifies best practices for food skills programs to include:

- generating buy-in/fostering ongoing commitment;
- using supports available (resources, including human);
- sharing advice with other communities; and
- reviewing other programs prior to development for insight. [17]

Successful food skills programs have the following common attributes:

- hands-on, experiential learning opportunities (interactive learning more effective than Internet learning or just recipe provision);
- a strong curriculum tailored for the target audience;
- are community run and owned;
- develop or enhance partnerships;
- link to other community-based healthy eating and food security initiatives;
- build community capacity;
- are flexible;
- have supportive elements to reduce barriers (e.g. providing child care);
- are accessible, such as in school or community setting;
- are familiar and recognizable programming;
- provide opportunities for reducing social isolation;
- have incentives;
- empower participants; and
- have evaluation as a core element of the program.[18]

Learning and using food skills are impacted by barriers that need to be considered in the development of food literacy programs. These barriers include:

- socio-cultural environment (food experience, normalization of skills, emotional support);
- learning environment (including literacy, numeracy, experiential learning, and youth engagement);
- food and facilities (including food availability, meal provision, and cooking facilities); and
- living conditions (including income, employment and housing).[19]

Food Literacy Skills in Children and in Educational Institutions

In Ontario almost one third of children are at unhealthy weights. [20] Interventions are needed to reduce risk of chronic disease, and promote growth of healthy kids.[21] Although further research is needed to identify the most efficient and effective strategy to promote long term dietary behavior change in school aged children,[22] food literacy education has been advocated as a strategy to help children and youth develop lifelong habits and skills that encourage healthy eating, and promote health.[23]

Research on the impact of cooking classes for children suggests that food skills programs "may positively influence children's food-related preferences, attitudes, and behaviours."[24] A food skills environmental scan in Ontario highlighted thirty food skills programs.[25] Of these, nine programs targeted children ages 13 and under, and seven programs targeted youth, ages 14-18. These programs were administered through community health centres and public health agencies, and took place in settings such as after school programs and early years centres. Programs, such as "You're the Chef" in Niagara, involved cooking sessions in schools and other community settings[26] (Please see Attachment C for information on PPH's pilot of this program). Programs varied in the types and rigor of evaluation done. Of the thirty programs highlighted (targeted to all ages/audiences), ten programs identified high participant satisfaction, nine identified social benefit, and nine identified changes in skills or behaviour.

After home environments, it has been recognized that schools are a common avenue for children to learn knowledge and skills.[27] Children spend a significant amount of time in educational institutions, with more than 40% of their waking hours at school.[28] Effective school health promotion in schools involves a comprehensive approach, targeting areas such as the community, school environment, and curriculum.[29] A recent evidence brief by Public Health Ontario, synthesized data from programs examining impacts of multi-component food skills programs on fruit and vegetable intake in children and youth, 4-18 years old, mostly in school environments.[30] Fruit and vegetable intake was the outcome variable examined as intakes are low in 64% of Canadian children and youth, and recommended intakes are linked to reduced risk of chronic disease.[31] As there was no Canadian food skills research that met the inclusion criteria for study quality and outcomes examined, this brief had an international focus. Most school based programs were found to include the following three components:[32]

- **Classroom interventions** (e.g., nutrition education, food preparation lessons, skill building activities, workshops, watching videos, cooking lessons, taste testing, and gardening);
- **School level interventions** (e.g., media campaigns (posters, announcements, contests), assemblies, taste testing, increased fruit and vegetable exposure and variety in lunchrooms, healthier options in school snack shops, workshops for teachers, and training for food service staff on purchasing, promoting and preparing fruits and vegetables); and
- **Parental involvement, at home and community focused components** (e.g., parent education workshops and meetings, newsletters, brochures, healthy eating magazines and food calendars, homework activities and home packages, school cookbooks, family/parent nights, interactions with community organizations and connection with community gardens)[33]

Results indicated a low-to-moderate increase in fruit and vegetable consumption resulting from these multi-component interventions.[34] Food skills programs resulted in increased willingness to taste or try fruit and vegetables, increased preferences for fruit and vegetables, and increased nutrition and dietary knowledge.[35]

Sustain Ontario and the Ontario Edible Education Network work to promote food literacy in schools.[36] They advocate for universal Student Nutrition Programs that emphasize food literacy; recognition of school gardens as important to food literacy; and cooking/food skills programs that are accessible to all Ontario students.[37] School gardens foster food literacy skills through helping students learn about where food comes from. Research also suggests that school gardening programs lead to children preferring and consuming more fruits and vegetables, compared to nutrition education programs without gardening components.[38]

While food literacy programs present an important opportunity for reaching all students, barriers such as funding, full curriculum, and inadequate facilities, exist, particularly in elementary schools. This makes it challenging to deliver certain modes of food literacy programs (e.g., hands on cooking classes for all students). However, there are opportunities to build upon existing programs with the goal of sustaining feasible food literacy programs in schools (see further below for details on existing programs).

Food literacy also needs to be considered across the life-span. For example, a Canadian qualitative study found that a factor impacting food literacy in young adults is what they experience and learn about food and nutrition during childhood in school settings and home environments.[39] Interestingly, this study found that the childhood home environment and parental role-modeling had greater impact on food literacy of young adults, than home economics courses.[40] Families have an important role in modelling and teaching food literacy to children. Parents demonstrate cooking and food purchasing practices, and influence the food available in homes. Further research is needed to identify best practices related specifically to children's cooking programs, such as evidence based strategies to improve food literacy of children in the context of families.[41]

Existing programs that incorporate food literacy in educational institutions

Both Elementary and Secondary:

Student Nutrition Programs (SNP) **-** In Ontario, SNPs model healthy food selection, which is an important component of food skills and food literacy. Through the Ministry of Child and Youth Services 2016 Ontario SNP Nutrition Guidelines, programs are trained to serve healthy food choices, and to involve children and youth in food preparation, where possible.[42] There are currently 48 SNPs across Peterborough County and City.

Legislation and Policy **-** Through influencing available food and beverages in schools, *The Healthy Food for Schools Act* (2008) and Ontario's School Food and Beverage Policy, PPM 150 (2010) model healthy food selection, and are part of a comprehensive school approach to promoting nutrition and food literacy.[43]

Gardens **-** There were eighteen food gardens in Peterborough County and City schools as of Spring 2016. Garden facilities and applications vary by school, and may be used in classroom education, cooking events, student nutrition programs, or for selling, and fundraising.

Elementary:

Bright Bites - In Ontario, Bright Bites (formerly, Nutrition Tools for Schools) was developed by OSNPPH dietitians to target nutrition and food literacy in elementary schools, using a comprehensive approach to school health.[44] Bright Bites is a free program that allows teachers and schools to engage students to build healthy habits, learning environments, and personal skills. Classrooms and Schools engage in nutrition topics, as they earn recognition "badges." The sixteen badges available for schools to earn include topics such as packing school lunches and snacks, edible gardens, and preparing food. Earning each badge involves 4 steps:

1) Ask students (e.g., engage students with questions about what they know and experience about a nutrition or food literacy topic)
2) Start a conversation (e.g., involve parents, community partners, or public health)
3) Do a Nutrition check up (e.g., translate current research into tips for students)
4) Make it fun (e,g., come up with creative ways to help others get involved and excited about the topic)

Bright Bites includes resources, ideas, and in some cases, lesson plans that integrate Ontario curriculum with nutrition and food literacy topics. Please see the Cook it Up badge for an example related to food literacy.

PPH promotes Bright Bites to schools. A PPH Registered Dietitian will be presenting at upcoming board-wide P.A. days to provide teachers with information and resources for using Bright Bites to promote nutrition and food literacy in schools.

Teacher/School Elective Activities - In some elementary schools, teachers may elect to incorporate food literacy into lessons (e.g., field trips to the grocery store, or incorporating gardening into lesson plans). Elementary schools may also have food literacy events. For example, local schools have offered one-off events to teach cooking skills to students/families.

Curriculum - Certain components of food literacy (e.g., selection of healthy food choices) are incorporated into Health and Physical Education Curriculum.[45] While home economics was once offered in many elementary schools, it was not a required course across Ontario. Currently competing pressures, inadequate facilities, budgets and focused curriculum in elementary schools would make it difficult to make home economics mandatory.

Secondary:

Curriculum – Like elementary schools, certain components of food literacy (e.g., selection of healthy food choices) are incorporated into Health and Physical Education Curriculum in secondary schools, and are taken by all students.[46] There are no existing educational standards that mandate teaching hands-on food skills and food safety, or comprehensive approaches to food literacy in secondary curriculum. Elective courses and programs that teach hands-on food skills in secondary schools include specialist majors, Learning and Life Skills (LLS), family studies/food/nutrition courses (Social Sciences and Humanities curriculum) and hospitality/tourism (Technological Education curriculum).

Other Work:

Ontario Society of Nutrition Professionals in Public Health (OSNPPH) has a provincial food literacy working group. This committee is a collaboration of public health dietitians who share best practices, and food literacy initiatives. The OSNPPH Food Literacy Working group developed a document advocating for the inclusion of food literacy in the OPHS (Attachment B). PPH, along with 20 other public health partners, are participating in a Public Health Ontario funded Locally Driven Collaborative Project to determine how to measure food literacy and its attributes for public health context.

Food Literacy Programs

Peterborough Public Health currently runs programs supporting food literacy in children and adults (Attachment C).

Rationale

Research suggests that hands on food skills education initiatives positively influence health behaviours when incorporated into a multi-strategy approach targeting classrooms, schools, policy, parents, and the community. Feasibility, facilities, budgetary constraints, and full curriculum present challenges for elementary schools to implement hands-on food skills programs. Peterborough Public Health's role is to encourage multi-strategy approaches in addressing the important issue of food literacy skill development in school-aged children.

The Board of Health has been an effective and credible advocate for food literacy in Peterborough. PPH dietitians play a leadership role in addressing food literacy across the lifespan, and in priority populations. There are several actions that the board of health can take to continue its efforts on this important community issue.

Continuing to support elementary and secondary schools with further developing a comprehensive food literacy and healthy eating approach

Comprehensive approaches to school nutrition are being promoted in elementary schools through "Bright Bites" and Healthy Kids Community Challenge. Policies (such as PPM 150, under review) and Guidelines (such as the SNP guidelines) contribute to food literacy in schools.

Support advocacy efforts of the Ontario Home Economics Association in Secondary Schools (OHEA)

Secondary school food and nutrition courses address components of food literacy, but are not mandatory for all students. The OHEA has initiated a petition to advocate for making at least one food & nutrition course compulsory, so that all Ontario students learn about food and components of food literacy such as understanding food labels, food budgeting, reducing waste, and cooking. The Board of Health is invited to sign the OHEA petition advocating for mandatory food and nutrition courses (see the Links section below).

Continuing to support parents and families with food literacy skills

The Board of Health can continue to support the work being done by PPH with improving food literacy across the lifespan. You're the Chef, is a program designed to target food literacy specifically in children. Programs such as "Come Cook With Us" and "Collective Kitchens" promote food literacy for priority populations. Parents who gain confidence and skills from these programs are empowered to model and share food skills with their children (please see Attachment C).

Advocate for food literacy within the Ontario Public Health Standards

Research supports the expansion of the definition of food skills, to food literacy (Attachment B). Food literacy is important to health and prevention of chronic disease. It is therefore critical for public health to address this topic. The current modernization and review of the Ontario Public Health Standards provides an opportunity for the Board of Health to support and advocate for OSNPPH's recommendations to include the expanded definition of food literacy as a key to public health's role.

Strategic Direction

This report applies to the strategic direction of *Determinants of Health and Health Equity* by providing current evidence on food literacy best practices for working with children and educational institutions.

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Attachments:

Attachment A: A Study of Food Literacy
Attachment B: Ontario Society of Nutrition Professionals in Public Health (2016). Ontario Public Health Standards Modernization/Review: Advocating for Food Literacy [technical brief]
Attachment C: Peterborough Public Health Food Literacy Programs for Children and Priority Populations

Links:

Bright Bites: http://brightbites.ca/
Ontario Home Economics Association Petition: http://www.food-literacy.ca/

References:

[1] Ministry of Health and Long-Term Care (2008). Ontario Public Health Standards Retrieved from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf

[2] Ontario Society of Nutrition Professionals in Public Health (2016). Ontario Public Health Standards Modernization/ Review: Advocating for Food Literacy

[3] Ibid.

[4] Ministry of Health Promotion (2010). Healthy Eating, Physical Activity and Healthy Weights. Retrieved from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/healthyeating_physicalactivity_healthyweights_gd.pdf

[5] Ibid.

[6] Ibid.

[7] Ontario Society of Nutrition Professionals in Public Health (2016). Ontario Public Health Standards Modernization/ Review: Advocating for Food Literacy [technical brief].

[8] Chenhall, C. (2010). Improving Cooking and Food Preparation Skills: A Synthesis of the Evidence to Inform Program and Policy Development. Government of Canada. Retrieved from: http://www.hc-sc.gc.ca.proxy1.lib.uwo.ca/fn-an/nutrition/child-enfant/cfps-acc-synthes-eng.php#a43

[9] Desjardins, E. and Azevedo, E. (2013). "Making Something out of Nothing": Food Literacy among Youth, Young pregnant women and young parents who are at Risk for Poor Health, a Locally Driven Collaborative Project of Public Health Ontario. Retrieved from: https://www.osnpph.on.ca/upload/membership/document/food-literacy-study.ldcpontario.final.dec2013.pdf

[10] Ibid.

[11] Ibid.

[12] Ibid.

[13] Ibid.

[14] Ontario Society of Nutrition Professionals in Public Health (2016). Ontario Public Health Standards Modernization/ Review: Advocating for Food Literacy [technical brief].

[15] Cullen T, Hatch J, Martin W, Higgins JW, Sheppard R. (2015). Food literacy: definition and framework for action. Can J Diet Pract Res. 76(3):140–145

[16] Government of Canada (2010). Profile of Promising Cooking and Food Preparation Skills: A Profile of Promising Practices in Canada and Abroad. Retrieved from: http://www.hc-sc.gc.ca.proxy1.lib.uwo.ca/fn-an/nutrition/child-enfant/cfps-acc-profil-apercu-eng.php

[17] Practice Based Evidence in Nutrition: Food Skills Knowledge Pathway (2015) Retrieved from: http://www.pennutrition.com/KnowledgePathway.aspx?kpid=22933&pgcatid=148&pgid=22979

[18] Ibid.

[19] Desjardins, E. and Azevedo, E. (2013). "Making Something out of Nothing": Food Literacy among Youth, Young pregnant women and young parents who are at Risk for Poor Health, a Locally Driven Collaborative Project of Public Health Ontario. Retrieved from: https://www.osnpph.on.ca/upload/membership/document/food-literacy-study.ldcpontario.final.dec2013.pdf

[20] Ontario Ministry of Health and Long-Term Care. 2013. No time to wait: The healthy kids strategy [Ontario]. Toronto, Canada. Retrieved from: http://www.health.gov.on.ca/en/common/ministry/publications/reports/healthy_kids/healthy_kids.pdf

[21] Ibid.

[22] Chenhall, C. (2010). Improving Cooking and Food Preparation Skills: A Synthesis of the Evidence to Inform Program and Policy Development. Government of Canada. Retrieved from: http://www.hc-sc.gc.ca.proxy1.lib.uwo.ca/fn-an/nutrition/child-enfant/cfps-acc-synthes-eng.php#a43

[23] Ontario Edible Education Network (2013). Next Phase in Ontario's Education Strategy [letter to: Hon. Liz Sandals]. Retrieved from: http://sustainontario.com/work/edible-education/wp-content/uploads/sites/5/2014/08/SustainOntario_EducationStrategySubmission.pdf

[24] Hersch D., Perdue, L., Ambroz, T., Boucher, J.L. (2014). The Impact of Cooking Classes on Food-Related Preferences, Attitudes, and Behaviours of School- Aged Children: A Systematic Review of the Evidence, 2003-2014. *Preventing Chronic Disease,* 11(193)

[25] Nutrition Resource Centre (2013). Food Skills Programming Environmental Scan. Retrieved from: http://opha.on.ca/getmedia/56548d88-dc44-4387-a957-fcbb363e2808/Food-Skills-Programming-Environmental-Scan.pdf.aspx

[26] Ibid.

[27] Chenhall, C. (2010). Improving Cooking and Food Preparation Skills: A Synthesis of the Evidence to Inform Program and Policy Development. Government of Canada. Retrieved from: http://www.hc-sc.gc.ca.proxy1.lib.uwo.ca/fn-an/nutrition/child-enfant/cfps-acc-synthes-eng.php#a43

[28] Ontario Ministry of Health and Long-Term Care. 2013. No time to wait: The healthy kids strategy [Ontario]. Toronto, Canada. Retrieved from: http://www.health.gov.on.ca/en/common/ministry/publications/reports/healthy_kids/healthy_kids.pdf

[29] WHO Regional Office for Europe's Health Evidence Network (HEN) (2006). What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach? Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0007/74653/E88185.pdf

[30] Ontario Agency for Health Protection and Promotion (Public Health Ontario), Mensah G. (2016). Evidence Brief: Impact of food skills programs on fruit and vegetable consumption among children and youth. Toronto, ON: Queen's Printer for Ontario. Retrieved from: http://www.publichealthontario.ca/en/eRepository/Evidence_brief_food_skills_programs.pdf

[31] Ibid.

[32] Ibid.

[33] Ibid.

[34] Ibid.

[35] Ibid.

[36] Sustain Ontario (2010). Ontario Edible Education Network- Network Activities. Retrieved from: http://sustainontario.com/initiatives/ontario-edible-education-network/activities

[37] Sustain Ontario (2014). Action Plan, Summary of Priority Actions. Retrieved from: http://sustainontario.com/wp2011/wp-content/uploads/2013/06/EdibleEducationActionPlan_Summary1.pdf

[38] Langellotto, G., Gupta, A. 2012. Gardening Increases Vegetable Consumption in School-aged Children: A Meta-analytical Synthesis. Hort Technology 22(4) 430-445. Retrieved from: http://horttech.ashspublications.org/content/22/4/430.full

[39] Colatruglio, S. & Slater, J. (2016). Challenges to acquiring and using food literacy: Perspectives of young Canadian Adults. Canadian Food Studies, 3(1). Retrieved from: http://webcache.googleusercontent.com/search?q=cache:j72pwQ_vr8IJ:canadianfoodstudies.uwaterloo.ca/index.php/cfs/article/download/72/145+&cd=10&hl=en&ct=clnk&gl=ca

[40] Ibid.

[41] Chenhall, C. (2010). Improving Cooking and Food Preparation Skills: A Synthesis of the Evidence to Inform Program and Policy Development. Government of Canada. Retrieved from: http://www.hc-sc.gc.ca.proxy1.lib.uwo.ca/fn-an/nutrition/child-enfant/cfps-acc-synthes-eng.php#a43

[42] Ministry of Children and Youth Services (2016). Student Nutrition Program Nutrition Guidelines. pp8. Retrieved from: http://www.children.gov.on.ca/htdocs/English/documents/studentnutrition/SNP-nutrition-guidelines-2016.pdf

[43] Ontario Ministry of Education (c2016). Healthy Schools: New School Food and Beverage Policy. Retrieved from: http://www.edu.gov.on.ca/eng/healthyschools/policy.html

[44] Ontario Society of Nutrition Professionals in Public Health. What is Bright Bites? (2016). Retrieved from: http://brightbites.ca/about-us/what-is-brightbites/

A study of

FOOD LITERACY

…among youth, young pregnant women and young parents who are at risk for poor health

FOOD LITERACY FOR LIFE

WHAT WE WANTED TO KNOW

1. What does food preparation mean to these groups? How do they feel about it?
2. What types of foods can they prepare? What do they commonly prepare?
3. How are they learning food skills? What do they want to learn?
4. What challenges do they face with preparing food? What strategies do they use?
5. What types of supports would help?

A Locally Driven Collaborative Project with health professionals from eight Public Health Units in Ontario

In-depth interviews with 85 young people, 16 to 25 years of age, in a mix of rural, urban and Northern places including:

- Chatham-Kent
- City of Hamilton
- City of Kawartha Lakes
- London
- Northumberland County
- Sudbury & District
- Waterloo
- Windsor-Essex County

WHY THIS MATTERS

In our current food environment where processed convenience foods are readily available, expensive and often unhealthy, becoming food literate is a life skill that enhances resilience. Through youth and new parents, we have an opportunity to begin to influence a new generation of healthy eating.

WHAT IS FOOD LITERACY

- It is a set of skills and attributes that help people sustain the daily preparation of healthy, tasty, affordable meals for themselves and their families.
- It builds resilience, because it includes food skills (techniques, knowledge and planning ability), the confidence to improvise and problem-solve, and the ability to access and share information.
- It requires external support with healthy food access and living conditions, broad learning opportunities and positive socio-cultural environments.

"So if you learn how to make stuff from basically nothing, like just make it from different stuff that you have around the house, then you have something to eat."
-Steve, age 18

"Before, I was living with a lot of other people and I cooked and baked for them. But it's harder to cook for yourself than for fourteen people. I do like cooking, just not for myself."
-Sadie, age 18

WHAT DID WE LEARN?

- The range of food skills among these young people is broad and evolves over time. They are motivated to prepare food because of factors that include:
  - Cost, taste, personal health, child health, independence, pleasure, and creativity
- Preferred ways of learning:
  - Direct experiential learning
  - School-based opportunities
  - Community cooking programs
- The most common reason for preparing their own food was "knowing what's in it"
- Recipes and online learning were not a substitution for hands-on opportunities
- Many young people never used recipes and valued the ability to improvise
- Preparing food for others or with their children was a source of pride and satisfaction
- Confidence in the kitchen was higher among those who learned earlier in life

WHAT DID THEY TELL US?

Food preparation is an important life skill for everyone. However, what they knew how to make and what they actually prepared on a daily basis depended on personal and environmental factors:

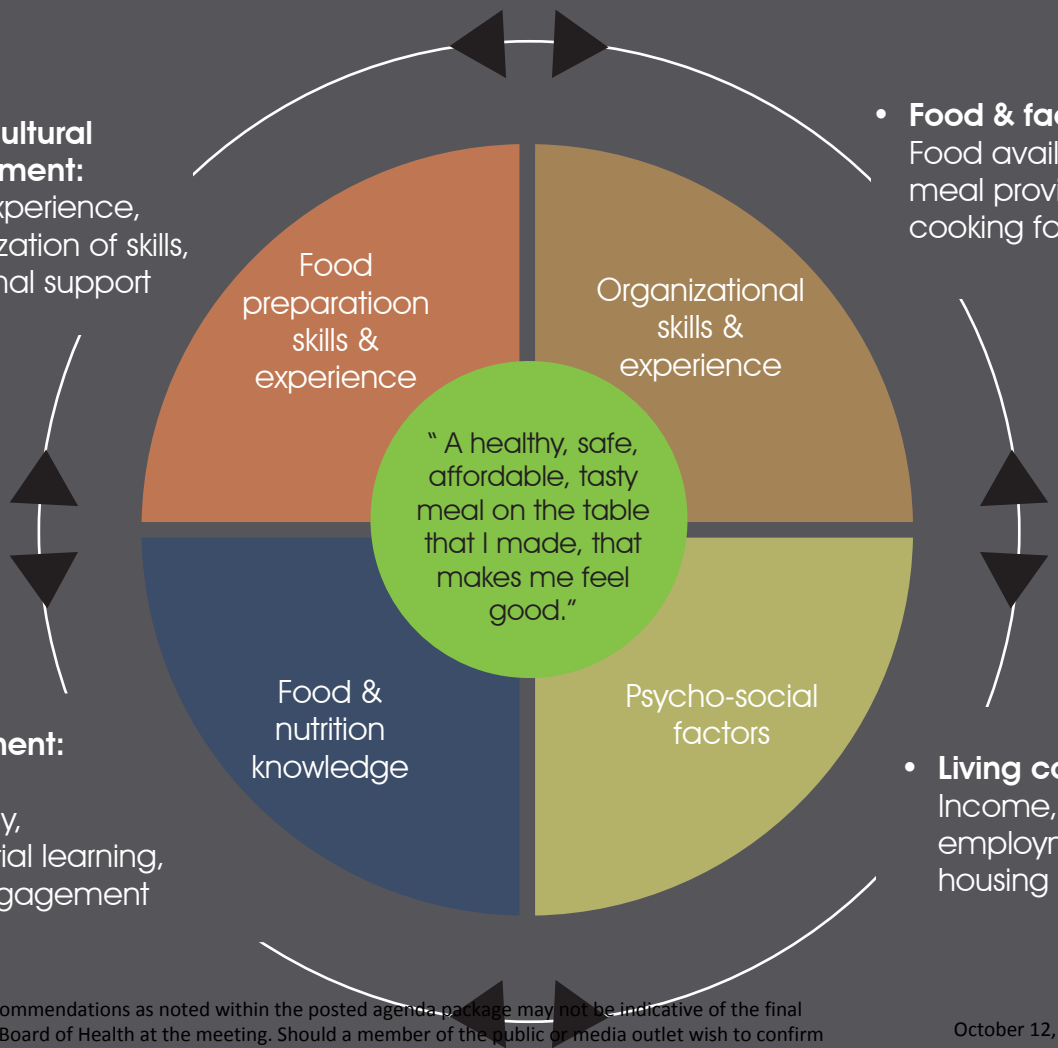
Food Preparation Skills & Experience
- Ability to use food preparation utensils, appliances
- Ability to use recipes and follow instructions
- Ability to improvise with ingredients

Organizational Skills & Experience
- Planning
- Budgeting
- Buying and storing food

Food & Nutrition & Knowledge
- Knowledge about food, nutrition, food safety
- Interpreting food labels, where to find information
- Where food comes from

Psycho-Social Factors
- Satisfaction, creativity, social connectedness (eating together, transferring skills), feeling healthy
- Resilience, self-efficacy, confidence, control, household food security

WHAT DETERMINES FOOD LITERACY?



PROMISING PRACTICES:

- Community Food Advisors or Peer Nutrition Programs
- Food Hubs or Centres

Opportunities to incorporate food literacy into existing programs:

- Canada Prenatal Nutrition Program
- Healthy Babies, Healthy Children
- Student involvement in food preperation in cafeterias and student nutrition programs
- Ontario school curriculum
- Before and after school programs
- Good Food Box programs
- Community gardens
- Community kitchens

"I took a foods class at school for two years and then when I was pregnant, Building Healthy Babies used to do cooking classes so I learned stuff there. That was good because I realized I had to cook for myself so I might as well learn. It's just like you learned how to walk and you walk for the rest of your life. So if you are taught in simple ways that's easy to remember, patterns of how you do things like how you cut onions and tomatoes – like I showed my sister how to do it and now she has no problem to do it."
– Anya, age 21, 3 children

"When I move out is when I'm starting to cook on my own. My dad always kind of like showed me, but no -- I've never tried anything. So now I found this little apartment and I figure I have only $150 for food each month, and like I'm scared, man. Like I was just starting to do my budgeting thing, and I'm going to go out shopping for food, and I need some pots and pans too."
- Jay, age 17

WHAT CAN WE DO?

- Public health units have an important role in building community capacity for food literacy programs and partnerships.
- Incorporate food literacy into the school system:
  - Curriculum and classroom
  - Before and after programs
  - Community use of schools
- Increase the number of community programs with a cooking component, in both rural and urban areas.
- Train teachers and food skills facilitators to combine food literacy programs with resiliency building.
- Encourage parents/teachers to involve children in age-appropriate food preparation from a young age.
- Advocate for affordable housing with functional kitchens, and increased access to healthy food.
- Create programs that build job skills e.g., incubator kitchens, culinary training, food service, catering, safe food handler courses.
- Advocate for adequate program funding and appropriate kitchen facilities in community settings.

The team gratefully acknowledges funding received from Public Health Ontario through the Locally Driven Collaborative Projects program. The views expressed in this publication are the views of the project team and do not necessarily reflect those of Public Health Ontario. The technical report for this study "Making something out of nothing": Food literacy among youth, young pregnant women and young parents who are at risk for poor health", 2016 is available at www.osnpph.on.ca/resources/index.php

Ontario Society of Nutrition Professionals in Public Health
La société ontarienne des professionnel(le)s de la nutrition en santé publique

Technical Brief
August 2016
www.osnpph.on.ca

Ontario Public Health Standards Modernization/Review: Advocating for Food Literacy

Introduction

In the current Ontario Public Health Standards (OPHS) (1), the Chronic Disease and Injury Program Standards (Chronic Disease Prevention Health Promotion and Policy Development Requirement 8) state: "The board of health shall provide opportunities for skill development in the areas of food skills and healthy eating practices for priority populations.". This technical brief provides evidence-informed information about how food literacy, which includes food skills, has both nutritional and mental health benefits (e/g., self-efficacy, social connectedness) which may impact on chronic disease prevention. Current evidence also suggests the nomenclature of food skills be changed to food literacy. It is the recommendation of the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) that OPHS modernization will include food literacy and that health units will continue to provide opportunities for food skill development. Research conducted by several health units between 2012-2014 generated rich data about the meaning of food skills for youth, young pregnant women and young parents who are at risk for poor health in Ontario (2). Findings produced a definition and conceptual framework for food literacy and recommendations to inform public health policy and school-based and community programming. Currently, 15 health units comprise a Locally Driven Collaborative Research Project (LDCP) to identify attributes of food literacy and food skills for the purpose of developing key indicators and a validated tool to measure food literacy, including food skills (to be completed in 2019).

Background

Chronic diseases, including cancer, cardiovascular disease, chronic respiratory disease, and diabetes are the leading causes of death and disability. In 2007, nearly 60% of reported deaths in Ontario were attributed to unhealthy lifestyle behaviours such as poor diet, smoking, excessive alcohol consumption, physical inactivity, and high stress (3). Diet quality has been identified as the most important risk factor for chronic disease (4).

Many adults and youth do not have healthy diets. Fruit and vegetable consumption, for example, is an indicator of a healthy diet but half of all adults do not consume a minimum of five servings of vegetables and fruit daily (5). The adapted Healthy Eating Index assesses two aspects of diet quality: adequacy and moderation, whereby a score of 100 points approximates a high diet quality (6). In 2004, the average score on the Canadian adaptation of the Healthy Eating Index was 58.8 for the total population aged two or older, and approximately 55 in the 14-to-30 years of age (6).

The current challenge is that the consumption of quality diets has been significantly influenced by a change in eating patterns. Today, a greater proportion of foods are consumed away from home. Additionally, processed and pre-packaged foods are more readily available in the food environment. Consuming pre-prepared and convenience food has become normalized within the eating patterns for

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Canadian children of all ages and their families (7). According to the Canadian Council of Food and Nutrition report, Tracking Nutrition Trends - VII (2008), a third to over half of Canadians eat a meal not prepared at home at least once a day (8). This is a concern as foods prepared away from home have been associated with increased energy intake and decreased nutritional quality (8). Additionally, high consumption of processed foods is associated with poorer health outcomes (9). The current food environment does not consistently support healthy eating and as such it has resulted in an increase in overall caloric consumption and a decrease in individuals' nutritional quality (10-15). This shift in consumption has become a public health nutrition challenge.

Concurrent to this trend, time spent preparing food at home has declined along with a loss of domestic food preparation skills (16, 17). Since 1900, there has been an eight-fold decrease (from 360 minutes per day in the 1900s to 45 minutes per day in 1985) in the average daily time spent on the task of meal preparation and cleaning up after the meal (16). Overall, fewer people cooked in 2007-2008 compared to 1965-1966 across all income groups (17). The proportion of women who cooked decreased from 92% to 68% over the same time period (17). Although modern conveniences, such as microwaves ovens, have helped to reduce food preparation times, the predominant change in eating and meal preparation culture is due to most adults working outside the home, participation in busier lifestyles, and an increased number of hours spent at work during the week (17).

Traditionally, mothers transferred their food skills onto their children, but because of workforce realignment and the decrease of food skills education opportunities in the schools, children may be missing out on opportunities to learn cooking skills and enhance their food literacy in the process. A lack of cooking knowledge and skill decreases a person's propensity to cook; however, those who report being more involved in food purchasing and preparation or those who cook most often are more likely to meet dietary guidelines (18, 19).

Healthy diets are influenced by many factors. Limited awareness of food, cooking skills, and knowledge about how foods are grown and harvested can lead to barriers in healthy food consumption, and ultimately the achievement and maintenance of a healthy weight (20). The foods people cook, the food preparation skills they utilize, and where they cook are all influenced by social, economic, and cultural contexts that are constantly changing (21-23). Independent of preparation skills, there are also several factors that drive an individual's food selection including physiology, food availability, taste, price, marketing, convenience, social norms, and cues (23). Barriers to developing individual food skills have been defined and include lack of time, attitudes, cost, confidence, and lack of skills (19). As previously mentioned, there is a decline in domestic food preparation skills (often called "deskilling") due to a lack of introduction to and opportunity for the acquisition of cooking skills from parents, grandparents,

and/or school environments (23, 25-29). These complex factors, which contribute to a healthy diet and consequently a healthy weight, are known as food literacy.

The Evolution of Food Literacy

The term "food literacy" is a relatively new concept that has emerged both in the literature and in practice-based research since 2011.

In the Ministry of Health Promotion's Guidance Document: Healthy Eating, Physical Activity and Healthy Weights (30), food skills is defined as a complex, interrelated, person-centred set of skills that are necessary to provide and prepare safe, nutritious, and culturally-acceptable meals for all members of one's household. (30) This definition encompasses five general categories (30):

- **Knowledge** (nutrition, label reading, food safety, food varieties, ingredients, substitution);
- **Planning** (organizing meals, budgeting, food preparation, teaching food skills to children);
- **Conceptualizing food** (creative thinking about leftovers, adjusting recipes);
- **Mechanical techniques** (preparing meals, chopping/mixing, cooking, following recipes); and
- **Food perception** (using your senses – texture, taste, when foods are cooked).

Environmental or external factors that impact the attainment of food skills at the individual level are not covered in the definition of food skills above despite in the fact that the literature acknowledges the importance of these factors in achieving a healthy diet.

The report from a previous LDCP research project with eight health units in Ontario conducted between 2012-2014, ***Making Something out of Nothing: Food literacy among youth, young pregnant women and young parents who are at risk for poor health*** (2) helped shed light on the meaning of food skills from the perspective of selected priority populations including youth (16-19 years), pregnant women (16-25 years) and young parents (16-25 years). The results from this study exceeded the current Ministry of Health's definition of food skills and included a comprehensive definition for food literacy that included both personal factors and broader environmental factors. Food literacy was defined as (2):

- ***Food literacy is a set of skills and attributes*** that help people sustain the daily preparation of healthy, tasty, affordable meals for themselves and their families;
- ***Food literacy*** builds resilience, because it ***includes food skills*** (techniques, knowledge and planning ability), the confidence to improvise and problem-solve, and the ability to access and share information; and,
- ***Food literacy requires external support*** with healthy food access and living conditions, broad learning opportunities, and positive socio-cultural environments.

These findings are supported by a number of recent studies and papers, geographically dispersed and independently conducted, that have further explored the concept of food literacy (31-36). For the purpose of this project, Colatruglio & Slater (37) and Vidgen and colleague (31) are of unique importance as they speak to the continued evolution in defining food literacy. The definition of food literacy, when compared with the previous definitions of food skills, should be one that encompasses a more critical understanding of the differing cultural, familial and spiritual beliefs related to foods and nutrition, the greater interaction with the food system, and the overall enhancement of nutritional health and well-being that could be attributed to being food literate. It is also important to note that psycho-social factors such as social connectors, self-efficacy, and confidence are outcomes cited in the literature when individuals attain food skills and become more food literate (2). Vidgen and colleague (31) remarks that these factors reflect the 'scaffolding' of the concept of food literacy, which enables a better understanding of the various components and complexity of food literacy and how best to measure it in a public health context.

Broadly speaking, the indicators of food literacy and the associated definitions are not consistent in the literature, making it difficult to generalize results. Likewise, there is a notable absence of reliable and valid tools specific to the measurement of food skills and other contextual attributes of food literacy including access to food, self-efficacy and confidence.

Current LDCP Research to Measure Food Literacy

Public Health Ontario (PHO) supports applied research and program evaluation through the Locally Driven Collaborative Project (LDCP) program. The LDCP program brings public health agencies together to develop and run research projects on issues of shared interest related to the Ontario Public Health Standards. (1)

The current LDCP project involving 15 health units has outlined a multi-phase approach to address, within public health practice, how best to measure food literacy and its attributes. Specifically, the project focuses on high-risk groups of youth (16 to 19 years of age), young parents (16-25 years of age) and pregnant women (16 to 25 years of age).

The first phase of this LDCP project utilized a scoping review and identified 14 food literacy attributes and their associated descriptors (summary report in progress). The findings from the scoping review will be validated and prioritized through a Delphi process. The final list of attributes will be used to develop key indicators. From these indicators we will create a validated measurement tool that will be tested for its ability to assess food literacy and to measure its attributes within the public health context. The

research for the indicator development, questionnaire development, a validity testing will all commence in the next year. We are optimistic that we will have a valid tool for broad distribution within two years.

Recommendations for OPHS Modernization re: Food Literacy and Call to Action for Public Health Units

As identified in this technical report, food skills are part of the broader definition of food literacy and fall within the mandate of Public Health, therefore, it is essential that health units in Ontario respond to this identified need to enhance food literacy for all Ontarians. To achieve this, food literacy and the development of food skills must continue to be included in the OPHS modernization and Public Health must advocate for:

- Age-appropriate programs and classes at elementary, alternatives, and high schools, as well as after-school and community programs that enhance food literacy and align with the curriculum topics;
- Programs to be practical, experiential, confidence-building, skill-related, and learning-level-related;
- Adequate funds to cover expenses for equipment, facilities, leaders' competence and wages, food, and other ingredients;
- Sufficient funding to support child care costs and transportation to community-based programs to facilitate participation by the community (38);
- Funding for safe, inspected premises (under the Ontario Food Premises Regulation 562) for community use – e.g., in schools, universities, community venues, shelters, and community food hubs or community food centres;
- Community-based food literacy programs must have a certified Food Handler on site in all food premises;
- Additional and newly developed affordable and rent geared to income housing with functional kitchens which include operational major appliances (38);
- Ensure housing developers and existing landlords include community gardening space as well as gardening equipment storage; build housing units to facilitate growing, cooking, and eating of healthy foods (e.g., adequate balconies for container gardening, kitchen space to allow for food preparation, eating, storage capacity, and accessibility); establish centralized food supports including emergency food cupboards, community freezers, and food literacy program/cooking classes (38);
- Ensure affordable and adequate public transportation, safe pedestrian routes to food resources in the community, cooking programs, healthy corner stores, healthy food outlets, Good Food Box locations, mobile markets, and community gardens (38);

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- Fully coordinated plans and strategies for food and housing with full integration into Official Plans:
- Ensure access to healthy food is considered in underserviced and new developments; and,
- Living wages and an adequate food allowance for social assistance.

Public Health can work with partners to:

- Create/nurture strong social networks to share food skills and use the Youth Engagement Principles to promote peer-led food skill programs;
- Include food literacy as part of resiliency skill building activities in Public Health programs focused on youth;
- Promote eating and cooking together and healthy food preparation as a normal life skill for everyone in school and community food programs;
- Train teachers and food skills facilitators to combine food literacy programs with self-esteem building, body weight acceptance, and referral for counseling if necessary;
- Provide training and support for facilitators re: food skills, youth engagement training, sensitivity training (e.g., for teachers, public health Registered Dietitians, public health nurses, Healthy Babies Healthy Children home visitors, peer workers, and community workers);
- Provide Registered Dietitian-led grocery store tours with priority groups;
- Implement food literacy programs across Ontario, targeted specifically to youth;
- Ensure that community programs are offered in rural and remote areas;
- Provide resources that aid food skill development such as slow cookers, Basic Shelf Cookbooks (39), spice kits, grocery hampers with ingredients, “meals in a bag” including kitchen implements, food vouchers (farmers market coupons, grocery store gift cards, Good Food Box incentives/certificates;
- Link with and promote community programs that increase access to healthy food (i.e., Good Food Box programs, farmers markets??, collective kitchens)
- Create programs that build job skills, e.g., incubator kitchens, culinary training, food service, catering, certified food handler courses;
- Assist with establishing free or low cost community kitchen programs; and,
- Help with establishing meal programs at hostels and shelters for youth who are homeless, in transition, upgrading, or finishing high school.

OSNPPH is the independent and official voice of over 200 Registered Dietitians working in Ontario’s public health system. OSNPPH provides leadership in public health nutrition by promoting and supporting member collaboration to improve the health of Ontario residents. With the modernization of the OPHS, it would be important to include these evidence-informed recommendations in the revisions.

Ontario Public Health Standards Modernization/Review: Advocating for Food Literacy

Food literacy is an evolving field within public health and many of our members are considered leaders within this area of expertise. For more information about the LDCP project or food literacy recommendations to be included in the OPHS modernization, please contact:

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Heather Thomas, PhD, RD
Public Health Dietitian
Middlesex-London Health Unit
Phone: (519) 663-5317 ext. 2222
heather.thomas@mlhu.on.ca

Thank you for your attention to our recommendations. We look forward to hearing back from you at your earliest convenience.

Sincerely,

Candice Einstoss, RD
Co-Chair Year 2, OSNPPH

Erinn Salewski, RD
Co-Chair Year 1, OSNPPH
Chair, OSNPPH Advocacy Committee

References:

Ontario Public Health Standards Modernization/Review: Advocating for Food Literacy

1. Ministry of Health and Long-Term Care. Ontario public health standards. 2008: Revised May 1, 2014. Toronto, ON: Queen's Printer for Ontario. Retrieved August 17, 2016 from http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf
2. Desjardins, E., et al. 2013. Making something out of nothing: Food Literacy among youth, young pregnant women and young parents who are at risk for poor health. Retrieved August 17, 2016 from https://www.publichealthontario.ca/en/ServicesAndTools/Documents/LDCP/LDCP.Food.Skills_Report_WEB_FINAL.pdf
3. Manuel, D.G., et al. 2012. Seven more years: The impact of smoking, alcohol, diet, physical activity and stress on health and life expectancy in Ontario. Toronto, ON: Public Health Ontario; Institute for Clinical Evaluative Sciences. Retrieved August 17, 2016 from https://www.publichealthontario.ca/en/eRepository/PHO-ICES_SevenMoreYears_Summary_web.pdf
4. Murray, C.J., et al. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: A systematic analysis for the global burden of disease study 2010. 2012. Lancet *380*(9859): 2197-223.
5. Hung, H.C., Joshipura, et al. 2004. Fruit and vegetable intake and risk of major chronic disease. Journal of the National Cancer Institute *96*(21): 1577-84.
6. Garriguet, D. 2009. Diet quality in Canada. Health Repository *20*(3): 41-52.
7. Chenhall, C. 2010. Improving cooking and food preparation skills: A synthesis of the evidence to inform program and policy development. Ottawa, ON: Government of Canada. Retrieved August 17, 2016 from: http://www.hc-sc.gc.ca/fn-an/alt_formats/pdf/nutrition/child-enfant/cfps-acc-synthes-eng.pdf
8. Canadian Council of Food and Nutrition (CCFN). 2008. Tracking nutrition trends VII. Mississauga, ON: CCFN. Retrieved August 17, 2016 from from https://www.cfdr.ca/Downloads/CCFN-docs/C1180---TNT-VII-FINAL-REPORT---full-report--Sept-1.aspx
9. Todd, J.E., et al. 2010. The impact of food away from home on adult diet quality. Washington, DC: U.S. Department of Agriculture, Economic Research Service. Retrieved August 17, 2016 from: http://www.ers.usda.gov/media/136609/err90_1_.pdf
10. Taveras, et al. 2005. Association of consumption of fried food away from home with body mass index and diet quality in older children and adolescents. Pediatrics *116*(4):e518-24.
11. Guthrie. J.F., et al. 2002. Role of food prepared away from home in the American diet, 1977-78 versus 1994-96: Changes and consequences. Journal of Nutrition Education and Behavior *34*(3): 140-50.
12. Larson, N.I., et al. 2006. Food preparation by young adults is associated with better diet quality. Journal of the American Dietetic Association *106*(12): 2001-7.
13. Hilton, C.L., et al. 2011. Healthy habit changes in pre-professional college students: Adherence, supports, and barriers. Occupational Therapy Journal of Research *31*(2): 64-72.
14. Stead, M., et al. 2004. Confident, fearful and hopeless cooks: Findings from the development of a food-skills initiative. British Food Journal *106*(4): 274-87.

15. van der Horst, K. et al. 2011. Ready-meal consumption: Associations with weight status and cooking skills. Public Health Nutrition *14*(2):239-245 Retrieved August 17, 2016 from: http://journals.cambridge.org/download.php?file=%2FPHN%2FPHN14_02%2FS1368980010002624a.pdf&code=d5af442879b54f26799cf8f415584175
16. Bowers, D.E. 2000.Cooking trends echo changing roles of women. Food Review *23*(1): 23-9.
17. Canadian Grocer. 2000. The road ahead: Consumer trends in food. Canadian Grocer *114*(5):22-3.
18. Smith, L.P., et al. 2013. Trends in US home food preparation and consumption: Analysis of national nutrition surveys and time use studies from 1965–1966 to 2007–2008. Nutrition Journal *12*(1): 45.
19. Safe Food. 2014. Food Skills: Definitions, influences and relationships with health. Cork: Ireland. Retrieved August 15, 2016 from www.safefood.en/safeFood/media/SafeFoodLibrary/Documents/Publications/Research%20Reports/Food-Skills-Edited-Final-Report.pdf
20. Smith, L.P., et al. 2014. Resistant to the recession: Low-income adults' maintenance of cooking and away-from-home eating behaviors during times of economic turbulence. American Journal of Public Health. *104*(5): 840-6.
21. Lang, T., et al. 2001. Is there a culinary skills transition? Data and debate from the UK about changes in cooking culture. Journal of the HEIA. *8*(2): 2-14.
22. Short, F. 2003. Domestic cooking practices and cooking skills: Findings from an English study. Food Service Technology *3*(3-4): 177-185.
23. Lang, T. et al. 1999. Cooking skills and health. London, England: Health Education Authority; 1999 Retrieved August 17, 2016 from: http://www.nice.org.uk/proxy/?sourceUrl=http%3A%2F%2Fwww.nice.org.uk%2Fnicemedia%2Fdocuments%2Fcooking_skills_health.pdf
24. Ontario Society of Nutrition Professionals in Public Health (OSNPPH) Workplace Nutrition Advisory Group. 2012/ Call to action: Creating a healthy workplace nutrition environment. Retrieved August 17, 2016 from http://www.osnpph.on.ca/membership/documents/loadDocument?id=50&download=1#upload/membership/document/call-to-action-final-october-26-2012.pdf
25. Short F. Domestic cooking skills-what are they? Journal of the HEIA [serial online]. 2003 [cited 2015 Jun 16];10(3):13-22 Available from: http://www.mv.helsinki.fi/home/palojoki/english/GBG%202007/francesshort.pdf
26. Lang T, Caraher M. Is there a culinary skills transition? Data and debate from the UK about changes in cooking culture. Journal of the HEIA. 2001; 8(2): 2-14.
27. Caraher M, Lang T. Can't cook, won't cook: A review of cooking skills and their relevance to health promotion. International Journal of Health Promotion and Education. 1999; 37(3): 89-100.
28. Lai Yeung WT. A study of perceptions of food preparation skills in Hong Kong. Journal of the Home Economics Institute of Australia. 2007; 14(2): 16.
29. Lang T, Caraher M, Dixon P,Carr-Hill R. Cooking skills and health. [Report online]. London, England: Health Education Authority; 1999 [cited 2015 Jun 01]. Available from:

http://www.nice.org.uk/proxy/?sourceUrl=http%3A%2F%2Fwww.nice.org.uk%2Fnicemedia%2Fdocuments%2Fcooking_skills_health.pdf

30. Ministry of Health Promotion. 2010. Healthy Eating, Physical Activity and Healthy Weights. Retrieved August 17, 2016 from http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/healthyeating_physicalactivity_healthyweights_gd.pdf
31. Vidgen HA and Gallegos D. Defining food literacy, its components, development and relationship to food intake: A case study of young people and disadvantage. [Report online]. Brisbane, Queensland: Queensland University of Technology; 2012 [cited 2015 Sep 11]. Available from: http://eprints.qut.edu.au/53786/1/Food_literacy_and_young_people_report.pdf.
32. Pendergast D, Dewhurst Y. Home economics and food literacy: An international investigation. IJHE [serial online]. 2012 [cited 2015 Jun 22];5(2):245-263 Available from: http://www98.griffith.edu.au/dspace/bitstream/handle/10072/49572/84492_1.pdf?sequence=1.
33. Rawl R, Kolasa KM, Lee J, Whetstone LM. A learn and serve nutrition program: The food literacy partners program. J Nutr Educ Behav. 2008; 40(1): 49-51.
34. Smith MG. Food or nutrition literacy?: What concept should guide home economics education. IJHE. 2009; 2(1): 48-64.
35. Vidgen HA and Gallegos D. What is food literacy and does it influence what we eat: A study of Australian food experts. [Report online]. Brisbane, Queensland: Queensland University of Technology; 2011 [cited 2015 Sep 11]. Available from: http://eprints.qut.edu.au/45902/1/45902P.pdf.
36. Vileisis A. Kitchen literacy: How we lost knowledge of where food comes from and why we need to get it back. Washington, DC: Island Press; 2010.
37. Colatruglio, S.2016. Challenges to acquiring and using food literacy: Perspectives of young Canadian adults. Canadian Food Studies *3*(1), 96-118.
38. Andrée, P., et al. 2015. Food Access, Housing Security and Community Connections: A Case Study of Peterborough, Ontario. Retrieved August 25, 2016 from https://legacy.wlu.ca/documents/62514/Food_Access_Housing_Security_and_Community_Connections_Peterborough_Case_Study_FINAL.pdf
39. Canadian Public Health Association. 2011. The Basic Shelf Cookbook. Ottawa: The Canadian Public Health Association.

Peterborough Public Health Food Literacy Programs for Children and Priority Populations

You're the Chef (YTC) is a train-the trainer food literacy program for children (6 to 11 years old) that was created by public health dietitians in 2004, and is now used throughout the province, in schools and in child care. YTC was trialed with a Peterborough childcare centre in March 2016. Funding from the Healthy Kids Community Challenge (HKCC) will be used to implement a train-the-trainer program, with the first two sessions in December of 2016, and February of 2017. The target audience of this program in Peterborough is childcare workers and children who attend before and after school programs.

The goals of this program, funded locally through HKCC, are to:

- Promote water as the recommended replacement for sugar-sweetened beverages
- Promote vegetable and fruit consumption
- Teach food literacy skills so kids learn to prepare their own healthy meals, drinks and snacks

Childcare facilities were chosen for this pilot, due to the high potential for program sustainability in the Peterborough County and City. Childcare centers have paid staff, program and food budget, and time to run programming. PPH's existing relationships with childcare facilities allows potential for long term reach of food literacy programs for children.

Feedback from the March 2016 trial of YTC in childcare indicated that this program was very well received, increased children's confidence in the kitchen, and resulted in children being enthusiastic about making recipes for their families, and going to the grocery store with their families to buy ingredients.

Nourish is a community partnership dedicated to eating, cooking, growing, and advocating for good food to cultivate health, build community, and promote fairness. Hands on food literacy programing, held in Myrtle's Kitchen at PPH, is a key component of Nourish. Nourish is also investigating food literacy programming for school-aged children.

Come Cook With Us (CCWU) is a four to five week food skills program that is offered at no charge to priority population groups throughout the City and County of Peterborough, as well as to Hiawatha and Curve Lake First Nations. Led by PPH Community Workers, CCWU brings together people to learn how to prepare a meal, share recipes and cooking tips while also learning about healthy eating and food safety. Participant barriers are addressed by providing childcare, transportation and grocery gift cards.

Collective Kitchens participants, supported by PPH, meet monthly to cook food for themselves and their families. Prices for the meals are kept low by planning around grocery store specials and the support of generous funders who support food costs, childcare and transportation.

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Correspondence for Information**

Date: October 12, 2016

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:

1. Letter dated September 19, 2016 from the Board Chair to Ministers Philpott and Hoskins regarding Lyme Disease.* (p. 47)

2. Letter dated September 23, 2016 from Minister Hoskins to the Board Chair regarding base and one-time finding for 2016. (p. 49)

3. Letter dated September 30, 2016 from the Board Chair to Federal Ministers Philpott, Morneau, Brison, Sohi and Duclos regarding food security and universal hot meal programs in schools.* (p. 50)

4. Letter dated September 30, 2016 from the Board Chair to Ontario Ministers Hunter, Jaczek and Coteau regarding food security and universal hot meal programs in schools.* (p. 52)

5. Letter dated October 6, 2016 from the Board Chair to Minister Hoskins regarding the expansion of the publicly funded human papillomavirus (HPV) vaccination program and adequate funding.* (p. 54)

6. Updates from the Ministry of Health and Long-Term Care regarding the Modernization of the Ontario Public Health Standards:
   a. Accountability Committee – Highlights #4 (p. 56)
   b. Executive Steering Committee - Highlights #4 (p. 57)
   c. Practice and Evidence Program Standards Advisory Committee – Highlights #2 (p. 58)

**Enclosures previously circulated, available upon request.*

Peterborough Public Health

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September 20, 2016

The Honourable Dr. Jane Philpott
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9

The Honourable Dr. Eric Hoskins
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Honourable Ministers:

Re: Lyme Disease

At its meeting held on September 14, 2016, the Board of Health for Peterborough Public Health considered correspondence from Grey Bruce Health Unit and Niagara Region regarding the above noted matter.

In the past few years, Lyme disease (LD) has surpassed West Nile virus as the predominant vector-borne disease of concern in the province of Ontario. In the past six years, in Peterborough County and City, we have seen an increase in the number of tick submissions, with a corresponding increase in ticks that have tested positive for LD.

However, the current financial and human resources to continue with the increased public consultations on tick submissions are inadequate, and therefore, we are requesting that the Government of Canada and the Province of Ontario increase funding in the areas of research, treatment, surveillance and education for LD. For this reason, our board has endorsed the attached motions from our Ontario board of health colleagues.

The Board appreciates your attention to this important public health issue.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Hon. Kathleen Wynne, Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health, MOHLTC

Maryam Monsef, MP, Peterborough-Kawartha
Kim Rudd, MP, Northumberland-Peterborough South
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock
Jeff Leal, MPP, Peterborough
Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

Ministry of Health and Long-Term Care

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10th Floor, Hepburn Block
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Ontario

SEP 2 3 2016

iApprove-2016-00823

Mr. Scott McDonald
Chair, Board of Health
Peterborough County-City Health Unit
185 King Street
Peterborough ON K9J 2R8

Dear Mr. McDonald:

I am pleased to advise you that the Ministry of Health and Long-Term Care will provide the Board of Health for the Peterborough County-City Health Unit up to $399,864 in additional base funding and up to $241,300 in one-time funding for the 2016-17 funding year to support the provision of mandatory and related public health programs and services in your community.

The Assistant Deputy Minister of the Population and Public Health Division will write to the Peterborough County-City Health Unit shortly concerning the terms and conditions governing this funding.

Thank you for your dedication and commitment to Ontario's public health system.

Yours sincerely,

Dr. Eric Hoskins
Minister

c: Hon. Jeff Leal, MPP, Peterborough
Dr. Rosana Salvaterra, Medical Officer of Health, Peterborough County-City Health Unit

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September 30, 2016

Hon. Jane Philpott, MP
Minister of Health
Jane.Philpott@parl.gc.ca

Hon. Bill Morneau, MP
Minister of Finance
Bill.Morneau@parl.gc.ca

Hon. Scott Brison, MP
President of the Treasury Board
Scott.Brison@parl.gc.ca

Hon. Amarjeet Sohi, MP
Minister of Infrastructure and Communities
Amarjeet.Sohi@parl.gc.ca

Hon. Jean-Yves Duclos
Minister of Families, Children and
Social Development
Jean-Yves.Duclos@parl.gc.ca

Dear Honourable Ministers:

At the September 14, 2016 meeting of the Board of Health for Peterborough Public Health, correspondence from the Thunder Bay District Health Unit regarding food security and universal hot meal programs in schools was received.

Peterborough Public Health is one of the many partners of Food For Kids Peterborough and County who work to ensure that Student Nutrition Programs (SNPs) are offered and available in local elementary and secondary schools. In 2013, the Board of Health endorsed a local report entitled "Student Nutrition Programs: Best Practices, Actions for and Call to Action for Food for Kids Peterborough County".

In the 2015-16 school year, Food For Kids Peterborough and County served over 2.5 million breakfasts and snacks to over 17,000 local students with the dedication of 1,000 volunteers. The Board of Health has endorsed the vision of SNPs, delivered in Peterborough County and City schools by Food For Kids Peterborough and County, that all students who would benefit can achieve the positive health, learning and behavioural outcomes that result from this key nutrition strategy and sound public policy.

In December 1997, a "national school nutrition program" was recommended by the Standing Committee on Finance. Despite evidence supporting the need for universal SNPs and local programs meeting international best practices, funding for local programs is at a critical point. Increasing student need, expanding programs, increasing food costs and decreased funding from foundations traditionally supporting SNPs, means that Food For Kids Peterborough and County programs are currently vulnerable.

Currently local programs receive financial support in the form of grants from the Ministry of Children and Youth Services, administered for the Central East SNP through the Peterborough Family Resource Centre, along with additional funding and donations from grants, businesses, service clubs, school boards, community members and parents.

We request/urge that the Canadian government invest to leverage provincial efforts for student meal programs, through the development of a national Universal Healthy School Food Program. This partnership with provincial governments would allow funding to better reflect program costs of existing universal student nutrition programs in elementary and secondary schools across the country, while supporting student learning in regions currently lacking such programs.

In closing, we look forward to working with you, as well as our active community partners to address the need for increased funding for SNPs. Thank you for your immediate attention to this matter.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Maryam Monsef, MP, Peterborough-Kawartha
Kim Rudd, MP, Northumberland-Peterborough South
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock
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September 30, 2016

Hon. Mitzie Hunter, MPP
Minister of Education
mhunter.mpp.co@liberal.ola.org

Hon. Helena Jaczek, MPP
Minister of Community and Social Services
hjaczek.mpp@liberal.ola.org

Hon. Michael Coteau, MPP
Minister of Children and Youth Services
mcoteau.mpp.co@liberal.ola.org

Dear Honourable Ministers:

At the September 14, 2016 meeting of the Board of Health for Peterborough Public Health, correspondence from the Thunder Bay District Health Unit regarding food security and universal hot meal programs in schools was received.

Peterborough Public Health is one of the many partners of Food For Kids Peterborough and County who work to ensure that Student Nutrition Programs (SNPs) are offered and available in local elementary and secondary schools. In 2013, the Board of Health endorsed a local report entitled "Student Nutrition Programs: Best Practices, Actions for and Call to Action for Food for Kids Peterborough County".

In the 2015-16 school year, Food For Kids Peterborough and County served over 2.5 million breakfasts and snacks to over 17,000 local students with the dedication of 1,000 volunteers. The Board of Health has endorsed the vision of SNPs, delivered in Peterborough County and City schools by Food For Kids Peterborough and County, that all students who would benefit can achieve the positive health, learning and behavioural outcomes that result from this key nutrition strategy and sound public policy.

Despite a decade of evidence supporting the need for universal SNPs and local programs meeting international best practices, funding for local programs is at a critical point. Increasing student need, expanding programs, increasing food costs and decreased funding from foundations traditionally supporting SNPs, means that Food For Kids Peterborough and County programs are currently vulnerable.

Currently local programs receive financial support in the form of grants from the Ministry of Children and Youth Services, administered for the Central East SNP through the Peterborough Family Resource Centre, along with additional funding and donations from grants, businesses, service clubs, school boards, community members and parents.

We request/urge that the Ontario government enhance funding to better reflect program costs of existing universal SNPs in elementary and secondary schools across the province. This is in line with recommendations of both the local report previously noted as well in the 2012 provincial report, No Time to Wait: The Healthy Kids Strategy.

In closing, we look forward to working with you, as well as our active community partners to address the need for increased funding for SNPs. Thank you for your immediate attention to this matter.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Jeff Leal, MPP, Peterborough
Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
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October 6, 2016

Hon. Dr. Eric Hoskins, MPP
Minister of Health and Long-Term Care
ehoskins.mpp.co@liberal.ola.org

Dear Minister Hoskins:

At the September 14, 2016 meeting of the Board of Health for Peterborough Public Health, a motion was passed to endorse the resolution shared by Algoma Public Health regarding "Changes to the HPV Immunization Programs". As this resolution clearly articulates, while expansion of public health delivery of expanded immunizations is a positive move for public health, the funding model for these expanded programs is inadequate. We, therefore join the Board of Algoma Public Health in urging the Ministry of Health and Long-Term Care (MOHLTC) to increase the annual funding for the Vaccine Preventable Disease Program to levels necessary to meet the mandate.

Public Health is the most appropriate agency to deliver vaccination programs to school-aged children. The expansion of the publicly funded human papillomavirus (HPV) vaccination program to boys in grade 7 will see a potential 154,000 additional students in Ontario receiving the benefits of this vaccine. The current model of funding for this program however, at $8.50 per dose, does not reflect the real cost of programs delivery. Calculations based on experience at Peterborough Public Health is that the real cost of supplies, needle disposal, nursing and clerical staff time are approximately $14.25 per dose. We are concerned that as the immunization programs expand, it will inevitably lead to the erosion of other important public health programs.

The Board of Health commends the MOHLTC for its commitment to effective immunization programs and the recognition for the role of Public Health in delivering it to students across the province. Please take the proposed actions to ensure adequate funding for full delivery. Thank you for your consideration.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/ag
Encl.

cc: Hon. Dr. Bob Bell, Deputy Minister, MOHLTC
Roselle Martino, Executive Director, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Jeff Leal, MPP, Peterborough
Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

Accountability Committee for Standards Modernization September 2016 Highlights #4

The Accountability Committee (AC) held its fourth meeting on August 31, 2016. The AC continued to discuss the approaches health units are using to demonstrate accountability to their boards of health and municipalities. The presentations by committee members highlighted that there is a fair amount of consistency in the tools and approaches used across boards of health. More in depth information being provided that what is captured through the various reporting processes to the ministry. It was also noted that there is substantial variation in the way health units track program expenditures in relation to outputs and outcomes.

Dr. Chris Mackie shared the experience of the Middlesex-London Health Unit with "Program Budgeting Marginal Analysis". This resource reallocation methodology allows for a rational and comprehensive review of how resources are allocated and could be reallocated to address priorities and improve efficiencies. A software program supports the analysis of submitted proposals for reallocations, using scoring criteria and consideration of the potential positive and negative impacts on clients and the community.

The AC discussed a draft logic model of the Accountability Framework as well as the opportunity for a narrative to the framework to support its dissemination.

The next meeting will focus on reviewing the Fiscal Responsibility and the Governance components of the working draft of the Accountability Framework.

For information, contact: Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Ministry of Health and Long-Term Care at Paulina.Salamo@ontario.ca or (416) 327-7423.

Standards Modernization Executive Steering Committee September 2016 Highlights #4

The Executive Steering Committee for the Standards Modernization (the “ESC”) continues the review of the Ontario Public Health Standards (OPHS) with a goal to strengthen and enhance accountability and transparency within the public health system.

ESC meetings have focussed on discussing opportunities related to system integration, new and emerging issues of public health importance, approaches to revise the OPHS to ensure greater emphasis on population health assessment to inform planning of programs and services, the scope of the OPHS, and opportunities for flexibility within the OPHS to address local needs.

On August 4, 2016, ESC members had a teleconference meeting and discussed the role of public health in mental health promotion and opportunities to include mental health promotion as part of the OPHS. ESC also discussed opportunities to strengthen population based activities in the Environmental Health Program Standards aimed at emerging public health priorities including climate change and the built environment.

Future meetings will focus on discussing recommendations on changes to the Standards from the Practice and Evidence Program Standards Advisory Committee (PEPSAC), re-visiting the scope of the OPHS taking into consideration the recommendations from PEPSAC, discussing a consultation strategy, value-for-money, and transparency.

For information, contact: Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Ministry of Health and Long-Term Care at Paulina.Salamo@ontario.ca or (416) 327-7423.

Standards Modernization
Practice and Evidence Program Standards Advisory Committee
September 2016
Highlights #2

The Practice and Evidence Program Standards Advisory Committee for the Standards Modernization (the "PEPSAC") continues the review of the Ontario Public Health Standards (OPHS) with a goal to recommend a set of program standards that are informed by evidence and best practice. The PEPSAC Terms of Reference are included in Appendix I.

Following its May 9, 2016 meeting, the PEPSAC members formed seven program-specific sub-groups to support standard specific discussions. The seven sub-groups are: Foundational Standard; Chronic Disease and Injuries Program Standards; Family Health Program Standards; Infectious Diseases Program Standards; Vaccine Preventable Diseases Program Standard; Environmental Health Program Standard; and the Emergency Preparedness Program Standard.

In July and August, the PEPSAC reconvened for its fourth and fifth meetings. On July 25, 2016, the PEPSAC was provided with an update on the ongoing discussions with Indigenous organizations to identify opportunities to address the needs of Indigenous Communities in the OPHS. The PEPSAC met again on August 15, 2016 and discussed the role of public health in mental health promotion and opportunities to include mental health promotion as part of the OPHS. The PEPSAC also reviewed and discussed opportunities to strengthen population based activities in the Environmental Health Program Standards aimed at emerging public health priorities including climate change and the built environment. The PEPSAC agreed that further work and discussions are required on these work streams, which will continue in future meetings.

The July and August meetings also provided an opportunity for the sub-groups to report-back to the broader membership of the Committee. Sub-groups continued to meet throughout the summer. The PEPSAC will meet again in September to discuss the recommended set of standards once the work of the sub-groups has been completed.

Future meetings will focus on revisiting preliminary discussions on cross-cutting themes, including opportunities for equity; transparency; flexibility; as well as development of the consultation strategy.

For information, contact: Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Ministry of Health and Long-Term Care at Paulina.Salamo@ontario.ca or (416) 327-7423.

Standards Modernization Practice and Evidence Program
Standards Advisory Committee
TERMS OF REFERENCE

BACKGROUND

As part of the public health renewal agenda, the ministry released the Ontario Public Health Standards (OPHS) in 2008 and the Ontario Public Health Organizational Standards (the "Organizational Standards") in 2011. The OPHS and 27 incorporated protocols are guidelines issued by the Minister under the *Health Protection and Promotion Act* (HPPA); which establish the minimum requirements for fundamental public health programs and services to be delivered by Ontario's 36 boards of health. The Organizational Standards establish the minimum management and governance requirements for all boards of health and public health units and are operationalized via the Public Health Funding and Accountability Agreement.

CONTEXT

Health care system transformation is underway in Ontario, with a focus on access, quality and value for money. The foundation for an accountable, transparent, integrated, and evidence-informed system that provides the right care at the right time in the right place and promotes healthy living has been established through Action Plan for Health Care, 2012. The person-centred framework established in the Patients First: Action Plan for Health Care, 2015 aims to: provide faster access to the right care; deliver better coordinated and integrated care in the community, closer to home, provide the education, information and transparency people need to make the right decisions about their health, and protect the universal public health care system by making decisions based on value and quality.

As part of the broader health system transformation efforts underway in Ontario, the Ministry of Health and Long-Term Care (MOHLTC) is conducting a review of the OPHS and Organizational Standards (Standards Modernization). Demonstrating an accountable, efficient and transparent system are key objectives of Ontario's health care transformation agenda and public health can play a key role in achieving these aims through the Standards Modernization process. The Standards Modernization process will provide an opportunity to clearly define public health's role and contributions within the broader health system transformation process.

MANDATE

The Practice and Evidence Program Standards Advisory Committee (PEPSAC) is being convened to support the review of the OPHS and recommend a set of program standards that are informed by evidence and leading practice in the areas of health protection, health promotion, population health assessment and surveillance, and emergency preparedness. The outcome of PEPSAC's work will inform the modernized OPHS which will reflect the scope of programs and services that government will expect boards of health to provide.

The OPHS Modernization placemat can be found in Appendix A.

RESPONSIBILITIES

The PEPSAC is charged with the task of providing advice to the Executive Steering Committee (ESC) for the Standards Modernization and guidance to Expert Teams to support the development of new program standards. Specifically, the PEPSAC will:

- Provide recommendations on new program standards requirements in response to government priorities, based on a review of evidence;
- Provide recommendations on eliminating any current program standards requirements, based on review of evidence;
- Provide input into a decision-making framework that can be used to define the scope and mandate of public health in Ontario;
- Provide input on the scope of the program standards for public health as identified by the ministry;
- Identify and discuss relevant evidence to support the standardization or flexibility within the program standards that is responsive to the need for transparency and accountability for programs and service delivery;

The PEPSAC will carry out these responsibilities by:

- Receiving direction from ESC and responding to requests from ESC for input and advice;
- Reviewing available evidence[1] and best practice to inform recommendations to ESC for revised or new program standards;
- Where evidence is not available, seeking expert advice, identifying leading practice within and outside of Ontario and determining a rationale and methodology for standardization or discontinuation of program standards requirements;
- Accessing available resources (i.e., expert advisors, Public Health Ontario and field surveys) to inform drafting of the program standards; and providing guidance to, and working with, the Expert Team(s) that, wherever applicable, will be responsible for drafting the program standards.
- Making recommendations for the development of a consultation strategy and, where appropriate, participating in the processes for consulting and validating the program standards with the public health community;
- Providing guidance and advice on a roll-out strategy for the program standards to support their implementation and uptake, including the development of accompanying tools; and
- Providing advice on a process and structure for ongoing review and refinement of the program standards.

If necessary, the PEPSAC will commission specific work or research to support its activities.

[1] As defined by the National Collaborating Centre for Methods and Tools (NCCMT) evidence refers to information sourced from research; data related to the frequency, causes, and modifying factors of local community health issues; from people about community and political preferences and actions; and from various governments and programs about public health resources.

DELIVERABLES

The PEPSAC will conclude its mandate following submission of a recommended set of renewed program standards to the Executive Steering Committee (ESC) for review.

The PEPSAC will communicate key messages and process updates on a regular basis. Key messages will form part of a broader MOHLTC communication strategy.

MEMBERSHIP

The PEPSAC will be chaired by Dr. David Williams, Chief Medical Officer of Health. Membership on the Committee will reflect a balance of experts in public health, including those from public health units, Public Health Ontario, and government representatives (from MOHLTC and Ministry of Children and Youth Services).

Committee decisions based on vote will be derived from external member votes and not include government representatives. Wherever applicable, electronic approval of specific items will be used.

Members will sign confidentiality agreements due to the sensitive nature of some of the items discussed and brought for the Committee's review and consideration.

In order to sustain the momentum of Committee work, there will be no delegates permitted to attend meetings.

See Appendix B for a list of members.

ACCOUNTABILITY

Through the chair, the PEPSAC will be accountable to the ESC, which in turn is accountable to the MOHLTC.

RELATED WORKING GROUPS

The PEPSAC will function as one of several sub-committees within the program standards review process. By reporting to the ESC, appropriate linkages between the sub-committees will be ensured. In addition to the PEPSAC, the following sub-committees will provide support to the ESC:

- Accountability Committee
- Intra-ministerial Committee
- Capacity and Infrastructure Committee

There will also be ongoing communication between the ESC, the Inter-ministerial Liaison, and processes for the engagement of Indigenous Communities.

TIME FRAME

The PEPSAC will be convened for a specific period of time, which is expected to be from January, 2016 – December, 2016.

Meetings may occur as frequently as every 3-4 weeks. Meetings will occur in-person in Toronto, with potential for teleconference meetings when appropriate. The MOHLTC will cover eligible travel expenses to Toronto when accompanied by receipts.

LEAD SECRETATIAT

Population and Public Health Division, MOHLTC

APPENDIX A: STANDARDS MODERNIZATION (OPHS)

Goals of Review

1. **To develop programmatic standards that are responsive to emerging evidence and priority issues in public health and are aligned with the government's strategic vision and priorities for public health within a transformed health system.**
2. **To develop recommendations that address capacity and infrastructure needs for implementation of modernized standards.**

Drivers for Change

- **System Integration**
- **Accountability**
- **Transparency**
- **Organizational Capacity**
- **Efficiency/Value for Money**
- **Expert Advice**
- **Evidence based**
- **Service gaps (First Nations, Mental Health etc.)**

Objectives

Identify what public health should deliver	Identify how public health should deliver services	Identify capacity to deliver public health services	Identify the systems and structures required to deliver effective and efficient public health services

Activities

Identify what public health should deliver

- Identify evidence to support requirements for public health programs and services based on core public health functions.
- Reduce variation in service delivery through increased standardization, taking into consideration the parallel need to foster flexibility to respond to local needs and priorities.
- Identify service gaps and areas of duplication to improve coordination of services across the continuum of care and other sectors.
- Enhance the role of public health in addressing determinants of health and decreasing health inequities.
- Identify opportunities for public health to increase its role in addressing the needs of priority populations.

Identify how public health should deliver services

Through:

- Strengthening and enhancing accountability and transparency.
- Improving efficiency of public health program & services.
- Establishing collaborative partnerships to support system efficiency across the continuum of care.
- Establishing a performance measurement and management framework to capture public health sector contribution to population health outcomes (value for money).

Identify capacity to deliver public health services

- Identify public health capacity needs to ensure the effective and efficient delivery of public health services.
- Identify roles and responsibilities for public health disciplines that improve efficiency and effectiveness of public health service delivery.
- Identify processes to ensure a sector with qualified professionals to provide required services.

Identify the systems and structures required to deliver effective and efficient public health services

- Identify required IM & IT and infrastructure to support effective and efficient delivery of public health programs and services.
- Identify opportunities for integration of public health IM & IT systems with EMRs and the broader system, where appropriate.
- Identify how current systems support transparency across the public health sector.
- Identify current and required systems to support performance measurement across the public health sector.

Inputs

- **Jurisdictional Scans**
- **Literature Reviews**
- **Technical Reviews (PHO and others)**
- **Expert Advice**
- **Stakeholder Consultation and Engagement**

Outputs

- A recommended set of evidence based program standards reflective of current accepted practice in the areas of health protection and health promotion that support key government priorities, address service gaps, and the needs of priority populations.
- A recommended approach to performance measurement at all system levels to ensure accountability, support transparency, and demonstrate value for money.
- Recommendations to address capacity requirements for the effective and efficient delivery of public health services.
- Recommendations for systems and structures which support the effective and efficient delivery of public health services.

Timelines

PHASE 1: Development of modernized program standards for public health (Fall 2015 to December 2016)

PHASE 2: Recommendations for system implementation in terms of capacity and infrastructure to support modernized standards (January 2016 to June 2017)

Result

Recommendations for modernized standards and practice guidance, in alignment with the vision and principles of Health System Transformation, that facilitate optimal delivery of public health functions and support co-ordinated delivery of public health programs and services across the full continuum of health.

APPENDIX B:

Membership of the Practice and Evidence Program Standards Advisory Committee

Chair

Dr. David Williams	Chief Medical Officer of Health of Ontario, MOHLTC

Members from Health Units and Other Organizations

Mr. John Barbaro	Epidemiologist, Simcoe Muskoka District Health Unit (APHEO nominee)
Ms. Maureen Cava	Manager Professional Development & Education, Toronto Public Health (OAPHNL nominee)
Dr. Ray Copes	Chief, Environmental and Occupational Health, Public Health Ontario
Ms. Kelly Farrugia	Chief Nursing Officer, Chatham-Kent Public Health Unit (OAPHNL nominee)
Mr. Atul Jain	Manager, Inspection Services, Peterborough Public Health (ASPHIO nominee)
Dr. Isra Levy	Medical Officer of Health, Ottawa Public Health (COMOH nominee)
Dr. Heather Manson	Chief, Health Promotion, Chronic Disease and Injury Prevention, Public Health Ontario
Dr. Liana Nolan	Medical Officer of Health, Region of Waterloo Public Health (COMOH nominee)
Dr. George Pasut	Vice-President, Science and Public Health, Public Health Ontario
Dr. Brian Schwartz	Chief, Communicable Diseases, Emergency Preparedness and Response, Public Health Ontario
Mr. Eric Serwotka	Director, Health Protection, Hastings Prince Edward Public Health (ASPHIO nominee)
Dr. Paula Stewart	Medical Officer of Health, Leeds, Grenville & Lanark District Health Unit (COMOH nominee)
Dr. Penny Sutcliffe	Medical Officer of Health, Sudbury & District Health Unit (Health Equity and Population Health Policy representative)
Ms. Emma Tucker	Manager and Senior Epidemiologist, Halton Region Public Health (APHEO nominee)

Practice and Evidence Program Standards Advisory Committee Support (MOHLTC, MCYS)

Ms. Nina Arron	Director, Public Health Policy and Programs Branch, Population and Public Health Division, MOHLTC
Ms. Laura Pisko	Director, Health Promotion Implementation Branch, Population and Public Health Division, MOHLTC
Ms. Paulina Salamo	A/Director, Public Health Standards, Practice and Accountability Branch, Population and Public Health Division, MOHLTC
Mr. Clint Shingler	Director, Emergency Management Branch, Population and Public Health Division, MOHLTC
Ms. Elizabeth Walker	Director, Public Health Planning and Liaison Branch, Population and Public Health Division, MOHLTC
Ms. Stacey Weber	A/Director, Early Child Development Branch, Ministry of Children and Youth Services
Ms. Jackie Wood	A/Director, Strategic Initiatives Branch, Population and Public Health Division, MOHLTC

Staff Report

Health Care Worker Influenza Immunization 2015-16

Date:	October 12, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Edwina Dusome, Manager, Infectious Disease Programs and Emergency Preparedness

Proposed Recommendations:

That the Board of Health for Peterborough Public Health receive the staff report, *Health Care Worker Influenza Immunization 2015-16*, for information.

Financial Implications and Impact

There are no financial implications for the Board arising from this report

Background

Influenza transmission and outbreaks in hospitals and long-term care homes are well documented and can result in significant patient, resident and staff morbidity and mortality. Four randomized controlled trials have shown that health care worker (HCW) influenza immunization in chronic care/long-term care home facilities for the elderly reduces patient mortality. The increased risk of influenza to residents and patients in these facilities is related to their advanced age and underlying health problems, as well as the settings in which they are cared for in close proximity to a range of HCWs. HCWs can acquire influenza from patients/residents and the community and then may readily transmit infection to other patients/residents, other HCWs and their family members. Despite comprehensive, multifaceted programs to encourage HCW immunization, HCW influenza immunization coverage rates have remained unacceptably low. As a result, numerous public health agencies

and professional associations, such as the Canadian National Advisory Committee on Immunization (NACI), the Canadian Nurses Association, and the United States Centers for Disease Control and Prevention, recommend that influenza immunization of HCWs be a condition of service or appointment.[1]

The Provincial Infectious Diseases Advisory Committee (PIDAC) Best Practices for Infection Prevention and Control Programs in Ontario in All Health Care Settings (May 2012) states that: Annual influenza vaccination should be a condition of continued employment in, or appointment to, health care organizations. HCWs with medical contraindications to influenza vaccination should be accommodated by reassignment, or other methods used to protect patients and staff (e.g., HCW wearing mask in client/patient/resident care areas) during influenza season.[2]

Influenza vaccination provides benefits to HCWS and to the patients/clients they care for. Transmission of influenza between infected HCWS and their vulnerable patients/clients results in significant morbidity and mortality. Randomized controlled trials conducted in geriatric long-term care settings have demonstrated that vaccination of HCWS is associated with substantial decreases in morbidity and mortality in the residents. Influenza vaccination of HCWs who have direct patient contact (i.e., activities that allow opportunities for influenza transmission between a HCW and a patient) is an essential component of the standard of care for the protection of patients. HCWs who have direct patient contact should consider it their responsibility to provide the highest standard of care, which includes annual influenza vaccination.[3]

Annual influenza vaccination should be a condition of continued employment in, or appointment to, health care organizations. Influenza immunization for health care providers involved in direct client/patient/resident care (including physicians, nurses, students, emergency response workers, and employees of long-term care homes who have contact with residents, providers of home care, visiting nurses and volunteers) is a standard of care. "In the absence of contraindications to the vaccine, refusal to be immunized against influenza is a failure in a health care provider's duty of care to patients".[4]

The Association of Medical Microbiology and Infectious Disease, Canada, position paper, 2012 on mandatory influenza immunization of HCWs states that there are: "Three criteria have been proposed that must be met to justify mandating compliance with a preventive intervention. First, there should be clear medical value from the intervention to the individual. Second, the public health benefit of the intervention must be clear. Third, a requirement must be considered the only option. It is the position of AMMI Canada that these three criteria have been met in relation to HCWs and influenza immunization. HCWs and their employers have an ethical obligation to act in the best interest of the patients for whom they provide care. Influenza immunization should be required annually for all workers who spend time in areas where patient care is provided and/or patients are present."[5]

The Canadian Nurses Association (CNA) believes that policies that place immunization as a condition of service should be introduced if HCW influenza immunization coverage levels are not protective of patients, and reasonable efforts have been undertaken with education and enhancing accessibility to immunization. The CNA considers mandatory immunization policies by employers to be congruent with the *Code of Ethics for Registered Nurses in Canada* and the obligation to act in the public interest.[6]

The Infection Prevention and Control Guidelines for Clinical Office Settings document, which is linked to the College of Physicians and Surgeons of Ontario, states: "To protect the health of patients and themselves, it is particularly important that staff be immune to measles, mumps, rubella, pertussis, varicella, hepatitis B and receive influenza vaccine annually."[7]

Influenza vaccination provides benefits to HCWs and to the patients for whom they care. NACI considers the provision of influenza vaccination to be an essential component of the standard of care for all HCWs for the protection of their patients. Transmission of influenza between infected HCWs and their vulnerable patients results in significant morbidity and mortality. Randomized controlled trials conducted in geriatric long-term care settings have demonstrated that vaccination of HCWs is associated with substantial decreases in morbidity and all-cause mortality in the residents. Therefore, HCWs should consider annual influenza vaccination included in their responsibility to provide the highest standard of care. In the absence of contraindications, refusal of HCWs to be immunized against influenza implies failure in their duty of care to patients.[8]

Immunization programs are highly effective and are a critical component of the occupational health and safety program. Health care providers must be offered appropriate immunizations. Immunizations should be based on requirements such as Ontario Hospital Association/Ontario Medical Association/Ministry of Health and Long-Term Care communicable disease surveillance protocols, and be consistent with recommendations from NACI for health care providers. Appropriate vaccine use protects the health care provider, colleagues and the client/patient/resident. Vaccines appropriate for susceptible health care providers include: annual influenza vaccine.[9]

Each season, 20% of HCWs get influenza, and 28% to 59% of young healthy adults who get it have asymptomatic or subclinical infections. Some of them may shed virus up to a day before symptoms appear. It is time that all people who work in a health care institution are vaccinated. Compulsory vaccination may be regarded as ethically questionable because it violates a person's autonomy. But in the case of influenza vaccination, the autonomy of HCWs comes into conflict with the best interests of the patient. Patients should come first, and in similar situations they do already. For example, a surgeon infected with HIV or a hepatitis virus is not allowed to operate. To justify compulsory vaccination, there must be an outbreak of serious illness; immunity levels must be low; the vaccine must be effective, safe and available; and vaccine uptake must be low. These conditions appear to be met for annual seasonal influenza.[10]

Ontario's College of Nurses recognizes that immunization is a key measure in reducing nurses' susceptibility to certain diseases, including influenza and hepatitis.[11]

The Centre for Disease Control (CDC) and the Advisory Committee on Immunization Practices (ACIP), recommend that all U.S. health care personnel get vaccinated annually against influenza.[12]

The following organizations also have position statements on mandatory influenza immunization of health care workers include the following organizations: American Academy of Family Physicians (2011); American Academy of Pediatrics (2015); American College of Physicians (2013); American Hospital Association (2011); American Medical Directors Association (2011); American Pharmacists Association (2011); American Public Health Association (2011); Association for Professionals in Infection Control and Epidemiology (2011); Infectious Diseases Society of America (2013).[13]

Rationale

Five influenza long-term care facility outbreaks were reported for 2015/2016 surveillance season.

Influenza is a highly contagious acute viral infection of the respiratory tract which causes widespread illness, including outbreaks and pandemics. It is associated with complications such as bacterial pneumonia and death. Annual immunization of persons at high risk, and of HCWs and others, who are capable of transmitting influenza to those at risk, is the most effective measure for reducing the impact of influenza.

The MOHTLC requires the collection of influenza vaccine coverage rates for staff from nursing homes (NH) and hospitals. The staff immunization coverage rates were collected as of December 15, 2015. Since outbreaks occur in retirement residences, Peterborough Public Health actively collects immunization coverage rates from these facilities. The data are included in the following table:

Table 1: Influenza Immunization Rates for Peterborough Health Care Facility Staff, 2015-2016 Season

Facility	Coverage Rate		LTCH		
	% Staff* Immunized 2014/2015	% Staff* Immunized 2015/2016	Change >5% but coverage < 80	Coverage > 80% but change < 5%	Change >5% and coverage > 80%
Applewood (RR)	51	73	X	-	-
Canterbury Gardens (RR)	96	90	-	X	-
Centennial Place (NH)	85	84	-	X	-
Empress Gardens (RR)	94	94	-	X	-
Extendicare Lakefield (NH)	76	63	-	-	-

Facility	Coverage Rate		LTCH		
	% Staff* Immunized 2014/2015	% Staff* Immunized 2015/2016	Change >5% but coverage < 80	Coverage > 80% but change < 5%	Change >5% and coverage > 80%
Extendicare Peterborough (NH)	79	69	-	-	-
Fairhaven Home for Seniors (HFA)	76	69	-	-	-
Jackson Creek (RR)	58	75	X	-	-
Mapleview (RR)	68	74	X	-	-
Mount St. Joseph (RR and NH)	80	61	-	-	-
Peterborough Retirement Residence (RR)	53	65	X	-	-
Pleasant Meadow Manor (NH)	85	88	-	X	-
Princess Gardens (RR)	96	91	-	X	-
Riverview Manor (NH)	80	77	-	-	-
Royal Gardens (RR)	91	83	-	X	-
Rubidge Hall (RR)	53	74	X	-	-
Springdale Country Manor (NH)	70	64	-	-	-
St. Joseph's at Fleming (NH)	89	66	-	-	-
Average reported rates	**76**	**75**			
Peterborough Regional Health Centre	76	67	-	-	-

NOTE: Retirement Residence (RR); Nursing Home (NH); *Staff data includes employees on payroll, licensed independent practitioners, adult student/trainees, volunteer staff and other contract staff. Other retirement residences which did not provide immunization information are not included in this table.

The Board of Health has required annual immunization against influenza for all of its employees since 2002. For 2015/2016, the influenza vaccination coverage rate for eligible active staff (without medical exemptions) at the Peterborough Public Health was 96%.

Strategic Direction

The delivery of influenza immunization programs supports the Board of Health strategic direction of *Community-Centred Focus.*

Contact:

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Manager, Infectious Disease Programs and Emergency Preparedness
(705) 743-1000, ext. 271
edusome@peterboroughpublichealth.ca

References

[1] Toronto Public Health, 2015 Influenza Update:
http://www.toronto.ca/legdocs/mmis/2015/hl/bgrd/backgroundfile-85948.pdf

[2] Provincial Infectious Disease Advisory Committee, Best practices for infection prevention and control programs in Ontario in all health care settings (3rd ed). May 2012. Available at http://www.publichealthontario.ca/en/eRepository/BP_IPAC_Ontario_HCSettings_2012.pdf

[3] Canadian National Immunization Guide, 2016, Part 3: Vaccination of Specific Populations (http://healthycanadians.gc.ca/publications/healthy-living-vie-saine/3-canadian-immunization-guide-canadien-immunisation/index-eng.php?page=11)

[4] Best Practices for Prevention of Transmission of Acute Respiratory Infection In All Health Care Settings Provincial Infectious Diseases Advisory Committee (PIDAC), March 2013 (http://www.publichealthontario.ca/en/eRepository/PIDAC-IPC_Annex_B_Prevention_Transmission_ARI_2013.pdf)

[5] Bryce E, Embree J, Evans G, Johnston L, Katz K, McGeer A, et al. AMMI Canada position paper: 2012 mandatory influenza immunization of health care workers. Canadian Journal of Infectious Disease and Medical Microbiology 2012; 23(4):e93-5. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3597405/)

[6] Influenza Immunization of Registered Nurses Position Statement: Canadian Nurses Association, November 2012 http://cna-aiic.ca/~/media/cna/page-content/pdf-en/ps_influenza_immunization_for_rns_e.pdf

[7] Infection Prevention and Control for Clinical Office Practice, Provincial Infectious Diseases Advisory Committee (PIDAC) revised April 2015 (http://www.publichealthontario.ca/en/eRepository/IPAC_Clinical_Office_Practice_2013.pdf)

[8] Advisory Committee Statement (ACS) - National Advisory Committee on Immunization (NACI) Canadian Immunization Guide Chapter on Influenza and Statement on Seasonal Influenza Vaccine for 2016-2017 (http://www.phac-aspc.gc.ca/naci-ccni/flu-2016-grippe-eng.php#iii2)

[9] Routine Practices and Additional Precautions In All Health Care Settings, 3rd edition Provincial Infectious Diseases Advisory Committee (PIDAC), Revised November 2012 (http://www.publichealthontario.ca/en/eRepository/RPAP_All_HealthCare_Settings_Eng2012.pdf)

[10] Flegel, Ken: Health Care Workers Must Protect Patients from Influenza By Taking the Annual Vaccine; CMAJ Editorial, Volume 184, 17, November 2012, http://www.cmaj.ca/content/184/17/1873.full.pdf+html

[11] Influenza Vaccinations, Practice Guidelines, College of Nurses of Ontario, June 2009, (http://www.cno.org/Global/docs/prac/41053_fsInfluenza.pdf)

[12] Centre for Disease Control website: http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm

[13] Immunization Action Coalition website: http://www.immunize.org/honor-roll/influenza-mandates/

Staff Report

Food Insecurity in Peterborough

Date:	October 12, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Carolyn Doris RD, Registered Dietitian

Proposed Recommendations

That the Board of Health for Peterborough Public Health:

- receive the staff report, *Food Insecurity in Peterborough,* for information;
- receive the Limited Incomes Report for information; and
- send a letter to the Ministers of Health and Long-Term Care, Community and Social Services and Poverty Reduction, with copies local MPPs, the Ontario Chief Medical Officer of Health, the Association of Local Public Health Agencies, and Ontario Boards of Health, to share local findings from the Limited Incomes Report, and request that the Ontario government:
    - continues to monitor food insecurity rates yearly as part of the Canadian Community Health Survey; and,
    - participates in the development and implementation of a pan-Canadian government-led strategy that includes coordination of policies and programs to ensure all households have consistent and sufficient income to be able to pay for basic needs, including food.

Financial Implications and Impact

There are no financial implications arising from this report.

Decision History

- At the November 9, 2005 Board of Health meeting, the Board recommended that all low income and social assistance recipients receive an increase that will cover the cost of nourishing food in addition to a Special Diet Allowance for those with specified medical conditions. Letters were sent to Premier McGuinty, the Provincial Ministers of Child and Youth Services, Community and Social Services, Finance, Health and Long-Term Care, Health Promotion and local municipal government officials.

- On July 30, 2008, members of the Board of Health and Peterborough Public Health (PPH) staff met with M.P.P. Jeff Leal to discuss the need for 2008 funding for the Food Security Community Partnership Program (FSCPP). Board members explained that poverty and health are strongly related and that this initiative supported community members who clearly want to make healthier food choices but cannot afford to due to low incomes. The FSCPP complemented local food security programs by filling in identified gaps in services and using local resources effectively.

- At the October 8, 2008 Board of Health meeting, the Board endorsed the Ontario Public Health Association resolution passed in November 2007 calling for a comprehensive poverty reduction strategy; endorsed the 25-in-5 Declaration; and requested the Minister of Community and Social Services and the Minister of Children and Youth Services respond to the recommendations made in the Special Diet Expert Review Committee Final Report regarding the increases and expansions to the current Special Diet Schedule.

- At the May 9, 2012 Board of Health meeting, Susan Hubay and Joëlle Favreau provided a comprehensive update on food security, which included details for the Nourish project which sought to build community connections and reduce isolation from poverty through skills sharing opportunities. Deputy Mayor Sharpe offered to champion the initiative in the County of Peterborough.

- At the September 12, 2012 Board of Health meeting, the Board received the 2012 Nutritious Food Basket results, "Limited Incomes: A Recipe for Hunger" and strategies to improve food security among individuals and families living on low incomes locally.

  At that same meeting, following a Staff Report on "Cuts to Social Assistance Benefits: A Public Health Perspective", the Board sent a letter to John Milloy, Minister of Community and Social Services, Dr. Eric Hoskins, Minister of Children and Youth Services, Kathleen Wynne, Minister of Municipal Affairs and Housing, and Deb Matthews, Minister of Health and Long-Term Care, with copies to MPPs Jeff Leal and Laurie Scott, Ontario Boards of Health and the Association of Local Public Health Agencies (alPHa), to request enhanced provincial funding of discretionary benefits for people receiving social assistance, and continued support for housing retention, moving, and home maintenance expenses.

- At the December 12, 2012 Board of Health meeting, the Board sent letters to the Premier of Ontario, the Minister of Community and Social Services, and the Minister of Health and Long-Term Care requesting that:
    - the government increase social assistance rates to a level that reflects the true costs of nutritious food and housing. In the interim, providing an immediate increase of $100 per month is critical, for every adult in receipt of social assistance.
    - any revisions to the Special Diet Program be developed in collaboration with Dietitians of Canada - Ontario.

  The Board also requested a presentation from staff about a proactive strategy to address the long-term funding situation for the Food for Kids Peterborough and County Student Nutrition Programs (breakfast clubs and snack programs). This was presented in January, 2013.

- In December 2012, the Board sent a letter to the federal Minister of Health and the Chief Public Health Officer requesting that the Public Health Agency of Canada enhance funding for the Canada Prenatal Nutrition Program.

- At the November 12, 2014 Board of Health meeting, the Board received a Food Insecurity in Peterborough staff report focusing on the 2014 Nutritious Food Basket Costing for information and requested that contents of the report be shared with members of the City of Peterborough Joint Services Steering Committee, Peterborough County and City Councils, local Rotary clubs, Ministry of Finance and AMO. Presentations were made to eight township councils, Joint Social Services, the Board of Kawartha Food Share and letters were sent to local Rotary Clubs.

- At the October 14, 2015 Board of Health meeting, the Board received the staff report, *Food Insecurity in Peterborough,* for information; received the Limited Incomes Report for information and shared it with the community; directed staff to send a letter to The Honourable Helena Jaczek, Minister of Community and Social Services requesting an update on the transformation of social assistance in Ontario noting that currently, social assistance rates do not reflect the actual costs of nutritious food and adequate housing; and, was the first Board of Health in Ontario to endorse the Ontario Society of Nutrition Professionals in Public Health Position Statement on Responses to Food Insecurity.

Background

Boards of Health are mandated to monitor food affordability annually by the Ontario Public Health Standards.[1] PPH staff price out local food costs required to provide a basic nutritious diet. These costs are compared to a variety of income scenarios to determine affordability. According to the 2016 PPH Nutritious Food Basket results, the monthly cost of feeding a family of four is $907 in Peterborough City and County.[2] The report notes that local food prices have increased 22% in the past six years. As well, the Bank of Canada's online inflation calculator shows rising food costs have outpaced the overall rate of inflation (10.36% for that same period

of time).[3] It must be stressed, however, that the issue of affordability is not primarily from the cost of food, but that incomes are too low.

People living on low incomes find that after paying for rent and utilities there is not enough money to buy nourishing food. For example, a single male living on Ontario Works would find himself $204 in the negative at the end of the month, if he purchased nourishing food as recommended in Canada's Food Guide. A number of factors impact on the ability to choose nourishing food, however income and the cost of housing are by far the most significant. Under current conditions, the result is food insecurity, which is the inadequate or insecure access to healthy food in the context of financial constraints.[4]

Table 1: May 2016 Peterborough Nutritious Food Basket Scenarios

	Single Person Households			**Households with Children**			
Monthly Income/ Expenses	**Single Man** (Ontario Works)	**Single Man** (Ontario Disability Support Program)	**Single Elderly Woman** (Old Age Security/ Guaranteed Income Supplement)	**Single Parent, 2 Children** (Ontario Works)	**Family of 4** (Ontario Works)	**Family of 4** (full-time Minimum Wage earner)	**Family of 4** Average Income (after tax)
Monthly Income including Benefits Tax Credits	$768	$1,206	$1,563	$2016	$2,227	$2,940	$7,448
Estimated Shelter Cost	$666	$816	$816	$959	$1,172	$1,172	$1,172
Cost of a Nutritious Diet	$306	$306	$221	$685	$907	$907	$907
What's Left?	**-$204**	**$84**	**$526**	**$372**	**$148**	**$861**	**$5,369**
% Income Required for Shelter	87%	68%	52%	48%	53%	40%	16%
% Income required for nutritious food	40%	25%	14%	34%	41%	31%	12%
REMEMBER: Out of 'What's Left' people still need to pay for utilities, phone, transportation, cleaning supplies, personal care items, clothing, gifts, entertainment, internet, school essentials, medical and dental costs and other purchases.							

Note: Shelter costs may or may not include utilities.

Unfortunately, the financial pressure on families and individuals living on low incomes in Peterborough continues to increase. Clearly Nutritious Food Basket costing shows that over the years, although food costs are rising, a lack of sufficient income means that people, especially for those living on fixed incomes or who are minimum wage earners, have little, if any money left over to cover basic monthly expenses after paying for shelter and food. As noted by the Dietitians of Canada, household food insecurity is much more than a food problem and while emergency food initiatives in a community may provide some food relief, food insecurity is most effectively reduced by addressing the underlying problems of poverty and material deprivation.[5]

Food Insecurity in Peterborough

The Canadian Community Health Survey Household Food Security Survey Module (CCHS HFSSM) was first conducted in 2004 and has been is used both by local public health agencies and researchers across Canada to measure food insecurity. The module includes an 18-item questionnaire and results are used to determine if households are food secure, marginally, moderately or severely food insecure.[6]

Based on this data, there is significant concern in Peterborough that many people in the community are not food secure. According to the 2013-14 CCHS, 11.5% of Peterborough households experience some degree of household food insecurity, including compromising food quality and/or quantity due to a lack of money or disrupted eating patterns and reduced food intake.[7] For 5% of households, the situation is severe, and people, including children, do not have enough to eat because of a lack of money.[8] Currently statistics for those who are marginally food insecure, defined as "worrying about running out of food", is not included in locally calculated measures of food insecurity. Additionally, for local households with children under 18 years of age, 23.6% experience food insecurity compared to 8.7% for all of Ontario.[9] This translates to one in four households with children in Peterborough reporting food insecurity.[10] A recent national report from PROOF - Food Insecurity Policy Research team based at the University of Toronto states "an examination of food insecurity in the 27 major urban areas in the provinces and territories that participated in the 2013-2014 survey revealed considerable variation. Although the estimate must be interpreted with caution because of a small sample size, the prevalence of food insecurity in 2013-14 was highest in Peterborough, Ontario (17.6%) where over 1 in 6 households experienced food insecurity. Halifax (15.1%), Moncton (16.3%), Saint John (16.6%), and Windsor, Ontario (15.2%) also had relatively high rates."[11] (page 18).

Food Insecurity in Ontario and Canada

In 2014, 11.9% or 594,900 Ontario households experienced food insecurity.[12] In Canada, food insecurity continues to be highest among:

- households with low incomes, whether from government sources (i.e., Employment Insurance), or low/precarious wages;
- households with children under 18 years, especially those headed by a lone female;
- unattached adults, living alone or with others;

- adults between 60-64, especially if living alone;
- Indigenous Peoples (whether living off reserve or living on reserve and/or in more remote or northern communities);
- people who identified cultural or racial background as Black, Latin American or Arab/West Asian;
- newcomers to Canada (immigrants and refugees);
- households living in market rental accommodation; and
- households in which individuals had one or more chronic physical and/or mental health conditions.[13]

It is of significant concern that there appears to be a trend with provinces opting out of the yearly CCHS HFSSM.[14] Ongoing provincial monitoring of food insecurity using the CCHS HFSSM is critical so that changes in food insecurity across Ontario and Canada can be determined using a strong evidence base. This is supported by the Dietitians of Canada Position Statement and Recommendations for Addressing Household Food Insecurity in Canada.[15]

Rationale

The Board of Health has been an effective and credible advocate for food security in Peterborough. PPH staff continue to play leadership roles in addressing food insecurity and advocating for change. As outlined under Proposed Recommendations there are several actions that the Board of Health can take at this point to continue its efforts on this important community issue.

Strategic Direction

This report applies to the strategic direction of *Determinants of Health and Health Equity* by providing current evidence related to the impacts of poverty and food insecurity.

Contact:

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(705) 743-1000, ext. 251
cdoris@peterboroughpublichealth.ca

Attachments:

Attachment A – Limited Incomes: A Recipe for Poor Health
Attachment B – Food Security in Canada, Dietitians of Canada ***(web hyperlink)***

References:

1. Ministry of Health Promotion, Nutritious Food Basket Guidance Document, May 2010.

2. Peterborough County-City Health Unit, "Limited Incomes: A Recipe for Poor Health", September, 2016. (Appendix A)

3. http://www.bankofcanada.ca/rates/related/inflation-calculator/

4. Ibid.

5. Dietitians of Canada (2016) Food insecurity in Canada. (Appendix B)

6. Health Canada, The Household food Security Survey Module Retrieved from http://www.hc-sc.gc.ca/fn-an/surveill/nutrition/commun/insecurit/hfssm-mesam-eng.php

7. Canadian Community Health Survey (CCHS) 20011-2011, Statistics Canada, Share File, Ministry of Health and Long-Term Care.

8. Ibid.

9. Ibid.

10. Peterborough County-City Health Unit, "Limited Incomes: A Recipe for Poor Health", September, 2016. (Appendix A)

11. Tarasuk, V, Mitchell, A, Dachner, N. (2016). Household food insecurity in Canada, 2014. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from http://proof.utoronto.ca.

12. Ibid.

13. Dietitians of Canada (2016). Executive Summary, Addressing household food insecurity in Canada: Position Statement and Recommendations. Retrieved from http://www.dietitians.ca/Dietitians-Views/Food-Security/Household-Food-Insecurity.aspx.

14. Canadian Community Health Survey (CCHS) 20011-2011, Statistics Canada, Share File, Ministry of Health and Long-Term Care.

15. Dietitians of Canada (2016). Executive Summary, Addressing household food insecurity in Canada: Position Statement and Recommendations. Retrieved from http://www.dietitians.ca/Dietitians-Views/Food-Security/Household-Food-Insecurity.aspx.

Peterborough Public Health

Serving the residents of **Curve Lake** and **Hiawatha First Nations**, and the **County** and **City of Peterborough**

Limited Incomes: A Recipe For Food Insecurity

October 2016

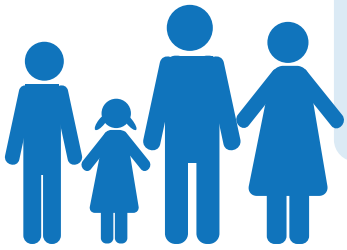
Food Insecurity in Peterborough

Food insecurity – inadequate or insecure access to food because of financial constraints – is a serious social and public health problem in Ontario. People who live with food insecurity cannot afford to buy the food they want or need for good health. Limited incomes are the main reason why people are food insecure in Peterborough.

In 2014, 11.9% or 549,000 Ontario households experienced food insecurity. A recent national report of food insecurity in 27 major urban areas found that food insecurity was highest in Peterborough, at 17.6%. Over 1 in 6 households experience food insecurity.

People living in food insecure households:
- worry about not having enough to eat,
- compromise the quality and/or quantity of food eaten, or
- do not have a variety of food choices on hand.

For 5% of people in Peterborough households the situation is severe and people, including children, do not have enough to eat because of a lack of money. In local households with children under 18 years of age, 23.6% experience food insecurity compared to 8.7% in Ontario. This means that one in four households with children in Peterborough is food insecure.



Low Incomes Don't Add Up

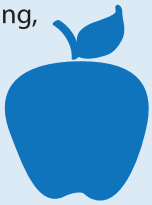
- People living on social assistance find that, after paying for rent and utilities, there is not enough money to buy nourishing food. Food insecurity affects 64.5% of Ontario households living on social assistance.
- Food insecurity is highest among aboriginal Canadians, low income households on fixed incomes, single mothers and people who do not own a home.
- 59% of Ontario households struggling to put food on the table are part of the labour force but are trapped in low-paying or unstable jobs.

Poverty and Health... Did You Know?

- People living on low incomes have more health problems and die younger than people with higher incomes. They may eat less fruit, vegetables and milk products because they cannot afford them. People are forced to skip meals or fill up on cheap foods that are not necessarily nutritious.
- Children living in low income households are more likely to get sick and are less able to do well at school.
- Parents living on low incomes feed their children first. They will do without to ensure that their children can eat. As a result, parents' nutrition and health suffers.

About the Nutritious Food Basket

In May 2016, Peterborough Public Health staff priced the Nutritious Food Basket (NFB). The NFB is Ontario's standardized food costing tool used by Health Units to measure the cost of healthy eating, based on Canada's Food Guide. The food costs are recorded according to the lowest available price at the grocery store. *(See over for results.)*



Understanding the Nutritious Food Basket

Generally, highly processed foods and food with little or no nutritional value (such as soft drinks and potato chips) are not included. The food basket does not contain any foods for special diets, such as gluten-free products. Personal and household care items, like toothpaste, soap and cleaning supplies are not included.

The Nutritious Food Basket design assumes:
- most people have the necessary time, food skills and equipment to be able to prepare most meals from scratch; and,
- people have access to quality grocery stores.

How Do We Know Some People Don't Have Enough Money For Food?

A summary of some real life situations for people living in Peterborough appears in Table 1. These scenarios illustrate that after paying for shelter and food, minimum wage earners and households on fixed incomes have little, if any money left over to cover other basic monthly expenses.

Table 1: **May 2016 Peterborough Nutritious Food Basket Scenarios**

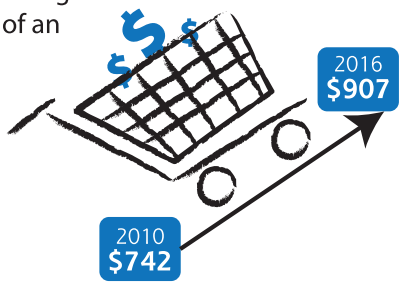
	Single Person Households			Households with Children			
Monthly Income/ Expenses	**Single Man** (Ontario Works)	**Single Man** (Ontario Disability Support Program)	**Single Elderly Woman** (Old Age Security/ Guaranteed Income Supplement)	**Single Parent, 2 Children** (Ontario Works)	**Family of 4** (Ontario Works)	**Family of 4** (full-time Minimum Wage)	**Family of 4** Average Income (after tax)
Monthly Income including Benefits & Credits	$768	$1,206	$1,563	$2,016	$2,227	$2,940	$7,448
Estimated Shelter Cost	$666	$816	$816	$959	$1,172	$1,172	$1,172
Cost of a Nutritious Diet	$306	$306	$221	$685	$907	$907	$907
What's Left?	**-$204**	**$84**	**$526**	**$372**	**$148**	**$861**	**$5,369**
% Income Required for Shelter	87%	68%	52%	48%	53%	40%	16%
% Income required for nutritious food	40%	25%	14%	34%	41%	31%	12%

REMEMBER: People still need to pay for utilities, phone, transportation, cleaning supplies, personal care items, clothing, gifts, entertainment, internet, school essentials, medical and dental costs and other purchases. **NOTE:** Shelter costs may or may not include utilities.

How much do you spend on food in a month?

The cost of feeding a family of four in Peterborough was $907 in May 2016. That represents 12% of an average family's income.

In contrast, the Nutritious Food Basket cost ($907) represents 31% of the income of a family supported by a minimum wage earner or 41% of the income for a family receiving Ontario Works.



Does Food Cost Too Much?

Local food costs have increased by 22% over the past six years. However, the cost of food is not the issue for most people. The issue is that incomes are too low. For people living on low incomes, there is not enough money left to buy healthy food after paying rent and utility bills.

What Can We Do About Poverty and Food Insecurity?

1. Learn more about the impact of food insecurity on health. Visit ***proof.utoronto.ca***
2. Speak up and ask for change. Write to your local M.P. or M.P.P. or Council member. Use this report to increase their understanding of poverty and its impacts on the most vulnerable in our community. Incomes must be addressed to impact food insecurity.
3. Advocate for solutions that will ensure healthy food for all. Learn more about the concept of a Basic Income Guarantee (BIG) as a policy that will provide an income sufficient for life's basic needs, guaranteed by the government to all. Visit ***www.basicincomecanada.org*** or ***nourishproject.ca/basic-income-peterborough-network***.
4. Support local food programs while working to end poverty. Help by fundraising or volunteering your time with food programs including the Nourish Project, community gardens, collective kitchens, gleaning, community meal programs, student nutrition programs and food boxes. Visit ***www.foodinpeterborough.ca*** and ***nourishproject.ca***.
5. Buy local foods whenever possible to support local farmers and our local economy.

For food cost details and references, please call the Nutrition Promotion Program, Peterborough Public Health, at **705-743-1000** or visit ***www.peterboroughpublichealth.ca***.

Peterborough Public Health

Staff Report

Amended 2016 Budget Approval – Cost-Shared Budget from the Ministry of Health and Long-Term Care

Date:	October 12, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Dale Bolton, Manager, Finance

Proposed Recommendation

That the Board of Health for Peterborough Public Health approve the amended 2016 provincial share of cost-shared budget for public health programs and services per summary below:

Programs Funded Jan. 1 to Dec. 31, 2016	2016 Provincial Share of Budget Request	2016 Provincial Share of Approved Budget	Comments
Cost-Shared Budget* – Provincial Share	$6,131,237	$5,915,900	Shortfall of $215,337. See "Financial Implications and Impact" section

**The Cost-Shared Budget above includes Mandatory Public Health Programs, Small Drinking Water Program, Mandatory Program Building Occupancy and the Vector Borne Diseases Program.*

Financial Implications and Impact

This budget includes cost-shared budgets funded by the Ministry of Health and Long-Term Care (MOHLTC) as well as Curve Lake and Hiawatha First Nations, and the County and City of

Peterborough, but does not include other Peterborough Public Health (PPH) programs and services that are funded 100% by the MOHLTC, or by other Ministries of the Province. Early communication from the MOHLTC indicated that the Board should not expect to see a funding increase in 2016 for Mandatory Programs. The budget submission requested an increase of 2.9% over the 2015 approval, as PPH wanted to take advantage of one-time cost-shared opportunities, if available. The Province did not approve cost-shared one-time budgets, but in an unprecedented move, approved one-time budget requests as 100% funded (refer to Staff Report: Amended 2016 Budget Approval – 100% Funded Programs and One-Time Funding from the MOHLTC, for details).

The budget approval reflects a shortfall of $215,337, comprised primarily of two amounts: $159,238 (which represented the afore-mentioned 2.9% increase) from the original budget submission which was not approved; and, the reallocation of $56,162 in dental funding to the Healthy Smiles Ontario Program (HSO), as part of the newly integrated dental system. The dental funds previously covered dental preventative treatment costs under Mandatory Programs will now be recorded under HSO.

As the Province approved less than we requested in the budget submission, the municipal contribution to operations exceeds the local share based on the traditional funding formula of 75% Province / 25% Municipalities. The excess local funding from operations for 2016 will be used to match Provincial funding for one-time building costs.

The Board did receive a small amount of “equity funding” in the amount of $1,362 for Mandatory Programs. This relates to the public health funding formula that was introduced last year. Although only a small increase, there are sufficient savings to date to maintain operations until the end of the year at existing levels.

The shortfall should not affect programming and Executive should be able to manage operations by prioritizing Public Health Standards within the MOHLTC funding provided. PPH should not anticipate the need to use program reserves to balance operations for 2016. As a result, the reserves will be available to maintain existing programming in 2017.

Decision History

On December 9, 2015 the Board approved the 2016 cost-shared budgets in the amount of $8,174,982, including Mandatory Public Health, Small Drinking Water, Mandatory Program Building Occupancy and Vector Borne Diseases. The Provincial share of the cost-shared budget was $6,131,237.

Year-to-date operations indicate Mandatory Programs are operating within the budget approval for 2016.

Background

The Health Protection and Promotion Act section 72(1) states that the budget for public health programs and services is the responsibility of the obligated municipalities. In 2004, the provincial government announced, "the Ministry will review Board of Health-approved budgets in relation to guidelines and approve its share according to the following" funding ratio "75% province, 25% municipalities".

The 2016 budget is prepared on the basis of 75% funding grant from the MOHLTC, and 25% from Curve Lake and Hiawatha First Nations, the County of Peterborough and the City of Peterborough. The County and City fund Peterborough Public Health based on census population data, while Curve Lake and Hiawatha First Nations contribute based on funding agreements with the Board of Health.

Rationale

Under the *Ontario Public Health Standards*, the Board is required to approve an annual budget.

Strategic Direction

The amended budget allows the Board to address all its strategic priorities.

Contact:

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Manager, Finance
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dbolton@peterboroughpublichealth.ca

Staff Report

Amended 2016 Budget Approval – 100% Funded Programs and One-Time Funding from the Ministry of Health and Long-Term Care

Date:	October 12, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Dale Bolton, Manager, Finance

Proposed Recommendation

That the Board of Health for Peterborough Public Health approve the amended 2016 budgets funded 100% by the Ministry of Health and Long-Term Care, and one-time funding as follows:

100% Ministry of Health and Long-Term Care (MOHLTC) Funded Programs

Programs Funded Jan. 1 to Dec. 31, 2016	Type	2016 Budget Request	2016 Approved Budget	Comments
Healthy Smiles Ontario	100%	$0	$763,100	See "Financial Implications and Impact" section.
Chief Nursing Officer	100%	$128,923	$121,500	Overage will be covered through approved cost-shared budget.
Infection Prevention and Control Nurses	100%	$91,867	$90,100	Overage will be covered through approved cost shared budget.
Infectious Diseases Control	100%	$247,300	$222,300	No increase approved. See "Financial Implications and Impact" section.

Programs Funded Jan. 1 to Dec. 31, 2016	Type	2016 Budget Request	2016 Approved Budget	Comments
Social Determinants of Health - Public Health Nurses	100%	$185,030	$180,500	Overage will be covered through approved cost shared budget.
Enhanced Safe Water	100%	$15,500	$15,500	No Increase
Enhanced Food Safety – Haines	100%	$25,000	$25,000	No Increase.
Needle Exchange	100%	$45,000	$45,000	Approved as submitted. See "Financial Implications and Impact" section.
Smoke-Free Ontario	100%	$388,800	$388,800	Approved as submitted.
Electronic Cigarettes Act: Protection and Enforcement	100%	$29,300	$29,300	Approved as submitted.

One-Time Funding Approvals – 2016 Programs - 100% MOHLTC Funded

	Type	2016 Budget Request	2016 Approved Budget	Comments
Pharmacist Integration – Universal Influenza Immunization Program (January 1 – August 31/16)	100%	$17,081	$17,100	Funding will offset program expenditures incurred to date.
Immunization Clinics (January 1 – December 31/16)	100%	$78,728	$63,000	Funding sufficient for program needs given timing of approval.

One-Time Funding Approvals – April 1, 2016 to March 31, 2017 – 100% MOHLTC Funded

	Type	Budget Request	Approved Budget	Comments
Mandatory Program: WiFi Implementation	100%	$44,000	$38,300	Requested as cost shared but approved as 100% funded. Funding sufficient for program needs.
Public Health Inspector Practicum Program	100%	$20,000	$20,000	Approval for two students.
Panorama	100%	$0	$72,900	See "Financial Implications and Impact" section.

	Type	Budget Request	Approved Budget	Comments
Smoke-Free Ontario: Expanded Smoking Cessation	100%	$30,000	$30,000	Approved as submitted.

Financial Implications and Impact

In 2016, the newly integrated Healthy Smiles Ontario Program was initiated by the MOHLTC to provide preventative, routine and emergency dental treatment for children and youth. When the 2016 budget was submitted to the Province in February, no funding request was required for the Healthy Smiles Ontario Program. The MOHLTC indicated they would determine budget amounts based on projections from the previous year operations and new requirements under Healthy Smiles Ontario program. In 2015, Peterborough Public Health (PPH) operated based on approved funds of $481,528, including base funding of $427,300 and one-time transition/ operational pressure funding of $54,228. Funding for 2016 has been cash flowed based on the 2015 approval. While it is considered to be a 100% funded program, the financial model requires that the dental clinic earn additional revenues from other sources to balance the budget. The 2016 budget approved by the MOHLTC is $763,100, an increase of $388,902 to support the new protocol under the newly integrated Healthy Smiles Ontario Program. The increase also includes funds reallocated from Mandatory Programs for dental integration, in the amount of $56,162. At this time, there is still uncertainty regarding the program operations under the newly integrated system which require further consultation with, and direction from, the MOHLTC. The clinic expenditures are currently operating in line with the approved budget, however until further clarification is received we are unable to confirm the ability to meet all program requirements within the approved budget amount.

The Infectious Diseases Control Program budget request included an increase of 11.2% from 2015 to support the hiring of an Administrative Assistant for the program. The MOHLTC did not approve a funding increase for 2016. There is no financial impact on current program operations as the hiring of additional staff was pending MOHLTC approval.

The Needle Exchange Program is funded 100% by the MOHLTC. The funding approved by the MOHLTC for 2016 was $45,000, representing a 31.9% increase over 2015 and reflects prior year actual costs. The additional funds will continue to support the program, however current program operations indicate by the end of the year expenditures may exceed the budget. Program activity will continue to be monitored. The Board may need to request one-time funding, if available, or utilize existing reserve funds to address any program overage by the end of the year.

The Panorama Initiative is funded 100% by the MOHLTC. A request for funding was not required as part of the 2016 budget submission. The approved MOHLTC one-time funding for 2016 is $72,900. This funding will continue to support the ongoing implementation and

operations, including staffing and upgrades to the previously implemented Panorama System which supports our immunization programs (immunization registry and vaccine inventory).

In an unprecedented move, the Province approved all one-time requests as 100% for 2016. As a result, funding from local partners or reserves will not be required to fund these initiatives and can therefore be used to maintain operations at existing levels until the end of the year.

Decision History

In the past, we have not asked the Board to adjust its approved budgets to reflect the MOHLTC approval. It is beneficial for the Board to approve the amended budgets to help simplify the provincial budget approval and request process for the following year. The approval will allow the Board to work with current budget information, in order to make more accurate funding requests to support operations for the next year.

Background and Rationale

The Board approves annually 100% MOHTLC funded and one-time request budgets.

Strategic Direction

The Healthy Smiles Ontario Program will contribute to the strategic goal of *Determinants of Health and Health Equity* by addressing the oral health needs of identified priority populations, including the needs of children. In particular, it will ensure dental access for members of the community who would not be able to afford treatment.

The Smoke-Free Ontario Programs and Electronic Cigarettes Act will help to contribute to the strategic goal of *Determinants of Health and Health Equity* by providing access to programs and services and addressing the needs of community residents.

The 100% funded programs help to enhance the organization's strategic goals of *Capacity and Infrastructure* as well as *Quality and Performance* to achieve public health goals for the community through our programs and services.

Contact:

Dale Bolton
Manager, Finance
(705) 743-1000, ext. 302
dbolton@peterboroughpublichealth.ca

To: All Members
Board of Health

From: Chief Phyllis Williams, Chair, First Nations Committee

Subject: **Committee Report: First Nations**

Date: October 12, 2016

The First Nations Committee met on September 13, 2016. At that meeting, the Committee requested that the following items come forward to the Board of Health:

1. **Meeting Minutes**

   Proposed Recommendation:

   That the Board of Health for Peterborough Public Health receive for information, meeting minutes from June 14, 2016, of the First Nations Committee.

2. **Terms of Reference**

   Proposed Recommendation:

   That the Board of Health for Peterborough Public Health approve the revised Terms of Reference for the First Nations Committee.

3. **Strategic Planning**

   Proposed Recommendation:

   That the Board of Health for Peterborough Public Health consider the use of the Calls to Action from the Truth and Reconciliation Commission, and the United Nations Declaration on the Rights of Indigenous Peoples as part of its next strategic planning process.

4. **Indigenous Health Strategy**

   Proposed Recommendation:

   That the Board of Health for Peterborough Public Health:
   - *Receive the staff report, Indigenous Health Strategy, for information;*
   - *Endorse the overall goal that and indigenous health strategy be created for the Peterborough area; and*
   - *Recommend that PPH support local indigenous leaders and representatives in this process, by*

partnering with the CE-LHIN to provide staffing to support the development of the strategy.

5. Blanket Exercise

Proposed Recommendation:

That the Board of Health for Peterborough Public Health host a blanket exercise and invite staff and municipal partners to attend.

At the September meeting, the Committee began reviewing the Calls to Action from the Truth and Reconciliation Commission and prioritizing actions from this list. Among the items that were identified for action included the following:

> *"**57.** We call upon federal, provincial, territorial, and municipal governments to provide education to public servants on the history of Aboriginal peoples, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal–Crown relations. This will require skillsbased training in intercultural competency, conflict resolution, human rights, and anti-racism."*

The Committee felt a blanket exercise would be a valuable activity to address this item. A blanket exercise is an interactive learning experience, led by a facilitator, that teaches participants about the historic and contemporary relationship between Indigenous and non-Indigenous peoples in Canada. Details about the blanket exercise can be found at http://kairosblanketexercise.org/.

Attachments:
Attachment A – Meeting Minutes – June 14, 2016
Attachment B – Revised Terms of Reference, First Nations Committee
Attachment C - Calls to Action from the Truth and Reconciliation Commission *(web hyperlink)*
Attachment D - United Nations Declaration on the Rights of Indigenous Peoples *(web hyperlink)*
Attachment E – Staff Report, Indigenous Health Strategy

Board of Health for the
Peterborough County-City Health Unit
MINUTES
First Nations Committee Meeting
Tuesday, June 14, 2016 – 4:34 p.m.
Dr. J.K. Edwards Board Room, 185 King Street, Peterborough

Present:	**Chief Phyllis Williams** **Deputy Mayor John Fallis** **Councillor Art Vowles**
Regrets:	**Ms. Kerri Davies**
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health** **Ms. Patti Fitzgerald, Assistant Director, Chief Nursing and Privacy Officer** **Ms. Natalie Garnett, Recorder** (4:37 p.m.)
Guest:	**Ms. Liz Stone**

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1. Call to Order

Dr. Salvaterra called the meeting to order at 4:34 p.m.

2. Confirmation of Elections

2.1 Chairperson

Dr. Salvaterra called for nominations for the position of Chairperson.

MOTION:
That Chief Williams be elected Chairperson of the First Nations Committee.
Moved: Deputy Mayor Fallis
Seconded: Councillor Vowles
Motion carried. (M-2016-001-FN)

Chief Williams assumed the Chair.

2.2 **Vice Chairperson**

Chief Williams called for nominations for the position of Vice Chairperson.

MOTION:
That Councillor Vowles be elected Vice Chairperson of the First Nations Committee.
Moved: Deputy Mayor Fallis
Seconded: Chief Williams
Motion carried. (M-2016-002-FN)

3. Welcome – New Volunteer Committee Members

3.1 **Introductions**

Ms. Liz Stone was introduced to the Committee Members.

3.2 **Request to the Board of Health to Appoint Volunteer Members**

MOTION:
That it be recommended to the Board of Health, that Liz Stone and Lori Flynn be appointed as volunteer members of the First Nations Committee.
Moved: Deputy Mayor Fallis
Seconded: Councillor Vowles
Motion carried. (M-2016-003-FN)

3.3 **Review Committee Terms of Reference**

This item will be deferred until Ms. Flynn is in attendance.

4. Confirmation of the Agenda

5. Declaration of Pecuniary Interest

6. Delegations and Presentations

7. Confirmation of the Minutes of the Previous Meeting

7.1 **Notes - January 8, 2016**

MOTION:
That the notes of the First Nations Committee Meeting held January 8, 2016 be approved as circulated and provided to the Board of Health at its next meeting for information.

Moved: Deputy Mayor Fallis
Seconded: Councillor Vowles
Motion carried. (M-2016-004-FN)

7.2 **Notes – April 14, 2016**

MOTION:
That the notes of the First Nations Committee Meeting held April 14, 2016 be received and provided to the Board of Health at its next meeting for information.
Moved: Deputy Mayor Fallis
Seconded: Councillor Vowles
Motion carried. (M-2016-005-FN)

8. Business Arising from the Minutes

8.1 **Meetings with Curve Lake and Hiawatha to Discuss Dedicated Staff**

Ms. Fitzgerald will contact staff members at Curve Lake and Hiawatha to set up meetings which will include Council members.

8.2 **Truth and Reconciliation Commission of Canada: Calls to Action – Next Steps**

Dr. Salvaterra reviewed the information discussed at the April 14, 2016 meeting. It was agreed that the Committee will prioritize the action list at the Tuesday, September 13, 2016 meeting.

8.3 **185 King Street Update**

Dr. Salvaterra advised that an annual audit is undertaken at the Health Unit to ensure diversity.

9. Staff Reports

9.1 **Staff Report: Provincial Public Health Update**

MOTION:
That the First Nations Committee of the Board of Health for the Peterborough County-City Health Unit receive the staff report, Provincial Public Health Update for information.
Moved: Deputy Mayor Fallis
Seconded: Councillor Vowles
Motion carried. (M-2016-006-FN)

10. Consent Items

11. New Business

11.1 **Choose to be Smoke-Free Evaluations**

It was noted that Ownership, Control, Access and Possession (OCAP) requires an agreement to release the Choose to be Smoke-Free evaluations.

11.2 **Toronto Indigenous Health Strategy**

A staff report on this item will be provided at the next Committee meeting.

11.3 **Develop Committee Work Plan**

12. In Camera to Discuss Confidential Matters

13. Motions for Open Session

14. Date, Time and Place of Next Meeting

Tuesday, September 13, 2016 at 4:30 p.m. in the Dr. J.K. Edwards Board Room, Peterborough County-City Health Unit, 185 King Street, Peterborough.

15. Adjournment

MOTION:
That the meeting be adjourned.
Moved: Deputy Mayor Fallis
Seconded: Councillor Vowles
Motion carried. (M-2016-007-FN)

The meeting was adjourned at 5:30 p.m.

Chairperson

Medical Officer of Health

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-352	**Title:** First Nations Committee, Terms of Reference
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2016-02-10**
Signature:		**Author:** First Nations Working Group
Date (YYYY-MM-DD)**:** 2016-02-10		
Reference:		

NOTE: This is a **CONTROLLED** document for internal use only, any document appearing in a paper form should **ALWAYS** be checked against the online version prior to use.

Goal

To deepen awareness, sensitivity and meaningful actions on issues that are of relevance and public health importance to indigenous people living within the Peterborough County-City Health Unit (PCCHU) catchment area.

Objectives

The First Nations Committee will:

1. provide a forum for Committee Members to brainstorm, explore and propose public health-related agenda items for the Board of Health (BOH) to consider that are of importance to indigenous people living within the PCCHU catchment area. In particular, this includes a review of the Calls to Action from the Truth and Reconciliation Commission, which redress the legacy of residential schools and advance the process of reconciliation.

2. advise and support the BOH to become a stronger and more effective ally and advocate with respect to its two First Nation (FN) Communities and on matters that impact on the health and well-being of their members and environment;

3. advise and support the BOH and its staff on ways to strengthen relationships with Curve Lake First Nation (CLFN), ~~and~~ Hiawatha First Nation (HFN) and the broader Indigenous stakeholder community.

4. collaborate with CLFN and HFN on strategies and initiatives that will benefit their communities and the well-being and future of indigenous populations living in the PCCHU catchment area; and

5. advise staff on organizational strategies to address and improve indigenous public health.

Membership

The Committee will be composed of a minimum of three Board Members in addition to the Chair. This membership must include representation from both CLFN and HFN.

In addition, the Board will seek community members representing the broader ~~l~~indigenous stakeholder community (e.g., Nogojiwanong Friendship Centre, Nijijkiewenidaa).

The Committee will elect its own Chair and Vice-Chair at the first meeting of each calendar year.

Internal staff resources will be provided for the Committee through the Medical Officer of Health or his/her designate.

Quorum

A majority of Committee members constitute a quorum.

Reporting

The Committee will provide its minutes, once approved, to the Board of Health at the next scheduled meeting.

The Chair will take motions and/or recommendations deemed appropriate by the Committee forward to the Board of Health at the next scheduled meeting.

Meetings

The Committee will meet quarterly, at a minimum, and may meet more frequently as needed.

Minutes

The Executive Assistant to the Board of Health, or designate, will record the proceedings at meetings and provide secretarial support to the Committee.

The minutes are circulated in draft to Committee members prior to the next Committee meeting. Minutes are corrected and approved at the next meeting of the Committee.

The approved minutes are signed by the recorder and the Chairperson. Original copies of the approved minutes are kept in a binder in the Administration office.

Agendas

Agendas will be prepared and distributed according to the format set forth in Section 4 – Agenda and Order of Business, as written in Board of Health By-Law #3, Calling of and Proceedings at Meetings.

Terms of Reference

The Terms of Reference will be reviewed and updated at the first meeting of each new year or more often as needed.

Review/Revisions

On (YYYY-MM-DD)**:**

On (YYYY-MM-DD)**:**

On (YYYY-MM-DD)**:**

On (YYYY-MM-DD)**:**

Staff Report

Indigenous Health Strategy

Date:	September 13, 2016
To:	Board of Health First Nations Committee
From:	Dr. Rosana Salvaterra, Medical Officer of Health
Original approved by	
Rosana Salvaterra, M.D.	

Proposed Recommendations

That the First Nations Committee of the Board of Health for Peterborough Public Health (PPH):

- receive the staff report, Indigenous Health Strategy, for information; and (if applicable)
- endorse the overall goal that an indigenous health strategy be created for the Peterborough area; and
- recommend that PPH support local indigenous leaders and representatives in this process, by partnering with the CE-LHIN to provide staffing to support the development of the strategy.

Financial Implications and Impact

If the board supports the recommendations, there would be staffing demands for PPH that may exceed existing capacity. It may be necessary to redirect existing staff resources. Additional provincial funding, through one time requests, may be required as well.

Decision History

This will be the first time this matter is being considered by the board. However, by establishing a First Nations Committee, the board has created the opportunity for collaborations such as this to emerge and grow.

Background

According to Statistics Canada, 2013, there are 4,810 persons of indigenous heritage living in the Peterborough County-City Health unit. Of these, an estimated 2,605 reside in the City of Peterborough. The remainder lives in the County, or in one of two First Nation communities, Curve Lake or Hiawatha. This represents 3.6% of the total population of this health unit.

The Central East LHIN (CE-LHIN) has been engaged with this population through two advisory groups that have been meeting since 2010. Both the CE-LHIN First Nations Health Advisory Circle and the CE-LHIN Métis, Inuit and Indigenous Peoples Health Advisory Circle have been meeting on a quarterly basis. In addition to these meetings, special meetings have been held to address specific issues such as mental health and addictions planning, collaboration with the Central East Community Care Access Centre and work plan development. Annual Joint Circle meetings have taken place and have been well attended by Circle members, community members and other partners. These two circles provide the CE-LHIN with advice on a variety of topics reflecting provincial and LHIN goals and priorities that pertain to the Indigenous communities represented. The terms of reference are currently being revised and will be finalized at the next Annual Joint Circle meeting scheduled to take place at Curve Lake First Nation on October 28, 2016.

Up until now, there has not been a comprehensive plan for the overall health protection and promotion of indigenous people living outside of Peterborough's two First Nations.

Lessons Learned: Toronto

Across Ontario, urban indigenous representatives are joining with partners such as public health, aboriginal community health centres or access centres, and other parts of the health care system to develop an urban health strategy. For example, the process to develop an indigenous health strategy in Toronto (TIHS) has just been completed. Although the relationship building process took many years to develop to the point where there was a strong foundation of mutual trust, the actual strategy took one year to complete. The process began in March 2015 and saw the strategy being officially launched at a community feast on March 23, 2016 at the Native Canadian Centre of Toronto.

Before the health strategy could be developed, several key procedural components had to be put into place. First of all, an Advisory Circle was established to act as a steering committee to the work. Only the indigenous members had voting privileges – both Toronto Public Health (TPH) and the Toronto Central LHIN (TC-LHIN) were ex-officio members and provided secretarial support to the process. An intergenerational approach was used, with both an Elders Council and a Youth Council being formed, with representatives assigned to the Advisory Circle. An indigenous facilitator was hired with TC-LHIN funds, and an academic consultant was recruited to ensure that the strategy would be consistent with treaties and principles of self-governance. The collaborative received advice from Dr. Bernice Downey (Indigenous health governance specialist) to ensure the TIHS was situated within the context of national and international

Indigenous rights (Truth and Reconciliation Commission of Canada and the United Nations Declaration on the Rights of Indigenous Peoples).

The Advisory Circle met monthly during the development of the strategy.

The TIHS was developed from several key inputs, including:

- a review of findings from engagement sessions with diverse segments of the Indigenous community;
- findings from community stakeholder interviews;
- community health and socio demographic data;
- local Indigenous programs and services;
- urban Indigenous health strategies in similar Canadian jurisdictions;
- guidance from the TIHAC Elders' Council and Youth Council;

Three overarching themes emerged during the planning and are woven throughout the TIHS:

1. **Reclamation of Well Being** - TIHS reclaims Indigenous-centric governance and improved access to Indigenous healing knowledge and practice.

2. **Spirit of Reconciliation: Making it Right** - TIHS is based on calls to action for governments and the health system to redress the legacy of colonization and residential schools.

3. **Reinforce a Population Health Approach** - TIHS aims to reduce health inequities in Indigenous health in order to ensure wellbeing across the population.

In order to complete the strategy, the following five operating principles were adopted:

1. **Health plans are developed with Indigenous Peoples as full partners.** The process was facilitated by an indigenous consultant and staffed by both the LHIN and Toronto Public Health, but the content and process were led by indigenous people. The process itself was respectful and inclusive of indigenous spirituality and culture, and an intergenerational approach was used to ensure that both Elders and Youth were able to contribute.

2. **Wherever Indigenous Peoples go to access programs and services, they receive culturally appropriate, safe and proficient care, and all barriers to optimal care have been removed.** As part of its participation in the strategy, Toronto Public Health ensured that all staff and board members became more culturally competent. The same expectation would exist for all service providers and partners.

3. **Care is planned to be responsive to community needs and is appropriate, efficient, effective and high quality at both systems and interpersonal levels.** Although this principle focuses on the care side of the equation, by adding a public health lens to the strategy, a comprehensive plan that also addresses the social determinants of health can be developed

to ensure that it is more effective, appropriate and of high quality, both at the population level as well as at the level of the family and individual.

4. **Dedicated resources and funding for Indigenous Health programs and services will support a coordinated and collaborative system.** Once the strategy was developed, it is now being used as a template to prioritize the services and actions necessary to improve health outcomes in this population. Earlier this year, Ontario announced additional funding for indigenous health. By following the lead of other communities like Toronto in having a strategy, Peterborough could be positioning itself to secure dedicated funds and additional resources.

5. **Leverage and build the capacity of Indigenous leadership and Indigenous communities to care for themselves.** By engaging youth, the future leaders , the strategy builds capacity and secures longstanding buy-in. In addition, the strategy includes a commitment to train and recruit indigenous personnel.

These five principles may or may not resonate with local indigenous leadership here in Peterborough but they serve as an example of how the strategy must grow out of a respectful and inclusive process that is indigenous led. If a local partnership embarks on a similar project, the Peterborough Indigenous Health Advisory Circle that oversees the work will need to articulate its own values and principles, as part of its formation.

Indigenous Health Strategies – Next Steps for Toronto

Now that the strategy has been developed, the Advisory Council that oversaw this work is continuing to be engaged in implantation. Some of the strategic actions require meetings with partners such as school boards, and actions that may be achieved without the allocation of additional resources. Other actions require new sources of funding and both the province and federal government are being approached where appropriate. Because much of the strategy impacts urban populations and not First Nations, most of the follow-up for the THIS will be provincial or local. TPH continues to support this work.

Rationale for a Peterborough Initiative

Indigenous peoples in Peterborough make up just under 4% of the total population in the geographic public health unit, for a population of about 5,000 people. As two First Nations are located in this area, a portion of this population resides in these communities, and some in the adjacent rural and urban areas. Part of this population's location would be more fluid, with time spent in and out of the First Nation communities.

In addition to the two established organizations within the city of Peterborough, Niijkiwendidaa Friendship Centre and the Nogojiwanong Friendship Centre, the Lovesick Lake Native Women's Association also has a membership and holds programs and activities.

Peterborough also benefits from Trent University's Department of Indigenous Studies, which has agreed to participate if invited.

The CE-LHIN has been engaging with indigenous representatives for several years and would make a natural partner to work on a strategy as many of the recommendations would probably impact on LHIN-funded agencies and organizations. A partnership with PPH would allow for both organizations to collectively share existing resources to support the development of a local strategy that could set the future direction for resource allocation and policy making for many years to come.

Strategic Direction

This report applies to the following strategic direction:

- Community-Centred Focus

Contact:

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atanna@peterboroughpublichealth.ca

Attachments:

Attachment A – Toronto's First Indigenous Health Strategy (2016-21) ***(web hyperlink)***