The Board of Health for the Peterborough
County-City Health Unit
Agenda
Board of Health Meeting
4:45 p.m. Wednesday, April 11, 2012
(Council Chambers, County Court House
County of Peterborough, 470 Water Street)

1. Call to Order

2. Declaration of Pecuniary Interest

3. Confirmation of the Agenda

4. Delegations and Presentations

4.1. **A Day In The Life – Youth Engagement and Student Peer Leaders**
Presenters: Jennie Carr, Student Peer Leader
Alex Stinson, Student Peer Leader
Keith Beecroft, Youth Development Worker

5. Confirmation of the Minutes of the Previous Meeting

5.1. **March 14, 2012**

6. Business Arising From the Minutes

7. Correspondence

8. Program Reports

Vice Chair Councillor Jill Smith will assume the Chair for this portion of the meeting*

9. New Business

9.1. **Emergency Preparedness - Continuity of Operations Plan**
Presenter: Donna Churipuy, Manager, Environmental Health Programs

9.2. **Staff Report: Healthy Babies, Health Children 2012 Budget**
Karen Chomniak, Manager, Family Health Programs

9.3. **Staff Report: Audit Letter of Engagement**
Brent Woodford, Director, Corporate Services

9.4. **Public Health Ontario and Cancer Care Ontario Report: Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario**
Presenter: Dr. Rosana Pellizzari, Medical Officer of Health
(Presentation Link)
Full Report: http://www.oahpp.ca/resources/documents/takingactionreport%20Mar%2015-12.pdf

9.5. **Staff Report: 2012/13 Infant & Toddler Development Program Budget**
Brent Woodford, Director, Corporate Services

9.6. **Staff Report: 2012 Smoke Free Ontario Budget**
Brent Woodford, Director, Corporate Services

9.7. Update on First Nations Public Health in Ontario
Dr. Rosana Pellizzari, Medical Officer of Health

9.8. **Waterloo Region Smoke-Free Community Housing Video**
Dr. Rosana Pellizzari, Medical Officer of Health

9.9. **alPHa Resolutions**
Dr. Rosana Pellizzari, Medical Officer of Health

10. Committee Reports

Board Chair Deputy Mayor Andy Sharpe will resume the Chair for the remainder of the meeting*

11. In Camera to Discuss Confidential Personnel Matters

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

Wednesday, May 9, 2011, 4:45 p.m.; *Council Chambers, County Court House County of Peterborough, 470 Water Street.*

13. Adjournment

c: All Members, Board of Health
Medical Officer of Health
Directors

“A Day in the Life”

PCCHU’s Youth Development Worker and Student Peer Leaders

Peterborough County-City HEALTH UNIT
...because health matters!

Schools

Student Peer Leaders

Community Partners

PCCHU

Central East Region

Provincial

Tobacco Use Prevention

Peterborough County-City HEALTH UNIT ...because health matters!

Community Partners …

Using the five strategies set out in the Ottawa Charter: build healthy public policy; create supportive environments; strengthen community action; develop personal skills and; orient health services.

PARN
YOUR COMMUNITY AIDS RESOURCE NETWORK

NEW CANADIANS CENTRE
PETERBOROUGH

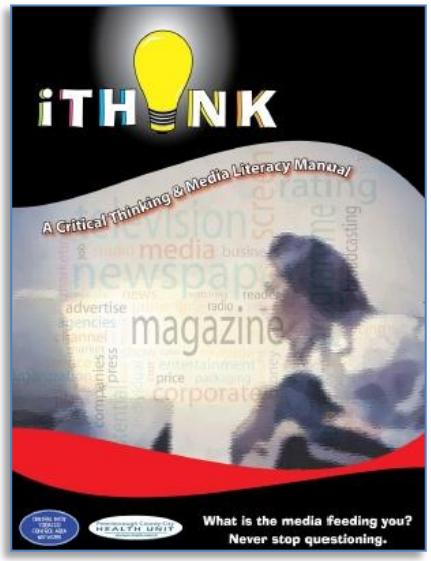
JSH
Empowering people. Building community.

AANIIN WELCOME
CURVE LAKE FIRST NATION
TERRITORY

Peterborough County-City HEALTH UNIT
...because health matters!

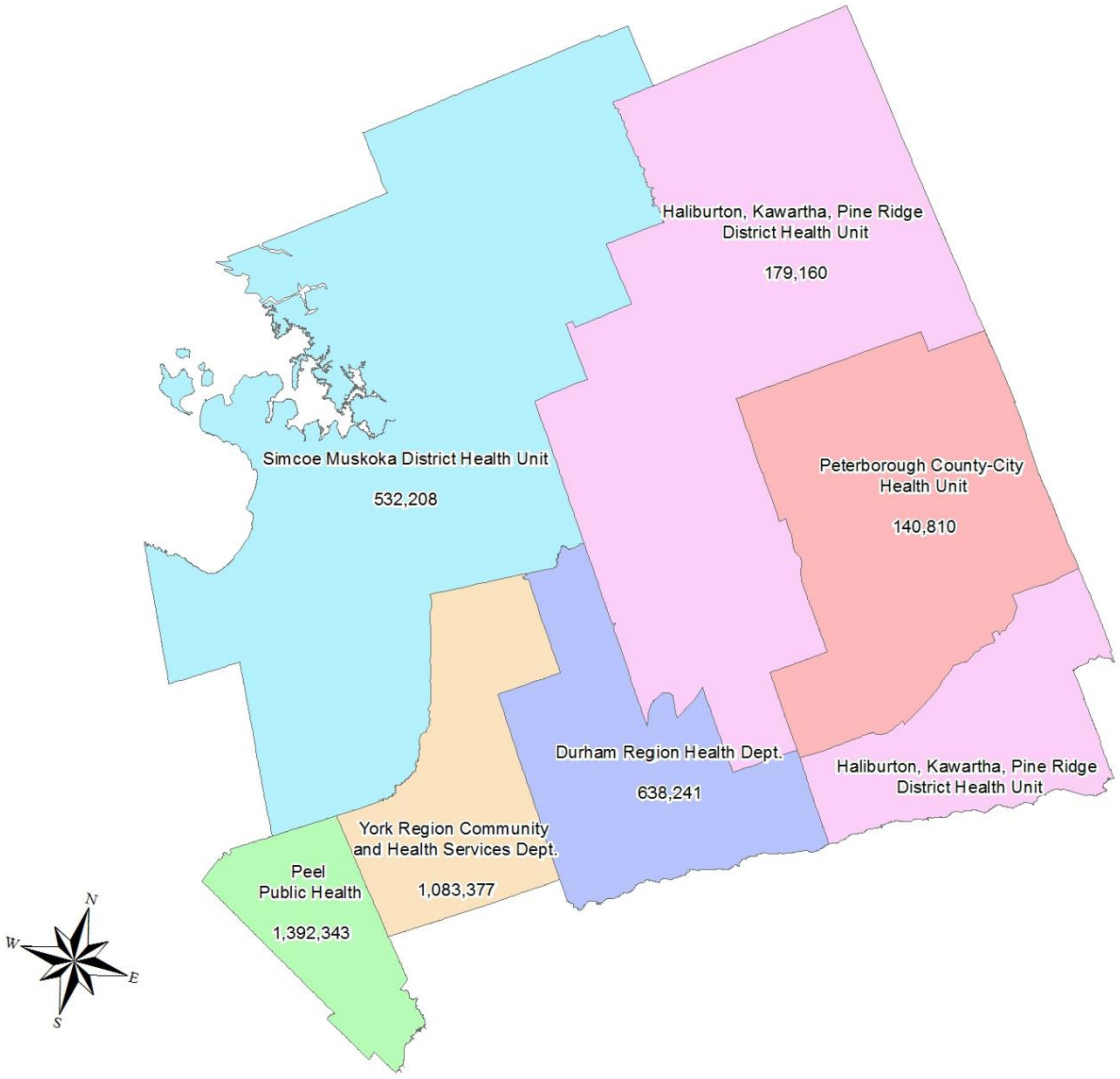
Schools …

- Intramural Leadership Day at Trent University
- Youth Engagement “Booster” in eight schools
- iThink manual



Peterborough County-City HEALTH UNIT
...because health matters!

Central East Region…



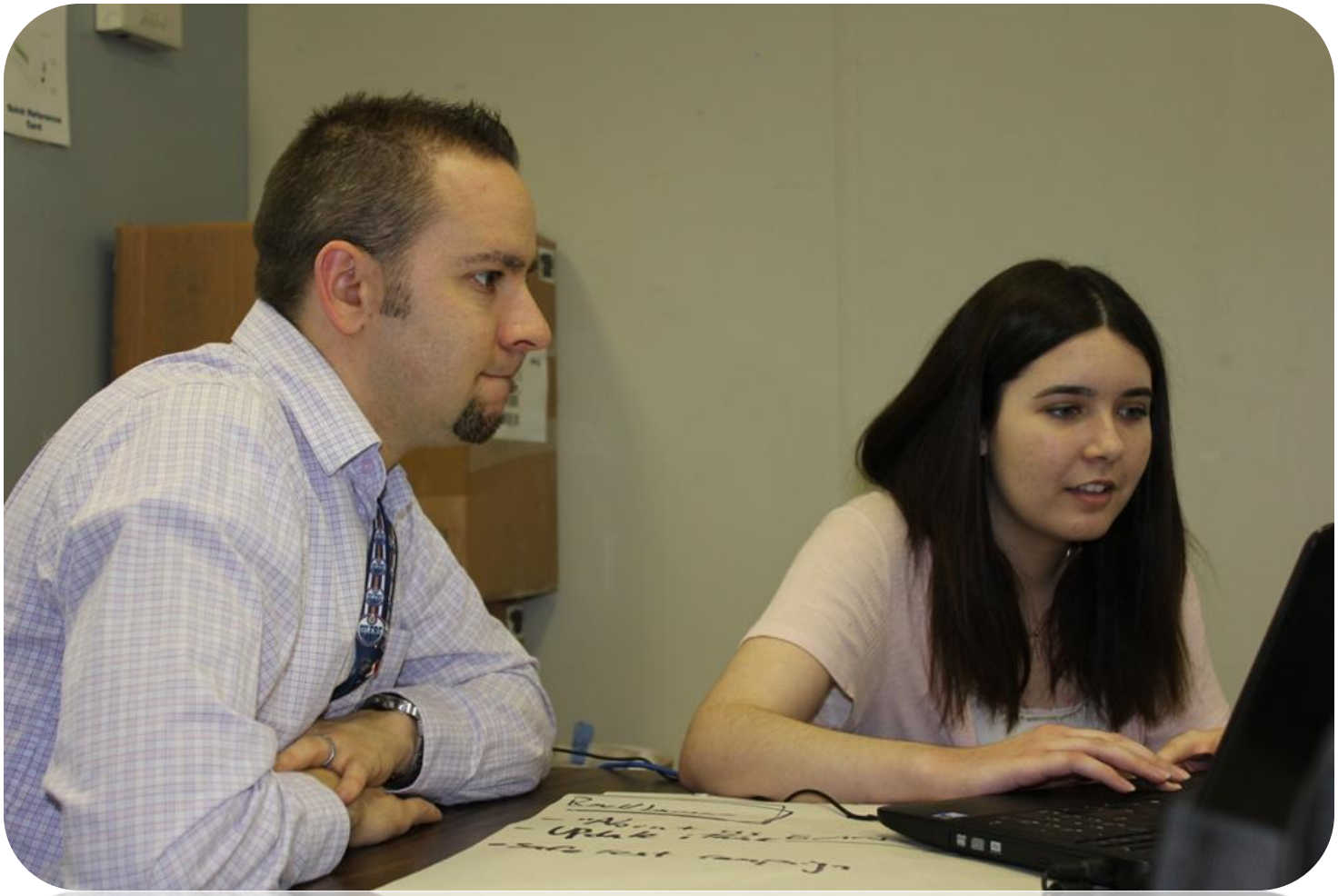
Peterborough County-City
HEALTH UNIT
...because health matters!

Provincially …

Student Peer Leaders …

- Two days each week my day starts at 12 PM and goes until 8 PM

Peterborough County-City HEALTH UNIT
...because health matters!



Office Work

Peterborough County-City HEALTH UNIT
...because health matters!

Advocacy & Policy Work

Peterborough County-City HEALTH UNIT
...because health matters!

Out & About

Peterborough County-City HEALTH UNIT
...because health matters!

Presentations

Peterborough County-City HEALTH UNIT
...because health matters!

The TEAM

Peterborough County-City HEALTH UNIT
...because health matters!

Thank you – any questions?

Peterborough County-City HEALTH UNIT
...because health matters!

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Minutes of Board of Health Meeting, March 14, 2012**

Date: April 11, 2012

Recommendation:

That the minutes of the Board of Health meeting held on March 14, 2012 be adopted as circulated.

Please refer to the attached.

Original signed by

Rosana Pellizzari, M.D.

Board of Health for the
Peterborough County-City Health Unit
Minutes
Wednesday, March 14, 2012
Board Room, 10 Hospital Drive

Present:

Board Members: Deputy Mayor Andy Sharpe, Chair
Councillor Andrew Beamer
Councillor Henry Clarke
Mr. Jim Embrey
Mayor John Fallis
Mr. Paul Jobe
Chief Keith Knott
Councillor Lesley Parnell
Councillor Jill Smith
Reeve Mary Smith
Mr. David Watton

Regrets:

Staff: Mrs. Donna Churipuy, Manager, Environmental Health Programs
Mrs. Carolyn Doris, Public Health Nutritionist
Ms. Susan Hubay, Public Health Nutritionist
Mrs. Barbara Matwey, Administrative Assistant, Recorder
Dr. Rosana Pellizzari, Medical Officer of Health
Mrs. Kerri Tojcic, Computer Technician Analyst
Mr. Brent Woodford, Director, Corporate Services

1. Call to Order

Deputy Mayor Sharpe called the meeting to order at 4:50 p.m. Deputy Mayor Sharpe informed the Board of Health that Vice Chair Councillor Jill Smith would Chair a portion of the meeting.

2. Declaration of Pecuniary Interest

There were no declarations of pecuniary interest.

3. Confirmation of Agenda

Moved by Councillor Beamer — Seconded by Mr. Embrey

That the agenda be approved as circulated with the addition of item 9.7, Rural Ontario Municipal Association (ROMA) Convention and 9.8, Trichloroethylene (TCE) Testing.

- Carried - (M-12-31)

4. Delegations and Presentations

Deputy Mayor Sharpe informed the Board of Health that two delegations had been declined, both requests were related to wireless technologies. The Board will defer any further delegations on this item until a report is received from Public Health Ontario. One request was referred to internal staff, a meeting has already taken place with the individual.

4.1 A Day in The Life – Nutrition Program
Presenters: Susan Hubay, Public Health Nutritionist
Carolyn Doris, Public Health Nutritionist

5. Confirmation of the Minutes of the Previous Meeting

Moved by Councillor Parnell — Seconded by Chief Knott

That the minutes of the Board of Health be approved as amended, amending Item 4, Delegations and Presentations, to reflect the standard practice of only recording decisions.

- Carried - (M-12-32)

6. Business Arising From the Minutes

Nil.

7. Correspondence

Moved by Councillor Clarke — Seconded by Reeve Smith

That the following documents be received for information.

1. Correspondence related to Wi-Fi:
a. Email dated February 14, 2012 from Dr. Pellizzari to Mr. Rusty Hick, Director,

Kawartha Pine Ridge District School Board (KPRDSB) regarding wireless connections as KPRDSB schools.

b. Letter dated March 5, 2012 from KPRDSB in response to correspondence item 1a.

c. Emails dated February 21 and 25, 2012, from Mr. P. Stumpf.

d. Form letter response provided to correspondence items 1e-j.

e. Email dated February 21, 2012 from Mr. and Mrs. H. Lunn.

f. Letter dated February 21, 2012 from Mr. C. Niziolek.

g. Email dated February 22, 2012 from Ms. L. McColl.

h. Email dated Feburary 24, 2012 from Ms. M. Welch.

i. Email dated February 26, 2012 from Mr. C. Niziolek.

j. Email dated March 5, 2012 from Ms. M. Nuen.

2. Correspondence related to the Drummond Report:
   a. Letter dated February 23, 2012, from the Ontario Public Health Association (OPHA), to Minister Matthews, Ministry of Health and Long-Term Care (MOHLTC).
   b. Staff Report dated February 24, 2012 for the Toronto Board of Health.
   c. Letter dated March 1, 2012 from the Association of Local Public Health Agencies (alPHa), to Premier McGuinty, Government of Ontario.
3. Letter dated February 2, 2012 from Minster Aglukkaq, Ministry of Health, to Chairman Sharpe, in response to his original letter dated May 30, 2011, regarding the advertisement of breast-milk substitutes.
4. Letter dated February 15, 2012 from Dr. Pellizzari to Minster Hoskins, Ministry of Children and Youth Services, regarding funding for the Infant and Toddler Development Program.
5. Email dated February 22, 2012 from Dr. Pellizzari to Linda Stewart, Executive Director, alPHa, regarding the status of explorations with the OPHA for shared resources.
6. Letter dated February 23, 2012, from Minister Matthews, MOHLTC, regarding funding for Panorama.
7. News release from the Ministry of Education regarding new concussion legislation, forwarded by email from Linda Stewart, alPHa, on March 6, 2012.
8. Email received March 6, 2012 from alPHa regarding the 2012 alPHa Annual Conference (June 10-12, 2012, Niagara, ON).
9. Letter dated March 7, 2012 to Minister Matthews, MOHLTC, from Chairman Sharpe, regarding influenza vaccination rates for health care workers.
10. Letter dated March 7, 2012 to Minister Matthews, MOHLTC, from Chairman Sharpe, regarding HPV vaccination.
11. Letters/Resolutions from other Health Units:
    Durham Region
    Nutritious Food Basket

- Carried (M-12-33)

Moved by
Mayor Fallis

Seconded by
Chief Knott

That the Peterborough County-City Health Unit prepare a letter to the Ministry of Health and Long-Term Care to recommend that it support recommendations from Toronto

Public Health and the Association of Local Public Health Agencies (alPHa) with respect to the Drummond Report.

- Carried (M-12-34)

Moved by
Mayor Fallis

Seconded by
Councillor Parnell

That the Board of Health for Peterborough County-City Health Unit prepare a letter to the Honourable Gerry Ritz, Minister of Agriculture and Agri-Food and the Canadian Wheat Board, concerning the advertisement of breast-milk substitutes and the violation of the International Code of Marketing of Breast-milk Substitutes.

- Carried (M-12-35)

Moved by
Mr. Embrey

Seconded by
Councillor Parnell

To allow Vice Chair Councillor Smith, Chair the meeting from this point.

- Carried (M-12-36)

8. Program Reports

Nil.

9. New Business

9.1 Staff Report: Small Drinking Water Systems Program Update
Tom Cathcart, Manager, Inspection Services

Moved by
Mayor Fallis

Seconded by
Mr. Watton

That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Small Drinking Water Systems Program Update, for information.

- Carried (M-12-37)

9.2 Staff Report: One-Time Funding Requests
Brent Woodford, Director, Corporate Services

Moved by
Councillor Clarke

Seconded by
Mr. Watton

That the Board of Health for the Peterborough County-City Health Unit approve, in principle, the submitted supplemental budgets for one-time funding for 2012.

- Carried (M-12-38)

9.3 Sustainable Peterborough Partnership

Presenter: Donna Churipuy, Manager, Environmental Health Programs

Mrs. Churipuy provided an overview of the Sustainbility Plan Partnership. Development of the Integrated Community Sustainability Plan has been a collaborative endeavour that has taken place over 18 months. Mrs. Churipuy thanked the Township of Smith-Ennismore-Lakefield as they have signed on at the Champion level, and encouraged the Board of Health to consider becoming a partner at the same level.

Moved by Mr. Embrey — Seconded by Mr. Jobe

That the Board of Health for the Peterborough County-City Health Unit request membership in the Sustainable Peterborough Partnership as a "Champion".

- Carried (M-12-39)

9.4 Natural Heritage Strategy

Presenter: Donna Churipuy, Manager, Environmental Health Programs

Mrs. Churipuy provided an overview of the Natural Heritage Strategy (NHS). The *Kawarthas, Naturally Connected Project*, a community-driven initiative, provides an opportunity for communities to sustain the wealth and health of natural areas, in a way that considers health and cultural, social, environmental and economic values. Goals include identifying and mapping a connected system of natural areas that can help sustainable land use planning and resource management decision-making; determining the best areas for stewardship and restoration projects; setting priorities for conservation land purchases; and identifying what further information and inventories are needed to improve their efforts. All municipalities and First Nations communities are encouraged to participate.

Moved by Councillor Clarke — Seconded by Councillor Parnell

That the Board of Health for the Peterborough County-City Health Unit receive the presentation, Natural Heritage Strategy, for information.

- Carried (M-12-40)

The following item, originally 9.8 in the agenda, was moved up to allow for Mrs. Churipuy to be present to answer questions from Board Members.

Trichloroethylene (TCE) Update

Presenter: Dr. Rosana Pellizzari, Medical Officer of Health

Dr. Pellizzari informed Board of Health members that recent testing of the groundwater TCE plume from the former Outboard Marine Corporation (OMC)

site has raised concerns that there may be vapour intrusion into homes. Mrs. Churipuy's staff and Ministry of the Environment (MOE) staff have visited 45 homes in the area of Romaine St. and Brioux St. to invite them to participate in indoor air sampling. Information has been posted on the Health Unit's website. The Health Unit will address any health-related issues while the MOE will be responsible for environmental concerns.

9.5 Risk Management

Presenter: Brent Woodford, Director, Corporate Services

Mr. Woodford presented on 'risk management', the possibility or chance of danger, loss, injury or other adverse consequences and the consequential mitigations and contingencies that would involve Health Unit response. Some examples of risks to our community include atmospheric events, human health emergencies and epidemics, hydrologic hazards, agriculture and food emergencies, and technological risks, energy emergencies or hazardous material spills. Other health emergencies could involve our community acting as a host if neighbouring areas needed to evacuate their communities. In some instances of emergency, the Health Unit would take the lead, while in others, it would support a partner agency as required.

9.6 alPHa Winter Symposium (February 2012) – Oral Update

David Watton, Reeve Mary Smith, Dr. Pellizzari

Mr. Watton and Reeve Smith provided a brief overview of the topics that were discussed at the conference.

9.7 Rural Ontario Municipal Association (ROMA) Convention – Oral Update

Deputy Mayor Sharpe

Members of the Board of Health met with Liz Sandals, M.P.P. Guelph, Parliamentary Assistant to the Honourable Deb Matthews, Minister of Health and Long-Term Care, regarding funding issues. Deputy Mayor Sharpe did request that M.P.P. Sandals provide us with a written response. This has not been received yet.

Moved by Councillor Parnell

Seconded by Mr. Embrey

That the Board of Health for the Peterborough County-City Health Unit request another meeting with the Honourable Deb Matthews at the upcoming Association of Municipalities of Ontario (AMO) Conference scheduled in August.

- Carried (M-12-41)

Dr. Pellizzari will contact Brian Horton, Chief Administrative Officer for the City of Peterborough prior to August.

9.8 Health Hazard Update – TCE
Presenter: Dr. Rosana Pellizzari, Medical Officer of Health

This item was moved up in the agenda, please refer to item 9.4 for details.

10. Committee Reports

10.1 Governance Committee

Moved by Mr. Watton — Seconded by Reeve Smith

That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Governance Committee for January 27, 2012, approved by the Committee on February 29, 2012.

- Carried (M-12-42)

10.2 Terms of Reference – Forum for Governance Committee and Non-Union Staff Discussions

Moved by Chief Knott — Seconded by Councillor Parnell

That the Board of Health Peterborough County-City Health Unit accept the Terms of Reference – Forum for Governance Committee and Non-Union Staff Discussions, as written.

- Carried (M-12-43)

Moved by Councillor Parnell — Seconded by Mr. Watton

That the meeting be Chaired by Deputy Reeve Sharpe.

- Carried - (M-12-44)

11. In Camera to Discuss Confidential Property and Personnel Matters

Moved by Councillor Parnell — Seconded by Councillor Clarke

That the Board of Health go In Camera to discuss confidential Property and Personnel matters.

- Carried - (M-12-45)

Moved by
Councillor Parnell
That the Board of Health rise from In Camera.

Seconded by
Chief Knott

- Carried – (M-12-46)

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

April 11, 2011, Board Room, 10 Hospital Drive

13. Adjournment

Moved by
Councillor Clarke
That the meeting be adjourned.

Seconded by
Mr. Watton

- Carried – (M-12-47)

The meeting adjourned at 7:50 p.m.

_____
Chairperson

_____
Medical Officer of Health

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Correspondence**

Date: April 11, 2011

Recommendation:

That the following documents be received for information and acted upon as deemed appropriate.

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1. Correspondence related to Wi-Fi:

    a. Email dated March 12, 2012 from P. Stumpf. ***(REF. P. 2-24)***
    b. Email dated March 13, 2012 from the Kawartha Safe Technology Initiative. ***(REF. P. 25-33)***
    c. Email dated March 19, 2012 from C. Niziolek. ***(REF. P. 34-35)***
    d. Email dated March 20, 2012 from M. Manon, and response issued on Apr. 4, 2012. ***(REF. P. 36-37)***
    e. Email dated April 2, 2012 from O. Johansson, and response issued on Apr. 4, 2012. ***(REF. P. 38-44)***

2. Letter dated March 14, 2012 from Chairman Sharpe to Ms. Kate Manson, Smith, Assistant Deputy Minister, Ministry of Health and Long-Term Care, regarding the delivery of the Healthy Communities Fund Partnership Stream. ***(REF. P. 45-46)***

3. Email dated March 16, 2012 from Linda Stewart, Association of Local Public Health Agencies (alPHa), regarding Healthy Smiles Ontario. ***(REF. P. 47)***

4. Email dated March 21, 2012 from Gordon Fleming, alPHa, regarding the Winter Symposium held in February 2012. ***(REF. P. 48)***

5. Letter dated March 21, 2012 from Minster Hoskins, Ministry of Children and Youth Services, to Dr. Pellizzari, in response to her original letter dated February 15, 2012, regarding funding for the Infant and Toddler Development Program. ***(REF. P. 49)***

6. Letter dated March 23, 2012 from Minster Gerry Ritz, Ministry of Agriculture and Agri-Food and Minister for the Canadian Wheat Board, to Chairman Sharpe, in response to

his original letter dated May 30, 2011, regarding the advertisement of breast-milk substitutes. ***(REF. P. 50-51)***

7. Letters/Resolutions from other Health Units:

   Niagara
   - Infant and Toddler Development Program ***(REF. P. 52)***

Original signed by

Rosana Pellizzari, M.D.

Summary of technical specifications and communications on Safety Code 6 to satisfy the " Requirement for integration and validation of wifi in local school environment compliant to Safety Code 6."

Peter Stumpf, P.Eng., PMP, MSc.Me
1521 Forestview Dr., Buckhorn, ON
Ph. 705 657 7299 (res.), 705 740 7091 (bus.)
E-mail: changescape@sympatico.ca

March 08, 2012

Proposed purpose for meeting on March 8th, 2012 at Peterborough County-City Health Unit:
" Requirement for integration and validation of wifi in local school environment compliant to Safety Code 6."

Attendants: Donna Churipuy, Peter Stumpf

Issue:
Kawartha Pine Ridge District School Board (KPRDSB) has not followed the measurement requirements for RF-exposure levels as described in Safety Code 6.

Facts:

- RF-equipment installation and validation of RF-exposure levels must be compliant with Safety Code 6 specification published by Health Canada with focus on *section* 2.2 (pg. 18) *"Exposure of Persons Not Classed as RF and Microwave Exposed Workers (including the General Public)"* and requirement for RF-exposure measurements outlined in Appendix V of Safety Code 6.
- Safety Code 6 does not exclude or exempt the school environment of Kawartha Pine Ridge District School Board (KPRDSB).
- The routers of type Meru AP-300 installed in Buckhorn Public School (BPS) require integration in compliancy to Safety Code 6 as instructed in Appendix D of the Installation Guide (pg. 86, Meru Access Point Installation Guide, Document Number: 882-70037 Rev D Rel 3.7 Ver 8).
- Kawartha Pine Ridge District School Board (KPRDSB) misinformed the public with the statement that wifi is integrated compliant to Safety Code 6 but measurement results were derived not compliant to Safety Code 6.
- E-mail from Dr. Copes and Dr. Pellizzari to Mr. Rusty Hick support the request to have an accredited third party complete wifi-exposure measurements at BPS compliant to safety code 6.

Require:
Complete a RF-field study to measure wifi exposure levels compliant to Safety Code 6 at KPRDSB's schools.

- Assess the risk of wifi exposure based on actual measurement results compliant to Safety Code 6.
- Advise the general public of actual exposure levels at local schools and plan on how to eliminate or reduce the impact of wifi effectively.

Appendix 1:

Extract of Safety Code 6
(Copy of Safety Code 6 provided for meeting)

RF-equipment installation and validation of RF-exposure levels must be compliant with Safety Code 6 specification published by Health Canada with focus on *section* 2.2 (pg. 18) *"Exposure of Persons Not Classed as RF and Microwave Exposed Workers (including the General Public)"* and requirement for RF-exposure measurements outlined in Appendix V of Safety Code 6.

2.2 Exposure of Persons Not Classed as RF and Microwave Exposed Workers (Including the General Public)

2.2.1 Field Strength Limits

(a) A person other than an RF and microwave exposed worker shall not be exposed to electromagnetic radiation in a frequency band listed in Column 1 of Table 5, if the field strength exceeds the value given in Column 2 or 3 of Table 5, when averaged spatially and over

time, or if the power density exceeds the value given in Column 4 of Table 5, when averaged spatially and over time. The spatial averaging is carried out over an area equivalent to the vertical cross-section of the human body (projected area). A time-averaging period of 0.1 h (6 min) should be employed for frequencies up to 15 000 MHz. Above these frequencies, a different averaging time is used and is described in Section 2.3.2.

(b) Where the electromagnetic radiation consists of a number of frequencies in the same or different frequency bands, shown in Column 1 of Table 5, then the ratio of the measured value at each frequency to the limit at that given frequency shown in Column 2, 3, or 4 shall be determined, and the sum of all ratios thus obtained for all frequencies shall not exceed unity when averaged spatially and over time. For field strength measurements, the measured values and the limits shall be squared before determining the ratios. See Section 2.1.1 for more details on calculating the sum.

Table 5
Exposure Limits for Persons Not Classed As RF and Microwave Exposed Workers (Including the General Public)

1 Frequency (MHz)	2 Electric Field Strength; rms (V/m)	3 Magnetic Field Strength; rms (A/m)	4 Power Density (W/m^2)	5 Averaging Time (min)
0.003–1	280	2.19		6
1–10	$280/f$	$2.19/f$		6
10–30	28	$2.19/f$		6
30–300	28	0.073	2*	6
300–1 500	$1.585 f^{0.5}$	$0.0042 f^{0.5}$	$f/150$	6
1 500–15 000	61.4	0.163	10	6
15 000–150 000	61.4	0.163	10	$616\,000/f^{1.2}$
150 000–300 000	$0.158 f^{0.5}$	$4.21 \times 10^{-4} f^{0.5}$	$6.67 \times 10^{-5} f$	$616\,000/f^{1.2}$

* Power density limit is applicable at frequencies greater than 100 MHz.

Notes: 1. Frequency, f, is in MHz.
2. A power density of 10 W/m^2 is equivalent to 1 mW/cm^2.
3. A magnetic field strength of 1 A/m corresponds to 1.257 microtesla (μT) or 12.57 milligauss (mG).

2.2.2 Basic Restrictions – *Specific Absorption Rate* (*SAR*) Limits

SAR, as defined in Appendix VIII, is a measure of the rate at which electromagnetic energy is absorbed into the body. Methods for *SAR* determination are described in Appendix V. At frequencies between 100 kHz and 10 GHz, *SAR* limits take precedence over field strength and power density limits and shall not be exceeded.

The *SAR* should be determined for cases where exposures take place at 20 cm or less from the source. For conditions where *SAR* determination is impractical, field strength or power density measurements shall be carried out. In cases where *SAR* determination is appropriate, the values in Table 6 shall not be exceeded:

Table 6
SAR Limits for Persons Not Classed As RF and Microwave Exposed Workers (Including the General Public)

Condition	*SAR* Limit (W/kg)
The *SAR* averaged over the whole body mass	0.08
The local *SAR* for head, neck and trunk, averaged over any one gram (g) of tissue*	1.6
The *SAR* in the limbs, as averaged over 10 g of tissue*	4

* Defined as a tissue volume in the shape of a cube.

Although not a requirement of the Code, it is suggested that whenever possible, the organ-averaged *SAR* for the eye not exceed 0.2 W/kg. As stated in Appendix VII, this suggestion shall remain until sufficient scientific information is available to accurately assess the health effects of RF exposure on the eye.

Appendix 2:

Measurement Procedure proposed for RF-exposure measurements at Buckhorn Public School compliant to Safety Code 6

Recommended procedure to conduct wi-fi signal field strength measurements at Buckhorn Public School

Date: 2011 09 16
By: Peter Stumpf, P.Eng.

1.0 Assessment Goal:

Conduct electro magnetic field strength measurements in compliance to Safety Code 6.

2.0 Anticipated assessment results:

Results of these measurements will provide a technological understanding of micro-wave exposure levels at Buckhorn Public in compliance to the guideline provided by Safety Code 6

3.0 Requirements:

3.1 Measurement locations:
Every router location: start with router in Grade 1 class room

Minimum measurement locations in Grade 1 class room:

- directly under router, center of isle near class room wall (near field)
- closest bench or chair perpendicular to wall adjacent to router (near field)
- middle of class room (far field)
- other highly frequented location

3.2 Set performance parameters for router type: "Meru AP 300"

Frequency	2.40 GHz	5.15 GHz
Average Antenna Gain	2.2 dBi	3.0 dBi
Average Transmit Power	17 dBm	18 dBm

Ref: http://www.merunetworks.com/ps/accesspoints/ap300.php

3.3 Class room configuration:

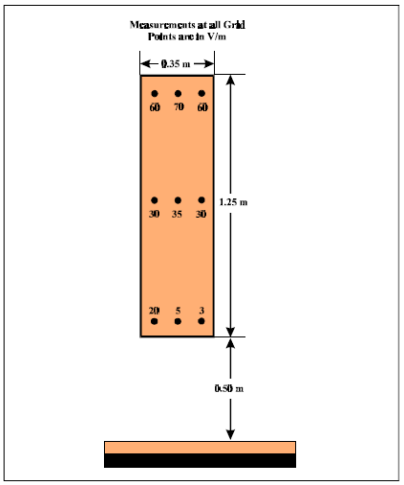
- Install and power-up expected number of lap-tops, PDMs or PCs in each class room during all measurements

3.4 Measurement equipment required:

- One or Three, Extech 480846 RF Electromagnetic Field Strength Meter (supplied by school board): must be calibrated
- Tripod

4.0 Measurement Process:

4.1 Characterize Measurement Field for spatial averaging as described in Appendix A2 of Safety Code 6 (pg. 53) for 9 measurement points per measurement location:



Extract: Safety Code 6

4.2 Conduct time averaging measurements at each measurement point.

The measurement log will entail the following measurement data:

Below example (items 4.2.1 & 4.2.2) show the measurement data log for both frequency ranges at the near field location directly under the router

4.2.1: Measurements Near Field in isle directly below router

F= 2.4GHz

A.Gain = 2.2 dBi

Transmit Power = 17dBm

Msmnt.Point	Elec. Field Strength (V/m)	Magnetic Field Strength (A/m)	Power Density (W/m^2)	Averaging Time
1				6 min
2				6 min
3				6 min
4				6 min
5				6 min
6				6 min
7				6 min
8				6 min
9				6 min

4.2.2: Measurements Near Field in isle directly below router

F= 5.15 GHz

A.Gain = 3.0 dBi

Transmit Power = 18dBm

Msmnt.Point	Elec. Field Strength (V/m)	Magnetic Field Strength (A/m)	Power Density (W/m^2)	Averaging Time
1				6 min
2				6 min
3				6 min
4				6 min
5				6 min
6				6 min
7				6 min
8				6 min
9				6 min

5.0 Final Assessment of results:

The average field strength can then be calculated by use of below equation:

$$F = \frac{1}{\sqrt{n}} \left[\sum_{i=1}^{n} F_i^2 \right]^{1/2} ,$$

6.0 Presentation of measurement results:

Measurement Location	Average Elec. Field Strength (V/m)	Average Magnetic Field Strength (A/m)	Average Power Density (W/m^2)	Safety Code 6 Expose limit: Power Density (W/m^2)
Grade 1 – isle adjacent to router				
Grade 1 - nearest desk				
Grade 1 – center of class room				
Grade 1 – other location				
Next class room				
Location 1				
Location 2				
Location 3				

7.0 **Note**:

I believe that completing requested wi-fi field strength measurements will provide Kawartha Pine Ridge District School Board with true and valuable reference data in compliance to the guideline provided by Safety Code 6.

I believe that results of these measurements will provide the basis for good judgment on the use of wifi routers in Buckhorn Public School.

8.0 References:

- E-mail from Mrs. Shelly Roy from Sept. 08, 2011
- Safety Code 6: Limits to Human Exposure to Radiofrequency Electromagnetic Fields in the Frequency Range from 3kHz to 300 GHz – Safety Code 6, 1999

Appendix 3

MERUN router specifications and installation requirement for Safety Code 6 compliancy.

A3.1 Technical Specifications

Meru AP 300. Specification can be found at this link: http://www.merunetworks.com/ps/accesspoints/ap300.php

AP300 SERIES

MERU NETWORKS

MERU AP300 ACCESS POINT

The AP300 series are Meru's most flexible high-performance access point. Equally at home on the trading floor of a stock exchange as it is in the halls of a hospital, enjoy the benefits of full-speed 802.11n, anywhere, anytime.

DUAL RADIO 802.11N ACCESS POINT

Features and flexibility to overcome virtually any obstacle, Performance to blow past virtually all expectations

PRODUCT OVERVIEW

With the AP300 Series, enterprises and businesses can reap the benefits of 802.11n wireless technology now with 802.11n services option enabled as conditions permit for the ultimate in deployment flexibility.

Ideally suited for bandwidth intensive applications, flexible scalability and high speed data transmissions, the AP300 series allows enterprises and businesses to rely on their wireless networks for mission critical applications.

- Air Traffic Control™ technology provides high performance full-speed 802.11n while supporting legacy a/b/g devices, allowing the WLAN to effectively meet bandwidth demands and support the highest possible wireless client density.
- No complex channel planning when combined with a Meru Controller – enjoy plug-and-play installation for simple deployment.
- Antenna options deliver 3x3 MIMO (Multiple Input, Multiple Output) and up to 300 Mbps data rates.

The AP300 Series Access Point provides the incomparable user experience of Meru's Virtual Cell architecture while delivering speed and reliability.

Product Benefits

- Flexible deployment options – activate 802.11n radios as conditions permit
- Ideal for Meru's 99.99% wireless availability and toll-quality voice service assurance programs
- Plug and Play deployment using centralized Meru Controller
- Powered by a standard 802.3af power source
- Supports all 802.11a/b/g/n devices
- 802.11n support in both 2.4GHz and 5GHz frequency bands using 40MHz channel bonding
- Increase scalability and efficiency with virtualization

| MERUNETWORKS.COM | AP300 SERIES

AP300 TECHNICAL SPECIFICATIONS

APPLICATION SUPPORT AND OVER-THE-AIR QoS

SIP and H.323 support
Dynamic out of the box support for SIP and H.323v1 applications and codecs

QoS
Configurable dynamic QoS rules Over-the-air resource reservation Automatic, stateful flow detectors for SIP, H.323, Cisco SCCP, Spectralink SVP and Vocera
User-configurable static and dynamic QoS rules per application (user-defined) and per user (stations, users, and port numbers) Call Admissions Control and Call Load Balancing
WMM Support

SECURITY

Authentication
Combination of captive portal, 802.1x and open authentication
Advanced security using WPA2
802.1X with EAP-Transport Layer Security (EAP-TLS), Tunneled TLS (EAP-TTLS), Protected EAP (PEAP) MS-CHAPv2, Smartcard/Certificate, Lightweight EAP (LEAP), EAP-FAST and EAP- MD5, with mutual authentication and dynamic, per user, per session unicast and broadcast keys
Secure HTTPS web-customizable Captive Portal utilizing RADIUS

Encryption support
Static and dynamic 40-bit and 128-bit WEP keys, TKIP with MIC, AES

Security Policy
Radius Assisted, Per User and Per ESSID Access control via MAC Filtering
Multiple ESSID/BSSID each with flexibility of separate and shared Security Policy

Rogue Detection and Suppression
All radios capable of scanning 802.11n, 802.11a and 802.11b/g for rogue devices

MOBILITY

Zero-loss Handoffs Infrastructure-controlled zero-loss handoff mechanism for standard Wi-Fi clients

CENTRALIZED MANAGEMENT

Zero-Configuration
Automatically selects power and channel settings
Automatically discovers controllers and download configuration settings
Zero touch, plug and play deployments

System Management
Centralized and remote management and software upgrades via System Director web- based GUI, SNMP, Command-Line Interface (CLI) via serial port, SSH, Telnet, centrally managed via EzRF Management Suite
Centralized Security Policy for WLAN, Multiple ESSIDs and VLANs with their own administrative/security policies

Intelligent RF Management
Coordination of access points with load-balancing for predictable performance
Centralized auto-discovery, auto-channel configuration, and auto-power selection for APs
Co-channel interference management

WIRELESS SPECIFICATIONS

Wireless Standards
IEEE 802.11 a/b/g/n, IEEE 802.11i support (AES, WEP, WPA, WPA2), IEEE 802.11e, WMM

Power Management
Optimal power control in 1 dBm increments
Ability to disable unused radios via software to lower power consumption

Antenna
Standard multiband, omni-directional white antennas (included); Standard Antenna Gain:- 2.2 dBi for 2.4 GHz and 3 dBi for 5 GHz. Antenna gain not included in Average Transmit Power specified. RP-SMA connectors for external antenna options

Client Support
Support for clients that perform active scanning and passive scanning
Support for clients that pre-authenticate
Support for clients that change to and from power save mode rapidly
Power Save Mode for clients in both QoS mode and non-QoS mode

IEEE802.11n (Upgradeable)

Frequency Band
2.402 to 2.485 GHz, 5.15 to 5.25 GHz, 5.725 to 5.825 GHz

Operating Channels
1 through 11 for 2.4 GHz band
32 through 160 for 5 GHz band

Data Rates (Mbps)
20 MHz: 130, 117, 104, 78, 65, 58.5, 54, 52, 48, 39, 36, 26, 24, 19.5, 18, 13, 12, 11, 9, 6.5, 5.5, 2, 1 Mbps
40 MHz: 300, 270, 243, 216, 162, 135, 121.5, 108, 81.5, 81, 54, 48, 40.5, 36, 27.5, 27, 24, 18, 13.5, 12, 11, 9, 6, 5.5, 2, 1 Mbps with automatic rate adaption

Average Transmit Power
2.4n (20 HT): 17 dBm, 2.4n (40 HT): 16 dBm
5.0n (20 HT): 16 dBm, 5.0n (40 HT): 16 dBm

Receive Sensitivity (for max data rates)
11n: -77 dBm, 11n (5 GHz): -72 dBm, 11g: -77 dBm,
11n (2.4 GHz): -74 dBm

IEEE802.11a

Frequency Band
5.180 – 5.240 GHz; 8 Channels (34, 36, 38, 40, 42, 44, 46, 48), 5.260 – 5.320 GHz; 4 Channels (52, 56, 60 and 64), 5.745 -5.825 GHz; 5 Channels (149, 153, 157, 161, and 165), 5500-5700: 11 channels (100, 104, 108, 112, 116, 120, 124, 128, 132, 136, 140)

Operating Channels
Configurable based on country regulations

Data Rates
54, 48, 36, 24, 18, 12, 9 and 6 Mbps with automatic rate adaptation

Average Transmit Power
17 dBm

Receive Sensitivity
-77 dBm at 54 Mbps and -89 dBm at 6 Mbps

IEEE802.11b/g

Frequency Band
Hardware supports 2.40-2.50 GHz 2.4 GHz – 2.4835 GHz (US, Europe), 2.4 GHz – 2.497 GHz (Japan only)

Operating Channels
1-11 US/Canada, 1-13 Europe and 1-14 Japan
3 non-overlapping channels

Average Transmit Power
17 dBm

802.11b Data Rates
11, 5.5, 2 and 1 Mbps with automatic rate adaptation

802.11g Data Rates
54, 48, 36, 24, 18, 12, 11, 9, 6, 5.5, 2, 1 Mbps with automatic rate adaptation

802.11b/g Receive Sensitivity
-73 dBm at 54 Mbps and -84 dBm at 1 Mbps

PHYSICAL SPECIFICATIONS

Dimensions
9.78" width x 6.78" height x 1 1/16" depth
(25 cm width x 17.5 cm height x 2.7 cm depth)

Weight
3lbs 0 oz. (1.36 kgs)

Power
802.3af PoE, 802.3 at 9V DC input
Draws 11.9W to 17W depending on configuration

Environmental
Operating Temperature: 0° to 50° C (32° F to 122° F)
Operating Humidity: 90% (non-condensing)
Storage Temperature: -10° to +70° C ambient
Storage Humidity: 95% (non-condensing)

Interfaces
1 Auto sensing 10/100/1000 Base-TX Ethernet (RJ-45)
Dualband Radios support any combination of 802.11n, 802.11a, 802.11b, 802.11g
3-6 External antenna interfaces (reverse polarity SMA)
Kensington MicroSaver Lock compatible
1 RJ45 console port (reserved for future use)
5 LEDs for monitoring power, Ethernet activity, 802.11 activity and 802.11 receive

Standard Warranty
Limited lifetime warranty

AP300 Series Part Numbers

AP320 Dual radio 802.11a/b/g/n AP, includes six dual band 802.11a/b/g/n omni-directional antennas

AP311 Dual radio 802.11a/b/g/n AP with one a/b/g radio, includes six dual band 802.11a/b/g/n omni-directional antennas*

AP310 Single radio 802.11a/b/g/n AP, includes three dual band 802.11 a/b/g/n omnidirectional antennas

AP302 Dual radio 802.11a/b/g AP with two 802.11a/b/g radios, includes six dual band 802.11a/b/g omnidirectional antennas*

AP301 Single radio 802.11a/b/g AP with one 802.11a/b/g radio, includes three dual band 802.11a/b/g omnidirectional antennas*

* a/b/g radios are software upgradable to a/b/g/n in the future

Certifications

Wi-Fi Certified a/b/g/n

Standards Safety
UL 60950-1
CAN/CSA-C22.2 No. 60950-1
IEC 60950-1

For radio approvals, please contact your local Meru representative for U.S., Canada, Japan, and Europe regulatory codes.

Meru Networks | develops and markets wireless infrastructure solutions that enable the All-Wireless Enterprise. Its industry-leading innovations deliver pervasive, wireless service fidelity for business-critical applications to major Fortune 500 enterprises, universities, healthcare organizations and local, state and federal government agencies. Meru's award-winning Air Traffic Control technology brings the benefits of the cellular world to the wireless LAN environment, and its WLAN System is the only solution on the market that delivers predictable bandwidth and over-the-air quality of service with the reliability, scalability and security necessary to deliver converged voice and data services over a single WLAN infrastructure.

DS_AP300_0311_v6

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For more information about Meru AP300 visit | www.merunetworks.com | Or email your questions to: info@merunetworks.com

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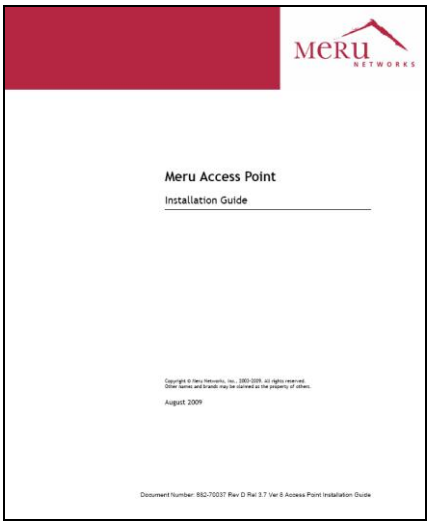
Critical performance parameters of "Meru AP 300" routers

Frequency	2.40 GHz	5.15 GHz
Average Antenna Gain	2.2 dBi	3.0 dBi
Average Transmit Power	17 dBm	18 dBm

A3.2. Extract: Installation Instructions of MREUN Routers

Installation Guide can be found at link:
ftp://ftp.sysob.com/MeruNetworks/documentation/3.7/3.7%20Ver%208%20Access%20Point%20Installation%20Guide.pdf

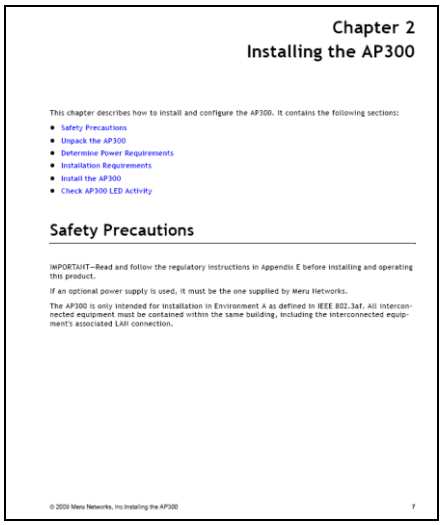


Meru Access Point

Installation Guide

August 2009

Document Number: 882-70037 Rev D Rel 3.7 Ver 8 Access Point Installation Guide



Chapter 2
Installing the AP300

This chapter describes how to install and configure the AP300. It contains the following sections:

- Safety Precautions
- Unpack the AP300
- Determine Power Requirements
- Installation Requirements
- Install the AP300
- Check AP300 LED Activity

Safety Precautions

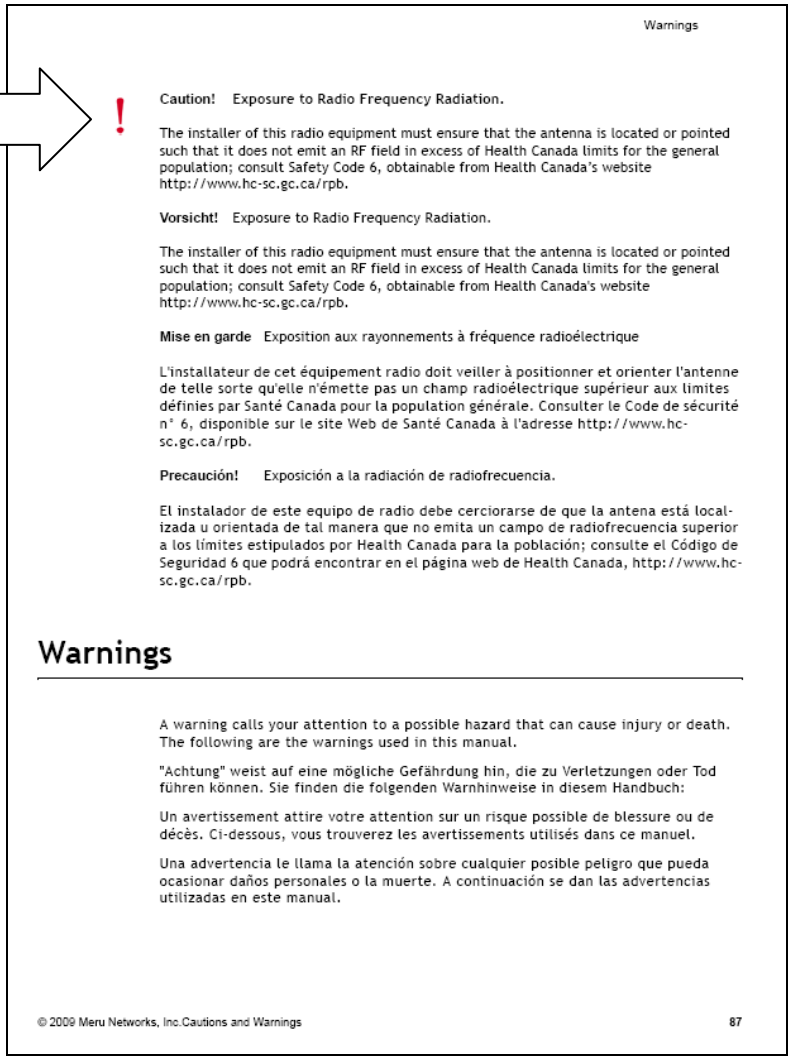
IMPORTANT—Read and follow the regulatory instructions in Appendix E before installing and operating this product.

If an optional power supply is used, it must be the one supplied by Meru Networks.

The AP300 is only intended for installation in Environment A as defined in IEEE 802.3af. All interconnected equipment must be contained within the same building, including the interconnected equipment's associated LAN connection.

© 2009 Meru Networks, Inc.Installing the AP300 7

Fact: Routers of type Meru AP-300 installed in Buckhorn Public School (BPS) require integration in compliancy to Safety Code 6 as instructed in Appendix D of the Installation Guide (pg. 86, Meru Access Point Installation Guide, Document Number: 882-70037 Rev D Rel 3.7 Ver 8).



Warnings

Caution! Exposure to Radio Frequency Radiation.

The installer of this radio equipment must ensure that the antenna is located or pointed such that it does not emit an RF field in excess of Health Canada limits for the general population; consult Safety Code 6, obtainable from Health Canada's website http://www.hc-sc.gc.ca/rpb.

Vorsicht! Exposure to Radio Frequency Radiation.

The installer of this radio equipment must ensure that the antenna is located or pointed such that it does not emit an RF field in excess of Health Canada limits for the general population; consult Safety Code 6, obtainable from Health Canada's website http://www.hc-sc.gc.ca/rpb.

Mise en garde Exposition aux rayonnements à fréquence radioélectrique

L'installateur de cet équipement radio doit veiller à positionner et orienter l'antenne de telle sorte qu'elle n'émette pas un champ radioélectrique supérieur aux limites définies par Santé Canada pour la population générale. Consulter le Code de sécurité n° 6, disponible sur le site Web de Santé Canada à l'adresse http://www.hc-sc.gc.ca/rpb.

Precaución! Exposición a la radiación de radiofrecuencia.

El instalador de este equipo de radio debe cerciorarse de que la antena está localizada u orientada de tal manera que no emita un campo de radiofrecuencia superior a los límites estipulados por Health Canada para la población; consulte el Código de Seguridad 6 que podrá encontrar en el página web de Health Canada, http://www.hc-sc.gc.ca/rpb.

Warnings

A warning calls your attention to a possible hazard that can cause injury or death. The following are the warnings used in this manual.

"Achtung" weist auf eine mögliche Gefährdung hin, die zu Verletzungen oder Tod führen können. Sie finden die folgenden Warnhinweise in diesem Handbuch:

Un avertissement attire votre attention sur un risque possible de blessure ou de décès. Ci-dessous, vous trouverez les avertissements utilisés dans ce manuel.

Una advertencia le llama la atención sobre cualquier posible peligro que pueda ocasionar daños personales o la muerte. A continuación se dan las advertencias utilizadas en este manual.

© 2009 Meru Networks, Inc.Cautions and Warnings 87

Appendix 4:

Key Correspondence

1. Correspondence to Kawartha Pine Ridge District School Board

From: changescape@sympatico.ca
To: rusty_hick@kprdsb.ca ; Rosana Pellizzari ; ray.copes@oahpp.ca ; Greg Kidd ; ronald_plazier@kprdsb.ca ; John Lawrence ; Jodi Whetung ; vyoung@etfo.org ; president@kpretfo.ca ; contact@kpretfo.ca ; changescape@sympatico.ca
Sent: Tuesday, February 21, 2012 7:24 PM
Subject: Follow Up: Request for help on wifi field study in reference to the PCCHU Bo

Hello Mr. Hick:

Thank you for your reply.

I can not agree that the RF-exposure measurement procedure specified in Safety Code 6 excludes or exempts the school environment.

Facts are:

* Section 2.2 (pg. 18) of Safety Code 6 *"Exposure of Persons Not Classed as RF and Microwave Exposed Workers (including the General Public)" clearly specifies in items 2.2.1 a. under heading "Field Strength Limits"* that the spatial averaging technique is to be completed over the projected area of the human body in addition to time averaging field strength measurements.
For further details, refer to the attached copy on Safety Code 6.

* The Canadian Medical Association Journal published on the issue of "Limiting wifi in schools".
Extract from this publication: *"The use of devices that emit nonionizing electromagnetic radiation such as cell phones and WiFi networks in schools should be limited because they constitute a workplace hazard, according to the Ontario Catholic Teachers Association."*
For further details on CMAJ's publication refer to CMAJ's web-site at: http://www.cmaj.ca/site/earlyreleases/briefly.xhtml

Next steps:

*** I am asking Dr. Pellizzari and Dr. Copes if the Peterborough County Board of Health professionally exempts the Kawartha Pine Ridge District School Board from the responsibility to conduct RF-exposure measurements in compliancy to Safety Code 6.**

*** The parent council of Buckhorn Public School has asked for an accredited third party to conduct RF-exposure measurements in compliancy to Safety Code 6.**
I am asking Dave Wing and Valence Young if ETFO's health and safety committee, on behalf of affected teachers, accepts that RF-exposure measurements are "not" conducted in compliancy to Safety Code 6.

Sincerely, Peter Stumpf, P.Eng.

From: Rusty Hick
To: changescape@sympatico.ca
Cc: rpellizzari@pcchu.ca ; ray.copes@oahpp.ca ; Greg Kidd ; Ronald Plaizier ; John Lawrence ; Jodi Whetung
Sent: Tuesday, February 21, 2012 5:16 PM
Subject: Re: Follow Up: Request for help on wi-fi field study in reference to the PCCHU Bo

Dear Mr. Stumpf:
Thank you for your e-mail concerning the monitoring of WiFi in our schools. We want to assure you that safety is and always will be our first priority as a school board.
As you can understand, in areas of public health we rely on the guidance and direction established by experts in the field. In this case, Health Canada, the World Health Organization, and provincial health authorities have all concluded that the use of wireless technology does not pose a public health risk.
Although the detailed procedures that you have developed are comprehensive in nature, that type of monitoring is more appropriate in an industrial worksite or setting that uses high powered radio transmitting equipment or medical equipment that emits high density electromagnetic frequency levels. The regimen that you suggest would require hours of monitoring in every classroom in every school in our jurisdiction.

The equipment we are using in our schools is the same as that used in hospitals, libraries and homes around the world. The main purpose for our monitoring is to give the public that extra level of comfort knowing that our schools are safe. All the technology that we acquire must conform to the following:

Federal Communications Commission (FCC); Information technology equipment safety (60950-1) from Underwriters Laboratories (UL), Canadian Standards Association (CAN/CSA-C22.2) and Commission Electrotechnique Internationale (IEC) as well as Health Canada Safety Code 6

Electronics Manufacturers are not able to design develop or sell technology that exceeds these safety codes in Canada. This makes it extremely unlikely that we will come across any anomaly in our readings due to our equipment. The monitoring we have conducted in our schools gives us the added confidence that our technology is operating well below the Safety Code 6 limits established by Health Canada. Should we encounter any school site that produces an anomalous reading, even if it is still below the legislated safety standards, we would certainly conduct a more detailed and thorough analysis to determine the source. At this time none of the readings we've measured has given us any cause for concern.

Furthermore, we would like to assure you in your concern that the routers installed in Buckhorn Public School are integrated in compliance to Safety Code 6 as instructed in Appendix D of the Installation Guide. Our procedures and processes for monitoring demonstrate that the technology we are using in our schools is operating well within the Safety Code 6 limit and are accepted by respected authorities.

Once again we thank you for sharing your technical expertise in this matter and please be assured that we share your concerns for student and staff safety in our schools.

Sincerely,

W. R. (Rusty) Hick
Director of Education
Kawartha Pine Ridge District School Board
1-877 741-4577, extension 2005
Fax: 705 741-0839

From: Rosana Pellizzari
To: Rusty Hick
Cc: changescape@sympatico.ca
Sent: Wednesday, December 21, 2011 10:08 AM
Subject: FW: Follow up: Action on wi-fi field studies from PCCHU Board of Health Meeting, Nov. 9/11

Dear Mr. Hicks,
You may be aware that the Board of Health has asked for a report on the safety of wireless technologies. Health Unit staff is currently undertaking an assessment of background radiofrequency exposures through-out the city of Peterborough and will be making that available as soon as it is completed, sometime in the new year. As part of our investigations, we invited Dr. Ray Copes, Director of Occupational and Environmental Health at Public Health Ontario, to provide an update on the evidence for the Board of Health's November meeting.

Mr. Peter Stumpf, who I have copied on this email, made a deputation to the Board of Health that evening. He is a parent of four children and is concerned about the RF measurements at Buckhorn Public School. He shared his desire that the Board of Education hire an accredited third party to conduct the assessment of RF exposures at the school with Dr. Copes and the Board of Health. Dr. Copes agreed that this request was reasonable and should be considered.

In follow-up to those remarks, I have agreed to make you aware of both Mr. Stumpf's concerns and his request for a third party assessment. I am attaching his deputation to the Board of Health and his proposed procedure.

I encourage you to communicate your response and any interest that you may have in his proposal directly to Mr. Stumpf.

Thank you for considering this request from a concerned parent.

Rosana Pellizzari, MD, CCFP, MSC, FRCPC
Medical Officer of Health,
Peterborough County-City Health Unit

----- Original Message -----
From: Shelly Roy
To: changescape@sympatico.ca
Cc: Ronald Plaizier ; Jodi Whetung ; Greg Kidd ; Catherine Foy
Sent: Wednesday, September 07, 2011 7:28 PM
Subject: Re: FW: Measurements of wifi signal strenght at Buckhorn public

<changescape@sympatico.ca> writes:
Hello Shelly:

Jodi Whetung asked me to send you my previous request - see below e-mail from Aug. 31st.

Could you please provide me with answers to the below questions which focus merely on the technical details of how the measurements are conducted and how the results are calculated.

I have thoroughly read the board's publication on the web. This information does not present the engineering data I am looking for.

Would it be at all possible to meet with you and Ronald Plazier in order to discuss respective details.

Thank you, Peter Stumpf P.Eng.

----- Original Message -----
From: changescape@sympatico.ca
To: ronald_plazier@kprdsb.ca
Cc: Jodi Whetung ; peterstumpf@bell.net
Sent: Wednesday, August 31, 2011 10:04 PM
Subject: Measurements of wifi signal strenght at Buckhorn public

Hello Ronald:

Jodi Whetung provided me with your contact information in regards to measuring wifi signal strength at Buckhorn Public School.

I am very interested in finding out how these measurements will be conducted and respective results of the measurements.

Would you please provide us with answers to below items:

1. Conduct field measurements as outlined in the Canada Health guideline for Safety Code 6
* Conduct background filed measurement with wifi routers deactivated
* Conduct background filed measurement with all wifi routers activated
* Conduct measurement with one, two or three devices running in wifi mode (devices can be lap-top, PC or I-pods)

2. Measure in direct proximity of the device in wifi mode (devices can be lap-top, PC or I-pods)
* Measure in realistic proximity around the device (ie in a 10cm, 20cm or 50cm radius around device)

3. Advise on frequency range and peak frequency measured for items 1 & 2

4. Advise on minimum and maximum (peak) signal strength measurements

5. Advise on averaged signal strength level

6. Advise on how many routers are installed
Advise how many routers are activated during measurements

7. Advise on type and make of routers

8. Advise on type, make and calibration norm of measurement device

9. Advise if you measure magnetic field strength, electric field strength or power density

Thank you for your help!

Best regards, Peter Stumpf

Hello Mr. Stumpf:

Thank you for your patience while we compiled this information requested. Attached below is the information to your questions from Ron Plazier. As you can see much of this infomation can be found on our public website.

Most of the information being requested can be found on our public web site at
http://www.kprschools.ca/Spotlight/spotlight_2.html
or was provided in previous e-mails but I'll endeavor to compile it all here again.

Would you please provide us with answers to below items:

1. Conduct field measurements as outlined in the Canada Health guideline for Safety Code 6
* Conduct background filed measurement with wifi routers deactivated
* Conduct background filed measurement with all wifi routers activated
* Conduct measurement with one, two or three devices running in wifi mode (devices can be lap-top, PC or I-pods)

We do conduct field measurements as outlined in Health Canada's Safety Code 6
We have conducted pre-implementation readings at all schools (prior to WiFi being installed) to collect base line readings and make observations of any other potential sources of EMF such as neighbouring Wifi or Cell tower signals.
Post implementation readings (with Wifi activated) are underway at all schools but with only one technician dedicated to this task serving 90+ locations this all takes a fair bit of time. These post implementation readings also involve taking readings at locations where we see a concentration of mobile devices, perhaps a in a computer lab or mobile netbook cart if possible as well as readings from a typical or average classroom and Staff room

2. Measure in direct proximity of the device in wifi mode (devices can be lap-top, PC or I-pods)
* Measure in realistic proximity around the device (ie in a 10cm, 20cm or 50cm radius around device)

We have done this and continue to do so

3. Advise on frequency range and peak frequency measured for items 1 & 2

The equipment used in our Schools is Meru AP 300 and supports both 2.4 ghz and 5ghz frequencies.The WiFi technology used in KPR Schools operates on similar frequencies and is subject to the same safety standards as the technology presently used in many homes, public libraries and hospitals

4. Advise on minimum and maximum (peak) signal strength measurements

Signal strength readings (pre and post implementation as well as annual) are recorded on the boards website for all schools. We measure maximum signal strengths only.
http://www.kprschools.ca/EMF/index.asp

For Buckhorn P.S.

Electromagnetic Field Readings:

Important Note: The limit set by Health Canada in Safety Code 6 is 10.0 W/m².

Most Recent Reading - September-01-11	
CheckPoint	**Reading (W/m²)**
"average" class room (rm 102)	0.000
BHP-AP1 / kindergarten rm 104	0.006
BHP-AP2 / library	0.001
BHP-AP3	0.002
BHP-AP4	0.001
computer lab	0.001
staff rm	0.000

Previous Reading - August-08-11	
CheckPoint	**Reading (W/m²)**
"average" class room (rm 102)	0.000
BHP-AP1 / kindergarten rm 104	0.000
BHP-AP2 / library	0.000
BHP-AP3	0.000
BHP-AP4	0.000
computer lab	0.000
staff rm	0.000

5. Advise on averaged signal strength level

We don't record averaged signal strength. We record maximum peak signal strength

6. Advise on how many routers are installed

There are 4 Access Points installed at Buckhorn P.S.

Advise how many routers are activated during measurements

All 4 are active.

7. Advise on type and make of routers

Meru AP 300. Specification can be found at this link:
http://www.merunetworks.com/ps/accesspoints/ap300.php

8. Advise on type, make and calibration norm of measurement device

Extech 480846. Specifications can be found at this link:
http://www.extech.com/instruments/product.asp?catid=57&prodid=594

9. Advise if you measure magnetic field strength, electric field strength or power density

We measure power density.

As a board we recognize your concerns and we will continue to monitor the Wifi at each of our school sites. I have taken the liberty of copying the information from our website so that you will have this information at your disposal.

We will continue to provide further information and updates throughout the year.

Sincerely

Shelly Roy

» Wireless Facts and Monitoring

Statement From the Medical Officer of Health Regarding WiFi Safety (PDF, 817 KB)

Backgrounder - Safety of Wireless Technology in Schools (PDF, 57 KB)

Online Statement From Dr. King (PDF, 298 KB)

Wireless Technology - A Review of the Science (Power Point, 776 KB)

Public Health Risk of Wi-Fi Extremely Low (PDF, 66 KB)

Letter to the Editor - The Peterborough Examiner (PDF, 12 KB)

INSTRUCTIONAL TECHNOLOGY PLAN

KPR Instructional Technology Plan (PDF, 1MB)

Implementation Update - Feb. 2011 (PDF 127KB)

PUBLIC INFORMATION SESSION
Wireless Technology in Schools

Shelly Roy
Superintendent of Education - Student Achievement
Kawartha Pine Ridge District School Board
1994 Fisher Drive, P.O. Box 7190
Peterborough, On K9J 7A1
Tel: (705) 742-9773 Ext 2173
Toll free: 1- 877- 741-4577
Email: shelly_roy@kprdsb.ca

2. Correspondence to Environmental and Occupational Health, Public Health Ontario

----- Original Message -----
From: Ray Copes
To: changescape@sympatico.ca ; rpellizzari@pcchu.ca
Cc: rusty_hick@kprdsb.ca
Sent: Thursday, February 02, 2012 6:01 AM
Subject: RE: Follow Up: Request for help on wi-fi field study in reference to the PCCHU Board of Health Meeting, Nov. 9/11

Peter,

Yes, I agree with your assessment and yes, we do have a Narda SRM-3006.

As a point of minor embarrassment, we have had a technical problem with the instrument and it was returned to the factory for repairs under warranty. I've been informed that we can expect its return next month.

I know of one outstanding request from another health unit to borrow it but I believe they have requested it for April.

We will, of course, endeavour to meet any requests from other health units for loan of the instrument.

Ray.

Ray Copes, MD, MSc
Scientific Director, Environmental and Occupational Health
Public Health Ontario
Associate Professor, University of Toronto
480 University Avenue, Ste 300
Toronto, Ontario
M5G 1V2

Off 647-260-7491
fax 647-260-7600
ray.copes@oahpp.ca
www.oahpp.ca

From: changescape@sympatico.ca [mailto:changescape@sympatico.ca]
Sent: February-01-12 12:31 PM
To: rpellizzari@pcchu.ca; Ray Copes
Cc: rusty_hick@kprdsb.ca; changescape@sympatico.ca
Subject: Follow Up: Request for help on wi-fi field study in reference to the PCCHU Board of Health Meeting, Nov. 9/11

Hello Dr. Pellizzari and Dr. Copes:

Thank you for considering my request and following up with yesterday's e-mails.

Could you please verify that the Narda selective radiation meter mentioned in Dr. Copes' e-mail is capable of measuring RF-exposure levels at 2GHz-6GHz range due to the fact that the routers installed at Buckhorn Public School currently work at both frequencies 2.4GHz and 5.15Gz based on below table.
For this frequency range, I believe only the Narda SRM-3006, 9kHz-6GHz selective radiation meter is capable for a field study.

Table 1: Performance Parameters of "Meru AP 300" routers

Frequency	2.40 GHz	5.15 GHz
Average Antenna Gain	2.2 dBi	3.0 dBi
Average Transmit Power	17 dBm	18 dBm

Ref: http://www.merunetworks.com/ps/accesspoints/ap300.php

Please advise if you have any questions or if you require further information.

Regards, Peter Stumpf, P.Eng.

From: rpellizzari@pcchu.ca
To: Ray.Copes@oahpp.ca; changescape@sympatico.ca
CC: rusty_hick@kprdsb.ca
Date: Tue, 31 Jan 2012 08:51:34 -0500
Subject: RE: Request for help on wi-fi field study in reference to the PCCHU Board of Health Meeting, Nov. 9/11

Thanks Ray – Rusty and I were just chatting about this yesterday morning. I will forward this message to Donna Churipuy, our Health Hazards Manager to see if she thinks we would have the ability and capacity to do the measurements at Buckhorn School for the Board of Ed.
Rusty, you can follow up with us.

Rosana Pellizzari, MD, CCFP, MSC, FRCPC
Medical Officer of Health,
Peterborough County-City Health Unit

From: Ray Copes [mailto:Ray.Copes@oahpp.ca]
Sent: Monday, January 30, 2012 6:52 PM
To: changescape@sympatico.ca; Rosana Pellizzari
Cc: rusty_hick@kprdsb.ca
Subject: RE: Request for help on wi-fi field study in reference to the PCCHU Board of Health Meeting, Nov. 9/11

Peter,

Thank you for your note.

My comments on this issue are expressed well in Dr. Pellizzari's December 21 e-mail to Mr. Hick.

I hope you will receive a response from the Kawartha Pine Ridge District School Board advising you whether they see merit in this field study and whether they plan to proceed.

Rosana, as I understand it, the decision on whether to proceed with these measurements and the responsibility for performing them rest with the Kawartha Pine Ridge District School Board.

However, as you know, we did purchase the Narda selective radiation meter to lend to health units for use when they wished to conduct RF assessments. While I do not wish to interfere in a local decision, if borrowing our instrument would be helpful to you in resolving this matter please let me know.

Ray.

Ray Copes, MD, MSc
Scientific Director, Environmental and Occupational Health
Public Health Ontario | Sant? publique Ontario
Associate Professor, University of Toronto
480 University Avenue, Suite 300 | 480, avenue Universit?, bureau 300
Toronto, ON M5G 1V2
t: 647 260 7491 f: 647 260 7600 e: *ray.copes@oahpp.ca*

From: changescape@sympatico.ca [mailto:changescape@sympatico.ca]
Sent: January-29-12 7:21 PM
To: Ray Copes
Cc: EOH; Rosana Pellizzari; rusty_hick@kprdsb.ca
Subject: Request for help on wi-fi field study in reference to the PCCHU Board of Health Meeting, Nov. 9/11

Dear Dr. Copes:

Having had the pleasure and opportunity of meeting with you during the Board of Health's November 2011 meeting, I would like to ask you for your direct help on the following matter:

I am asking for your direct support and assistance in urging the Kawartha Pine Ridge District School Board (KPRDSB) to perform RF-exposure measurements in local schools by an accredited third party. Please note below e-mail from Dr.Pellizzari to Mr. Rusty Hick issuing same request on my behalf. To date there has been no response from Mr Hick or the school board.

The basis of my concern is that the Kawartha Pine Ridge District School Board (KPRDSB) has not followed the measurement requirements for RF-exposure levels as described in Safety Code 6 which KPRDSB documented to me.
* My concern is substantiated by the fact that the routers of type Meru AP-300 installed in Buckhorn Public School (BPS) require integration in compliancy to Safety Code 6 as instructed in Appendix D of the Installation Guide (pg. 86, Meru Access Point Installation Guide, Document Number: 882-70037 Rev D Rel 3.7 Ver 8).
* I want to ensure that field studies are performed compliant to Safety Code 6.

As you have seen from my presentation during the Board of Health meeting (see attached reference), I am specifically interested in the results of a compliant field study at Buckhorn Public School (BSP). As part of my commitment to volunteer with completing such as filed study at BSP as requested by the parent council, I issued the attached RF-measurement process guideline which should create awareness on respective measurement requirements. To date, KPRDSB has rejected to perform RF-exposure measurements in compliancy to Safety Code 6.

Thank you for your assistance in this matter!

Sincerely, Peter Stumpf, P.Eng.

----- Original Message -----
From: Rosana Pellizzari
To: Rusty Hick
Cc: changescape@sympatico.ca
Sent: Wednesday, December 21, 2011 10:08 AM
Subject: FW: Follow up: Action on wi-fi field studies from PCCHU Board of Health Meeting, Nov. 9/11

Dear Mr. Hicks,
You may be aware that the Board of Health has asked for a report on the safety of wireless technologies. Health Unit staff is currently undertaking an assessment of background radiofrequency exposures through-out the city of Peterborough and will be making that available as soon as it is completed, sometime in the new year. As part of our investigations, we invited Dr. Ray Copes, Director of Occupational and Environmental Health at Public Health Ontario, to provide an update on the evidence for the Board of Health's November meeting.

Mr. Peter Stumpf, who I have copied on this email, made a deputation to the Board of Health that evening. He is a parent of four children and is concerned about the RF measurements at Buckhorn Public School. He shared his desire that the Board of Education hire an accredited third party to conduct the assessment of RF exposures at the school with Dr. Copes and the Board of Health. Dr. Copes agreed that this request was reasonable and should be considered.

In follow-up to those remarks, I have agreed to make you aware of both Mr. Stumpf's concerns and his request for a third party assessment. I am attaching his deputation to the Board of Health and his proposed procedure.

I encourage you to communicate your response and any interest that you may have in his proposal directly to Mr. Stumpf.

Thank you for considering this request from a concerned parent.

Rosana Pellizzari, MD, CCFP, MSC, FRCPC
Medical Officer of Health,
Peterborough County-City Health Unit

March 13, 2012

Dear Chairman Sharpe and Board of Health Members:

At the February 8, 2012 Board of Health meeting, KSTI member Kathy McDermid presented new information from a January KSTI newsletter, on microwave radiation levels in KPR classrooms. In light of the compelling nature of information within this newsletter, the Board moved to question the KPR School Board on why it chose to use wireless technology versus continuing with existing hard-wired connections. We wish to address the KPR Board's response, dated March 5, 2012, as in our view, it contains some inaccuracies.

We also wish to address a letter that was sent out from the Peterborough County City Health Unit, written by a Public Health Inspector, to various members of the community, assuring them of the safety of wireless technology.

Our overall concern relates to the importance of accurate information coming from what are considered to be highly influential and trusted sources of public information in our community: our Public Health Unit and our Board of Education.

1. Letter from Health Unit:

a) The letter referred to above states:
"Exposure to RF from Wi-Fi represents only a small proportion of a person's exposure to RF. Research indicates that exposure to RFs from Wi-Fi is very low - 1000 times or more below exposure guidelines in Safety Code 6."

When a student is exposed to wi-fi radiation for 6 hours per day, this represents one quarter of their day. In a school year this represents approximately 15% of their exposure, multiplied by 14 years of schooling. This is not a small proportion or duration of exposure to RF, particularly for developing youngsters. This 15% is at levels which are likely much higher than any other RF exposures they might receive additionally within the course of their day simply due to the fact that our schools use commercial grade Wi-Fi. Further, those levels will *increase* as additional devices (laptops, ipods etc) connect to the internet via Wi-Fi. Our schools present a unique and disturbing scenario with respect to uncontrolled exposure. Considering the fact that one school in Simcoe County was recorded as having a level at a laptop that *exceeded* Safety Code 6 (**http://www.safeschool.ca/Unsafe_Levels_at_School.html**), on any given day, how many other laptops might be doing the same?

As for the levels of exposure, it is not accurate to say that Wi-Fi is 1000 times or more below Safety Code 6. When one compares a classroom ambient level reading of 0.038 W/m2 (Wi-Fi on, no laptops streaming) to the Safety Code 6 limit of 10 W/m2, 0.038 W/m2 is only 263 times lower than Safety Code 6 – not "1000 times or more below exposure guidelines". When considering levels taken at laptops accessing Wi-Fi, at 0.18 W/m2, this is only 55 times below Safety Code 6.

These Public Health statements should be amended for the benefit of the public.

b) The second item in the letter to bring to your attention is the following:
" The RF band is a band of non-ionizing radiation that ranges from 3 kilohertz to 300,000 megahertz and lacks sufficient energy to break chemical bonds."

While Health Canada continues to make this statement, Industry Canada acknowledges there are studies which show that non-ionizing radiation does have sufficient energy to break chemical bonds. What Industry Canada also says, however, is that the 'weight of evidence' does not show that this happens in the majority of cases. http://www.ic.gc.ca/eic/site/smt-gst.nsf/eng/sf08792.html

Quote from Industry Canada*: "The biological effects from laboratory studies reported in scientific peer-reviewed literature include those related to changes in temperature, blood brain barrier, melatonin, calcium efflux, DNA damage and gene expression. However, not all these biological effects have been established or are considered to be health effects. For example, blood brain barrier and melatonin effects have not been consistently replicated. Studies on DNA strand breaks have also failed numerous independent attempts at confirmation and calcium efflux changes are considered to be more of a biological response than an adverse health effect. Several laboratory studies have looked into whether RF energy can initiate and promote cancer. The overwhelming majority of these studies have found no evidence that RF energy damages DNA or that it is likely to act as an initiator or a promoter of carcinogenesis."*

As one can see, Industry Canada accepts that these changes have been documented in studies, yet due to the adoption of the 'weight of evidence' approach, Health Canada is not recognizing these studies. This is inconsistent, and therefore misleading to the public. Is it not in the best interests of the public for our local Health Unit to acknowledge that while they may not form the majority, there *are* studies that exist which demonstrate RF has sufficient energy to break chemical bonds? We would suggest statements like the one above, should not be so conclusively made by a public Health authority, which is responsible for disseminating accurate information to the public.

c) The final concern regarding this letter that has gone out to the community, deals with the Health Unit's denial that Wi-Fi is a Class 2b Possible Carcinogen. The letter states:
"There has been some confusion related to the classification by the International Agency for Research on Cancer (IARC) of cellular phone use as a possible carcinogen. The IARC did not make this classification for wireless devices like Wi-Fi which are of much lower power densities."

This statement is simply not true. Attached you will find a document authored by Dr. Henry Baan, from the IARC Monographs, in which he specifically states that Wi-Fi is included in the Class 2b Possible Carcinogen category. Here too is a link to a statement by Dr. Jonathan Samet, Chair of the IARC working group who made this recommendation. Dr. Samet states "The designation of group 2b is radio frequency electromagnetic fields, that is unspecified as to source so the group 2b classification would have broad applicability to sources with this type of emissions." http://www.youtube.com/watch?v=s4E2i5XFX9M

The above statement by the Health Unit should amended to make it clear to the public that Wi-Fi is included in the Class 2B classification by IARC.

2. KPR Board Letter dated March 5, 2012

The second piece of correspondence we wish to address is the response the Board of Health received from the Kawartha Pine Ridge District School Board.

a) The Board of Health members asked the KPR Board to explain why they needed Wi-Fi in their schools. Mr. Hick, Director of Education, and Ms. Lloyd, Chairperson of the Board of Trustees have provided you with a response. The KPR Board's defense of wireless technology is summarized in these paragraphs of their letter:

"In practical terms, WiFi enables a teacher to roll in a cart of netbooks and distribute them around the class without having 24 ethernet cables running from the cart to the student desks. This mobility allows students to move around the classroom, the school, and work in various groups again without cables strewn across the floor. WiFi also allows the teacher and their laptop to roam freely around the classroom. Last, but not least, WiFi allows students to bring in their own technology (laptops, netbooks, iPods, etc.) and connect to the internet without using cables. In fact many of the new, smaller portable devices do not even have ethernet ports on them and the only way they can connect to the internet is through WiFi or 3G data networking.

This anywhere/anytime access to the global world is a key tool in not just consuming information – but creating knowledge.

It is also important to note that wireless technology is an indispensable component of assisted technology devices that support some of our most vulnerable and medically fragile students."

In response to this "practical" use of Wi-Fi, KSTI would point out to the Board of Health, if it is not already quite apparent, that the overwhelming reason for Wi-Fi in schools is *convenience*. With Wi-Fi, teachers and students can roll in netbook carts and move around with their laptops without having to walk over, or be attached to, ethernet cables.

A secondary reason is that, by allowing students to bring in their own technology, the Board's own costs are reduced. And finally, it is suggested that Wi-Fi supports medically fragile students using assisted technology devices.

We wish to point out the following:

FACT: If the KPR Board is concerned about student/teacher mobility and cables strewn on the floor, they could research what is being done in countries like France and Switzerland, or even in schools in Canada, which have banned Wi-Fi, to see how the mobility and cable 'problems' are being dealt with. This would not appear to be a major hurdle to overcome.

FACT: Netbook carts, which have already been purchased (average 2 per school), can be equipped with their own wi-fi routers, which are much less powerful than the commercial grade routers that have been installed. These netbook cart wi-fi routers can be turned on when needed for the laptops and turned off when not in use. Considering the total number of classrooms in most schools, we project that an average of 2 hours per classroom per week is a realistic usage of this technology. While the KPR Board did not order this router option for all of the carts, it is a

relatively inexpensive addition that can still be made. Thus, the need for pervasive wi-fi becomes moot.

FACT: Accessing the internet for educational purposes can be done with the netbooks and netbook cart Wi-Fi. The purpose of bringing in student-owned technology needs to be questioned. What exactly is its educational value, when of the 16,000 unique internet hits in January, 15,000 of those came from personal devices? How much time will students (especially primary, junior, and intermediate) be accessing the internet for educational purposes during the instructional day?
Finally, as discussed on a recent CBC documentary about 'sexting', the students in this video discuss that, by schools having Wi-Fi fully accessible, cyberbullying is becoming rampant. Kids immediately post things on facebook and other social media websites in wi-fi equipped schools. Also, they note, that this constant access to the internet at school has allowed students constant access to pornography (**http://www.cbc.ca/video/#/Shows/1221254309/ID=2201416792**). So, the question must be asked, should the School Board provide the Wi-Fi 'anytime/anywhere' access to the internet if it enables students to more easily bully and access pornography? Would not a better alternative be to provide Wi-Fi only in classroom locations where teachers are able to properly supervise their students and where they are able to turn it off when not in use? While some of this discussion is unrelated to the public health mandate, what this Board should be concerned about is the public health consequences of bullying and the sexualization of our youth, as furthered by the introduction of Wi-Fi and student-owned technology in our schools.

FACT: The KPR Board says that Wi-Fi is necessary for "vulnerable and medically fragile students". This is a misleading statement. Most – if not all – computer programs needed by these students are software-based, and have no need for Wi-Fi. For some apps, such as Voice It, the data can be downloaded and then the app can be used in the school. It does not need to be connected to the internet. For the few rare cases where a specific student absolutely must have access to Wi-Fi, then this student could be accommodated by having a home-style router in proximity to the student's workspace. This would eliminate the need to expose all students in all schools across the board.

Additional statements in the letter from KPR were also made which require clarification.

b) Mr. Hick and Ms. Lloyd make the statement that AM / FM radio signals and cell phone signals are already in our community. Please note that AM / FM radio signals are not microwave signals, and, in fact, are much lower than emissions from many of the KPR routers, known as wireless access points (WAPs). As for cell phone emissions, Health Canada has recently issued warnings cautioning users under 18 to limit or restrict their use of cell phones due to increased risk of cancer.

c) Mr. Hick and Ms. Lloyd state that the World Health Organization does not feel that wireless emissions pose a public health risk. While this may be the case, the WHO does classify RF emissions (Wi-Fi) as a Class 2b Possible Carcinogen. Considering the duration, proximity, and intensity of exposure to these commercial grade routers in the KPR schools, this classification needs to be taken seriously.

d) It was also pointed out that the Peterborough Victoria Northumberland and Clarington Catholic District School board has had Wi-Fi routers in classrooms since 2006. While this is correct, what is not mentioned is that these routers were much lower in transmitting power than the current KPR WAPs. In fact, it was only last year that the PVNCCDSB changed over to the commercial grade WAPs also used by KPR.

e) Finally, their letter states that KPR uses the same technology that people have in their homes and that Wi-Fi is commonplace in cafes, libraries, universities, and hospitals, including the Hospital for Sick Children.

It should be noted that the Wi-Fi routers one can purchase for home use are less powerful than the commercial grade wireless access points (WAPs) both Boards of Education have purchased for their schools. This is due to their layered, channel technology and numerous multiple antennas, which in combination, maximize power output, well beyond that of home-style routers.

Also, while Wi-Fi may be commonplace, the public is not forced to stay in cafes, libraries, etc for prolonged periods in the way schoolchildren and teachers are at schools. There are also significant differences in the levels of exposure one would encounter in these places. Our tester has done a variety of measures in these locations, and the results may be surprising:

Location	Maximum Level RF Radiation Recorded	**# Times lower than Safety Code 6**
Starbucks	0.0008 W/m2	12,500 times lower
Toronto General Hospital	0.0008 W/m2	12,500 times lower
Trent University	0.0038 W/m2	2,631 times lower
Peterborough Library	0.0060 W/m2	1,666 times lower
Hospital for Sick Kids	0.0068 W/m2	1,470 times lower
KPR Recorded Measure	0.0410 W/m2	243 times lower
KPR WAP* (when measured as close to WAP as HSK)	0.1715 W/m2	58 times lower
One Laptop in KPR School	0.1800 W/m2	55 times lower
Ipod in KPR School	0.4385 W/m2	22 times lower

Similarly, if the KPR Board were to substitute pervasive Wi-Fi with the 'WAP on netbook carts' option, where students and teachers were directly exposed for a maximum of 2 hours per day, the cumulative impacts of exposure would reduce dramatically over time:

***Note:** Approximate calculation is based on 2 netbook carts being shared by all classes in a school.	Cumulative Exposure **Current Pervasive Wi-Fi Model** (Commercial Grade WAP) in hours	Cumulative Exposure **Proposed WAP on Netbook Cart** (Home-Style Router with on/off switch) in hours
Daily	6	0.4
Weekly	30	2
Monthly	120	8
Yearly	1164	77.6
*14 years of school	16 296	1086.4

3. Conclusion

In closing, we wish to emphasize the leadership role that the Board of Health, our Medical Officer of Health and our public Health Unit play as stewards of public health policy in our community. Given that the primary mission of the Peterborough County City Health Unit is to promote and protect health, the communication of complete, accurate information to citizens, businesses, and publicly run institutions is essential in the accomplishment of this mission.

In regards to wireless technology, we would like to ensure that the Peterborough County City Health Unit communicates factual information to both the KPR Board and the citizens it has been entrusted to protect. It is imperative that the PCCHU publicly acknowledges that Wi-Fi is considered to be a Class 2b Possible Carcinogen. In the case of Wi-Fi in schools, we ask the Board of Health to acknowledge that biological effects are known to occur from RF exposure.

Regarding KPR's March 5, 2012 letter, we would reiterate that your request to KPR was motivated by a delegation informing you that the radiation levels found in KPR schools with pervasive Wi-Fi exceeded Toronto's Prudent Avoidance Policy, and were bound to increase with additional computer use. Clearly there was enough concern at the time to question the decision in light of potential public health risk. KPR has now conveyed to you that their reasoning is, by and large, convenience-based. In their response, KPR did not address the Toronto Prudent Avoidance Policy standard, which applies to Wi-Fi in the City of Toronto.

We ask this Board of Health to be guided by what is right for the health and safety of our community, our students and our teachers. Do the stated benefits of wireless technology in our schools outweigh the need for precaution in light of such scientific uncertainty? Should the priority of convenience trump that of health?

As you are aware, action taken now, and even no action taken now, will alter the course of our future. For example, the Board of Health could advise the KPR Board of your preference for the lower transmitting Wi-Fi routers on the netbook carts, which can be turned on and off as needed, rather than using stronger, pervasive Wi-Fi that exposes all students to RF emissions all day, every day. This is a small action that will convey to the public a message to be prudent about wireless exposure, and will start to change behaviors. Alternatively, if the status quo is allowed to remain, we may not feel any negative impacts until years or decades later.

Therefore, do we accept the status quo and hope for the best, or do we take actions to guide the community's well-being with precaution in mind? The public trusts that your advice and guidance on this health issue will be based on prudence, due diligence, and the timely and accurate communication of facts.

The Kawartha Safe Technology Initiative requests that:
1) the factual inaccuracies in public documents as noted above be addressed; and
2) the Board of Health adopt our requests to you in our letter of Dec.2, 2011 as follows, with one addition*:

1. To advise School Boards to continue with hard-wired internet connections in all schools, and desist from the use of wireless technology, until such time as radio-frequency electromagnetic radiation has been reclassified by the World Health Organization and IARC as "Class 4 - Probably not Carcinogenic", to safeguard the health of our students and teachers. *New: As an interim measure, schools could be directed to use netcarts with individual home-style routers (with the capacity to be turned off when not in use) rather than pervasive Wi-Fi, in order to minimize the potentially negative impacts of prolonged exposure to rf-emf radiation.

2. To advise the general public through an education campaign about the precautionary use of wireless devices to minimize microwave radiation exposure; for instance, beginning by issuing a public precaution that wireless laptops not be placed on laps during operation.

3. To advise the City and County of Peterborough member municipalities, school boards and hospitals to adopt a precautionary approach with respect to the use of wireless technology, and reconsider its use in the context of all public places.

Respectfully submitted,

Kawartha Safe Technology Initiative
www.kawarthasafetechnology.org

-----Original Message-----
From: Robert Baan <BaanR@iarc.fr>
Date: Mon, 29 Aug 2011 09:47:10
To: connieahudson@yahoo.com<connieahudson@yahoo.com>
Cc: COM (com@iarc.fr)<com@iarc.fr>
Subject: EMF Class 2B Classification

Dear Dr Hudson,

Thank you for your message, which was forwarded to me, and to which I would like to respond as follows.

The IARC Working Group classified "Radiofrequency Electromagnetic Fields" (RF-EMF) as possibly carcinogenic to humans (Group 2B).
The information that formed the main basis for this evaluation was found in epidemiological studies on cell-phone use, where a slightly increased risk for glioma (a malignant form of brain cancer) and acoustic neuroma (a non-cancerous type) was reported among heavy users.
There were some indications of increased cancer among radar-maintenance workers (occupational exposure), but no reliable data from studies among, e.g., people living close to base-station antennas, radio/TV towers, etc (environmental exposure).
Although the key information came from mobile telephone use, the Working Group considered that the three types of exposure entail basically the same type of radiation, and decided to make an overall evaluation on RF-EMF, covering the whole radiofrequency region of the electromagnetic spectrum.
In support of this, information from studies with experimental animals showed that effects on cancer incidence and cancer latency were seen with exposures to different frequencies within the RF region.
So the classification 2B, possibly carcinogenic, holds for all types of radiation within the radiofrequency part of the electromagnetic spectrum, including the radiation emitted by base-station antennas, radio/TV towers, radar, Wi-Fi, smart meters, etc.
An important point is the radiation level. The exposure from cellular phones (personal exposure) is substantially higher and much more focused (usually on the brain) than exposures from radio/tv towers, antennas, or Wi-Fi.

I hope this is useful.

Thank you for your interest in our work.

Sincerely yours,

Robert A Baan PhD
The IARC Monographs
IARC, Lyon, FRANCE

From: Craig Niziolek [mailto:craigniziolek@gmail.com]
Sent: Monday, March 19, 2012 8:28 AM
To: Alida Tanna
Subject: WiFi Response to Board Of Health

Request it be included in the 'Correspondence' section of the next agenda.

Response from letter sent by Shawn Telford-Eaton, Public Health Inspector, Peterborough County-City Health Unit

Many parents who are concerned about radio frequency microwaves do not have mobile phones (which includes cordless phones), microwave ovens or WiFi in their homes. So their children's exposure to wireless radiation at school will be significant.

Some levels of microwave radiation measured near routers (WiFi transmitters) have been as high as 100 micro watts per centimeter squared which is about 10% of Safety Code 6. A study recently released in Brazil showed a 35% increase in cancer over a 10 year period to people living within 500 meters of mobile phone base transmitting stations. The highest reading recorded in this study was 41 micro watts per centimeter squared which is only 4% of what Safety Code 6 recommends as being safe from cellular thermal warming. Many other illness are occurring from this radio frequency microwave radiation.

According to the Philosophy of Science, if a statement such as 'all swans are white' was presented and data was collected where all swans were white, this still does not prove that all swans are white. As soon as one non-white swan is found the statement is falsified. So the myth that 'WiFi is safe' is absolutely false in the face of countless papers/studies and published reports that clearly link health hazards to wireless radiation at 2.4 Giga hertz which is the exact same frequency as WiFi and a similar low intensity levels.

Health Canada's "weight-of-evidence" approach means that if there is more studies interpreted as showing no harmful effect of microwave radiation, even if that study is industry-funded; Health Canada can ignore all other science no matter how compelling. It is a numbers game that errs on the side of profit. Thank God that the Parliamentary Assembly of the Council of Europe uses a 'weigh-of-evidence' approach that doesn't consider the 'no effect' studies but compares positive results against negative results.

Our health is already jeopardized by the over 110,000 known man-made chemicals. Toxins in the air, water and food as well as heavy metals and food containing 'unlabeled' genetically modified organisms. Now the air is being saturated with radio frequency micro waves, causing a 'new pollution' which is also contributing to the modern day 'civilization sickness'. So the logic presented suggests that by allowing children to be exposed to just a little more toxic radiation (everyday at school), the position of the Board of Health is that it is okay to add another straw to the camel's back?

Studies have concluded that microwave radiation causes cancer in animals and humans. Studies have shown that cancer can take about 10 years to develop - with low level exposure (around 1,600 hours over a 10 year period) close to a transmitter. This demonstrates that microwave

radiation is accumulative. Children cannot be studied in experiments due to ethics, but will spend about **1,000 hours each year** in school alone, exposed to microwave radiation and they will be close to transmitters (routers & computers). Wireless devices many children clutch in their hands are transmitters. This action resembles addictive behavior and once scientists convince governments how dangerous wireless radiation is, we will have to figure out how to help these children overcome this cell phone addiction. There are safer ways to use this technology. Why not implement a 'Prudent Avoidance Policy' and the 'Precautionary Principle' now?

It took 3 decades to realize that DDT was a deadly toxic chemical after the inventor was awarded the Nobel Prize in science. About the same amount of time for asbestos, tobacco smoke and lead in gasoline to be found extremely carcinogenic. As the data rolls in, I wonder why the U.S. Air Force's **1984** study which showed a significant increase in malignant tumors and noted affects in the adrenal glands and the entire endocrine system was hidden for over 27 years before becoming public. This study was based on the same frequency as WiFi, 2.4 GHz and at low levels of pulsed electro-magnetic radiation. This raises serious concerns to anyone with an open mind. WHO had to list wireless radiation as a possibly carcinogen in 2011 in the face of huge opposition from the Telecommunication industry or lose all credibility.

The Telecommunications Industry is not 'green'. Mobile phone transmitters require power 24/7 - no energy saving here? The telecommunications industry has surpassed the aviation industry as the biggest polluters of our time. How many ways does this impact Canadian health?

So if The KPRDSB sees fit to allow children to be radiated every day at school, then does the Board of Health know how to combat the effects of radiation on human cells? Microwave transmitters are rapid aging devices. One way microwave radiation affects healthy cells is by bleeding the cellular charge down resulting in red blood cells sticking together which affects blood circulation. Cancer caused by radiation is difficult to heal. Would the BoH recommend or provide powerful anti-oxidants to every child, each day at school?

People pushing the use of wireless technology must think that curing cancer is easy. What is the percentage of cancer victims that live 5 years after treatment? The life of one human being is worth banning peanuts from school. So what worth are we placing on children today, who are part of the 'wireless' experiment?

What if these children, constantly exposed to this type of radiation develop dementia problems by the time they are 30 or 40 years old? I've heard scientist call the children of today the 'lost generation' which for the first time ever, many parents may see their children die before them?

The World Health Organization lists 'electro-sensitivity' as a handicap. There are medical Doctors in Canada and the U.S. beginning to understand and diagnose 'electro-sensitivity'. Here in Canada we are not allowed by law to discriminate against any one with a handicap. So how will a School Board provide a safe work and learning environment for any person deemed to be 'electro-sensitive'?

How can we predict which child will be sensitive or develop sensitivities to electro-magnetic radiation?

If The Board of Health is so positive that the use of WiFi does not pose a public health risk then please provide me a study that states WiFi is safe for children. In lieu of this elusive document please provide our family with a written and signed letter from the Health Minister of Ontario or Peterborough's Medical Officer of Health confirming that consistent long term exposure to WiFi is safe for children. Along with this signed letter we want to know the name of the insurance company that insures our children have 3rd party medical indemnity against any damage caused by microwave radiation.

I can provide the Board of Health any study that backs all my statements here, upon request. How can there be any study on children being exposed to radio frequency microwave radiation when the school boards have just implemented this?

Be Well

Craig Niziolek

469 Hopkins Ave.

Peterborough, Ontario

K9H 2R9

From: Alida Tanna
Sent: Wednesday, April 04, 2012 3:16 PM
To: 'Malini Menon'
Subject: RE: BoH Wi-Fi Decision

Sent on behalf of Deputy Mayor Andy Sharpe, Board of Health Chair:

Dear Ms. Menon,

Thank you for your email of March 20, 2011. It will be included in the correspondence to the Board of Health for its next meeting in April. We do not believe that the level of radiofrequency exposure associated with the use of Wi-Fi in schools is placing children at risk. This was addressed by Dr. Ray Copes in his presentation to the Board in November. We have been advised by Dr. Copes that he will be reviewing the new IARC monograph when it becomes available and we anticipate that Public Health Ontario will be advising Dr. Arlene King, Ontario's Chief Medical Officer of Health, on any recommended policy changes based on the latest review of the evidence. Until then, the Board of Health will not be taking any action on this issue.

We anticipate that there will be an opportunity for you to respond to the anticipated Public Health Ontario report when it becomes available, and we will welcome deputations again at that point. In the meantime, let me assure you that our Medical Officer of Health and her staff remain vigilant on this issue.

Alida Tanna
Administrative Assistant to
Dr. Rosana Pellizzari, Medical Officer of Health
and the Board of Health
Peterborough County-City Health Unit
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e. atanna@pcchu.ca

From: Malini Menon [mailto:mmenon16@yahoo.ca]
Sent: Tuesday, March 20, 2012 12:09 PM
To: Alida Tanna
Subject: BoH Wi-Fi Decision

Dear Mr. Sharpe:

On reading a headline from last Thursday's Examiner, I was confounded to find that on Wednesday, March 14th, the Board of Health made a pronouncement about the safety of Wi-Fi. The paper quoted you as saying that "our staff has reviewed all the information and the Board has determined that Wi-Fi is safe".

This is especially bewildering in light of the fact that in response to my request for a delegation on Monday, March 12, I was informed by Dr. Pellizzari the following:

Currently in Ontario, the plan is to await for the detailed report of the IARC before making any further recommendations on RF exposures. This process will be led by Dr. Ray Copes at Public Health Ontario (PHO). All Medical Officers of Health will be advised by our provincial Chief Medical Officer of Health, Dr. Arlene King, if she will be advocating for any changes based on the most recent review of the evidence. Now that Ontario has an arms-length scientific advisory body such as PHO, the public should benefit from a more consistent approach to health protection. We do anticipate that this will unfold over the next several months.

In the meantime, the Board of Health has decided that it will not be able to accommodate any further deputations on this topic. I have been instructed by the Board Chair to convey his grateful decline of your invitation to address the Board this week. I will suggest that there is an opportunity to enclose a letter in the Board's monthly correspondence.

As such, I was of the distinct impression that the Board would not make such a decision until the PHO report came out, and for this reason, you would not be taking delegations.

To the contrary however, the Board refused verbal delegations, as well as a letter I submitted on behalf of Kawartha Safe Technology Initiative, more than 24 hours prior to the meeting, in accordance with your policy. (The paper suggested that two delegations were turned down, one being too lengthy and the other not having been submitted in time. Mine was neither of these.) The Board went so far as to issue a definitive pronouncement on this matter, even prior to your own staff's internal review of rf-emf measurements around town, which I understood from Dr. Pellizzari was due to commence in spring when the weather was more conducive.

I wish to understand further Mr. Sharpe, on what basis the Board made a decision regarding Wi-Fi at this particular time.

I would also like to obtain a list/copy of "all the information", as quoted above, which was reviewed in coming to your decision.

For almost two years, our group has collectively done countless hours of research on this topic. In light of the thousands of studies which conclude harm from emfs, we believe prudence/avoidance are required at this juncture. However, if there is evidence which you have read that makes it clear to you that there is no need for precaution regarding our children's forced, long-term exposure to a Class 2B Possible Carcinogen, then I am extremely interested in knowing what that is. Nothing would make concerned parents like myself happier than being able to be certain, beyond a reasonable doubt, that Wi-Fi in schools is safe.

Sincerely,

Malini Menon

From: Alida Tanna
Sent: Wednesday, April 04, 2012 4:12 PM
To: 'Olle.Johansson@ki.se'
Cc: Rosana Pellizzari
Subject: FW: Peterborough County - City Health Unit - Board of Health - Wi-Fi - Letter of information, April 2, 2012

Sent on behalf of Dr. Rosana Pellizzari, Medical Officer of Health:

Dear Dr. Johansson,

As acknowledged below, your correspondence will be provided to the Board at their next meeting. I have also shared your letter with scientists at Ontario's Agency for Health Protection and Promotion, Public Health Ontario (PHO).

We have been advised by Dr. Ray Copes, Scientific Director, Environmental and Occupational Health, PHO, that he will be reviewing the new IARC monograph when it becomes available and we anticipate that PHO will be advising Dr. Arlene King, Ontario's Chief Medical Officer of Health, on any recommended policy changes based on the latest review of the evidence. Until then, the Board of Health will not be taking any action on this issue.

A number of links to statements and reports from PHO, as well as from Dr. King, are included on our website.

Sincerely,

Rosana Pellizzari, MD, MSc, CCFP, FRCPC
Medical Officer of Health, Peterborough County-City Health Unit

From: Alida Tanna
Sent: Tuesday, April 03, 2012 3:41 PM
To: 'Olle Johansson'
Subject: RE: Peterborough County - City Health Unit - Board of Health - Wi-Fi - Letter of information, April 2, 2012

Hello Dr. Johansson,

Please accept this email as confirmation of receipt of your correspondence, it will be provided to the Board of Health at their next meeting on April 11, 2012.

Kindest regards,
Alida Tanna

Alida Tanna
Administrative Assistant to
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From: Olle Johansson [mailto:Olle.Johansson@ki.se]
Sent: Monday, April 02, 2012 2:36 PM
To: Alida Tanna
Subject: Peterborough County - City Health Unit - Board of Health - Wi-Fi - Letter of information, April 2, 2012

Dear Madame or Sir,

Please, see the enclosed pdf file.

Yours sincerely,

Olle Johansson, Ph.D., Assoc. Prof.,

The Experimental Dermatology Unit,

Department of Neuroscience,

Karolinska Institute,

171 77 Stockholm, Sweden

&

Professor,

The Royal Institute of Technology,

100 44 Stockholm, Sweden

Karolinska Institutet
Department of Neuroscience
Experimental Dermatology Unit

Stockholm, April 2, 2012

Board of Health,
Peterborough County-City Health Unit,
10 Hospital Drive, Peterborough, ON
K9J 8M1, Canada
E-mail: atanna@pcchu.ca [*please, allow this letter to be officially entered as 'Correspondence' on the Board of Health Meeting agenda*]

Dear Board of Health Members:

I understand your Board has very recently made a public pronouncement regarding the safety of Wi-Fi. As a neuroscientist who has been studying the biophysical and epidemiological effects of electromagnetic fields for over 30 years, I believe this designation is short-sighted.

Wireless communication is now being implemented in our daily life in a very fast way. At the same time, it is becoming more and more obvious that the exposure to electromagnetic fields not only may induce acute thermal effects to living organisms, but also non-thermal effects, the latter often after longer exposures. This has been demonstrated in a very large number of studies and includes cellular DNA-damage, disruptions and alterations of cellular functions like increases in intracellular stimulatory pathways and calcium handling, disruption of tissue structures like the blood-brain barrier, impact on vessel and immune functions, and loss of fertility. Whereas scientists can observe and reproduce these effects in controlled laboratory experiments, epidemiological and ecological data derived from long-term exposures in well-designed case-control studies reflect this link all the way from molecular and cellular effects to the living organism up to the induction and proliferation of diseases observed in humans. It should be noted that we are not the only species at jeopardy; practically all animals and plants may be at stake. Although epidemiological and ecological investigations as such never demonstrate causative effects, due to the vast number of confounders, they confirm the relevance of the controlled observations in the laboratories.

PRECAUTIONARY PRINCIPLE
Because the effects are reproducibly observed and links to pathology cannot be excluded, the precautionary principle should be in force in the implementation of this new technology within the society. This will inevitably be the only method to support the sustainability of these innovative wireless communication technologies.

The February 2, 2000 European Commission Communication on the Precautionary Principle notes: "The precautionary principle applies where scientific evidence is insufficient, inconclusive or uncertain and preliminary scientific evaluation indicates that there are reasonable grounds for concern that the potentially dangerous effects on the environment, human, animal or plant health may be inconsistent with the high level of protection chosen by the EU". Therefore, policy makers immediately should strictly control exposure by defining biologically-based maximal exposure guidelines also taking into account long-term, non-thermal effects, and including especially vulnerable groups, such as the elderly, the ill,

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the genetically and/or immunologically challenged, children and fetuses, and persons with the functional impairment, electrohypersensitivity.

SELETUN SCIENTIFIC STATEMENT, 2010
In November, 2009, I was involved in a Scientific Panel comprised of international experts on the biological effects of electromagnetic fields, which met in Seletun, Norway, for three days of intensive discussion on existing scientific evidence and public health implications of the unprecedented global exposures to artificial electromagnetic fields (EMF) from telecommunications and electric power technologies. This meeting was a direct consequence of on-going discussions already from the mid-nineties, when cellular communications infrastructure began to rapidly proliferate, and stretching through, among many, the Benevento (2006), Venice (2008) and London (2009) Resolutions from this decade. It further involved important conclusions drawn from the 600-page Bioinitiative Report published August 31, 2007, which was a review of over 2,000 studies showing biological effects from electromagnetic radiation at non-thermal levels of exposure, which partly was published subsequently in the journal Pathophysiology (Volume 16, 2009).

The Seletun Scientific Statement (2010) recommends that lower limits be established for electromagnetic fields and wireless exposures, based on scientific studies reporting health impacts at much lower exposure levels. Many researchers now believe the existing safety limits are inadequate to protect public health because they do not consider prolonged exposure to lower emission levels that are now widespread.

The body of evidence on electromagnetic fields requires a new approach to protection of public health; the growth and development of the fetus, and of children; and argues for strong preventative actions. These conclusions are built upon prior scientific and public health reports documenting the following:

1) Low-intensity (non-thermal) bioeffects and adverse health effects are demonstrated at levels significantly below existing exposure standards.
2) ICNIRP/WHO and IEEE/FCC public safety limits are inadequate and obsolete with respect to prolonged, low-intensity exposures.
3) New, biologically-based public exposure standards are urgently needed to protect public health world-wide.
4) It is not in the public interest to wait.

Accordingly, EMR exposures should be reduced now rather than waiting for proof of harm before acting. This is in keeping with traditional public health principles, and is justified now given abundant evidence that biological effects and adverse health effects are occurring at exposure levels hundreds to thousands of times below existing public safety standards around the world.

• The Seletun Panel (2011) recommends wired internet access in schools, and strongly recommends that schools do not install wireless internet connections that create pervasive and prolonged EMF exposures for children.

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• The Seletun Panel (2010) recommends preservation of existing land-line connections and public telephone networks.

• The Seletun Panel recommends against the use of cordless phones (DECT phones) and other wireless devices, toys and baby monitors, wireless internet, wireless security systems, and wireless power transmitters in SmartGrid-type connections that may produce unnecessary and potentially harmful EMF exposures.

• The Seletun Panel recognizes that wired internet access (cable modem, wired Ethernet connections, etc) is available as a substitute.

"NO PROOF OF HEALTH EFFECTS"
One often hears about "safe levels" of exposure and that there is "no proof of health effects", but my personal response to these seemingly reassuring statements is that it is very important to realize, from a consumer's point of view, that "no accepted proof for health effects" is not the same as "no risk". Too many times, 'experts' have claimed to be experts in fields where actually the only expert comment should have been: "I/we just do not know". Such fields were e.g. the DDT, X-ray, radioactivity, smoking, asbestos, BSE, heavy metal exposure, depleted uranium, etc., etc., etc., where the "no risk"-flag was raised before true knowledge came around. Later on, the same flag had to be quickly lowered, many times after enormous economic costs and suffering of many human beings.

In the case of "protection from exposure to electromagnetic fields", it is thus of paramount importance to act from a prudence avoidance/precautionary principle point of view. Anything else would be highly hazardous. Total transparency of information is the key sentence here, as I believe the public does not appreciate having the complete truth revealed years after a certain catastrophe already has taken place. For instance, it shall be noted, that today's recommended values for wireless systems, such as the SAR-values, are just recommendations, and not safety levels. Since scientists observe biological effects at as low as 20 microWatts/kg, can it truly be stated that it is safe to allow irradiation of humans at SAR 2 W/kg, or at 100,000 times stronger levels of radiation?

IMBALANCED REPORTING
Another misunderstanding is the use of scientific publications (as the tobacco industry did for many years) as 'weights' to balance each other. But one can NEVER balance a report showing a negative health effect with one showing no effect. This is a misunderstanding which, unfortunately, is very often used both by the industrial representatives as well as official authorities to the detriment of the general public. True balance would be reports showing negative health effects against exact replications showing positive effects. However, this is not what the public has been led to believe.

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NEED FOR INDEPENDENT RESEARCH

In many commentaries, debate articles and public lectures - for the last 20-30 years – I have urged that completely independent research projects must be inaugurated immediately to ensure our public health. These projects must be entirely independent of all types of commercial interests; public health cannot have a price-tag! It is also of paramount importance that scientists involved in such projects must be free of any carrier considerations and that the funding needed is covered to 100%, not 99% or less. This is the clear responsibility of the democratically elected body of every country.

WHO/INTERNATIONAL AGENCY FOR RESEARCH ON CANCER (IARC), 2011

Very recently (in Lyon, France, May 31, 2011) the WHO/International Agency for Research on Cancer (IARC) has classified radiofrequency electromagnetic fields as possibly carcinogenic to humans (Group 2B), based on an increased risk for glioma, a malignant type of brain cancer. This should be added to the previous (2001) 2B classification of power-frequent (ELF) electromagnetic fields – emitted at high levels from handheld gadgets, such as eReaders and mobile phones – as a risk factor for childhood leukemia. Given the 2001 very close votes (9 to 11) for moving it to 2A and all the new knowledge that has accumulated since 2001, today the association between childhood leukemia and power-frequent (ELF) electromagnetic fields would definitely be signed into the much more serious 2A ("probably carcinogenic") category. So, the 'red flag' is – unfortunately – flying very high.

INVOLUNTARY EXPOSURE

According to Article 24 of the UNICEF's Child Convention "children have the right to … a clean and safe environment, and information to help them stay healthy". We must all ensure that this article never is violated. This is about our social responsibility, and is very much a public health issue.

Many WiFi systems are close to beds, kitchens, playrooms, schoolrooms, and similar locations. These wireless systems are never off, and the exposure is not voluntary. They are being forced on citizens and their children everywhere. Based on this, the inauguration of wireless systems with grudging and involuntary exposure of millions to billions of human beings to pulsed microwave radiation should immediately be prohibited until 'the red flag' can be hauled down once and for all.

There has been insufficient public debate about whether children actually need these wireless applications in their school work or if there are pedagogic rationales supported by professional teachers behind these 'modernizations'. There should be debate rather than decision-making over parents' heads. It is the children (and their staff!) who will suffer the potential health consequences of living every minute in all these exposures from Wi-Fi, and similar wireless installations, and they have no choice in the matter. Approved man-made microwave exposures are one million billion times – or more – larger than natural evolutionary background levels, the latter being as low as 0.00000000001 $\mu W/m^2$.

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CONCLUSION

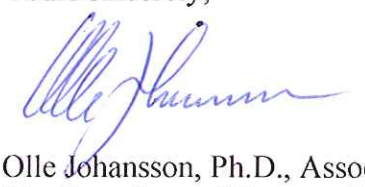
In conclusion, wireless systems, such as Wi-Fi routers, cannot be regarded as safe in schools, but must be deemed highly hazardous and unsafe for the children as well as for the staff.

I encourage governments and local health and educational bodies to adopt a framework of guidelines for public and occupational EMF exposure that reflect the Precautionary Principle. As noted, the Precautionary Principle states when there are indications of possible adverse effects, though they remain uncertain, the risks from doing nothing may be far greater than the risks of taking action to control these exposures. The Precautionary Principle shifts the burden of proof from those suspecting a risk to those who discount it — as some nations have already done. Precautionary strategies should be based on design and performance standards and may not necessarily define numerical thresholds because such thresholds may erroneously be interpreted as levels below which no adverse effect can occur.

Some 100 years back, we learned the hard lessons of ionizing radiation and the need for strict health protections – now we must openly face the possibility that we must take a seat in life's school and learn again. This time it is about non-ionizing radiation.

Based on all of the above, I strongly urge you to reconsider your public stance on the safety of Wi-Fi in schools.

Yours sincerely,



Olle Johansson, Ph.D., Assoc. Prof.,
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Peterborough County-City
HEALTH UNIT
...because health matters!

March 14, 2012

Ms Kate Manson-Smith, Assistant Deputy Minister
Ministry of Health and Long-Term Care
Standards, Programs and Community Development Branch
Health Promotion Division
777 Bay Street
23rd Floor, Suite 2302
Toronto, ON M7A 1S5

Re: Concerns Regarding the Delivery of the Healthy Communities Fund -Partnership Stream

Dear Ms Manson-Smith:

At the February 8, 2012 meeting of the Board of Health, we received and approved a proposed budget submission for Healthy Communities Ontario: Partnership Stream funding. After being provided with background information regarding this program's history and explanation for the last-minute submission, a motion was approved to express our concern for the local impact of the indecision, unrealistic timelines, and lack of consistent direction that been associated with this program.

On July 6, 2010, after much deliberation and development work, the Ministry of Health Promotion and Sport (MHPS - now Health Promotion Division of the Ministry of Health and Long-term Care (MOHLTC)) announced funding for the Healthy Communities Fund: Partnership Stream. The stated purpose of this funding was to "...create a culture of health and well-being; build healthy communities through coordinated action; create policies and programs that make it easier for Ontarians to be healthy; and enhance the capacity of community leaders to work together[i]." Health Units and their partners applauded the multi-faceted approach of the Partnership Stream as well as the required needs-based approach.

Peterborough County-City Health Unit (PCCHU) staff have reported to us that since the announcement in 2010, Healthy Communities Partnership in Peterborough has worked diligently to meet all submission requirements and to engage individuals and organizations in this important venture. The Peterborough Healthy Communities Partnership was able to: produce the first ever Community Assessment Report; engage over 500 citizens who expressed their views on the six Healthy Communities risk factors; and involve over 60 organizations to critically look at how we can minimize duplication and come together to work collectively in addressing the six risk factors. The work that our Healthy Communities Partnership completed in 2010 was well on its way to meeting the stated Ministry goals.

Unfortunately, our momentum in Peterborough has been compromised considerably. After March 31, 2011, the MOHLTC did not release any further funds for Partnerships despite submission of well articulated, evidence-based plans. This has limited the work that staff and partners have been able to do to build capacity in our community and move our healthy public policy agenda forward. Finally, on January 13, 2012, it was announced that funding would be provided to Partnerships; however, only to continue two of the six identified risk factors, and only for activities that could be completed by March 31, 2012.

10 Hospital Drive, Peterborough, ON K9J 8M1 P: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

I'm sure you will agree that developing and sustaining effective partnerships requires clarity of purpose and consistent support for coordination of planning and implementation. Shortfalls in this regard have significantly impacted the work that our Partnership completed since 2010. Staff report that partners have been lost and credibility of PCCHU as the sponsoring agency of this initiative has been called into question. Without further commitment from the MOHLTC to fund all six risk factors at the Partnership Stream level, we fear that it will erode further, if not negate all of the great work our Partnership has completed to date.

One final concern relates to the 2012 Healthy Communities Fund: Grant Stream announcement in January. It has been brought to our attention that the 2012 application form no longer includes a requirement for Local Grant projects to be linked to their local Healthy Communities Partnership. If the Local Grant Stream projects are not linked to the local Partnership, how can the Ministry ensure that these Local Grant Steam projects are using a needs-based approach and are proposing actions grounded in local evidence? We raise this as, to date, documenting local evidence has been a function of the Local Partnership.

The Board and staff of PCCH were initially very excited about the opportunity for engaging citizens and working with new partners that the Healthy Communities Partnership Stream presented. However, the delays, uncertainty and unreasonable demands experienced over the past 18 months have put the sustainability of this good work in jeopardy. We strongly encourage you and your staff to avoid further delays in funding announcements. We further request that the MOHLTC begin dialogue immediately with key stakeholders and come to a reasonable resolution about the future direction of Healthy Communities.

Sincerely,

Mr. Andrew Sharpe, Board of Health Chair
Peterborough County City-Health Unit

cc: Laura Pisko, Director
Laura Belfie, Manager
Nomi Caplan, Regional Public Health Consultant
Jeff Leal, MPP

[i] Letter from Penny Nelligan to Medical Officers of Health. Dated July 6, 2010.

From: allhealthunits-bounces@lists.alphaweb.org [mailto:allhealthunits-bounces@lists.alphaweb.org] **On Behalf Of** Linda Stewart
Sent: Friday, March 16, 2012 5:54 PM
To: All Health Units
Subject: [allhealthunits] Follow up Question

Please forward to BOH Members. Thanks. Linda

Dear Board of Health Member.

At the last BOH Section meeting on February 10, 2012. Roselle Martino, Executive Director (A) for the Public Health Division was asked how the Ministry calculates household adjusted family net income for the healthy smiles program. Roselle promised to follow up with a link to the calculation.

The calculation can be found on the Ministry of Finance website at:
http://www.rev.gov.on.ca/en/credit/incomeranges.html

Roselle has also provided the slides she presented that day, for your information.

I hope that this information is useful.

All the best.

Linda

Linda Stewart
Executive Director

Celebrating 25 Years!
Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
Toronto, ON M5B 1J3
Tel: (416) 595-0006 ext. 22
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linda@alphaweb.org

For scheduling, please contact Karen Reece, Administrative Assistant, at karen@alphaweb.org or call 416-595-0006 ext 24.

For more information visit our web site: http://www.alphaweb.org

NOTE: Powerpoint Slides available upon request (atanna@pcchu.ca)

From: allhealthunits-bounces@lists.alphaweb.org [mailto:allhealthunits-bounces@lists.alphaweb.org] **On Behalf Of** Gordon Fleming
Sent: Wednesday, March 21, 2012 4:12 PM
To: allhealthunits@lists.alphaweb.org
Subject: [allhealthunits] alPHa Winter Symposium Proceedings

ATTENTION
CHAIRS, BOARDS OF HEALTH
MANAGERS, ALL PROGRAMS
****

The proceedings of the 2012 alPHa Winter Symposium are now posted on the alPHa Web site. The page includes summaries, photos and all available presentations (both individual and packaged) from the plenary sessions. Please follow the link below to explore:

http://www.alphaweb.org/WS2012.asp

Gordon Fleming, B.A., BASc, CPHI(C)
Manager, Public Health Issues
Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
Toronto, Ontario
(416) 595-0006, ext 23
(416) 595-0030 Fax

Ministry of Children and Youth Services

Minister's Office

56 Wellesley Street West
14th Floor
Toronto ON M5S 2S3
Tel.: 416 212-7432
Fax: 416 212-7431

Ministère des Services à l'enfance et à la jeunesse

Bureau du ministre

56, rue Wellesley Ouest
14e étage
Toronto ON M5S 2S3
Tél. : 416 212-7432
Téléc. : 416 212-7431

Ontario

CMB-12-110267

Dr. Rosana Pellizzari
Peterborough County-City
Health Unit
10 Hospital Drive
Peterborough, Ontario
K9J 8M1

Dear Dr. Pellizzari:

Thank you for your letter regarding the Peterborough County-City Health Unit's Infant Development Program. I am pleased to respond.

As a physician, I recognize the lasting impact of a child's early experiences on their long-term development and our government is committed to giving children the best possible start in life. The Infant Development Program plays an important part in helping meet that commitment to provide critical support to children with developmental delays and their families. That is why our government provides over $257 million annually to support Healthy Child Development programs, including almost $20 million to the Infant Development Program.

Darryl Sturtevant, Assistant Deputy Minister of the ministry's Strategic Policy and Planning Division, would be happy to meet with you and the other members of the Peterborough County-City Board of Health to further discuss these issues. You may contact him by telephone at 416-327-9481 or by e-mail at Darryl.Sturtevant@ontario.ca.

Again, thank you for writing and for your ongoing commitment to providing high-quality services to children and families in Peterborough and the surrounding communities.

Sincerely,

Dr. Eric Hoskins
Minister

c: Mr. Jeff Leal, MPP, Peterborough
Ms. Laurie Scott, MPP, Haliburton–Kawartha Lakes–Brock
Mr. Darryl Sturtevant, Assistant Deputy Minister

Minister
of Agriculture and
Agri-Food
and Minister for the
Canadian Wheat Board

Ministre
de l'Agriculture et de
l'Agroalimentaire
et ministre de la
Commission canadienne du blé

Ottawa, Canada K1A 0C5

Quote: 172301

MAR 2 3 2012

Mr. Andy Sharpe
Chair
Board of Health
Peterborough County–City Health Unit
10 Hospital Drive
Peterborough, Ontario K9J 8M1

Dear Mr. Sharpe:

I am writing in response to your correspondence to the Right Honourable Stephen Harper regarding television advertising of Nestlé infant formula in Canada. I appreciate the opportunity to respond to your concerns.

As detailed in the response you received from the Minister of Health, the Honourable Leona Aglukkaq, the Canadian Food Inspection Agency (CFIA) is responsible for compliance and enforcement activities related to food, including those involving labelling and advertising requirements.

Your letter expresses concern that the Nestlé advertisement contravenes the *International Code of Marketing of Breast-milk Substitutes*. Please note that this Code has not been incorporated into Canadian domestic legislation. Canadian regulatory authority with respect to infant formula is outlined in Division 25 of the *Food and Drug Regulations* that prescribes both compositional and labelling requirements for infant formula. In addition, Section 5(1) of the *Foods and Drugs Act* prohibits false, misleading or deceptive labelling and advertising.

The CFIA does not have the authority to take enforcement action against advertisements that do not contravene Canadian-legislated requirements. Whereas Article 5.1 of the *International Code of Marketing of Breast-milk Substitutes* states that no advertising or promotion of these products should occur to the general public, Canadian law does not prohibit the advertising of infant formula; however, it must be truthful and not misleading.

.../2

Canada

In the specific case of the Nestlé Good Start advertisement, the CFIA has contacted Advertising Standards Canada (ASC) to communicate the nature of your concerns and identify whether the advertisement may be false or misleading as prohibited by Section 5(1) of the *Foods and Drugs Act*. ASC is the Canadian advertising industry self-regulatory body that reviews broadcast and advertising scripts that contain claims or endorsements for foods or non-alcoholic beverages. Any necessary follow-up with respect to these advertisements, based on Canadian legal requirements, would be initiated by ASC with support from the CFIA as required.

I trust that this information will be of assistance to you. Thank you for writing on this important subject.

Sincerely,

Gerry Ritz, PC, MP

c.c.: The Honourable Leona Aglukkaq, PC, MP

Niagara Region

PUBLIC HEALTH

DR. VALERIE JAEGER
Medical Officer of Health (A)

☑ **Main Office**
2201 St. David's Rd. Campbell East
Thorold, ON
Phone: 905-688-3762
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Branch Offices
□ **Niagara Falls**
5710 Kitchener Street
Niagara Falls, ON L2G 1C1
Phone: 905-356-1538
Fax: 905-356-7377
□ Sexual Health Centre
Phone: 905-358-3636
Fax: 905-358-2717

□ **Welland**
200 Division Street
Welland, ON L3B 4A2
Phone: 905-735-5697
Fax: 905-735-4895
□ Sexual Health Centre
Phone: 905-734-1014
Fax: 905-734-1770

□ **Fort Erie**
43 Hagey Avenue
Fort Erie, ON L2A 1W4
Phone: 905-871-6513
Fax: 905-871-3020
□ Sexual Health Centre
Phone: (905) 871-5320
Fax: (905) 871-3333

□ **St. Catharines Sexual Health Centre**
277 Welland Avenue
St. Catharines, ON L2R 2P7
Phone: 905-688-3817
1-800-263-5757
Fax: 905-688-6063

□ **Emergency Services Division**
509 Glendale Avenue East SS 4
Niagara on the Lake, ON L0S 1J0
Phone: 905-641-2218
Fax: 905-688-5079

□ **Community Mental Health**
3550 Schmon Parkway
Unit 2, Second Floor
PO Box 1042
Thorold, ON L2V 4T7
Phone: 905-688-2854
Fax: 905-684-9798

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Public Health Unit
www.niagararegion.ca

March 22, 2012

The Honorable Eric Hoskins
Minister of Children and Youth Services
14th Floor, 56 Wellesley Street West
Toronto, ON M5S 2S3

Dear Minister Hoskins,

I would like to welcome you to your new position as Minister of Children and Youth Services. The Board of Health of the Regional Municipality of Niagara has received Dr. Pellizzari's letter dated February 15, 2012 re: the Infant Toddler Development Program. On behalf of the Board of Health for Niagara Region, I have been directed to also request the opportunity for providers of this service to talk with you about the needs of Infant and Child Development Services (ICDS).

Niagara has experienced no growth in this budget for 10 years, and we have just reviewed the ICDS program and our role as lead agency. We continue to find important fit and efficiencies to keep this program within Public Health. However, the lack of budget adjustment threatens this program specifically, and has implications for our early childhood system more broadly.

The evidence around epigenetics and the neuroscience of early childhood has driven home the importance of investments during the earliest years for all children. The work done by the ICDS is part of "getting it right" for our most vulnerable citizens; when it is best and most effective, to make it right for life.

Niagara Region Board of Health, would welcome the opportunity to meet with yourself, Assistant Deputy Minister Sturtevant, and representatives from the other health units at your earliest convenience.

Best wishes,

Jaeger

Valerie Jaeger, MD, PhD, CCFP
Medical Officer of Health (A)
valerie.jaeger@niagararegion.ca

c: Darryl Sturtevant, Assistant Deputy Minister
Strategic Policy & Planning, MCYS
darryl.sturtevant@ontario.ca

c: Dr. R. Pellizzari, Medical Officer of Health
Peterborough County-City Health Unit
rpellizzari@pcchu.ca

c: Linda Stewart, Executive Director
Association of Local Public Health Agencies
linda@alphaweb.org

Emergency Preparedness Continuity of Operations Plan

Donna Churipuy,
Program Manager
April 11, 2012

Peterborough County-City HEALTH UNIT
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Ontario Public Health Standards

- Mandate
  - The board of health shall develop a continuity of operations plan to sustain the ongoing functioning of time-critical board of health services during business disruptions in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).

Ontario Public Health Standards

The plan shall:

i. Identify time-critical public health services that must continue to be delivered regardless of circumstance;
ii. Assign resources to maintain time-critical public health services;
iii. Outline the process for recovering time-critical public health services should they be disrupted;
iv. Be reviewed and updated on an annual basis at a minimum; and
v. Be approved by the Medical Officer of Health.

Ontario Public Health Standards

At a minimum, the process for developing and maintaining the board of health continuity of operations plan shall include:

- Engaging the board of health senior management team;
- Identifying time-critical public health services through a business impact analysis;
- Identifying the dependencies upon which time-critical public health services rely;

Ontario Public Health Standards

- Identifying vulnerabilities to the continued delivery of time-critical public health services; and
- Developing recovery procedures to guide the restoration/continuation of time-critical public health services.

Process of Developing the COOP

- Development of the draft COOP included:
  - Business Impact Analysis
  - Establishing recovery time objectives for all of the services and programs
  - Identification of internal and external stakeholders

Continuity of Operations Plan

- Purpose
  - To maintain operations under all circumstances, ensure safety, and restore time critical services
- Objectives
  - To assist in maintaining operation of critical services
  - To guide prioritization of recovery time objectives
  - To assist the PCCHU in recovery from business disruptions of any size or nature
  - To support the PCCHU Emergency Response Plan

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Planning Assumptions

- PCCHU's three sites and IT dependencies are vulnerable such that they may could be inoperable and/or inaccessible for a period of time.

Business Disruption

- ‘a failure or interruption of critical services or processes for a period of time which threatens the ability of the PCCHU to maintain its role of protecting and promoting the health of the community’
  - Examples,
    - Natural disasters, accidents, sabotage, power disruptions, labour disruptions, infrastructure failures, cyber attack

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Implementation of the COOP: Step 1

Assessment

- The assessment of a business disruption will be led by site specific assessment teams. Example:
  - Hospital Drive – Member of Executive, Manager of Emergency Preparedness, IT and Communications representatives, Custodian
- An Assessment Checklist will be used to assess all business disruptions

Implementation of the COOP: Step 2

Response

- Response to the Business Disruption functions under the Incident Management System. The Incident Commander provides leadership to the Business Continuity Team:
  - Business Continuity Officer
  - Secretarial Support
  - IT Representative
  - Custodial Staff
  - Alternate Site Contact
  - Senior Management Representative

Implementation of the COOP: Step 2

Response

- Service Prioritization
  - Programs and services have been prioritized from most time critical to least time critical:
    - 24 hours
    - 2-3 days
    - 2 weeks
    - Will not be completed during the Business Disruption
  - PCCHU has more than one service ranked highly
  - Overlap of Recovery Time Objectives of critical functions

Priority Public Health Services

15-Oct-09

Division	Program	Essential Activities	**Must Do** Critical services cannot be deferred or delegated	**High Priority** Do not defer if possible or bring it back as soon as possible	Profession Required
Health Protection and Promotion	All	Management of essential activities	x		Manager
Health Protection	Safe Water, Food Safety, Rabies Prevention and Control, Health Hazards Prevention	Maintain 24/7 on-call and response	x		Public Health Inspector
Health Protection	Safe Water	Provide information on safe drinking water practices (private)		x	Public Health Inspector
		Inform public of unsafe drinking water conditions/protective measures	x		Public Health Inspector
		Review reportable diseases wrt drinking water		x	Epidemiologist
		Receive and respond to adverse reports	x		Public Health Inspector
		Address hazardous conditions observed at beaches	x		Public Health Inspector
		Review sampling results and post where indicated	x		Student Public Health Inspector
		Inspect public pools, spas, and recreational water		x	Student Public Health Inspector
		Secretarial support to essential activities	x		Secretary
Health Protection	Sewage Disposal	Receive permit applications, prepare permits and reports		x	Secretary
		Respond to sewage complaints resulting in immediate threat to health	x		Public Health Inspector
		Inspection of construction sites		x	Public Health Inspector
Health Protection	Food Safety	Food safety complaints resulting in immediate threat to health	x		Public Health Inspector
		Class 1 food recalls	x		Public Health Inspector
		Secretarial support to essential activities	x		Secretary
Health Protection	Health Hazards Prevention	Health hazards complaints resulting in immediate threat to health	x		Public Health Inspector
		Facilities complaints resulting in immediate threat to health	x		Public Health Inspector
		Secretarial support to essential activities	x		Secretary
Health Protection	Tobacco Use Prevention	Indepth tobacco cessation counselling	x		Public Health Nurse
		Charges and compliance checks	x		Health Promoter
		Youth engagement		x	Youth Development Worker
Health Protection	Rabies Prevention and Control	Investigation of rabies exposure	x		Public Health Inspector
		Distribution of globulin and vaccine	x		Public Health Inspector
		Secretarial support to essential activities	x		Secretary
Health Protection	Infectious Diseases,	Follow-up of selected meningitis, tuberculosis, influenza	x		Registered Nurse, Public Health Inspector
	Tuberculosis, Vaccine	Follow up other reportable diseases		x	Registered Nurse, Public Health Inspector
	Preventable Diseases	Follow up of severe outbreaks	x		Registered Nurse, Public Health Inspector
		Telephone consultation for CID		x	Registered Nurse, Public Health Inspector
		Presentations on Infection Control		x	Registered Nurse, Public Health Inspector
		Follow-up of non-severe outbreaks		x	Registered Nurse, Public Health Inspector
		Receive and assess complaints re: daycare, LTC, personal service settings	x		Public Health Inspector
		Reportable disease surveillance	x		Epidemiologist
		Rabies vaccine distribution	x		Secretary, Public Health Inspector
		Arranging for Dispensing of TB Drugs		x	Registered Nurse
		Distribution of biologicals		x	Secretary, Registered Nurse
		Family Physician, Pharmacy, School Surveillance		x	Nurse, Public Health Inspector
		Telephone consultation for VPD		x	Registered Nurse
		[illegible]ering vaccine		x	Registered Nurse
Health Protection	Sexual Health/Sexually	Clinical ser[illegible]ing for HIV, Hep B and C, and syphillis	x		Public Health Nurse

CD Emergency - Staff Redeployed to IMS

21/10/2009

10:00am

Name	Profession	FTE Assigned to Essential Activities	FTE Deployed
Alida Tanna	Administrative Assistant		1
Barb Matwey	Administrative Assistant	0.4	0.6
Donna Sullivan	Bookeeper	0.5	0.5
Brittany Cadence	Communications		1
Kerri Tojcic	Computer Technician Analyst	0.2	0.8
Mamdouh Mina	Computer Technician Analyst		1
Lorraine Skipwith	Director		1
Maureen McKeen	Director		1
Tom Cathcart	Director		1
Penny Brown	Divisional Secretary		1
Wendy Freeburn	Divisional Secretary		1
Sarah Peacock	Epidemiologist		0.2
Christine Post	Health Promoter	0.4	0.6
Gail Chislett	Health Promoter		1
Jane Hoffmeyer	Health Promoter	0.4	0.6
Ann Keys	Manager		1
Edwina Dusome	Manager		1
Karen Chomniak	Manager		1
Larry Stinson	Manager		1
Rosana Pellizzari	Medical Officer of Health		1
Brittany Peel	Registered Nurse	0.8	0.2
Nicole Dunlop	Registered Nurse	0.8	0.2
Anne Robinson	Secretary		1
Beth Steinbeck	Secretary		1
Cathy Schofield	Secretary		1
Jane Naylor	Secretary		1
Zina Allen	Secretary	0.5	0.5

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Implementation of the COOP: Step 3

Recovery

- Executive Committee and the Manager for Emergency Preparedness are developing recovery strategies for priority corporate services, e.g., power outages, communications outages

Next steps

- Developing a MOU with an Alternate Site
- Exercise the COOP

Staff Report

Healthy Babies, Healthy Children Program

Date:	April 11, 2012
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original signed by	**Original signed by**
_____	_____
Rosana Pellizzari, M.D.	Karen Chomniak, Manager, Family Health

Recommendations

That the Board of Health for the Peterborough County-City Health Unit:

- approve the 2012 budget for the Healthy Babies, Healthy Children (HBHC) Program in the total amount of $828,413; and
- address the funding levels for the program with the Ministry of Children and Youth Services (MCYS) before next year and on an on-going basis.

Financial Implications and Impact

The 2012 budget has been completed in accordance with MCYS guidelines and is based on the approved provincial funding allocation of $828,413 (see Attachments A & B). The provincial base allocation has not been increased since 2008.

To aid in balancing the budget in 2012, the program has included funding of $22,190 from other sources and this will cover 0.39 full-time equivalent (FTE) of a Family Home Visitor (FHV). This will maintain the program's FHV complement at 2.8 FTE.

Of concern is that the 2012 budget has been prepared with an additional reduction to the program's Public Health Nursing (PHN) complement. In 2007, the program had budgeted for 5.2 FTE PHNs. The 2012 funding allocation provided by MCYS will only allow for 4.5 FTE PHNs. Significant financial impact will be exerted on our program due to the fact that five PHNs will

each be taking a one year pregnancy/parental leave of absence in the time span of December 2011 to September 2013. Costs include "the supplement or 'top up' of the Human Resources Development benefits payable to employees who are absent from work on pregnancy, parental or adoption leave" (Ontario Nurses Association Collective Agreement, 11.04 (i) (i)) projected to be $27,912, as well as the employer share of benefits costs.

Decision History

The Board of Health has hosted and supported the HBHC program since its inception in 1998. Letters have been sent by this Health Unit and other provincial public health agencies (such as alPHa) to the provincial government, government ministers, and opposition party critics. These letters have advocated that HBHC be maintained as a 100 percent provincially-funded program; and that sufficient increases to the annual budget be granted to keep pace with demands from client families, partner agencies, and the community, and on Health Units themselves as employers.

Background and Rationale

Introduced in 1998 by the Government of Ontario, the HBHC program is funded 100% by the MCYS. HBHC is mandated as a component of both Child Health and Reproductive Health programs of the Ontario Public Health Standards, Ministry of Health and Long-term Care.

HBHC is a prevention and early intervention program designed to help pregnant women and families with children from birth to six years of age. It is delivered by PHNs and FHVs (providing peer support) through telephone consultation and home visiting. The program gives families in Ontario the information and support they need to give their children a healthy start in life; and also to provide more intensive services and supports for families with children who may not reach their full potential due to identified risk factors. These interventions result in long-term health, education, and economic benefits.

Each HBHC program must set projected achievements based on performance targets established by MCYS. However, inadequate funding has diminished the capacity of our Health Unit to achieve these targets and to provide necessary services (see attached: Peterborough-Healthy Babies, Healthy Children Monitoring Reports and Staffing-Summary). Measures taken to date have included the discontinuation of weekend telephone assessment and support services to new parents; a waitlist for families in high risk situations (these are families experiencing inadequate coping skills, parenting concerns, mental health issues, social isolation, limited formal education, unemployment, no or limited finances, inadequate housing, substance abuse, intimate partner violence, physical health challenges); gapping of PHN positions, with a resultant increase in workload, stress, and personal safety concerns; and increased pressure on limited community services such as breastfeeding support, prenatal education and support for pregnant teens, and support for perinatal mood disorders.

HBHC has established itself as a valuable program in the community and has worked hard to build relationships with the Children's Aid Society, Ontario Early Years Centre, Peterborough Regional Health Centre, Family Health Teams, addictions and mental health agencies, housing and social services agencies, and adult education and pre-employment agencies. However, with diminished resources, one is only to be reminded of the 2001 Coroner's Report regarding the death of infant Jordan Heikamp as evidence of a system breakdown. In the recommendations, HBHC was identified in playing a role to ensure the provision of health education; routine health assessments, and feeding and care of baby; and effective linkages and referrals with other medical professionals.

MCYS has sought to review and enhance the HBHC program. Through 2008 to 2010, MCYS conducted research into the effectiveness of the PHN/FHV home visiting model and evaluated the introduction of a Social Worker to address specific risk factors. As a result of this research and an examination of best practices, a revised Family Service Plan and Family-Friendly Plan were introduced. (Peterborough's HBHC program participated as a comparator site in this research.) Health Units have the option of including a Social Worker, but must do so within existing funding.

Through its work with Dr. Charles Pascal, MCYS is intending to implement "improvements to HBHC to build a more robust early years system". Proposed changes include:

- development and implementation of a comprehensive screening tool to replace the current prenatal and postpartum screens (method of administration is yet to be determined);
- revision of the HBHC Protocol and guidance documents;
- provincial training for HBHC PHNs and FHVs to help ensure the effectiveness of home visiting;
- continued strategies to promote the Enhanced 18-Month Well-Baby Visit to physicians and parents; and
- a comprehensive information package, developed by MCYS, for every new parent before leaving the hospital. (This is in response to the plan to eliminate universal postpartum follow-up of the telephone call and offer of a home visit. However, a provincial Expert Panel has been assembled to examine the implications of eliminating the universal postpartum component. Currently all new parents receive an information package developed jointly by the Peterborough Regional Health Centre and the Peterborough HBHC program.)

Although MCYS is providing funding for provincial training of PHNs, it has indicated that implementation of all other proposed changes must be accomplished within current resource allocations.

Strategic Direction

The HBHC program is identified as a requirement under both the Reproductive Health and Child Health Standards in the Ontario Public Health Standards 2008. Approval of the budget will

maintain the program and the Health Unit's ability to continue to meet our mandate. Steps must be taken to advocate for and obtain increased stable funding for HBHC or the Health Unit will not be able to continue to meet its mandate.

As American human rights leader Frederick Douglass noted, "It is easier to build strong children than to repair broken men."

Contact:

Karen Chomniak, Manager, Family Health
Healthy Babies, Healthy Children Program
(705) 743-1000, ext. 242
kchomniak@pcchu.ca

Attachments:

Attachment A: Peterborough HBHC Program Monitoring Reports and Staffing, Summary
Attachment B: HBHC Budget Summary, 2012/13

Year	2007		2008		2009		2010		2011	
# live births	1174		1152		1198		1213		1197	
# resident families with one or more live births	1160		1145		1187		1192		1177	
# consenting families with a live birth	1124		1084		1085		1055		1039	
Indicator	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
# prenatal screens **(MCYS Target 25%)**	694	**59.8**	596	**52**	597	**50.3**	546	**45.8**	502	**42.7**
# families with a completed In-depth Assessment (IDA) **(MCYS Target 12%)**	190	**16.4**	183	**16**	152	**12.8**	156	**13.1**	129	**11**
Entry stage (# of IDAs completed):	*235*	**-**	*221*	**-**	*174*	**-**	*188*	**-**	*152*	**-**
Prenatal	*151*	***64.3***	*139*	***62.9***	*111*	***63.8***	*68*	***36.2***	*81*	***53.3***
Postpartum	*29*	***12.3***	*29*	***13.1***	*30*	***17.2***	*31*	***16.5***	*16*	***10.5***
Early ID	*55*	***23.4***	*53*	***24.0***	*33*	***19***	*89*	***47.3***	*55*	***36.2***
# postpartum phone calls within 48 hours **(MCYS Target 100%)**	921	**82.2**	908	**84.1**	890	**82.4**	868	**81.7**	771	**73.3**
- outside 48 hours	199	**17.8**	172	**15.9**	190	**17.6**	195	**18.3**	283	**26.8**
Total	1120 (99.5%)	**100**	1080 (99.6%)	**100**	1080 (99.5%)	**100**	1063 (100.7%)	**100**	1052 (101%)	**100.1**
#families receive a postpartum home visit **(MCYS Target 75%)**	797	**70.8**	681	**62.8**	561	**51.7**	332	**31.4**	168	**16.1**
# FHV home visits **(MCYS Ratio of Visits 75%)**	767	**64.2**	809	**63.7**	661	**61.1**	659	**62.3**	684	**57.3**
# PHN home visits **(MCYS Ratio of Visits 25%)**	427	**35.7**	456	**35.9**	420	**38.8**	397	**37.5**	507	**42.5**
# joint home visits	232	**19.4**	240	**18.9**	246	**22.7**	233	**22**	331	**27.7**
Staffing: PHNs / FHVs										
Budget	PHN 5.2 / FHV 2.8		PHN 5.2 / FHV 2.8		PHN 5.2 / FHV 2.8		PHN 4.6 / FHV 2.8		PHN 4.4 / FHV 2.75	
Actual	**PHN 6.29* / FHV 2.8**		**PHN 5.84* / FHV 2.8**		**PHN 4.71^ / FHV 2.8**		**PHN 4.6 / FHV 2.8** PHN 0.3 NGG		**PHN 4.74* / FHV 2.8**	

Peterborough – Healthy Babies, Healthy Children Program Monitoring Reports and Staffing – Summary

*includes one-time grant allocation from MCYS.
^Other than maintaining minimal staffing, PHNs and FHVs were redeployed for H1N1 activities from mid-October to first week of December, 2009.
NGG = Nursing Graduate Guarantee Funding via Health Force Ontario (position must be counted above staffing complement).

From 2007 to 2011, the Budgeted PHN FTE allocation dropped by 0.8 FTE (5.2 – 4.4) or 15.4%.
From 2007 to 2011, the Actual PHN FTE allocation dropped by 1.55 FTEs (6.29 – 4.74) or 24.6%.

Healthy Babies Healthy Children
Early Learning and Child Development Branch
Strategic Policy and Planning Division
Ministry of Children and Youth Services
2012 Request for Funding Schedule
January 1, 2012 - December 31, 2012

Public Health Unit: Peterborough County-City Health Unit

	Previous Year Approved FTE	Previous Year Approved Budget	Previous Year Actual FTE	Previous Year Actual Costs	Current Year Request FTE	Current Year Request	Current Year Approved Request Ministry Use
Salaries & Wages: Staff	10.2	623,449	10.33	605,623	10.3	617,867	
Employee Benefits		156,442		161,109		166,771	
Employee Benefits as % of S&W Staff		25.1%		26.6%		27.0%	
Contracted Services	-	28,000	-	28,000	-	28,000	
Operating Costs		37,712		33,678		37,965	
TOTAL REQUEST	10.2	845,603	10.33	828,410	10.3	850,603	
One-Time Grant Request	-	50,000	-	26,200	-	41,684	
5. One-Time Funding - NCAST		5,500		5,500		-	
6. Funding from other sources		(17,190)		-		(22,190)	
GRAND TOTAL	10.2	883,913	10.33	860,110	10.3	870,097	

Authorized by Chair Board of Health, CEO or Medical Officer of Health

Signature: _____

Name: Dr. Rosana Pellizzari

Date: _____

Public Health Unit: Peterborough County-City Health Unit

	Previous Year Approved FTE	Previous Year Approved Request	Previous Year Actual FTE	Previous Year Actual Costs	Current Year Request FTE	Current Year Request	Current Year Approved Request Ministry Use
1a. Salaries & Wages - Unionized							
Management	1.3	124,170	1.3	124,357			
Public Health Nurses	4.4	296,604	4.51	285,315	4.5	295,973	
Lay Home Visitors	2.8	129,679	2.8	122,110	2.8	123,805	
Social Workers							
Administration: Program Support	1.0	38,003	1.02	38,940	1.0	36,867	
Administration: ISCIS Data Entry Support	0.4	16,578	0.4	16,688	0.4	14,142	
Administration: ISCIS Release Support	0.3	18,415	0.3	18,213	0.3	18,543	
Other Professional (specify)							
Other Non-Professional (specify)							
Total Salaries & Wages - Unionized	10.2	623,449	10.33	605,623	9.0	489,330	
Employee Benefits - Unionized		156,442		161,109		132,966	
1b. Salaries & Wages - Non unionized							
Management					1.3	128,537	
Public Health Nurses							
Lay Home Visitors							
Social Workers							
Administration: Program Support							
Administration: ISCIS Data Entry Support							
Administration: ISCIS Release Support							
Other Professional (specify)							
Other Non-Professional (specify)							
Total Salaries & Wages - Non unionized	-	-	-	-	1.3	128,537	
Employee Benefits - Non unionized						33,805	
Total Salaries & Wages	10.2	623,449	10.33	605,623	10.3	617,867	
Employee Benefits		156,442		161,109		166,771	
2. Contract Services							
Other Professional (specify)		28,000		28,000		28,000	
Other Non-Professional (specify)							
Lay Home Visitors							
Administration: ISCIS Release Support							
Total Contract Services	-	28,000	-	28,000	-	28,000	
3. Operating Costs							
Office Supplies		5,500		5,500		5,500	
Office Equipment							
Professional Development &Training		2,500		2,406		2,500	
Travel		15,747		13,414		16,000	
Public Awareness/Promotion							
Program Resources		5,165		5,165		5,165	
Computer costs for ISCIS							
Audit and legal		3,800		2,300		3,800	
Other: Telephone and communication		5,000		4,893		5,000	
Total Operating Costs		37,712		33,678		37,965	
Total Request from MCYS (1+2+3+EB)	10.2	845,603	10.33	828,410	10.3	850,603	
4. One-Time Grant Request		50,000		26,200		41,684	
5. One-Time Funding - NCAST		5,500		5,500		-	
6. Funding from other sources		(17,190)		-		(22,190)	
Total	10.2	883,913	10.33	860,110	10.3	870,097	

Healthy Babies Healthy Children
Early Learning and Child Development Branch
Strategic Policy and Planning Division
Ministry of Children and Youth Services
2012 One-Time Grant Request
January 1, 2012 - December 31, 2012

Public Health Unit: Peterborough County-City Health Unit

One Time Grant - Details

One-Time Expenses	FTE	Proposed Budget $	Ministry Use
1a. Salaries & Wages, and Benefits Unionized			
(specify) PHN 1.0 FTE for six months	0.5	**32,030**	
(specify) benefits		**8,424**	
1b. Salaries & Wages, and Benefits Non unionized			
(specify)			
(specify)			
2. Contract Services			
(specify)			
(specify)			
3. Operating Costs			
(specify) Materials and supplies (printing, materials for presentations)		**700**	
(specify) Mileage (500 km x .58)		**290**	
(specify) Cell phone ($40 x 6 months)		**240**	
Total One-Time Expenses	**0.50**	**41,684**	

Description of request and anticipated outcomes:

We are requesting funding to hire a full-time PHN for six months to develop a process to ensure that the new HBHC high risk screening tool (replacing the Larson and the Parkyn) is correctly filled out, and forwarded to the Health Unit efficiently; and to provide training to hospital RNs and midwives on this new tool. Working with the hospital Maternal-Child Unit Staff Educator, this PHN would conduct a needs assesment of staff learning needs, develop a training plan, provide training to staff at times and locations most conducive to their needs, develop resources that will reinforce learning and that could be used for future reference, develop a training module for students and new staff coming on to the Maternal-Child Unit, evaluate the education program, and act as a consultant for those staff with any questions. This PHN would also be the project lead and provide education to her HBHC colleagues and relevant community partners. In addition, this PHN would work with the hospital's Staff Educator to ensure implementation of the new postpartum package - reviewing and revising resources to ensure that relevant local information and community programs and services are represented. We are asking for this funding due to serious budget constraints. In 2007, the program had budgeted for 5.2 FTE PHNs. The 2012 funding allocation provided by MCYS will only allow for 4.5 FTE PHNs. Significant financial impact will be exerted on our program due to the fact that five PHNs will each be taking a one year pregnancy/parental leave of absence in the time span of December 2011 to September 2013. Costs include “the supplement or ‘top up’ of the Human Resources Development benefits payable to employees who are absent from work on pregnancy, parental or adoption leave” (Ontario Nurses Association Collective Agreement, 11.04 (i) (i)) projected to be $27,912, as well as the employer share of benefits costs. This will reduce our base PHN complement even more. Therefore, the addition of a 0.5 PHN would facilitate the implementation of of two new HBHC strategies and permit the remaining HBHC staff to continue with service provision (telephone calls, home visiting, and service coordination) to families with identified risk factors.

Staff Report

Audit Letter of Engagement

Date:	April 2, 2012
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original signed by	**Original signed by**
_____	_____
Rosana Pellizzari, M.D.	Brent Woodford, Director, Corporate Services

Recommendations

That the Board of Health for the Peterborough County-City Health Unit sign the Collins Barrow Kawarthas LLP Letter of Engagement.

Financial Implications and Impact

Agreement will result in the annual auditors' fees. If the Letter of Engagement (Attachment A) is not signed the auditor will not be able to carry out the annual audit.

Decision History

Approval of the Letter of Engagement is required annually.

Background

Before the turn of this century auditors required their clients to sign a "Letter of Engagement" appointing the auditor, directing the auditor to audit the books of account and committing the organization to pay for the audit once the work was done. Then due accounting scandals (such as Worldcom or Encon) the audit societies increased the responsibilities and requirements of auditors, including reporting to the Board any relationships they may have with the Board.

These relationships include:

- Holding a financial interest, directly or indirectly, in the Board;
- Holding a position, directly or indirectly, that gives the right or responsibility to exert significant influence over the financial or accounting policies of the Board;
- A personal or business relationship with immediate family, close relatives, partners or retired partners of the Board;
- Having an economic dependence on the work of the Board;
- Providing services to the Board other than auditing (for example: consulting services).

The auditors have not identified any relationship.

The auditors have committed to expressing an opinion on whether our Financial Statements fairly represent, in a material way, the financial position of the Board.

The auditors note that their obligation is to obtain reasonable, but not absolute assurance that the financial statements are free of material misstatement. That is: the auditor will examine our records but will not guarantee they will find a misstatement, if one is present. This also means that there may be small misstatements but the misstatement will not have a significant bearing on our Financial Statements.

The auditors will:

- Assess the risk that the financial statements contain misstatement(s) that are material to the Financial Statements;
- Examine on a test basis the evidence supporting amounts and disclosures to the financial statements (for example: compare invoices to cheque amounts, lease commitments, etc);
- Assess the accounting principles used and their application;
- Assess the estimates made;
- Examine internal controls in place.

The Board is required to:

- Meet with the auditors prior to the release and approval of the financial statements to review audit, disclosure and compliance issues;
- If necessary, review matters raised by the auditors with management, and if necessary report back to the auditors on the Board's findings;
- Make known to the auditors any issues of fraud or illegal acts or non-compliance with any laws or regulatory requirements known to the Board that may affect the financial statements;
- Provide direction to the auditor on any additional work the auditor feels should be undertaken in response to issued raised or concerns expressed;

- Make enquiries into the findings of the auditor with respect to corporate governance, management conduct, management cooperation, information flow and systems of internal control;
- Review the draft financial statements; and
- Pre-approve all professional and consulting services to be provided by the auditors. In our case, there are none.

Rationale

This is a standard letter as required by the Canadian Institute of Chartered Accountants (CICA). An annual audit by external auditors is required by legislation and under Board Policy 2-130.

Contact:

Brent Woodford
Director Corporate Services
(705) 743-1000, ext. 231
bwoodford@pcchu.ca

Attachments:

Attachment A: Letter of Engagement, Collins Barrow Kawarthas LLP

Collins Barrow
Chartered Accountants

Collins Barrow Kawarthas LLP
272 Charlotte Street
Peterborough, Ontario
K9J 2V4

T. 705.742.3418
F. 705.742.9775

www.collinsbarrowkawarthas.com

April 2, 2012

Members of the Board of Health
Peterborough County - City Health Unit
10 Hospital Drive
Peterborough, Ontario
K9J 8M1

Re: Audit of the Consolidated Financial Statements of Peterborough County - City Health Unit

Dear Sirs and Mesdames:

This report is intended solely for the use of the Board of Health and should not be distributed without our prior consent. We accept no responsibility to a third party who uses this communication.

We have been engaged to express an audit opinion on the Consolidated financial statements of Peterborough County - City Health Unit ("the Health Unit") for the year ended December 31, 2011. Canadian Auditing Standards ("CAS") require that we communicate the following information with you in relation to your audit.

Management is responsible for establishing and maintaining an adequate internal control structure and procedures for financial reporting. This includes the design and maintenance of accounting records, recording transactions, selecting and applying accounting policies, safeguarding of assets and preventing and detecting fraud and error.

Auditor Independence

CAS require communications with audit committees, or other appropriate parties responsible for governance, at least annually, regarding all relationships between the Health Unit and our Firm that, in our professional judgement, may reasonably be thought to bear on our independence.

We will, through our planning process, identify any potential independence threats and will communicate any concerns we identify. The Health Unit, management and the Board of Health have a proactive role in this process, and are responsible for understanding the independence requirements applicable to the Health Unit and its auditor. You must also bring to our attention any concerns you may have, or any knowledge of situations or relationships between the Health Unit, management, personnel (acting in an oversight or financial reporting role) and our Firm, its partners/principals and audit team personnel that may reasonably be thought to bear on our independence.

In determining which relationships to report, these standards require us to consider relevant rules and related interpretations prescribed by the Institute of Chartered Accountants of Ontario and applicable legislation, covering such matters as:

(a) holding a financial interest, either directly or indirectly, in a client;

(b) holding a position, either directly or indirectly, that gives the right or responsibility to exert significant influence over the financial or accounting policies of a client;

(c) personal or business relationships of immediate family, close relatives, partners or retired partners, either directly or indirectly, with a client;

(d) economic dependence on a client; and

(e) provision of services in addition to the audit engagement.

In accordance with our professional requirements, we advise you that we are not aware of any relationships between the Health Unit and our Firm that, in our professional judgement, may reasonably be thought to bear on our independence.

Accordingly, we hereby confirm that our audit engagement team, our Firm and the other Collins Barrow offices are independent with respect to the Health Unit within the meaning of the Rules of Professional Conduct Rule 204 of the Institute of Chartered Accountants of Ontario.

Our Responsibilities as Auditor

As stated in the engagement letter, our responsibility as auditor of your Health Unit is to express an opinion on whether the Consolidated financial statements present fairly, in all material respects, the financial position, results of operations and cash flows of the Health Unit in accordance with Canadian Public Sector Accounting Standards.

An audit is performed to obtain reasonable but not absolute assurance as to whether the financial statements are free of material misstatement. Due to the inherent limitations of an audit, there is an unavoidable risk that some misstatements of the financial statements will not be detected (particularly intentional misstatements concealed through collusion), even though the audit is properly planned and performed.

Our audit includes:

- Assessing the risk that the financial statements may contain material misstatements that, individually or in the aggregate, are material to the financial statements taken as a whole;
- Examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements;
- Assessing the accounting principles used, and their application; and
- Assessing the significant estimates made by management.

As part of our audit, we will obtain a sufficient understanding of the business and internal control structure of the Health Unit to plan the audit. This will include management's assessment of:

- The risk that the financial statements may be materially misstated as a result of fraud and error; and

- The internal controls put in place by management to address such risks.

The engagement team must undertake a documented planning process prior to commencement of the audit to identify concerns, address independence considerations, assess the engagement team requirements, and plan the audit work and timing. It may be necessary to contact members of the Board of Health if significant matters arise from planning procedures.

An audit does not relieve management or those responsible for governance of their responsibilities for the preparation of the Health Unit's financial statements.

Board of Health Members' Responsibilities

The Board of Health's role is to act in an objective, independent capacity as a liaison between the auditor and management to ensure the auditors have a facility to consider and discuss governance and audit issues with parties not directly responsible for operations.

The Board of Health's responsibilities include:

- Being available to assist and provide direction in the audit planning process when and where appropriate;

- Meeting with the auditors as necessary and prior to release and approval of financial statements to review audit, disclosure and compliance issues;
- Where necessary, reviewing matters raised by the auditor with appropriate levels of management, and reporting back to the auditors their findings;
- Making known to the auditor any issues of disclosure, corporate governance, fraud or illegal acts, non-compliance with laws or regulatory requirements that are known to them, where such matters may impact the financial statements or the Independent Auditors' Report;
- Providing guidance and direction to the auditor on any additional work the auditor feels should be undertaken in response to issues raised or concerns expressed;
- Making such enquiries as appropriate into the findings of the auditor with respect to corporate governance, management conduct, cooperation, information flow and systems of internal controls;
- Reviewing the draft financial statements prepared by management, including the presentation, disclosures and supporting notes and schedules, for accuracy, completeness and appropriateness, and approve same to be passed to directors for approval; and
- Pre-approving all professional services and allowable consulting services to be provided by the auditors.

Audit Approach

Outlined below are certain aspects of our audit approach which are intended to help you in discharging your oversight responsibilities. Our general approach to the audit of Peterborough County - City Health Unit is to assess the risks of material misstatement in the financial statements and then respond by designing audit procedures.

Illegal Acts, Fraud, Intentional Misstatements and Errors

Our auditing procedures, including tests of your accounting records, will be limited to those considered necessary in the circumstances and will not necessarily disclose all illegal acts, fraud, intentional misstatements or errors should any exist. We will conduct the audit under CAS, which include procedures to consider (based on the control environment, governance structure and circumstances encountered during the audit), the potential likelihood of fraud and illegal acts occurring.

These procedures are not designed to test for fraudulent or illegal acts, nor will they necessarily detect such acts or recognize them as such, even if the effect of its consequences on the financial statements is material. However, should we become aware that an illegal or possible illegal act or an act of fraud may have occurred, other than one considered clearly inconsequential, we will communicate this information directly to the Board of Health.

It is management's responsibility to detect and prevent illegal actions. If such acts are discovered or the Board of Health becomes aware of circumstances under which the Health Unit may have been involved in fraudulent, illegal or regulatory non-compliance situations, such circumstances must be disclosed to us.

Related Party Transactions

During our audit, we conduct various tests and procedures to identify transactions considered to involve related parties. Related parties exist when one party has the ability to exercise, directly or indirectly, control, joint control or significant influence over the other. Two or more parties are related when they are subject to common control, joint control or common significant influence. Related parties also include management, directors and their immediate family members and companies with which these individuals have an economic interest.

We will ensure that any related party transactions that are identified during the audit have been represented by management to have been disclosed in the notes to financial statements, recorded in accordance with Canadian Public Sector Accounting Standards, and have been reviewed with you. Management is required to advise us if any related party transactions have occurred that have not been disclosed to us. The Board of Health is required to advise us if they are aware of or suspect any other related party transactions have occurred which have not been disclosed in the financial statements.

Significant Accounting Principles and Policies

The Health Unit's financial statements will be prepared by management using various accounting principles, which have been incorporated into the Health Unit's accounting policies and disclosed in the notes to the financial statements. Where accounting policies have changed from one period to the next, such changes will be noted and the effect of these changes will be disclosed.

The accounting policies adopted may be acceptable policies under Canadian Public Sector Accounting Standards; however, alternative policies may also be acceptable under Canadian Public Sector Accounting Standards. The Health Unit and the Board of Health have a responsibility to not adopt extreme or inappropriate interpretations of Canadian Public Sector Accounting Standards that may have inappropriate or misleading results. Alternative policies, if adopted, may produce significant changes in the reported results of the operations, financial position and disclosures of the Health Unit.

The Board of Health has a responsibility to review the accounting policies adopted by the Health Unit, and where alternative policies are available, make determinations as to the most appropriate policies to be adopted in the circumstances. If members of the Board of Health are concerned that the adoption or change of an accounting policy may produce an inappropriate or misleading result in financial reporting or disclosure, this concern must be discussed with management and the auditors. If the Board of Health believes that a policy or policies adopted are inappropriate or produce a misleading result in the circumstances, these concerns should be discussed with us directly, either privately or in Board of Health meetings.

Risk-based

Our risk-based approach focuses on obtaining sufficient appropriate audit evidence to reduce the risk of material misstatement in the financial statements to an appropriately low level. This means that we focus our audit work on higher risk areas that have a higher risk of being materially misstated.

Based on our knowledge of the Health Unit's business and our past experience, we have identified the following areas that have a potentially higher risk of a material misstatement.

a) Year-end cut-off of accounts receivable and accounts payable;

b) Useful life estimates for tangible capital assets; and

c) Year-end cut-off of environmental program deferred revenue.

Materiality

Materiality is defined as:

Materiality is the term used to describe the significance of financial statement information to decision makers. An item of information, or an aggregate of items, is material if it is probable that its omission or misstatement would influence or change a decision. Materiality is a matter of professional judgement in the particular circumstances.

We plan to use an overall materiality of $325,000 and a performance materiality of $275,000.

Materiality is used throughout the audit and in particular when:

a) Identifying and assessing risk of material misstatement;

b) Determining the nature, timing and extent of further audit procedures; and

c) Evaluating the effect of uncorrected misstatements, if any, on the financial statements and in forming an opinion on the auditors' report.

Audit Procedures

In responding to our risk assessment, we will use a combination of tests of controls, tests of details and substantive analytical procedures. The objective of the tests of controls is to evaluate whether certain controls operated effectively. The objective of the tests of details is to detect material misstatements in the account balances and transaction streams. Substantive analytical procedures are used to identify differences between recorded amounts and predictable expectations in larger volumes of transactions over time.

To ensure there is a clear understanding and record of the matters discussed, we ask that members of the Board of Health sign their acknowledgement in the spaces provided below. Should any member of the Board of Health wish to discuss or review any matter addressed in this letter or any other matters related to financial reporting, please do not hesitate to contact us at any time.

Yours very truly,

Collins Barrow Kawarthas LLP

per: Richard Steiginga, CA, Partner

Acknowledgement of Board of Health:

We have read and reviewed the above disclosures and understand and agree with the comments therein:

Peterborough County - City Health Unit

Are you aware of any frauds, illegal acts or management override of internal controls at the Health Unit?

Yes / No (please circle one)

If yes, please contact our office immediately

Name	Position
Name	Position

Cancer Care Ontario
Action Cancer Ontario
Public Health Ontario
PARTNERS FOR HEALTH
Santé publique Ontario
PARTENAIRES POUR LA SANTÉ

Taking action for a Healthier Ontario

Acknowledgements

- This report is a joint initiative of Public Health Ontario and Cancer Care Ontario
- PHO and CCO convened an overall prevention working group as well as five expert panels to develop the recommendations
- Extensive stakeholder consultation and input also guided the final product

Approach

- CCO-PHO Prevention Working Group with assigned risk factor leads
- Identification of key evidence sources and approach to evidence
- Expert panels for each risk factor and for overarching chronic disease prevention
- Input and feedback from Stakeholders:
  - Cancer Quality Council Ontario Forum Dec 5
  - Stakeholder submissions

Purpose

- Provide the Ontario government and key stakeholders with evidence to guide action in the prevention of chronic disease
- Summarize and understand the burden of chronic disease and the relationship between risk factors and chronic diseases in Ontario
- Support a comprehensive strategy and action across sectors and levels of society

Problem

"Ontario is confronted with a serious fiscal issue.

Every year, government spending on health care increases more than revenues. As a result the amount available for other government spending decreases. If current trends prevail, health care expenditures would make up 80 per cent of total program spending by 2030, up from 46 per cent today.

All other programs, such as education, would be funded out of the remaining 20 per cent.

This is not feasible."

TD Bank Financial Group. Charting a path to sustainable health care in Ontario: 10 proposals to restrain cost growth without compromising quality of care. TD Economics Special Reports [Internet]. Toronto: TD Bank Financial Group; 2010 [cited 2011 Oct 11]. Available from: http://www.td.com/document/PDF/economics/special/td-economics-specialdb0510-health-care.pdf

Enlarge this image

Politicians: Enough health-care planning, let's have some action

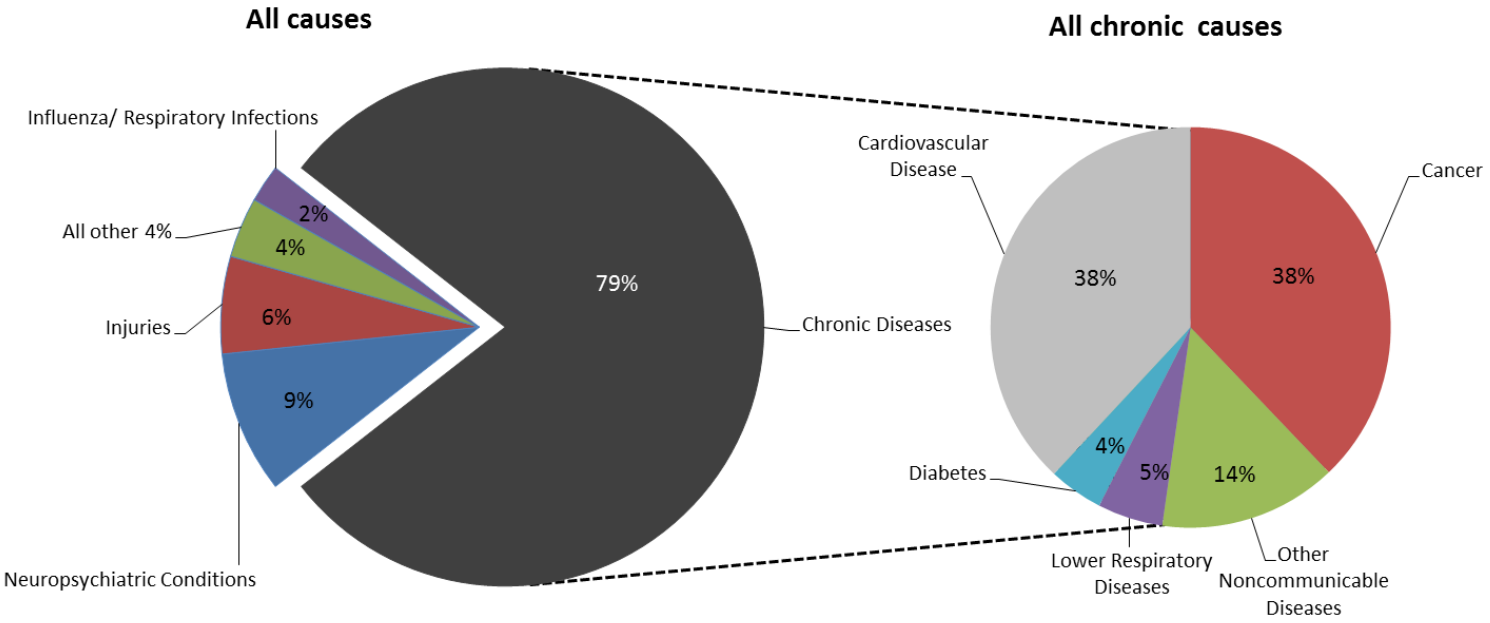
ANDRÉ PICARD | Columnist profile | E-mail
From Tuesday's Globe and Mail
Published Monday, Feb. 06, 2012 4:01PM EST
Last updated Tuesday, Feb. 07, 2012 9:34AM EST

comments 8 +1 0 Print/License A A

Last week, Ontario Health Minister Deb Matthews unveiled "An Action Plan for Health Care" in a speech to the Toronto Board of Trade.

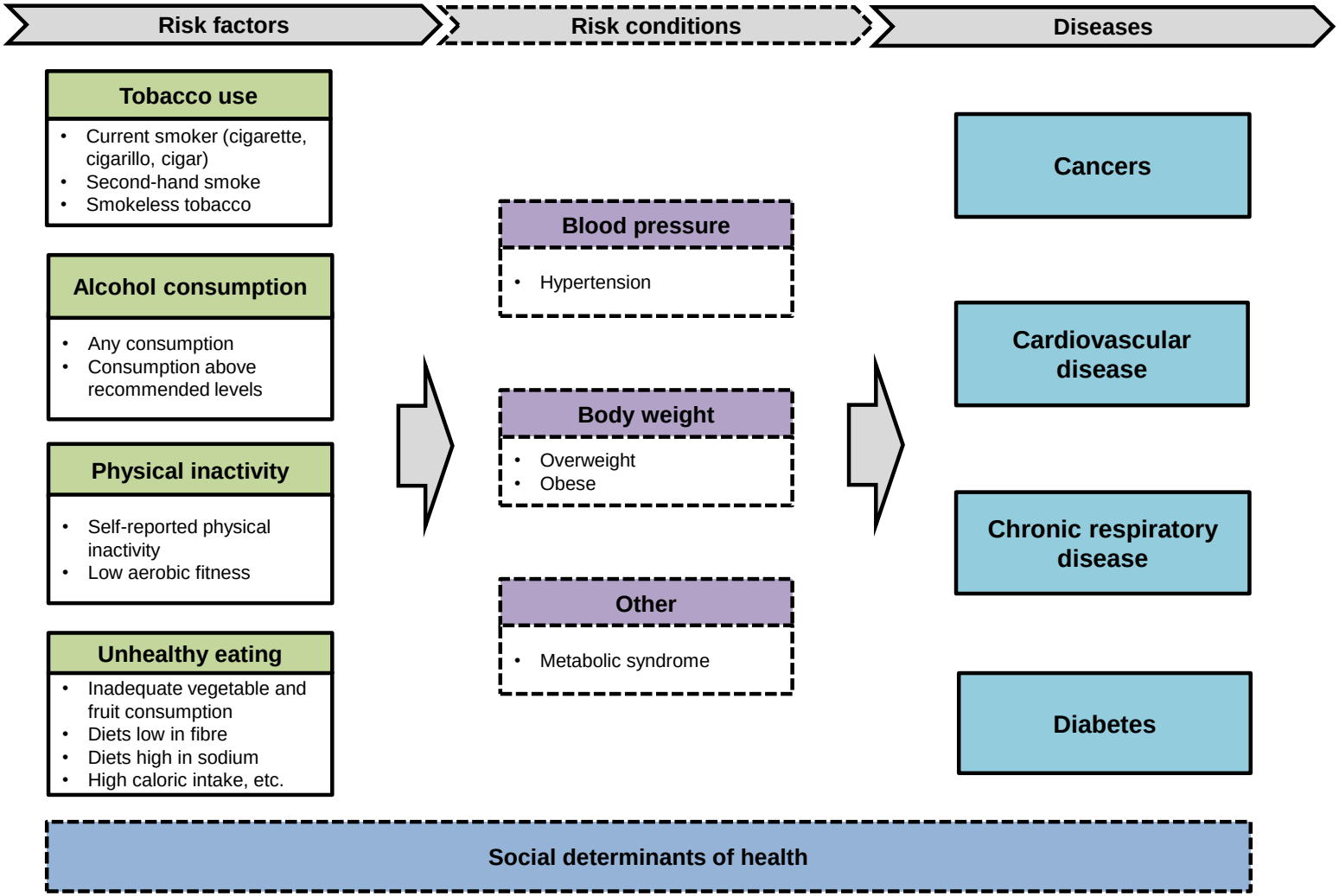
Chronic Diseases in Ontario: 79% Mortality

Cause of Death Ontario Residents, 2007



Source: Death, Ontario Ministry of Health and Long-Term Care, intelliHEALTH ONTARIO Date Data Last Refreshed Oct, 2011.
Note: ICD10 categories adopted from Word Health Organization Global Burden of Disease: data, source, methods and results. Available from: http://www.who.int/healthinfo/paper54.pdf.

Risk Factors and Chronic Diseases



Adapted from: Cecchini M, Sassi F, Lauer JA, Lee YY, Guajardo-Barron V, Chisholm D. Tackling of unhealthy diets, physical inactivity, and obesity: health effects and cost-effectiveness. Lancet. 2010 Nov 20;376(9754):1775–84.

Select specific diseases	Tobacco use			Alcohol	Physical inactivity		Unhealthy eating			
	Current smoker	Second-hand smoke	Smokeless	Alcohol consumption	Physical inactivity	Obesity	Inadequate vegetable & fruit	Diets low in fibre	High sodium	Trans fat
Cancer										
Breast	↑			↑↑	↑	↑↑				
Lung	↑↑	↑↑					↑			
Colon & rectum	↑↑			↑↑	↑↑	↑↑		↑↑		
Leukemia	↑↑									
Bladder	↑↑									
Body of uterus	↓↓				↑					
Kidney	↑↑					↑↑				
Oral cavity, pharynx	↑↑	↑	↑↑	↑↑			↑			
Cardiovascular disease										
IHD	↑↑	↑↑	↑	↑↓	↑↑	↑↑	↑↑	↑	↑↑	↑↑
Stroke	↑↑	↑	↑	↑↓						
Chronic respiratory disease										
Asthma										
COPD	↑↑	↑								
Diabetes										
Type 2 diabetes	↑			↑↓	↑↑	↑↑		↑		

IHD = ischemic heart disease; COPD = chronic obstructive pulmonary disease; ↑↑ = convincing increased risk; ↑ = probable increased risk; ↓↓ = convincing decreased risk; ↓ = probable decreased risk; ↑↓ = convincing J- or U shaped risk; ↑↓ = probable J- or U-shaped risk. Table 2 was assembled using expert evaluations performed by the World Health Organization, International Agency for Research on Cancer, United States Surgeon General and World Cancer Research Fund. This table includes only a selection of risk factors and the most common diseases associated with these risk factors. Directional arrows were included if the strength of evidence for the causal association between the risk factor and disease was rated as 'probable' or stronger by the expert panel. Unhealthy eating indicators were evaluated by the World Health Organization for cardiovascular disease as a whole; a distinction was not made between IHD and stroke

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57.4% of Ontarians 12 and older are not healthy eaters

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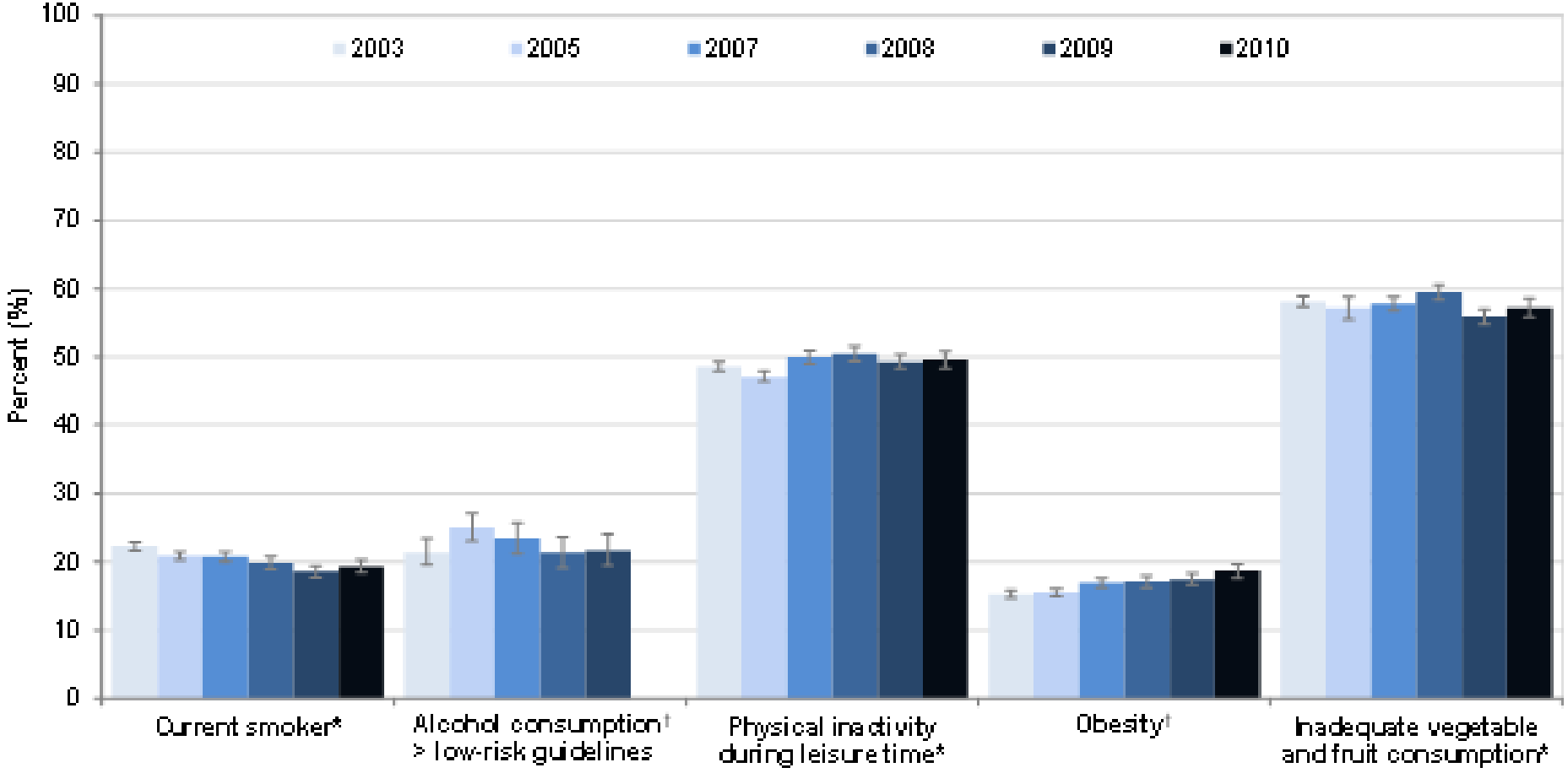
Recent trends – Percentage of Ontarian with selected modifiable risk factors, 2003-2010



Criteria for Recommendation Selection

- Within Ontario government's scope of control to directly implement
- Strength of the evidence
- Previously-identified
- Reflects the level of development of interventions for the risk factor area
- Also considered impact on health equity
- Limited to 4 recommendations per RF

Final report: recommended population-level interventions

- Tobacco use

1. Increase tobacco tax

Immediately increase tobacco tax on all products sold in Ontario. This tax to be equal to (or greater than) the average tobacco tax rate of other Canadian provinces or territories, and be indexed at (or greater than) inflation. It is recommended that the minimum dedicated tobacco tax (DTT) remain a constant percentage of the total, that this percentage may be increased and that the proceeds of the DTT fund the provincial tobacco control program.

2. Broaden and extend the integrated tobacco cessation system

Broaden and extend efforts to create an integrated and coordinated Ontario tobacco cessation system that builds upon existing resources in hospitals, primary care and community settings to increase access to cessation treatment and services for all tobacco users regardless of age or background.

Final report: recommended population-level interventions…cont'd

3. Implement a sustained social marketing campaign

Implement a sustained social marketing campaign that motivates tobacco users to quit, and informs tobacco users of the dangers of all types of tobacco use, and the different options and resources available within Ontario for becoming tobacco-free.

4. Ban smoking on bar and restaurant patios

Amend the *Smoke-Free Ontario Act* to include the prohibition of smoking on unenclosed bar and restaurant patios (including a buffer zone of nine metres from the perimeter of the patio).

Final report: recommended population-level interventions…cont'd

- **Alcohol consumption**

5. **Maintain and reinforce socially responsible pricing**

   Maintain and reinforce the socially responsible pricing of alcohol by:

   a) Establishing minimum pricing per standard drink across all alcoholic beverages indexed to inflation,

   b) Maintaining average prices at or above the consumer price index,

   c) Adopting disincentive pricing policies for higher alcohol content beverages to create disincentives for the production and consumption of higher-strength alcoholic beverages, and to reduce the overall per capita level consumption of ethyl alcohol.

6. **Ensure effective controls on alcohol availability**

   Control the overall risk of exposure to alcohol by:

   a) Ensuring that there is no increase in hours of sale,

   b) Ensuring that the overall population density of on- and off-premise outlets per capita does not increase,

   c) Not undertaking further privatization of "off-premise" alcohol retail sales in Ontario.

Final report: recommended population-level interventions…cont'd

7. Strengthen targeted controls on alcohol marketing and promotion

Adopt targeted control policies on alcohol advertising and marketing, especially marketing efforts adopting a "lifestyle promotion" approach to alcohol consumption, marketing targeting youth or high-risk drinkers, or marketing efforts encouraging high-risk drinking.

8. Increase access to brief counselling interventions

Increase access to brief counselling interventions for moderate to high-risk drinkers, including underage drinkers, via clinics, primary health care services, hospitals, university health care services, workplaces and the Internet.

Final report: recommended population-level interventions…cont'd

- Physical activity

9. Require physical education credits

Require students to earn a physical education credit in every grade from 9 to 12 to achieve high school graduation.

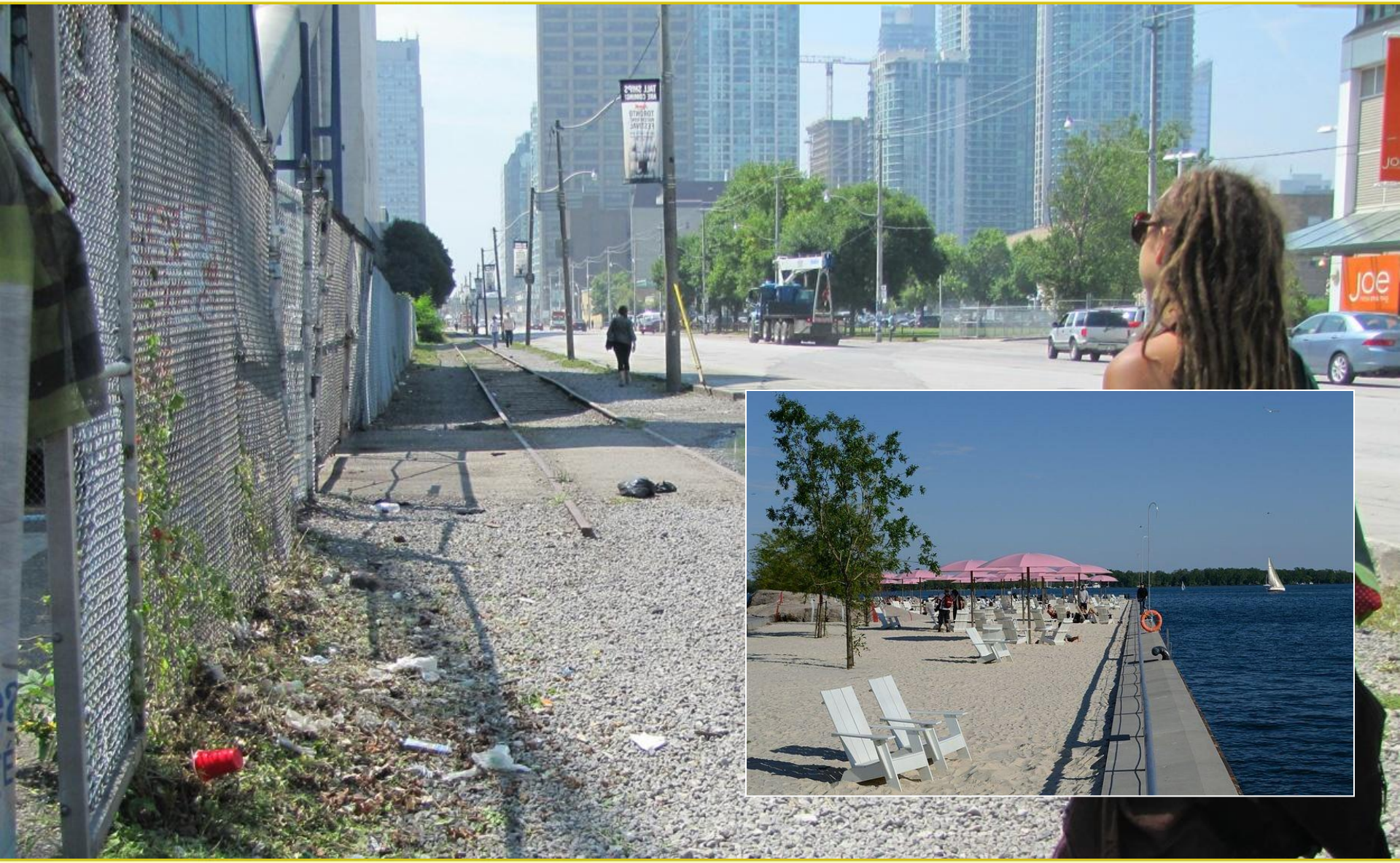
10. Evaluate daily physical activity

Evaluate the implementation, feasibility and quality of the daily physical activity policy in Ontario elementary schools, and address the need for continued implementation.

Cancer Care Ontario
Action Cancer Ontario

Public Health Ontario
PARTNERS FOR HEALTH

Santé publique Ontario
PARTENAIRES POUR LA SANTÉ



Final report: recommended population-level interventions

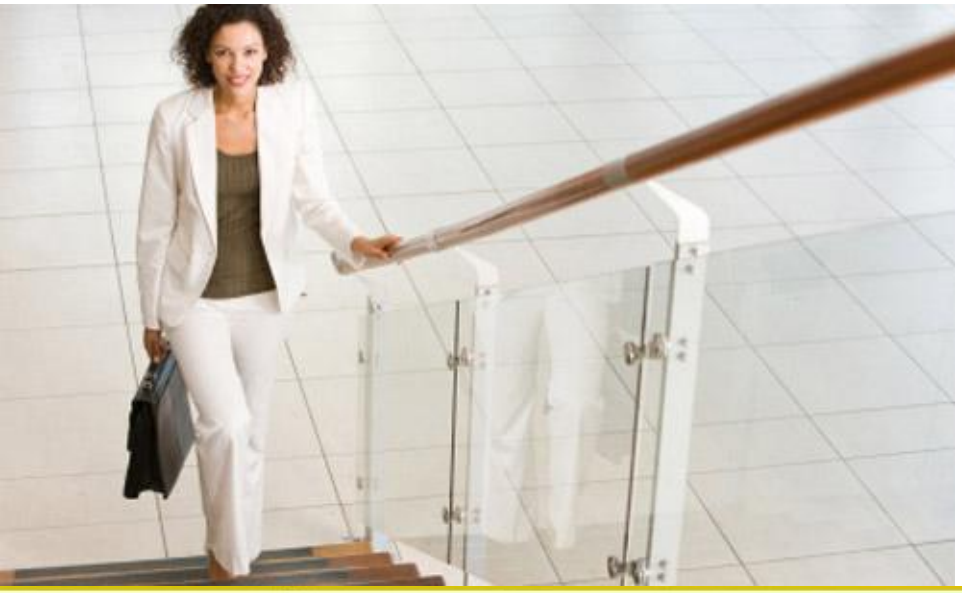
11. Support active transportation

Strengthen the *Planning Act* Provincial Policy Statement on active transportation, and provide dedicated funding to municipalities for building walking and cycling infrastructure.

Final report: recommended population-level interventions

11. Provide leadership through workplace physical activity policy

Provide leadership as a model employer by developing, implementing and evaluating a workplace-based policy to increase physical activity participation among employees.




Absenteeism
Productivity
Job Satisfaction

Final report: recommended population-level interventions

13. Create an Ontario food and nutrition strategy

Implement a whole-of-government, coordinated and comprehensive food and nutrition strategy for Ontario.

Final report: recommended population-level interventions

13. Include compulsory food skills in curricula

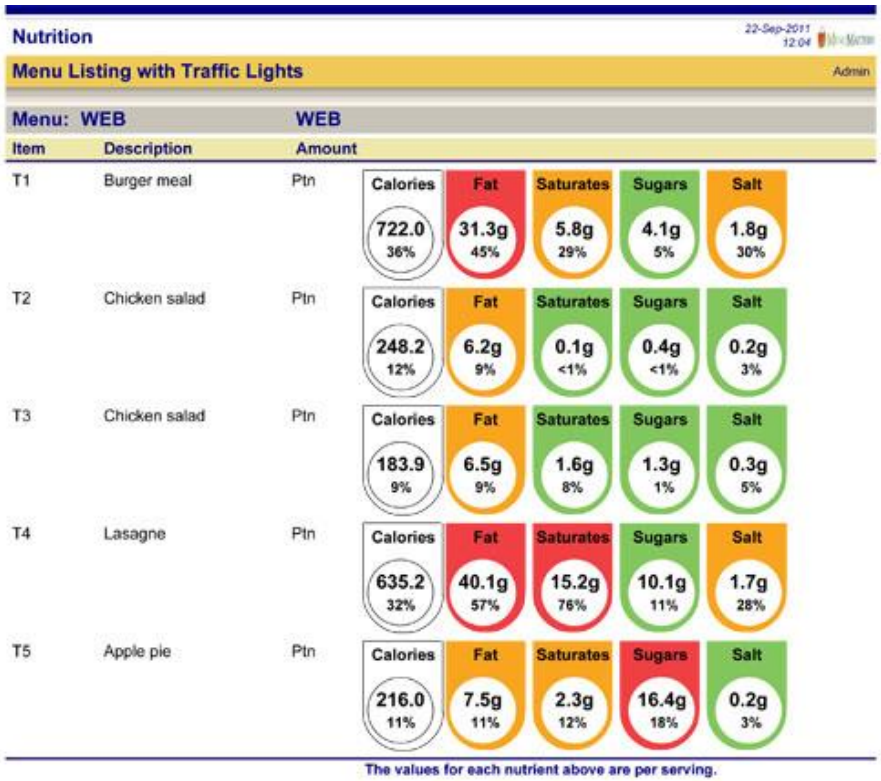
Include the development of food skills as a compulsory component of elementary and secondary curricula, preparing children and youth to be competent in food preparation.

Final report: recommended population-level interventions

15. Support healthy eating in publicly funded institutions

Implement evidence-informed food and nutrition policies that promote healthy eating in provincial workplaces and provincially funded institutions.

Final report: recommended population-level interventions



Nutrition

22-Sep-2011 12:04

Menu Listing with Traffic Lights

Admin

Menu: WEB WEB

Item	Description	Amount	Calories	Fat	Saturates	Sugars	Salt
T1	Burger meal	Ptn	722.0 36%	31.3g 45%	5.8g 29%	4.1g 5%	1.8g 30%
T2	Chicken salad	Ptn	248.2 12%	6.2g 9%	0.1g <1%	0.4g <1%	0.2g 3%
T3	Chicken salad	Ptn	183.9 9%	6.5g 9%	1.6g 8%	1.3g 1%	0.3g 5%
T4	Lasagne	Ptn	635.2 32%	40.1g 57%	15.2g 76%	10.1g 11%	1.7g 28%
T5	Apple pie	Ptn	216.0 11%	7.5g 11%	2.3g 12%	16.4g 18%	0.2g 3%

The values for each nutrient above are per serving.

15. Implement mandatory menu labelling in food service operations

Require mandatory menu labelling of food and beverages to be visible at point-of-purchase in all large-scale food service operations in Ontario.

Final report: recommended population-level interventions

- Capacity-building

17. Adopt a whole-of-government approach

Adopt a whole-of-government approach for the primary prevention of chronic disease. This approach would guide goal and objective setting, policy and program planning, performance monitoring and accountability, and coordination and management of partner relationships. To be successful, this requires:

a) Identifying a dedicated ministerial and senior public service lead with sufficient authority to coordinate activities between sectors and levels of government for the improvement of health,

b) Developing a comprehensive, multi-level health promotion and chronic disease prevention strategy for Ontario with goals, objectives and measurable outcomes,

c) Exploring legislation mandating health impact assessments for all laws and regulations,

d) Supporting innovation and action at the local level and disseminating lessons learned across the province,

e) Proactively participating at federal/provincial/ territorial tables to support the application of evidence-informed action federally and across the country.

Final report: recommended population-level interventions

18. Improve measurement, increase accountability

Create a coordinated, province-wide, population health assessment and surveillance system to provide complete, timely, continuous and accurate data essential for the planning, delivery and evaluation of policies and programs aimed at reducing the burden of chronic diseases and related risk factors.

19. Connect knowledge with practice

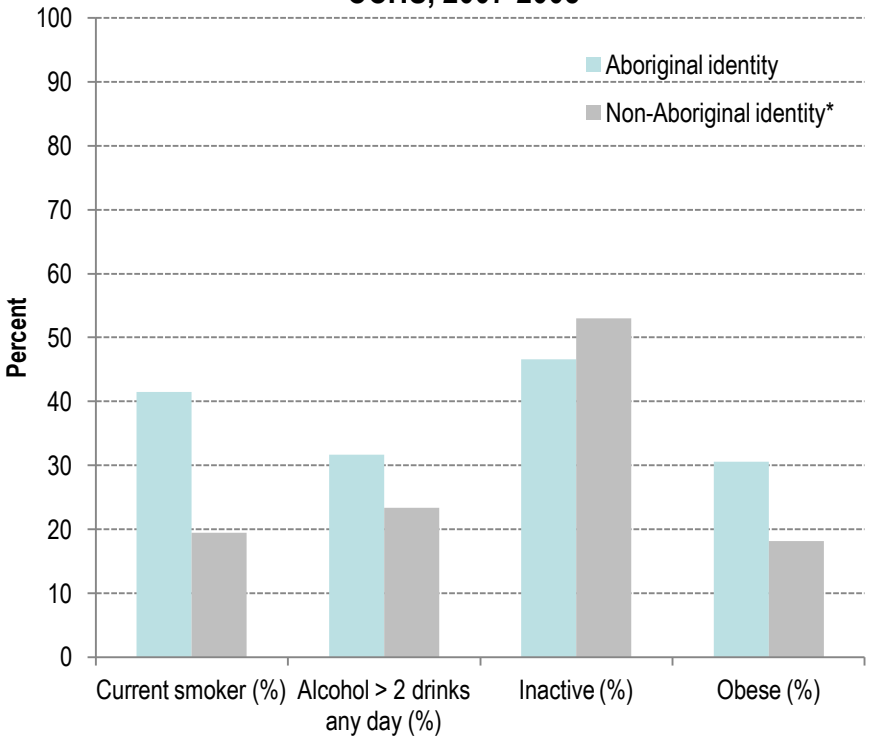
Build capacity for delivering effective chronic disease prevention interventions.

20. Implement a coordinated health communications campaign

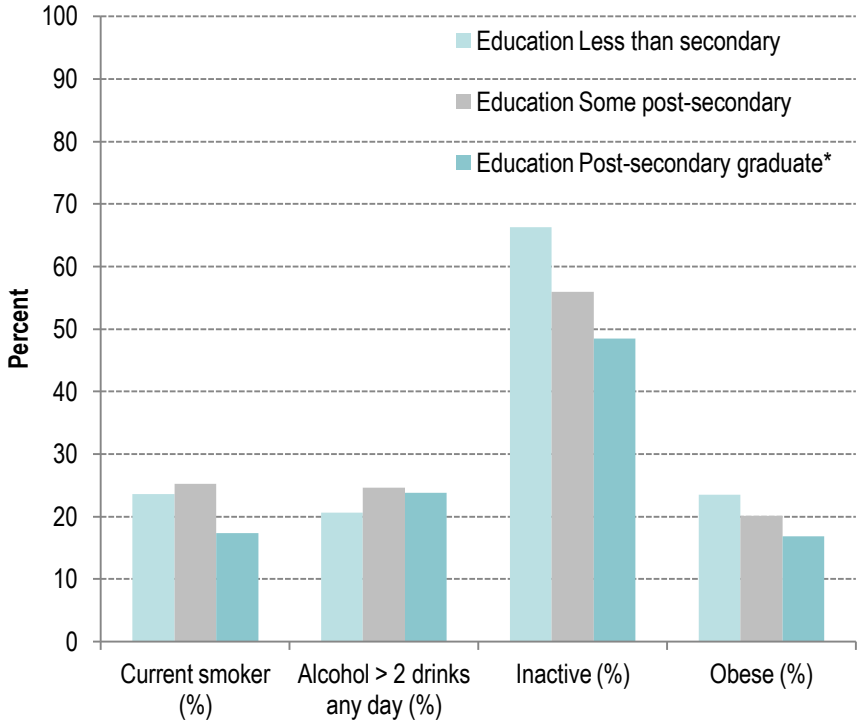
Implement and sustain an evidence-based, comprehensive, integrated and coordinated chronic disease prevention communications campaign that builds upon existing campaigns in Ontario.

Inequitable distribution of risk in Ontario

Percent of Ontario adults (aged 30+) with selected modifiable risk factors by Aboriginal identity CCHS, 2007-2008



Percent of Ontario adults (aged 30+) with selected modifiable risk factors by education CCHS, 2007-2008



Final report: recommended population-level interventions

21. Reduce health inequities

Reduce health inequities by ensuring that actions taken to address chronic diseases and their associated risk factors recognize the higher burden of disease experienced by some sub-populations in Ontario. To be successful, this requires:

a) Ensuring that provincial data collection systems adequately identify and assess disparities in exposure to risk factors and the burden of disease among sub-populations in Ontario,

b) Focusing greater attention on addressing the upstream determinants of health for these groups,

c) Conducting health equity impact assessments (HEIA) prior to program and policy implementation to capture—and enable planning to mitigate—the differential impact of interventions on sub-populations.

Final report: recommended population-level interventions

22. Address First Nations, Inuit and Métis health

Ensure that the actions taken to address risk factors associated with chronic diseases consider the barriers to health faced by First Nations, Inuit and Métis in Ontario.

To access the full report

- http://www.oahpp.ca/takingaction/index.html

- Available online:
  - Executive Summary
  - Main Report
  - Technical Appendix

Cancer Care Ontario
Action Cancer Ontario
Public Health Ontario
PARTNERS FOR HEALTH
Santé publique Ontario
PARTENAIRES POUR LA SANTÉ

Staff Report

2012/13 Infant & Toddler Development Program Budget

Date:	April 11, 2012
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health
Original signed by _____ Rosana Pellizzari, M.D.	**Original signed by** _____ Brent Woodford, Director, Corporate Services

Recommendation

That the Board of Health for the Peterborough County-City Health Unit approve the 2012/13 funding request for the Infant & Toddler Development Program in the total amount of $242,423.

Financial Implications and Impact

To submit a Board approved 2012/13 Infant & Toddler Development Program (ITDP) budget with supporting documentation to the Ministry of Community and Social Services (MCYS) for their approval of the funding request to enable the program to continue.

If the budget is not approved by the Board, the Ministry will not fund the program.

Decision History

The Board of Health is required by the Province to approve the fiscal budget annually. At its January 11, 2012 meeting, the Board approved to continue to administer the Infant Toddler Development Program for 2012/13. This report now includes detailed budget information which requires Board approval prior to submission to the MCYS (see Attachment A).

A letter was sent to the Honourable Eric Hoskins, Minister of Child and Youth Services, on February 15, 2012, regarding ITDP funding. A response was received from his office on March 27, 2012, this correspondence has been including in the April 2012 Board package. Minister Hoskins proposed a

meeting with his Assistant Deputy Minister, Darryl Sturtevant to discuss the issues. A meeting request has been sent to Mr. Sturtevant.

Background

The Infant & Toddler Development Program (ITDP) is 100% funded by the MCYS. The ITDP budget year began April 1, 2012 and ends March 31, 2013. The ongoing funding from the MCYS has not increased in the past eleven years for this program. The program's approved allocation remains at $242,423. The City of Peterborough has stepped in to subsidize the program through the province's "Best Start" initiative over the last couple of years. The program is not expected to receive additional "Best Start" funding for the current year to support the program.

Rationale

The 2012/13 budget is calculated at $253,173 including "Best Start" funding of $10,750 not expended in the previous year to support the program. This funding will allow us to continue operating the program with 2.15 full time equivalent (FTE) program staff for another year.

Strategic Direction

Important linkages have been established and by keeping the ITDP the Health Unit continues the strategic direction of "building on our leadership role" and maintaining a valuable service in our community.

Contact:
Bob Dubay, Accounting Supervisor
(705) 743-1000, Ext. 286
bdubay@pcchu.ca

Attachments:
Attachment A – ITDP Budget Summary, 2012/13

ATTACHMENT A

Service / Budget Submission
Budget Summary

Budget Year 2012/13

Organization Name Peterborough County-City Health Unit				Contract/Approval # & Date		Amendment # & Date		
TPBE #		41808						**TPR # 23673**
IFIS Line - Subline #		B078-B200						
Legislation		CFSA						
Ministry Detail Code		**A476**						**SUB - TOTAL** Page 1 of 1
Service Name	Allocated Central Administration	SCS - Children Infant Development						
FISCAL EXPENDITURES								
A Salaries/Benefits	14,259	222,064						236,323
B Other Service Costs	1,900	14,950						16,850
Gross Expenditures (A+B)	16,159	237,014						253,173
C1 Adjustments / Recoveries:								
C2 Adjustments / Recoveries:								
C3 Adjustments / Recoveries:								
C4 Adjustments / Recoveries:								
C5 Adjustments / Recoveries:								
C6 Adjustments / Recoveries:								
C7 Adjustments / Recoveries:								
C8 Adjustments / Recoveries:								
D Offsetting Revenue (-)		(10,750)						(10,750)
E Adjustments / Recoveries:								
Adjusted Service Expenditures (A to E)	16,159	226,264						242,423
F Allocated Central Administration	(16,159)	16,159						
G **Adjusted Gross Expenditures (A to F)**		242,423						242,423
H Less: Revenue (Legislated Share) (-)			( )	( )	( )	( )	( )	
I **Net Expenditures (G Less H)**		242,423						242,423
Allocated Central Administration Subsidy - $		16,159						16,159
Allocated Central Administration Subsidy - %		6.67%						6.67%
FISCAL SUBSIDY								
J **MCSS/MCYS Service Subsidy**		242,423						242,423
K Other :								
L Other :								
M Other :								
N Other :								
S **Total MCSS/MCYS Fiscal Subsidy**		242,423						242,423
ANNUALIZED SUBSIDY								
V **Total MCSS/MCYS Annualized Subsidy**		242,423						242,423

Staff Report

2012 Smoke Free Ontario Budget

Date:	April 11, 2012
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original signed by	**Original signed by**
_____	_____
Rosana Pellizzari, M.D.	Brent Woodford, Director, Corporate Services

Recommendation

That the Board of Health for the Peterborough County-City Health Unit approve the 2012 funding request for the Smoke Free Ontario Programs in the total amount of $300,724.

Financial Implications and Impact

To submit a Board approved 2012 Smoke Free Ontario Program budgets with supporting documentation to the Ministry of Health and Long-Term Care for their approval of the funding request to enable the program to continue.

Decision History

The Board of Health is required by the Province to approve the fiscal budget annually**.**

Background

The Smoke Free Ontario Program is funded 100% by the Ministry of Health and Long-Term Care. The Smoke Free Ontario Budget has not increased over the past couple of years and it is not anticipated that additional funding will be provided in 2012. The budget has been prepared based on the prior year funding.

Rationale

The budget is calculated at $300,724 for the current year. This funding will allow the programs to continue operating for another year.

Strategic Direction

The Smoke Free Ontario Programs will help the Board of Health to continue to meet its mandate, and better achieve the Ontario Public Health Standards.

Contact:
Bob Dubay, Accounting Supervisor
(705) 743-1000, Ext. 286
bdubay@pcchu.ca

Attachments:
Attachment A – Smoke Free Ontario Budget Summary, 2012

Ministry of Health and Long-Term Care - Smoke Free Ontario Programs

2012 Budget Request						
Form 2: Summary by Program						
23673	Peterborough County City Health Unit					
Program Code	Program Description	Approved Budget 2011	Approved Budget 2011	Budget Request 2012	Budget Request 2012	% Change
100	Smoke Free Ontario	A. Base	A. One-Time	C. Base	C. One-Time	E= (C-A)/A
101	Tobacco Enforcement	114,025	6,699	114,025	6,699	0%
102	Tobacco Control Area Networks					
104	Youth Engagement	80,000	-	80,000		0.00%
105	Tobacco Control Area Networks (Youth Engagement)					
108	Tobacco Control Coordination	100,000	-	100,000		0%
109	One Time Grant					
	Total	**294,025**	**6,699**	**294,025**	6,699	0.00%
	Offset Revenue (Form 7)			**-**		

TITLE **Alcohol Pricing and LCBO Revenue Generation**

SPONSOR Peterborough County-City Health Unit

WHEREAS The Liquor Control Board of Ontario (LCBO) will be implementing a number of measures to deliver $100 million per year in additional net revenue to the Province; and

WHEREAS Research has clearly established an association between easy access to alcohol (either through low prices or physical availability) and overall rates of consumption and damage from alcohol (Barbor et al., 2010); and

WHEREAS Ontario has a significant portion of the population drinking alcohol (79.1%), exceeding the low risk drinking guidelines (27.4%), consuming 5 or more drinks on a single occasion weekly (9%), and reporting hazardous or harmful drinking (16.7%) (CAMH Monitor, 2009); and

WHEREAS The low cost of alcohol from do-it-yourself brewing and winemaking facilities can potentially lead to individuals inexpensively producing and consuming harmful levels of alcohol (Recommendations for a National Alcohol Strategy, 2007); and

WHEREAS It has been established that increasing alcohol pricing can achieve the financial goal of increased revenues while realizing the health benefits of reduced alcohol consumption. Saskatchewan increased minimum prices and saw a decline in alcohol consumption of 135,000 litres of absolute alcohol and a revenue increase of $9.4 million last year (G. Thomas, CCSA, 2012); and

WHEREAS Increased alcohol sales will reduce overall provincial revenues since direct costs from alcohol-related healthcare and enforcement already leave Ontario with a $456 million annual deficit (G. Thomas, CCSA, 2012); and

WHEREAS Billions of dollars are spent each year in Canada on indirect costs associated with alcohol use (illness, disability, and death) including lost productivity in the workplace and home (The Costs of Substance Abuse in Canada, 2002);

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) urgently request that the Premier of Ontario (Dalton McGuinty), the Minister of Health and Long-Term Care (Deb Matthews), the Office of the Attorney General (John Gerretsen), the Minister of Finance (Dwight Duncan), and the Chief Medical Officer of Health (Arlene King), only consider revenue generation from increased pricing on alcohol, not fostering increased alcohol sales. Furthermore, the leader of opposition parties NDP (Andrea Horvath) and PC (Tim Hudak) should be copied on this communication.