The Board of Health for the
Peterborough County-City Health Unit
MEETING AGENDA
4:45 p.m. Wednesday, June 13, 2012
Lower Hall, Administration Building,
123 Paudash Street, Hiawatha First Nation

1. Welcome and Opening Prayer

2. Call to Order

3. Declaration of Pecuniary Interest

4. Confirmation of the Agenda

5. Delegations and Presentations

5.1. **Hiawatha Health and Social Services Update**
Presenter: Trudy Heffernan, Health and Social Services Manager

6. Confirmation of the Minutes of the Previous Meeting

6.1. **May 9, 2012**

7. Business Arising From the Minutes

8. Correspondence

9. Program Reports

10. New Business

10.1. **Peterborough Drug Strategy**
Presenter: Kerri Kightley, Strategy Coordinator
Peterborough Drug Strategy Initiative

10.2. **2011 Auditor's Report of the Consolidated Financial Statements**
Richard Steiginga, Partner
Collins Barrow Kawarthas LLP, Chartered Accountants

10.3. **Report - Reportable Diseases in Peterborough County-City 2011**
Presenter: Dr. Rosana Pellizzari, Medical Officer of Health
(Presentation Link)

10.4. **Staff Report – Designation, Chief Building Official**
Dr. Rosana Pellizzari, Medical Officer of Health

10.5. **Trichloroethylene (TCE) Update**
Dr. Rosana Pellizzari, Medical Officer of Health

10.6. alPHa Annual General Meeting Update
David Watton

11. Committee Reports

11.1. **Governance Committee**
David Watton

12. In Camera to Discuss Confidential Property Matters

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

Thursday, July 26, 2012, 4:45 p.m. – Location to be determined.

14. Adjournment

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

Hiawatha First Nation Health and Social Service Presentation

“Hiawatha First Nation is a vibrant, self sustaining, health community, rooted in the richness of its culture and traditional way of life while embracing its future”

Community Health Issues

Addictions

Obesity

Heart Disease

Diabetes

Mental Health

Housing

Water

Prescription Drugs

- Oxycontin
- Discontinuation
- Detoxification

Methadadone

- Increase in prescriptions
- Support through transportation
- Community Support workers counseling during appointments

Educating our young people

Gambling

- Gambling has existed in Hiawatha and First Nations for many years
- Seven times higher in First Nation Communities
- Concern about the effects of excessive gambling in families

Alcohol

- It is a Community Issue
- Accepted substance in society
- Passed generation, to generation
- FASD is prevalent in some families

Plan of Action-Addictions

- Education
- Public Awareness Campaigns
- Public Speaking
- Recreation Activities for Youth
- Discussion groups
- Counseling
- Sharing Circles
- Native Spiritual and Cultural Programs

Obesity

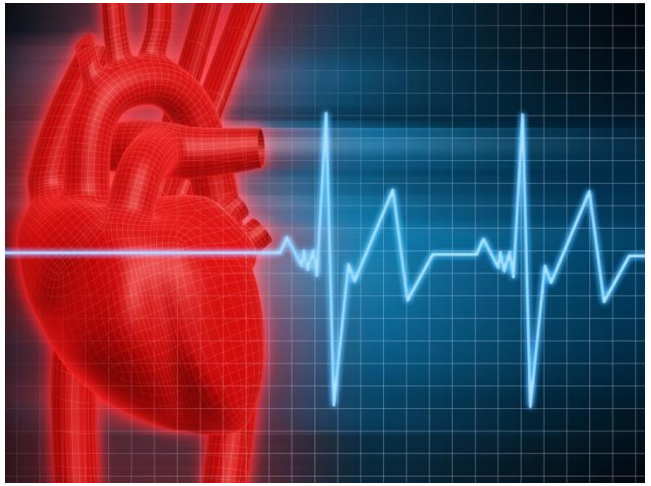
- Obesity is higher among Canada's Aboriginal First Nations
- Leading to other health factors
- Not just about over eating

Diabetes

- Type 2 Diabetes
- First Nations on reserve have a rate of diabetes three to five times higher
- Prevalent in Hiawatha
- Expected to rise

Heart Disease

- Native people more likely to have high blood pressure and type 2 diabetes which puts First Nation people at higher risk of heart disease
- Heart Disease and stroke are the two leading causes of death in Canada



Encourage Physical Activity in our Community Events

Plan of Action-Obesity, Diabetes, Heart Disease

- Community Health Nurse
- Home Visits
- Community Workshops and Education
- Encourage health eating and physical exercise
- Programs such as “Weight Wise Women”
- Healthy snacks and lunches offered
- Partnership with Health Agencies

Mental Health

- Loss of identity
- Discrimination in school
- Loss of language, traditions and culture
- Rates of mental health problems greater in Native communities

Plan of Action-Mental Health

- Psychologist or Therapist-on reserve would benefit
- Traditional Native concepts
- Recovery man involve a variety of different paths
- Difficult for people to get help

Housing

- Lack of funding
- Overcrowding
- Need more housing
- Elderly have difficult decisions to make

Water

- Quality
- Quantity
- Safety
- Correlation between water and illness?

Plan of Action-Water

- Staff on site
- Water samples
- Water adjustments
- Drinking purchased water
- Water treatments and purification system

Community Garden

Natural Health Care

- Reflexology
- Massage
- Aromatherapy
- Traditional teachings


Broadstone

Important to continue Traditional Healing to maintain culture

- Use of 4 medicines
- Regalia
- Sweat Lodges
- Full Moon Ceremony
- Feast of the Dead

Board of Health for the
Peterborough County-City Health Unit
Meeting Minutes
Wednesday, May 9, 2012
Council Chambers, County Court House
County of Peterborough, 470 Water Street

Present:

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

Regrets: Mr. Jim Embrey
Chief Keith Knott

Staff: Mrs. Brittany Cadence, Supervisor, Communications
Mrs. Ingrid Cathcart, Tobacco Enforcement Officer
Mrs. Susan Hubay, Public Health Nutritionist
Mrs. Barbara Matwey, Administrative Assistant, Recorder
Dr. Rosana Pellizzari, Medical Officer of Health
Mr. Larry Stinson, Director, Public Health Programs
Mrs. Alida Tanna, Administrative Assistant
Mrs. Ruth Walker, Public Health Nurse
Mr. Brent Woodford, Director, Corporate Services

1. Call to Order

Deputy Mayor Sharpe called the meeting to order at 4:50 p.m.

2. Declaration of Pecuniary Interest

Councillor Clarke declared pecuniary interest under correspondence Item 7, resolution A12-6, Energy Drink Regulations.

3. Confirmation of Agenda

Moved by
Mayor Fallis
Seconded by
Councillor Beamer
That the agenda be approved as circulated.

- Carried - (M-12-60)

4. Delegations and Presentations

Deputy Mayor Sharpe informed the Board of Health that a delegation had been declined regarding wireless technology.

4.1 A Day in The Life – Tobacco Enforcement Officer
Presenter: Ingrid Cathcart, Tobacco Enforcement Officer

5. Confirmation of the Minutes of the Previous Meeting

Moved by
Councillor Parnell
Seconded by
Reeve Smith
That the minutes of the Board of Health meeting held on April 11, 2012 be approved.

- Carried - (M-12-61)

6. Business Arising From the Minutes

Moved by
Reeve Smith
Seconded by
Councillor Parnell
That staff proceed to contact Peterborough Housing to present the Waterloo Region community housing smoke-free initiative.

- Carried - (M-12-62)

7. Correspondence

Moved by
Councillor Clarke
Seconded by
Councillor Beamer
That the following documents be received for information.

- Carried - (M-12-63)

1. Email dated March 9, 2012 from Dr. Paul Roumeliotis, President, alPHa, regarding collaboration with the OPHA.
2. Email dated April 6, 2012 from Ms. Kathy McDermid related to wireless technologies.
3. Letter dated April 5, 2012 from Nina Arron, Director, Public Health Division, Public Health Policy and Programs Branch, MOHLTC, regarding HPV immunization.

4. Letter dated April 20, 2012 from Chairman Sharpe to Mayor Bennett, City of Peterborough, regarding water-pipes.
5. Letter dated April 27, 2012 from Dr. Pellizzari to Premier McGuinty regarding the Drummond Report.
6. Letter dated May 2, 2012 from Chairman Sharpe to Premier McGuinty regarding Bill 74, An Act to help prevent skin cancer.
7. Email dated May 4, 2012, from Susan Lee, Susan Lee, Manager, Administrative and Association Services, alPHa, regarding resolutions for consideration for the June 2012 Annual General Meeting.
8. Letters/Resolutions from other Health Units:
   Durham
   - Infant and Toddler Development Program

   Hastings & Prince Edward Counties
   - Drummond Report

   Thunder Bay
   - All Terrain Vehicles

   Timiskaming
   - Drummond Report

Moved by — Seconded by
Mayor Fallis — Reeve Smith
That the Board of Health for the Peterborough County-City Health Unit support the first six resolutions go forward at the annual general meeting of alPHa.
- Carried - (M-12-64)

Moved by — Seconded by
Councillor Parnell — Mayor Fallis
That the Board of Health for the Peterborough County-City Health Unit support the resolution on energy drinks go forward at the annual general meeting of alPHa.
- Carried - (M-12-65)

Moved by — Seconded by
Mr. Watton — Mayor Fallis
That the Board of Health for the Peterborough County-City Health Unit contact Timiskaming Health Unit to urge them to take their resolution to the annual general meeting of alPHa.
- Carried - (M-12-66)

8. Program Reports

8.1 Q1 2012 Program Report
Presenter: Larry Stinson, Director, Public Health Programs

Mr. Stinson gave an overview of the Health Unit's activities during the first quarter of 2012.

Moved by	Seconded by
Mr. Jobe	Mr. Watton

That the Board of Health for the Peterborough County-City Health Unit receive the Q4 2012 Program Report for information.

- Carried - (M-12-67)

8.2 Q1 2012 Financial Report

Mr. Woodford gave an overview of the Health Unit's financial status for the first quarter of 2012.

Moved by	Seconded by
Councillor Clarke	Mayor Fallis

That the Board of Health for the Peterborough County-City Health Unit receive the Q4 2012 Program Financial Update for information.

- Carried - (M-12-68)

Councillor Smith to assume Chair at this point in the meeting.

9. New Business

9.1 Food Security Update

Presenters: Susan Hubay, Public Health Nutritionist
Joelle Favreau, Community Development and Compass Training Centre Supervisor, YWCA Peterborough

Susan Hubay and Joelle Favreau gave a very detailed update on Food Security. The YWCA recently received a two-year grant from the Trillium Foundation to initiate planning for the Kawartha Community Food Hub which seeks to build community connections and reduce isolation from poverty through food sharing opportunities. The long-term goal is to create Community Food Hubs in all townships and First Nations where residents gather to grow, cook, and enjoy food together, linking to local food producers wherever possible.

The following item, originally 10.1 in the agenda, was moved up to allow Mr. Watton to present as he had to leave the meeting early.

Governance Committee Report

Moved by
Reeve Smith

Seconded by
Councillor Parnell

That the Board of Health for the Peterborough County-City Health Unit receive the minutes of the Governance Committee for information.

- Carried - (M-12-69)

Moved by
Mr. Jobe

Seconded by
Nil

That the Board of Health for the Peterborough County-City Health Unit amend proposed changes to Revised Policy #2-200, Duties and Responsibilities of Board Members.

The motion was defeated.

Moved by
Mayor Fallis

Seconded by
Reeve Smith

That the Board of Health for the Peterborough County-City Health Unit approve the following documents referred by the Governance Committee:

- New Policy, #2-350, Terms of Reference Property Committee
- Revised Policy #2-200, Duties and Responsibilities of Board Members
- Revised Policy #2-270, Conduct, Board Members

- Carried - (M-12-70)

9.2 2009 Youth Survey – Sexual and Reproductive Health Program
Presenter: Ruth Walker, Public Health Nurse

Mrs. Walker summarized the results of a youth survey on sexual and reproductive health issues which was conducted back in 2009.

Moved by
Councillor Parnell

Seconded by
Deputy Mayor Sharpe

That the Board of Health for the Peterborough County-City Health Unit receive the survey results for information.

- Carried - (M-12-71)

Break for dinner at 6:26 p.m.

9.3 Staff Report: Cycling Infrastructure in Peterborough
Zahra Ismail, Health Promoter

Moved by
Deputy Reeve Sharpe

Seconded by
Councillor Parnell

That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Cycling Infrastructure in Peterborough, for information; and continue to support local and provincial cycling infrastructure advocacy efforts and contribute to policy initiatives.

- Carried - (M-12-72)

9.4 Staff Report: 2012 Supplemental Budgets
Brent Woodford, Director, Corporate Services

Moved by Mr. Jobe — Seconded by Councillor Beamer

That the Board of Health for the Peterborough County-City Health Unit approve the 2012 one-time grant request for the Healthy Babies, Healthy Children (HBHC) program in the amount of $41,684; and approve the following supplemental 2012 budget amounts funded 100% by the Ministry of Health and Long-Term Care as follows:

Enhanced Food Safety	$25,000
Enhanced Safe Water	$15,500
Needle Exchange program Initiative	$21,121
Infection Prevention and Control Week	$ 8,000
Sexually Transmitted Infections Week	$ 7,000
World Tuberculosis Day	$ 2,000

- Carried (M-12-73)

9.5 Approval of 2012/13 alPHa Membership Fee
Dr. Rosana Pellizzari, Medical Officer of Health

Moved by Councillor Clarke — Seconded by Councillor Beamer

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.

- Carried (M-12-74)

9.6 Risk Communications
Presenter: Mrs. Brittany Cadence, Supervisor, Communications

Ms. Cadence presented an overview of risk communications as it applies to public health, and provided examples where various methods of communication can be utilized (e.g. precautionary advocacy, outrage management, crisis communications).

10. Committee Reports

10.1 Governance Committee

This item was moved up in the agenda, please refer to item 9.1 for details.

Deputy Mayor Sharpe resumed position of Chair.

11. In Camera to Discuss Confidential Personnel Matters

Moved by Councillor Clarke — Seconded by Mr. Jobe

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

- Carried - (M-12-75)

Moved by Councillor Parnell — Seconded by Councillor Clarke

That the Board of Health rise from In Camera.

- Carried – (M-12-76)

Moved by Councillor Parnell — Seconded by Mr. Jobe

That the Board of Health for the Peterborough County-City Health Unit approve the 2012 budget for the Healthy Smiles Ontario Program in the total amount of $414,399; and hold a meeting in July 2012 to review a status report based on full implementation of services in the second quarter and projections to year end.

- Carried – (M-12-77)

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

Wednesday, June 13, 2012, 4:45 p.m. Hiawatha First Nation.

13. Adjournment

Moved by Councillor Parnell — Seconded by Reeve Smith

That the meeting be adjourned.

- Carried – (M-12-78)

The meeting adjourned at 8:00 p.m.

_____ Chairperson

_____ Medical Officer of Health

Accountability Agreement Indicators

Monitoring and Reporting

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

Direct Submission to MOHLTC

- Food premise inspections
- Class A Pool Inspections
- Influenza Vaccine Wastage (splitting of CAMMS data)
- Baby Friendly Initiative Status

Existing Data for Retrieval

- Small Drinking Water Systems (Rcat)
- GC reporting times (iPHIS)
- iGAS reporting times (iPHIS)
- HPV and Influenza vaccine (CAMMS)
- School based immunizations (IRIS)
- Tobacco vendor compliance (TIS)

External Data Sources

- Youth never smoked
- Fall related emergency room visits
- Low Risk Drinking Guideline adherence

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Correspondence**

Date: June 13, 2012

Recommendation:

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

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1. Letter dated April 13, 2012 from Kate Manson-Smith, Ministry of Health and Long-Term Care (MOHLTC) to Chairman Sharpe, in response to his initial letter dated March 14, 2012, regarding the Healthy Communities Fund. **REF. P. 3**

2. Letter dated April 27, 2012 from Saäd Rafi, MOHLTC to Chairs of Ontario Boards of Health regarding compensation for Non-Bargaining Employee Groups. **REF. P. 4-5**

3. Letter dated May 5, 2012 from Liz Sandals, Parliamentary Assistant to the Hon. Deb Matthews, MOHTLC, in follow up to a meeting held on February 27, 2012 with Board of Health members regarding public health funding. **REF. P. 6-7**

4. Letters dated May 7, 2012 to Warden J. Murray Jones, County of Peterborough and Reeve Mary Smith, Smith-Ennismore-Lakefield Township, from Chairman Sharpe regarding water-pipes. **REF. P. 8-11**

5. Letter dated May 9, 2012 from Roselle Martino and Kate Manson-Smith, MOHLTC, regarding performance targets for the 2011-13 Public Health Accountability Agreement Indicators. **REF. P. 12-20**

6. Letter dated May 16, 2012 from the Hon. Premier McGuinty to Dr. Pellizzari, in response to her original letter dated April 27, 2012 regarding the Drummond report. **REF. P. 21**

7. Email dated May 23, 2012, from Ms. Malini Menon related to wireless technologies. **REF. P. 22**

8. Letter dated May 25, 2012 from the Performance Management Working Group, Public Health Standards, Practice and Accountability Branch, MOHLTC, regarding performance management initiatives. **REF. P. 23-26**

9. Letters/Resolutions from other Health Units:

   Perth
   - All Terrain Vehicles **REF. P. 27**
   - Refugee Health Benefits **REF. P. 28-30**
   - Vienna Declaration **REF. P. 31-41**

   Wellington-Dufferin-Guelph
   - Immunization of School Pupils Act **REF. P. 42-43**

Original signed by

Rosana Pellizzari, M.D.

Ministry of Health and Long-Term Care

Office of the
Assistant Deputy Minister
Heath Promotion Division

777 Bay Street, 18th Floor
Toronto ON M7A 1S5
Tel: 416-326-4790
Facsimile: 416 326-4864

Ministère de la Santé et des Soins de longue durée

Bureau du sous-ministre adjoint
Division de la Promotion de la santé

777, rue Bay, 18e étage
Toronto ON M7A 1S5
Tél: 416 326-4790
Télécopieur: 416 326-4864

Ontario

April 13, 2012

Mr. Andrew Sharpe
Board of Health Chair, Peterborough County City-Health Unit
10 Hospital Drive
Peterborough ON K9J 8M1

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

Dear Mr. Sharpe:

Thank you for your inquiry regarding the Healthy Communities Fund (HCF) Partnership Stream.

The ministry recognizes the work of public health units and community partners. By assessing the health of their community, determining local health priorities, developing and sustaining valuable partnerships, and generating policy goals and strategies, community partners are in an excellent position to address local health priorities.

Community partners, including those participating in the HCF Local Grant program, continue to be encouraged to work with their public health units. As you may be aware, recent government decisions regarding transition of work of the former Ministry of Health Promotion and Sport to other ministries has resulted in the oversight for the HCF Local Grant stream being shifted to the Ministry of Tourism Culture and Sport (MTCS) and the HCF Partnership Stream being shifted to the Ministry of Health and Long-Term Care (MOHLTC). The MOHLTC is committed to working with the MTCS to ensure alignment between the Healthy Communities Fund streams and that funded initiatives meet local needs.

In regards to the future direction of Healthy Communities, the ministry is currently reviewing its spending plan for 2012-2013, the context of ministry priorities and the government's budget, and will inform public health units as soon as information is available. In addition, the ministry will continue to assess how best to support healthy public policy at the local level.

As always, thank you for your continued dedication and contribution to making Ontario a healthier place to live, work and play.

Sincerely,

per Kate Manson-Smith

Ministry of Health and Long-Term Care

Office of the Deputy Minister

Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto ON M7A 1R3
Tel.: 416 327-4300
Fax: 416 326-1570

Ministère de la Santé et Soins de longue durée

Bureau du sous-ministre

Édifice Hepburn, 10e étage
80, rue Grosvenor
Toronto ON M7A 1R3
Tél. : 416 327-4300
Téléc. : 416 326-1570

Ontario

HLTC3966AC-2012-199

APR 27 2012

AS

MEMORANDUM TO: Chairs of Boards of Health

FROM: Saäd Rafi
Deputy Minister
Ministry of Health and Long-Term Care

RE: Compensation for Non-Bargaining Employee Groups

As you are aware, many of the provisions in the *Public Sector Compensation Restraint to Protect Public Services Act,* 2010 (the Act) expired as of March 31, 2012.

However, I would remind you that a number of the provisions continue to be in force. Specifically, a compensation plan cannot provide compensation after March 31, 2012 to an employee or office holder to reflect compensation that he or she did not receive as a result of the compensation measures that were in effect during the 2010-2012 restraint period.

In the 2012 Budget, the government introduced proposed legislation that would manage compensation costs by extending compensation restrictions for designated executives, earning greater than $100,000 annually, at hospitals, universities, colleges, school boards and designated organizations for two years, effective March 31, 2012.

These proposed restraint measures would not apply to employees other than executives who do not collectively bargain compensation.

To achieve the 5 year fiscal plan to balance the province's budget, the government requires strong management of current and future compensation costs, including wages, benefits and pensions. As a result, please consider this proposed legislation when making determinations concerning compensation for non-bargaining employees and employee groups during this time of fiscal restraint.

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Should you have any questions or require any clarification regarding these restraint measures, please contact your respective ministry program representative.

Saäd Rafi

c: Dr. Arlene S. King, Chief Medical Officer of Health, Public Health Division, MOHLTC
Kate Manson-Smith, Assistant Deputy Minister, Health Promotion, MOHLTC
Medical Officers of Health
Business Administrators

Ministry of Health and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel 416-327-4300
Fax 416-326-157
www.health.gov.on.ca

Ministère de la Santé et des Soins de longue durée

Bureau du ministre

10e étage, édifice Hepburn
80, rue Grosvenor
Toronto ON M7A 2C4
Tél 416-327-4300
Téléc 416-326-1571
www.health.gov.on.ca

Ontario

OCMS # HLTC2972IT-2012-87

Warden J. Murray Jones
County of Peterborough
470 Water Street
Peterborough, ON K9H 3M3

Dear Warden Jones:

I would like to thank you and the representatives from the County of Peterborough for meeting with me at the Rural Ontario Municipal Association/Ontario Good Roads Association (ROMA/OGRA) Annual Conference in Toronto on February 27, 2012.

At the meeting, you recommended that the Ministry of Health and Long-Term Care:

- Protect public health funding in Ontario as an investment for the future health and well being of the population;
- Release a new public health funding formula that will address historic inequities in the funding of local boards of health;
- Grant the Peterborough County-City Board of Health a 3 per cent increase for its 2012 cost-shared budgets; and,
- Provide a 4 per cent increase to the Peterborough County-City Board of Health's base budget for accommodation costs.

In maintaining our commitment to renewing the province's public health system, we have made every effort to ensure appropriate funding is provided for boards of health, including uploading the cost of mandatory programs and providing additional funding to increase health promotion, illness prevention and screening, and help Ontario be better prepared for health threats like Sudden Acute Respiratory Syndrome or an influenza pandemic, such as H1N1. Between 2003 and 2011, provincial funding for mandatory and related public health programs and services for the Peterborough County-City Board of Health increased by approximately $4.6 million, over 170 per cent, including both uploaded costs and increased investments in public health capacity.

The Ministry is currently undertaking a review of public health funding to inform considerations regarding funding equity. The intent of the review is not to determine greater allocations, but rather to develop an evidence-informed funding approach that will aim to address historical funding inequities. Work on the funding review is still underway and further details will be shared with the sector at a later date.

For 2012, the Ministry expects that board of health budgets will continue to recognize and incorporate the identified needs of their communities, and will balance local priorities with the government's clear direction for fiscal restraint. Taking into account the fiscal reality facing the province, the Ministry will be reviewing 2012 board of health grant requests for mandatory programs within a provincial funding envelope that is yet to be determined.

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Currently, the government does not have an approved allocation to support board of health capital projects (i.e., costs related to the purchase or construction of a new facility). As such, the Ministry is not in a position to fund capital projects at this time. However, the Ministry may provide one-time funding to support leasehold improvements (i.e., minor structural changes to a building) and planning costs related to capital projects. Historically, all occupancy costs, including leasing and mortgage costs, have been funded through board of health operating budgets, which the government currently cost-shares with municipalities at 75 per cent of approved costs.

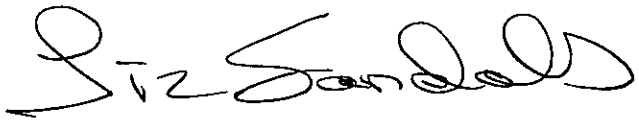
We acknowledge that many boards of health are dealing with infrastructure issues and the funding associated with their facilities needs. As we continue to explore long-term strategies to address this issue, I would encourage the Peterborough County-City Board of Health to continue to liaise with Ministry staff regarding their capital and funding needs.

In light of the current economic environment, the Ministry is unable to increase the Peterborough County-City Board of Health's base funding over and above any increases the Ministry may approve for mandatory programs over the coming years. Any extra costs over and above the approved provincial grant would not be eligible for cost-sharing by the Ministry, and would have to be borne by the obligated municipalities in Peterborough County and City.

Lastly, in your briefing note you make mention of the Drummond Commission's report which was released in February 2012. The Ministry will consider the Commission's recommendations, including those specifically related to public health, while continuing to be guided by Ontario's Action Plan for Health Care that was released on January 30, 2012. The plan clearly outlines how we can move toward providing better patient care through better value from our health care dollars.

Once again, thank you for taking the time to share your opinions and concerns.

Sincerely,



Liz Sandals, MPP Guelph
Parliamentary Assistant to the Minister of Health and Long-Term Care

c: The Honourable Deb Matthews, Minister of Health and Long-Term Care
Dr. Arlene King, Chief Medical Officer of Health
Roselle Martino, Executive Director (A), Public Health Division, Ministry of Health and Long-Term Care

May 7, 2012

SENT VIA EMAIL: warden@county.peterborough.on.ca

Warden J. Murray Jones
County of Peterborough
County Court House
470 Water Street
Peterborough, ON K9H 3M3

Dear Warden Jones:

Water-pipe use is increasing dramatically in communities throughout North America especially among youth and young adults. On Wednesday, November 9, 2011, the Board of Health for the Peterborough County-City Health Unit moved to request that local municipalities with smoking by-laws amend their bylaw to create a new definition of smoke and include prohibition of the burning of substances in all indoor public spaces, workplaces and outdoor public spaces. A copy of the staff report considered at that meeting has been attached for your reference.

A water-pipe, also known as "hookah", "shisha", "sheesha", "hubbly bubbly", "hubble-bubble", "goza" and "argileh", a device that originated in India and middle-eastern countries is used to smoke tobacco and herbal products. A water-pipe consists of a "head" where the product is heated, a bowl that is filled with water or other liquid, a pipe that connects the bowl to the head, and a hose with a mouthpiece from which the smoke is inhaled. The smoke is created by indirect heat applied to the product.

A typical hookah session lasts 20-80 minutes, with users taking up to 200 puffs. Some studies show that a typical water-pipe session is comparable to inhaling the same amount of smoke from 100 or more cigarettes.[1] As a result much more second-hand smoke is produced by an individual using a water-pipe than a cigarette. The research on the health effects of tobacco use in a water-pipe, while recognizing the different form of delivery, continues to identify exposure to toxins and similar health impacts to cigarette use.[2, 3] These risks may be higher, since water pipe smoking often involves a higher frequency of puffing, deeper inhalation, and longer smoking sessions than cigarette smoking.

The air quality in water-pipe cafés, as measured by particulate matter (PM) concentrations, has been shown to be poorer than in restaurants where cigarette smoking is allowed.[4] $PM_{2.5}$ concentrations in smoking rooms of water-pipe cafés have been found to be more than three times greater on average than for smoking rooms in restaurants and more than 41 times higher

than in smoke-free premises.[4] Both employees and non-smoking patrons that occupy a premises that allows water-pipe uses will be exposed to higher $PM_{2.5}$ concentrations than in a smoke-free environments.[4] Cigarette smoking is banned in indoor public places and by extension then, it is logical to assert that these bans should include the use of water-pipes as well. The current *Smoke-Free Ontario Act* does not contain provisions to deal with the public use of non-tobacco products in water-pipes. In view of growing evidence of water-pipe uptake by youth, the health impacts of use, public misperceptions on the health risks involved, and the growth of small businesses that offer unrestricted products, policy action by municipalities is warranted.

The Board of Health respectfully requests that the County take the steps to review its current by-law and make the appropriate amendments to include water-pipes. Our health unit staff would be happy to assist your legal counsel in making the appropriate changes. Your consideration of this request is appreciated.

Yours in health,

Andy Sharpe
Chair, Board of Health
for the Peterborough County-City Health Unit

Encl.

1. WHO Study Group on Tobacco Product Regulation. (2005).*Water-pipe Tobacco Smoking: Health Effects, Research Needs and Recommended Actions by Regulators*. Geneva, Switzerland: World Health Organization.
2. Cobb C, Ward KD, Maziak W, Shihadeh AL, Eissenberg T. (2010). Water-pipe tobacco smoking: An emerging health crisis in the United States. *American Journal of Health Behavior,* 34(3): 275-285.
3. Akl EA, Gaddam S, Gunukula SK, Honeine R, et al. (2010). The effects of water-pipe tobacco smoking on health outcomes: a systematic review. *International Journal of Epidemiology* 2010; 39: 834-857.
4. Cobb C, Vansickel A, Blank M, Jentink, K, Travers M, Eissenberg T. (2012). Indoor air quality in Virginia water-pipe cafe´s. *Tobacco Control*. doi:10.1136/tobaccocontrol-2011-050350

May 7, 2012

SENT VIA EMAIL: mjsmith@peterboro.net

Reeve Mary Smith
Township of Smith-Ennismore-Lakefield
1310 Centre Line, R.R. #4
Peterborough, ON K9J 6X5

Dear Reeve Smith:

Water-pipe use is increasing dramatically in communities throughout North America especially among youth and young adults. On Wednesday, November 9, 2011, the Board of Health for the Peterborough County-City Health Unit moved to request that local municipalities with smoking by-laws amend their bylaw to create a new definition of smoke and include prohibition of the burning of substances in all indoor public spaces, workplaces and outdoor public spaces. A copy of the staff report considered at that meeting has been attached for your reference.

A water-pipe, also known as "hookah", "shisha", "sheesha", "hubbly bubbly", "hubble-bubble", "goza" and "argileh", a device that originated in India and middle-eastern countries is used to smoke tobacco and herbal products. A water-pipe consists of a "head" where the product is heated, a bowl that is filled with water or other liquid, a pipe that connects the bowl to the head, and a hose with a mouthpiece from which the smoke is inhaled. The smoke is created by indirect heat applied to the product.

A typical hookah session lasts 20-80 minutes, with users taking up to 200 puffs. Some studies show that a typical water-pipe session is comparable to inhaling the same amount of smoke from 100 or more cigarettes.[1] As a result much more second-hand smoke is produced by an individual using a water-pipe than a cigarette. The research on the health effects of tobacco use in a water-pipe, while recognizing the different form of delivery, continues to identify exposure to toxins and similar health impacts to cigarette use.[2, 3] These risks may be higher, since water pipe smoking often involves a higher frequency of puffing, deeper inhalation, and longer smoking sessions than cigarette smoking.

The air quality in water-pipe cafés, as measured by particulate matter (PM) concentrations, has been shown to be poorer than in restaurants where cigarette smoking is allowed.[4] $PM_{2.5}$ concentrations in smoking rooms of water-pipe cafés have been found to be more than three times greater on average than for smoking rooms in restaurants and more than 41 times higher than in smoke-free premises.[4] Both employees and non-smoking patrons that occupy a

premises that allows water-pipe uses will be exposed to higher $PM_{2.5}$ concentrations than in a smoke-free environments.[4] Cigarette smoking is banned in indoor public places and by extension then, it is logical to assert that these bans should include the use of water-pipes as well. The current *Smoke-Free Ontario Act* does not contain provisions to deal with the public use of non-tobacco products in water-pipes. In view of growing evidence of water-pipe uptake by youth, the health impacts of use, public misperceptions on the health risks involved, and the growth of small businesses that offer unrestricted products, policy action by municipalities is warranted.

The Board of Health respectfully requests that the Township take the steps to review its current by-law and make the appropriate amendments to include water-pipes. Our health unit staff would be happy to assist your legal counsel in making the appropriate changes. Your consideration of this request is appreciated.

Yours in health,

Andy Sharpe
Chair, Board of Health
for the Peterborough County-City Health Unit

Encl.

1. WHO Study Group on Tobacco Product Regulation. (2005).*Water-pipe Tobacco Smoking: Health Effects, Research Needs and Recommended Actions by Regulators*. Geneva, Switzerland: World Health Organization.
2. Cobb C, Ward KD, Maziak W, Shihadeh AL, Eissenberg T. (2010). Water-pipe tobacco smoking: An emerging health crisis in the United States. *American Journal of Health Behavior,* 34(3): 275-285.
3. Akl EA, Gaddam S, Gunukula SK, Honeine R, et al. (2010). The effects of water-pipe tobacco smoking on health outcomes: a systematic review. *International Journal of Epidemiology* 2010; 39: 834-857.
4. Cobb C, Vansickel A, Blank M, Jentink, K, Travers M, Eissenberg T. (2012). Indoor air quality in Virginia water-pipe cafe´s. *Tobacco Control*. doi:10.1136/tobaccocontrol-2011-050350

Ministry of Health and Long-Term Care

Executive Director's Office

Public Health Division
11th Floor, Hepburn Block
Queen's Park
Toronto ON M7A 1R3

Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Office of the Assistant Deputy Minister

Heath Promotion Division
777 Bay Street, 19th Floor
Toronto ON M7A 1S5
Tel.: 416 326-4790
Facsimile: 416 326-4864

Ministère de la Santé et des Soins de longue durée

Bureau du directeur général

Division de la santé publique
Édifice Hepburn, 11e étage
Queen's Park
Toronto QN M7A 1R3

Téléphone: (416) 212-3831
Télécopieur: (416) 325-8412

Bureau du sous-ministre adjoint

Division de la Promotion de la santé
777, rue Bay, 19e étage
Toronto ON M7A 1S5
Tél. :416 326-4790
Télécopieur: 416 326-4864

Ontario

MAY 0 9 2012

Dr. Rosana Pellizzari
Medical Officer of Health
Peterborough County-City Health Unit
10 Hospital Drive
Peterborough ON K9J 8M1

Dear Dr. Pellizzari,

Re: Performance Targets for the 2011-2013 Public Health Accountability Agreement ("Accountability Agreement") Indicators

In follow-up to our communication sent to Board of Health Chairs, Medical Officers of Health, and CEOs on December 23, 2011 regarding the performance targets for the 2011-2013 Accountability Agreement indicators, the Ministry of Health and Long-Term Care (the "ministry") would like to thank you for submitting your response to the proposed targets for the performance indicators.

In our December 23, 2011 communication, the ministry proposed performance targets for the Accountability Agreement performance indicators. All boards were invited to negotiate performance targets with the ministry and propose alternate targets. Some boards accepted all ministry proposed targets, while most boards accepted some ministry targets and proposed alternate targets for some indicators.

We are pleased to advise you that we have reviewed your response to the ministry proposed targets and have prepared the attached response in Appendix A. The ministry is in agreement with some of your board's proposed targets and is proposing alternate targets for some of the indicators. The ministry considered several factors when reviewing the feedback received from boards of health, including the rationale supporting board proposed targets, and the discussions that we have had with boards of health throughout the negotiations process. We have used a consistent approach in our review of board proposed targets and our subsequent responses to boards of health. Even though the ministry has accepted some targets below those initially proposed by the ministry, we would like to emphasize that the targets sent on December 23, 2011 represent those that we would like the public health system to continue to work towards.

.../2

Dr. Rosana Pellizzari

Please review the attached ministry responses and advise us by e-mail if your board is in agreement with the ministry proposed targets or if you would like to schedule a meeting with ministry staff to further discuss the responses. Please e-mail Sylvia Shedden, Director, Public Health Standards, Practice and Accountability Branch at Sylvia.Shedden@ontario.ca and Laura Pisko-Bezruchko, Director, Standards, Programs & Community Development Branch, at Laura.Pisko@ontario.ca to advise them of your board's response. Following receipt of your board's agreement with the attached ministry proposed targets, the ministry will prepare an Amending Agreement and a revised Schedule D for signature. The Amending Agreement and revised Schedule D will be sent directly to the Board of Health Chair. Please be advised that performance corridors will not be included in Schedule D. As work on performance corridors has not been completed, reference to performance corridors in Schedule D will be removed.

The ministry is currently working on finalizing the reporting requirements for the Accountability Agreement indicators. These will be based on collecting the data required to calculate the results for the performance indicators as detailed in the *Technical Document*. The reporting requirements and reporting frequency will be communicated to all boards once finalized.

We are grateful for the contributions, support, and time, from our colleagues in the field in finalizing the Accountability Agreements and the performance indicators. Appendix B includes a summary of the milestones and process to date to finalize the Accountability Agreements, the performance indicators, and the performance targets. We look forward to continuing to work together to improve accountability and performance for all boards and public health units in Ontario, and the public health system as a whole.

If you have any questions, please contact Sylvia Shedden at 416-327-7423 for health protection indicators, or Laura Pisko-Bezruchko at 416-327-7445 for health promotion indicators.

Yours truly,

Roselle Martino
Executive Director (A)

Kate Manson-Smith
Assistant Deputy Minister

Enclosures

c: Sylvia Shedden, Director, Public Health Standards, Practice and Accountability Branch
Laura Pisko-Bezruchko, Director, Standards, Programs & Community Development Branch

Appendix A

Ministry of Health and Long-Term Care Response to Peterborough County-City Board of Health Proposed Targets

Health Protection Indicators:

1. % of high risk food premises inspected once every 4 months while in operation

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
86%	100%	100%	Y	N/A	100%	100%	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2012 and 2013 targets.

2. % of pools and public spas by class inspected while in operation

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
57%	≥ 75%	≥ 75%	Y	N/A	100%	100%	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2012 and 2013 targets.

3. % of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
Cannot be established	100%	100%	Y	N/A	100%	100%	Y	N/A

Comments/Rationale:

This target was not negotiable and it is noted that the board of health has accepted the target as identified.

4. Time between health unit notification of a case of gonorrhoea and initiation of follow-up

This indicator measures the percentage of confirmed gonorrhoea cases where initiation of follow-up occurred within 0-2 business days

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
93%	100%	100%	Y	N/A	100%	100%	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2012 and 2013 targets.

5. Time between health unit notification of an Invasive Group A Streptococcal Disease (iGAS) case and initiation of follow-up

This indicator measures the percentage of confirmed iGAS cases where initiation of follow-up

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
87%	100%	100%	Y	N/A	100%	100%	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2012 and 2013 targets.

7a. % of vaccine wasted by vaccine type that is stored/administered by the public health unit (HPV)

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
0.0%	Maintain current wastage rate	Maintain current wastage rate	Y	N/A	Maintain current wastage rate	Maintain current wastage rate	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2012 and 2013 targets.

7b. % of vaccine wasted by vaccine type that is stored/administered by the public health unit (influenza)

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
2.6%	Maintain or improve current wastage rate	Maintain or improve current wastage rate	Y	N/A	Maintain or improve current wastage rate	Maintain or improve current wastage rate	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2012 and 2013 targets.

9a. % of school-aged children who have completed immunizations for Hepatitis B

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
77.9%	Maintain or improve current coverage rate	Maintain or improve current coverage rate	Y	N/A	95.0%	80.0%	N	≥ 80.5%

Comments/Rationale:

Recognizing the challenges identified by boards of health in improving coverage rates, the ministry has responded with targets that are likely achievable within the timeframe of the Accountability Agreement and also move boards towards performance improvement. The ministry is in agreement with your suggestion of aiming for the provincial median. As vaccine coverage rates are reported with one decimal place, and the updated provincial median is 80.5%, the ministry is proposing a target of ≥ 80.5%. There will be ongoing opportunity for boards of health to provide explanation for any variances from the target, and discuss performance improvement strategies.

9b. % of school-aged children who have completed immunizations for HPV

This indicator measures the percentage of school-aged girls who have completed immunizations for HPV

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
46.0%	Maintain or improve current coverage rate	Maintain or improve current coverage rate	Y	N/A	90.0%	52.0%	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2012 and 2013 targets.

9c. % of school-aged children who have completed immunizations for meningococcus								
Baseline	**2012 Target**	**BoH 2012 Target Response**	**Ministry Accepts (Y/N)**	**Ministry 2012 Alternate Target**	**2013 Target**	**BoH 2013 Target Response**	**Ministry Accepts (Y/N)**	**Ministry 2013 Alternate Target**
79.6%	Maintain or improve current coverage rate	Maintain or improve current coverage rate	Y	N/A	90.0%	87.0%	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2012 and 2013 targets.

Health Promotion Indicators:

10. % of youth (ages 12-18) who have never smoked a whole cigarette								
Baseline	**2012 Target**	**BoH 2012 Target Response**	**Ministry Accepts (Y/N)**	**Ministry 2012 Alternate Target**	**2013 Target**	**BoH 2013 Target Response**	**Ministry Accepts (Y/N)**	**Ministry 2013 Alternate Target**
87.6%	N/A	N/A	N/A	N/A	89.4%	89.4%	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2013 target.

Boards of health have requested that the ministry clarify how it will be assessing the achievement of this indicator. Boards of health will be considered to have met targets if the 2013 target falls within the 95% confidence interval for the 2013 value at assessment. For example, if the 2013 value is 84.3%, with a confidence interval of 75.6% to 92.9%, the target will be considered met if the 2013 target falls between 75.6% and 92.9%. There will be ongoing opportunity for boards of health to provide explanation for any variances from the target, and discuss performance improvement strategies, both at the local level and at the provincial level.

11. % of tobacco vendors in compliance with youth access legislation at the time of last inspection								
Baseline	**2012 Target**	**BoH 2012 Target Response**	**Ministry Accepts (Y/N)**	**Ministry 2012 Alternate Target**	**2013 Target**	**BoH 2013 Target Response**	**Ministry Accepts (Y/N)**	**Ministry 2013 Alternate Target**
86%	≥ 90%	≥ 90%	Y	N/A	≥ 90%	≥ 90%	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2012 and 2013 targets.

12. Fall-related emergency visits in older adults aged 65+ (rate per 100,000 per year)

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
5,863	N/A	N/A	N/A	N/A	5,687	5,687	Y	Maintain or improve current rate

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2013 target.

Based on our review of boards of health's submissions, we are updating the fall-related emergency visit target for boards of health to "maintain or improve current rate." This updated target will contribute to a reduction in the projected provincial rate of falls. We encourage each board of health to collaborate with your Local Health Integration Network (LHIN) and other community partners to set consistent targets and share resources.

13. % of population (19+) that exceeds the Low-Risk Drinking Guidelines

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
36.2%	N/A	N/A	N/A	N/A	34.8%	34.8%	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2013 target.

Boards of health have requested that the ministry clarify how it will be assessing the achievement of this indicator. Boards of health will be considered to have met targets if the 2013 target falls within the 95% confidence interval for the 2013 value at assessment. For example, if the 2013 value is 31.3%, with a confidence interval of 26.1% to 36.5%, the target will be considered met if the 2013 target falls between 26.1% to 36.5%. There will be ongoing opportunity for boards of health to provide explanation for any variances from the target, and discuss performance improvement strategies, both at the local level and at the provincial level.

14. Baby Friendly Initiative Status (category)

Baseline	2012 Target	BoH 2012 Target Response	Ministry Accepts (Y/N)	Ministry 2012 Alternate Target	2013 Target	BoH 2013 Target Response	Ministry Accepts (Y/N)	Ministry 2013 Alternate Target
Designated	Designated	Designated	Y	N/A	Designated	Designated	Y	N/A

Comments/Rationale:

It is noted that the ministry and the board of health are in agreement with the 2012 and 2013 targets.

Appendix B

Key Milestones in the Establishment of Accountability Agreements, Performance Indicators, and Performance Targets

Establishment of the Indicator Technical Advisory Committee (InTAC) – April 2010
The InTAC was established to provide technical advice and recommendations into the development of performance indicators for board of health Accountability Agreements. The InTAC was comprised of members from the Ministry of Health and Long-Term Care, the former Ministry of Health Promotion and Sport, the Association of Public Health Epidemiologists in Ontario (APHEO), the Performance Management Working Group (PMWG), the Institute for Clinical Evaluative Sciences (ICES), and other representatives from boards of health. InTAC reviewed a pre-selected group of indicators and provided advice on technical specifications, implementation, and future measurement issues.

Establishment of the Joint Ministries/Boards of Health Committee (JMB) – October 2010
The JMB Committee was established to provide detailed feedback and advice on the language of the proposed Accountability Agreement template. Membership included representation from the Ministry of Health and Long-Term Care, the former Ministry of Health Promotion and Sport, the Association of Local Public Health Agencies (alPHa), the Council of Ontario Medical Officers of Health (COMOH), and public health units. The JMB Committee also provided advice on the proposed set of performance indicators for the accountability agreements. The JMB Committee will be reconvened to provide advice on the performance indicators for the Organizational Standards as well as to review any amendments required to the Accountability Agreement template for 2014 – 2016.

Consultation on the Draft Accountability Agreement template and Potential Performance Indicators – May 2011
Prior to finalizing the Accountability Agreement, the Ministry of Health and Long-Term Care and the former Ministry of Health Promotion and Sport undertook a consultation process to provide all boards of health an opportunity to ask questions and provide feedback on the draft Accountability Agreement template and the set of potential performance indicators to be included in the Accountability Agreement. The consultation process included a number of regional webinars followed by an e-survey open to all boards of health from May 9, 2011 to May 25, 2011. The feedback from the webinars and the results of the e-survey were presented to the JMB Committee for review and comment.

Feedback received through the consultation process and from the JMB Committee was incorporated into the final Accountability Agreement and the final set of performance indicators. A summary of the feedback, e-survey results, the changes to the Accountability Agreement template resulting from the consultation process, the final set of performance indicators, and timelines for next steps were presented at the alPHa Annual General Meeting on June 13, 2011.

Finalized Accountability Agreements including a final set of Performance Indicators – August 2011
The final 2011-2013 Public Health Accountability Agreements were sent to boards of health for signing on August 2, 2011. The performance indicators were included in the Accountability Agreements, however, baselines and performance targets for 2012 and 2013 were not established at the time.

All 36 Accountability Agreements were signed by the end of October 2011.

Release of the Technical Document – December 2011 (revised Technical Document sent January 2012)

The *Technical Document*, in support of the performance indicators included in the 2011-2013 Accountability Agreements, was sent to all Medical Officers of Health on December 2, 2011. The *Technical Document* includes a detailed description of each indicator, associated data sources and data sets, and detailed syntax, where relevant, to support board of health implementation of the indicators. The *Technical Document* also provides refinement of some health promotion indicators as a result of their technical development.

A revised *Technical Document* was sent to all boards of health on January 17, 2012 to incorporate syntax that is compatible with the new, national Low-Risk Drinking Guidelines.

Individualized baseline data sent to each Medical Officer of Health – December 2011

On December 9, 2011, Medical Officers of Health (MOHs) received an individualized document including their health unit baselines for all the performance indicators, except the Low-Risk Drinking Guidelines indicator as new syntax for that indicator was being developed at the time to correspond to the new, national Low-Risk Drinking Guidelines which were released on November 25, 2011. The documents included the baseline for each indicator and any specific comments, issues, or supporting information where relevant.

MOHs were asked to review the baseline data and provide clarification or validation, where relevant, to the Province. It was communicated that baseline data were going to be used by the Province as a starting point from which individualized targets for performance improvement would be established.

Performance negotiations packages sent to all boards of health – December 2011

On December 23, 2011, each board of health received an information package which included a joint communication from the Ministry of Health and Long-Term Care and the former Ministry of Health Promotion and Sport explaining the process for negotiation of the targets, two spreadsheets (one for health protection indicators and one for health promotion indicators) identifying the proposed performance targets for each indicator along with the rationale for the targets, and a document that included supplementary provincial data and a summary of proposed targets in relation to the baseline data for all indicators.

All boards of health were given the opportunity to either accept the proposed performance targets or propose alternate targets with a supporting rationale.

An informational webinar was held on January 16, 2012 to review the performance targets and negotiations process and to answer any questions.

Optional Meetings with individual boards and/or MOHs/CEOs – January 2012

All boards of health were given the opportunity to arrange a meeting with Sylvia Shedden, Director, Public Health Standards, Practice, and Accountability Branch, Public Health Division and/or Laura Pisko-Bezruchko, Director, Standards, Programs & Community Development Branch, Health Promotion Division, to discuss performance targets and to address any related questions or concerns. It was communicated at the January 16, 2012 webinar that the purpose of the meetings would be to discuss concerns and answer questions and that no decisions regarding the targets would be made at the meeting.

The Premier
of Ontario

Legislative Building
Queen's Park
Toronto, Ontario
M7A 1A1

Le Premier ministre
de l'Ontario

Édifice de l'Assemblée législative
Queen's Park
Toronto (Ontario)
M7A 1A1

Ontario

May 16, 2012

Rosana Pellizzari, MD, CCFP, MSC, FRCPC
Medical Officer of Health
Peterborough County-City Health Unit
10 Hospital Drive
Peterborough, Ontario
K9J 8M1

Dear Dr. Pellizzari:

Thank you for your letter on behalf of the Peterborough County-City Board of Health regarding the report of the Commission on the Reform of Ontario's Public Services and public health. Your views and concerns are important to me, and I appreciate your taking the time to share them.

I note that you have sent a copy of your letter to my colleague the Honourable Deb Matthews, Minister of Health and Long-Term Care. I trust the minister also values the issues you raised on behalf of the board, and will take your comments into consideration.

Thanks again for writing. Please accept my best wishes.

Yours truly,

Dalton McGuinty
Premier

c: The Honourable Deb Matthews

From: Malini Menon [mailto:mmenon16@yahoo.ca]
Sent: Wednesday, May 23, 2012 1:18 PM
To: Alida Tanna
Subject: Update on Wireless Technology in Schools

Dear Chairman Sharpe and Board of Health members:

In the continuing interests of the well-being of all students in our community, I would like to draw your attention to a number of recent international developments regarding wireless technology in schools.

1. The first is an eye-opening 3 minute video trailer from people we trust regarding the dangers of cell phones: http://youtu.be/hXGZ7Waa44s

While the focus of this video relates to cell phones, which are permitted in schools, it can also just as easily be extended to Wi-Fi, which emits the same frequency of microwave radiation. The only difference is that while cell phones are held to the head and thus exposure is more directly absorbed into the brain, Wi-Fi is spouted throughout a school at greater distance to the head, but for continual and longer periods of time.

2. The second is an article related to the April 24, 2012 Children with Cancer conference, held in London, England. Early headlines from this conference state that studies are split 50/50 as to whether cellphones cause cancer or not; and show a 50% increase in brain tumours in children between 1999 and 2009:
http://www.dailymail.co.uk/news/article-2134382/Risks-biggest-technological-experiment-history-species-Calls-research-links-using-mobile-phones-brain-cancer.html

3. The third is a letter from Dr. Magda Havas, which is an update of significant medical and scientific findings, relating to the *perceived* safety of Wi-Fi in schools:
http://www.magdahavas.com/wordpress/wp-content/uploads/2012/05/Wi-Fi-Open-Letter2012.pdf

4. Finally, a recent article from the UK, regarding its experience with disruption and pornography in schools due to the widespread use of cell phones in schools: http://www.dailymail.co.uk/news/article-2142085/Ofsted-chief-gets-tough-classroom-discipline-schools-penalised-failing-tackle-disruption.html#ixzz1uScLBe3C. This was also addressed in a recent CBC documentary about 'sexting', which points out that with students having access to pervasive Wi-Fi in schools, cyberbullying is becoming rampant, as is the accessing of pornography. This was sent to the Board earlier but is attached again for your
reference: (http://www.cbc.ca/video/#/Shows/1221254309/ID=2201416792). This video is disturbing.

If the above are any indication, the trendline is pointing to increased dangers from wireless technology in schools, not only to the physical health of students, but also to their social and emotional well-being.

Sincerely,

M. Menon
on behalf of
Kawartha Safe Technology Initiative
www.kawarthasafetechnology.org

Ministry of Health and Long-Term Care

Public Health Standards, Practice and Accountability Branch

Public Health Division

393 University Avenue, 21st Floor
Toronto ON M7A 2S1
Telephone: 416 314-2130
Facsimile: 416 314-7078

Ministère de la Santé et des Soins de longue durée

Direction des normes, des pratiques et de la responsabilisation en matière de santé publique

Division de la santé publique

393, avenue University, 21e étage
Toronto ON M7A 2S1
Téléphone : 416 314-2130
Télécopieur : 416 314-7078

May 25, 2012

Dear Colleagues:

Subject: Update on Performance Management Initiatives

We are pleased to report that work on establishing a performance management system for public health is progressing very well. Our current focus is the continued support of the Public Health Accountability Agreements and the development of a measurement strategy for the Ontario Public Health Organizational Standards.

Establishing performance targets for Ontario's public health system represents a significant milestone in the continued implementation of the government's public health renewal agenda, and the performance framework for public health. The Performance Management Working Group (PMWG) has been providing advice to the ministry regarding the target setting process for the 2011-13 Accountability Agreements over the past several months.

The ministry is currently working on finalizing the reporting requirements for the Accountability Agreement indicators which will be based on the *Technical Document: Public Health Accountability Agreement Indicators 2011-13*. In order to facilitate reporting and posting of data, the ministry is developing a web-based interface within the ministry's Directory of Networks (DoN) site. A user recruitment strategy is currently under development and will be communicated, along with reporting requirements and frequency, to all Boards of Health in the next few weeks, in preparation for mid-year monitoring.

The PMWG has also been working with the ministry to explore various options for measurement of the Organizational Standards. Boards of Health were encouraged to plan for local implementation during 2011, with measurement to begin in 2012*. It is anticipated that a measurement approach for the Organizational Standards will be incorporated into Accountability Agreements. The ministry and PMWG are committed to a field consultation process for the measurement approach prior to implementation.

* Boards of Health will have until January 2013 to implement the Chief Nursing Officer requirement, with measurement to begin in 2014.

Work to update the health unit profile data from the *Initial Report on Public Health* (2009) is underway and information on a planned two-phase release process will be communicated to Boards of Health in July 2012. It is expected that Boards of Health will be surveyed in September 2012 as part of updating the first set of variables. This update will be made available before year end. The second phase of work is expected to be completed in September 2013 and will include variables from the 2011 National Household Survey (NHS) and Stats Can population estimates based on the 2011 census.

Work is also underway on the developmental indicators identified in the 2011-13 Accountability Agreement, which outlines additional work required to identify performance measures. Many of those developmental indicators are health promotion related (physical activity; healthy eating and nutrition; child and reproductive health; comprehensive tobacco control) and preliminary work is underway to explore potential indicators in these areas for future use. As part of this process, the Health Promotion Division will be contacting health units in the coming weeks to request examples of indicators that health units are currently using to monitor and manage their own performance.

There have been some changes to our membership over the past year and we would like to acknowledge the significant contributions of those who have recently stepped down as well as to welcome our new recruits. Please see Appendix 1 for an up-to-date membership list.

If you have any questions regarding the work on the Performance Management Working Group, please contact Paulina Salamo at Paulina.Salamo@ontario.ca.

Sincerely,

Sylvia Shedden
Public Health Standards, Practice and Accountability Branch
Ministry of Health and Long-Term Care
Co-Chair, Performance Management Working Group

Dr. Rosana Pellizzari
Medical Officer of Health
Peterborough County-City Health Unit
Co-Chair, Performance Management Working Group

c: Dr. Arlene King, Chief Medical Officer of Health, Public Health Division, MOHLTC
Roselle Martino, Executive Director (A), Chief Medical Officer of Health Office, Public Health Division, MOHLTC
Kate Manson-Smith, Assistant Deputy Minister, Health Promotion Division, MOHLTC
Darryl Sturtevant, Assistant Deputy Minister, Strategic Policy and Planning Division, Ministry of Children and Youth Services
Performance Management Working Group Members

Appendix 1: Performance Management Working Group

Co-Chairs

Dr. Rosana Pellizzari	Medical Officer of Health, Peterborough County-City Health Unit
Sylvia Shedden	Director, Public Health Standards, Practice and Accountability Branch, MOHLTC

Members from Health Units and Other Organizations

Karen Beckermann	Manager, Planning and Performance, Toronto Public Health
Dr. Kathleen Dooling[*]	Associate Medical Officer of Health, Peel Regional Health Unit (*2008 – 2011)
Dr. Vera Etches	Associate Medical Officer of Health, Ottawa Public Health
Dr. Charles Gardner*	Medical Officer of Health and Chief Executive Officer, Simcoe-Muskoka District Health Unit (*2007 – 2011)
Ross Graham	Manager, Special Projects, Middlesex-London Health Unit
Pat Hewitt*	Manager, Public Health Administration, Halton Region Health Department (*2009 – 2011)
Dr. Jessica Hopkins	Associate Medical Officer of Health, Niagara Region Public Health
Dale Jackson*	Senior Business Administrator, Hastings and Prince Edward County Health Unit (*2009 – 2011)
Mary Johnson	Board of Health member, Eastern Ontario Health Unit
Dr. Jeff Kwong	Scientist, Institute for Clinical Evaluative Sciences
Dr. Robert Kyle	Medical Officer of Health, Durham Regional Health Unit
Dr. Hazel Lynn	Medical Officer of Health, Grey Bruce Health Unit
Monica Mitchell*	Associate Director Communicable Diseases Programs, Toronto Public Health (*2009 – 2011)
Dr. George Pasut	Vice President, Science and Public Health, Public Health Ontario
Suzanne Ross	Director, Public Health, Eastern Ontario Health Unit
Dr. Robert Schwartz	Deputy Director and Director of Evaluation & Monitoring University of Toronto
Shelley Stalker*	Manager, Epidemiology and Research, York Region Community and Health Services (*2010 – 2012)
Cynthia St. John	Chief Executive Officer, Elgin St. Thomas Health Unit
Dr. Jo Ann Tober	Chief Executive Officer, Brant County Health Unit
Dr. Erica Weir*	Associate Medical Officer of Health, York Region Community and Health Services (*2010 – 2012)
Shelley Westhaver	Director, Clinical Services Division, Sudbury & District Health Unit
Carol Woods*	Program Director, Research, Evaluation, Epidemiology, and Sexual Health, Algoma Public Health (*2011)

Members from the Ontario Government (MOHLTC, MCYS)

Nina Arron	Director, Public Health Policy and Programs Branch, Public Health Division, MOHLTC
Laura Belfie	Manager, Public Health Units & Standards, Standards, Programs and Community Development Branch, Health Promotion Division, MOHLTC
Domenic Della Ventura	Team Lead, Performance and Accountability, LHIN Liaison Branch, Health System Accountability and Performance Division, MOHLTC

[*] Indicates a member who has stepped down and the years participated on PMWG.

Brent Feeney	Manager, Program Funding and Accountability, Public Health Standards, Practice and Accountability Branch, Public Health Division, MOHLTC
Kelci Gershon	Manager (A), Strategic Policy & Planning Branch, Health Promotion Division, MOHLTC
Amy Hope	Manager, Executive Office, Chief Medical Officer of Health Office, Public Health Division, MOHLTC
Naomi Kasman	Senior Health Analyst, Health Analytics Branch, Health System Information Management & Investment Division, MOHLTC
Roselle Martino	Executive Director (A), Chief Medical Officer of Health Office, Public Health Division, MOHLTC
Laura Pisko-Bezruchko	Director, Standards, Programs and Community Development Branch, Health Promotion Division, MOHLTC
Paulina Salamo	Manger, Standards and Performance, Public Health Standards, Practice and Accountability Branch, MOHLTC
Stacey Weber	Manager, Early Learning and Child Development Branch, Early Years Programs Unit, MCYS
Michele Weidinger	Lead, Standards and Performance, Public Health Standards, Practice and Accountability Branch, MOHLTC

Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
519-271-7600 Fax 519-271-2195
www.pdhu.on.ca

May 23, 2012

The Honourable Bob Chiarelli
Minister of Transportation
Ministry of Transportation
Queen's Park/Minister's Office
77 Wellesley Street West
Ferguson Block, 3rd Floor
Toronto, ON M7A 1Z8

Re: All-Terrain Vehicle Safety

At its May 16, 2012 meeting, the Perth District Board of Health considered correspondence from Thunder Bay District Health Unit which contained the following resolution:

1. *Endorse the safety reminder issued by the Chief Coroner of Ontario that children under the age of 16 should not operate All-Terrain Vehicles (ATVs) intended for adults and that all ATV riders should complete an approved riders safety course in their area or through the Canada Safety Council;*
2. *Endorse mandatory helmet use for all ATV riders at all times;*
3. *Recommend persons under the age of 16 be under close supervision and accompanied by an adult;*
4. *Recommend that this legislation be enforced by a "peace officer".*

I would like to make you aware that this resolution was supported by the Board of the Perth District Health Unit.

Yours truly,

Randy C. Brown, Secretary
Board of Health of the Perth District Health Unit

RCB/ikl

c. Chief Medical Officer of Health
Minister of Health and Long-Term Care
Minster of Children and Youth Services
Ontario Public Health Association
Association of Local Health Agencies
Ontario Boards of Health
Local Police Chiefs

Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
(519) 271-7600

May 25, 2012

The Honourable Jason Kenney
Minister of Citizenship, Immigration and Multiculturalism
Ministry of Citizenship and Immigration Canada
325 East Block
House of Commons
Ottawa, ON K1A 0A6

Dear Minister Kenney:

The Board of Health of the Perth District Health Unit is deeply concerned about the planned cutbacks to the health benefits currently provided to refugee claimants under the Interim Federal Health Program (IFHP), as announced in April 2012 by your government.

The sudden discontinuation of these benefits on June 30, 2012, will result in a gap in primary care services and a downloading of costs to provincial health care and charitable support programs, which are already at or beyond capacity.

According to Citizenship and Immigration Canada, "Canada is recognized around the world for its leadership in resettling refugees and people who need protection" (Government of Canada, modified 2011). As a signatory to the United Nations' Conventions on both The Status of Refugees and The Rights of the Child, as well as being a responsible and wealthy global citizen, it is right that Canada should earn and maintain such a reputation.

The IFHP currently ensures basic medical, dental and vision care for newcomers to Canada. Research demonstrates that simple health care greatly benefits newcomers. The provision of primary care has the potential to reduce the need for treatment of advanced disease and emergency room care, which are far more costly than primary care. Finally, when newcomer health is maximized, they are better equipped to enter the workforce or studies and to care for family members.

Therefore, not only is it unethical to deny health care to any person in need, it is not a cost-saving measure.

The Board of Health of the Perth District Health Unit urges your government to re-examine this decision and ensure compassionate, complete and seamless health care services for all refugee claimants.

Sincerely,

Miriam Klassen, MD, MPH
Medical Officer of Health

c. The Boards of Health for all Ontario Public Health Agencies
Michael Barrett, CEO, South West Local Health Integration Network

Background Information:

On May 16, 2012, the Board of Health of the Perth District Health Unit unanimously voted to send a letter to the Federal Government urging it to rethink the cutbacks on refugee health care and copy this communication to other Public Health Units in Ontario.

Public Health in Ontario

The Ontario Public Health Standards describe the mandatory programs and services that local public health agencies are expected to provide (MOHLTC, modified 2009). One of the four guiding principles to ensure quality public health practice is the importance of understanding need, and in particular, priority populations who are at risk of experiencing inequities in health status. The Foundational Standards describe the roles of public health which include: identifying priority populations by socio-demographic characteristics, identifying gaps in public health and other health services, and sharing this important information with policy- and decision-makers at all levels of government and the community.

Refugees in Canada

Canadians have long supported immigration as a benefit to both the economy and diversity (CIC, 2011, Reitz, 2011). Additionally, while Canadians support reform of the refugee system, a 2010 Harris-Decima poll demonstrates that Canadians value a fair refugee system which offers asylum seekers the benefit of the doubt (Payton, 2010). Sixty-four percent of participants in the survey agreed that: "The Canadian system for dealing with people claiming refugee status is part of Canada's humanitarian tradition" (Berthiaume, 2010).

Refugees and Medical Needs

Part of welcoming refugees is ensuring that basic needs are met. These basic needs include shelter, food, employment, and health care. While immigrants in general tend to be healthier than Canadians upon arrival, it is understood that refugees are more likely to have experienced deprivation and stress and are therefore at higher risk of medical complications (Gushulak, 2011). Currently, refugees are at risk for a rapid decline in self-reported health after arrival, making access to medical care even more crucial (Pottie, 2011).

Along with a higher risk of medical needs and obvious lack of resources, this vulnerable population already faces challenges such as of lack of familiarity with the local area and customs, language barriers and transportation issues.

The prevention of disease, along with early detection and intervention, and the management of chronic diseases are more economical than treating advanced disease. Primary care is far less costly than emergency room care, which will be the only recourse left to vulnerable people. Additionally, healthy people are better able to contribute to the workforce as well as to their own families.

At this time, the Interim Federal Health Program (IFHP) offers a full range of health care benefits including dental care, vision care and pharmacy care until such time as a claimant receives coverage under a provincial plan. However, with the federal government's cutbacks, protected persons and refugee claimants will only be able to access health care services if "of an urgent or essential nature" and "Medication and vaccines only if needed to prevent or treat a disease that is a risk to public health or a condition of public safety concern" (Citizenship and Immigration Canada, modified 2012). Those identified as coming from Designated Countries of Origin will receive even less coverage. This will leave many people, including children, without access to basic health care.

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Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
(519) 271-7600

May 25, 2012

To: **Interested Parties**

Subject: **Vienna Declaration**

Substance misuse is a pervasive public health issue. Substance misuse is estimated to cost Canadians almost 40 billion dollars annually in terms of burden on the health care and enforcement systems, and the loss of productivity in the community and the workforce.[1]

While drug use and drinking in Perth County is generally similar to the rest of Ontario, rates of alcohol, cannabis and crystal meth use continue to be a particular concern in the southwest region.[2]

International efforts to date, heavily focused on drug prohibition, have failed to stop substance misuse, and have resulted in negative health and social consequences.

The Vienna Declaration calls for a reorientation of drug policy to use an evidence-based approach that recognizes substance misuse as a medical issue, and that respects and protects human rights. It calls for redirecting resources "towards where they are needed most: implementing and evaluating evidence-based prevention, regulatory treatment and harm reduction interventions."[3]

On May 16, 2012, the Board of Health of the Perth District Health Unit received the staff report, "The Vienna Declaration – Additional Information" (*attached*), and moved to:

- Endorse the Vienna Declaration, enabling Dr. Klassen to register the Perth District Health Unit as a signatory on the Vienna Declaration website
- Circulate a letter with the background information and Staff Reports to the Drug Strategy Task Force and all other Ontario Public Health Units encouraging their endorsement of the Vienna Declaration
- Create a media release to inform county residents of this endorsement as a follow-up action to the recent report, "Starting the Conversation: A report on Substance Abuse and Problem Gambling in Perth and Huron Counties".

By endorsing the Vienna Declaration, the Perth District Health Unit is advocating for policy makers to address the issue of substance misuse using a more inclusive and evidence-based approach.

We respectfully share this package for information purposes and to encourage you/your organization to likewise consider endorsing the declaration.

Sincerely,

Miriam Klassen, MD, MPH
Medical Officer of Health

c. The Boards of Health for all Ontario Public Health Agencies
Michael Barrett, CEO, South West Local Health Integration Network
Drug Strategy Task Force

Attachments:

- Staff Report: May 16, 2012, "The Vienna Declaration –Additional Information"
- Additional information on the Vienna Declaration, May 2012
- Staff Report: Nov 23, 2011, "The Vienna Declaration"
- The Vienna Declaration

References:

1. Rehm, J. et al (2006). The Costs of Substance Abuse in Canada 2002. Highlights, Canadian Centre of Substance Abuse. Retrieved from: http://www.ccsa.ca/2006%20CCSA%20Documents/ccsa-011332-2006.pdf

2. Social Research and Planning Council. (2012). Starting the Conversation: A Report on Substance Abuse and Problem Gambling in Perth and Huron Counties. Retrieved from: http://socialresearchandplanning.ca/Welcome_Page_SRPC_files/Starting%20The%20Conversation.pdf

3. The Vienna Declaration. (2010). Retrieved from: www.viennadeclaration.com

Staff Report

Date: May 16, 2012

To: Board of Health

From: Carol MacDougall

Subject: **Vienna Declaration – Additional Information**

PURPOSE: To provide additional information about the Vienna Declaration and rationale for why the Perth District Health Unit should support it.

FINANCIAL IMPLICATIONS: No financial implications for Perth District Health Unit.

IMPACT STATEMENT:

Support from our Board of Health would strengthen the ability of Perth District Health Unit staff to engage in concerted effort with community partners to address issues identified in recent Perth and Huron County reports (as listed below), through the implementation of evidence-based policy:

1. "Starting the Conversation: A Report on Substance Abuse and Problem Gambling in Perth and Huron Counties"

2. "It Affects Us All: A Report on Mental Illness in Perth County"

3. "The Time is Now: A Plan for Enhancing Community-based Mental Health and Addiction Services in the South West LHIN".

RECOMMENDATIONS:

It is recommended that the Board of Health:

- Endorse the Vienna Declaration, enabling Dr. Klassen to register the Perth District Health Unit as a signatory on the Vienna Declaration website.

- Consider circulating a letter with the attached background information and Staff Reports to the Drug Strategy Task Force and all other Ontario Public Health Units encouraging their endorsement of the Vienna Declaration.

- Consider a media release to inform county residents of this endorsement as a follow-up action to the recent report, "Starting the Conversation: A Report on Substance Abuse and Problem Gambling in Perth and Huron Counties".

BACKGROUND:

In November of 2011, the Board of Health of the Perth District Health Unit received the staff report, "The Vienna Declaration" (see attached), and voted to defer signing the declaration pending further information, which is now provided in this report (see attached.)

CONCLUSIONS:

This is an opportunity for the Perth District Health Unit to communicate the importance of implementing evidence-based approaches when addressing the issue of illegal drug use, and thereby optimally benefiting the citizens of our county.

CONTACT:

Carol MacDougall, Public Health Manager
Perth District Health Unit
(519) 271-7600 ext. 322

LIST OF ATTACHMENTS:

Staff Report –The Vienna Declaration, November 2011.
Additional Information on the Vienna Declaration, May 2012.

REFERENCES:

Huron Perth Social Research and Planning Council. (May 2012). Starting the Conversation: A Report on Substance Abuse and Problem Gambling in Perth and Huron Counties. Retrieved from: http://socialresearchandplanning.ca/Welcome_Page_SRPC_files/Starting%20The%20Conversation.pdf

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Whaley and Company for the South West Addiction and Mental Health Coalition and the South West Local Health Integration Network. (Nov 2011). The Time is Now: A Plan for Enhancing Community-based Mental Health and Addiction Services in the South West LHIN. Retrieved from: http://www.southwestlhin.on.ca/uploadedFiles/Public_Community/Current_Initiatives/Mental_Health/Community%20Capacity%20Report-final_Nov16_2011.pdf

ADDITIONAL INFORMATION ON THE VIENNA DECLARATION
Prepared for the Board of Health of the Perth District Health Unit
May 2012

Why Support for Evidence-Based Approaches to Drug Policy is Important for Perth County[1]

- The southwestern part of the province reports the highest average number of drinks consumed per week and one of the highest rates of driving after drinking.

- A significantly higher percentage of youth, aged 12 to 19 years, in Perth and Huron Counties report drinking alcohol and participating in binge drinking as compared to youth elsewhere in the province.

- Cannabis use in Southwestern Ontario nearly doubled between 1996 and 2007 for both men and women of all ages, and it is the most commonly used illegal drug among students in grades 7 to 12.

- Perth County was identified as the "meth capital of Ontario" by the Toronto Star after an alarmingly high number of meth labs were discovered throughout the County. A special task force was established in 2005 to explore effective prevention and treatment options.

- The number of drug related offences per capita in Stratford (Perth County) was significantly higher than the rate for Ontario and slightly higher than the rate for the entire Country (2003).

Background on the Vienna Declaration

- The Vienna Declaration[2] was drafted by a writing committee of international experts in the field of HIV and drug policy, including the International AIDS Society, the International Centre for Science in Drug Policy, and the British Columbia Centre for Excellence in HIV/AIDS.

- It was the official declaration of the 18th International AIDS Conference—the largest public health conference in the world, which was held in Vienna, Austria July 18-23, 2010 and had over 20,000 delegates.

- It has over 20,000 endorsements, including the International Union for Health Promotion and Education, and numerous law enforcement, judiciary and legal professionals

- In Canada, it has been endorsed by (among others):
  - five Provincial Health Officers
  - Canadian Association of HIV Research
  - Canadian Public Health Association
  - Canadian Drug Policy Consortium
  - Health Officers Council of British Columbia
  - City of Vancouver
  - Victoria City Council
  - Toronto City Council
  - City of Red Deer

Underlying Principles of the Vienna Declaration

- Drug prohibition and some enforcement approaches have not been successful (not with alcohol in the past, nor with drugs in current times), in fact, have caused harmful consequences such as increased HIV transmission, reduced access for drug users to prevention and care services, record incarceration rates, stigma towards people who use drugs, human rights violations, a massive illicit market, wasted tax dollars.

- There is an ethical and legal obligation to enact evidence-based strategies that can effectively reduce the harms of drugs without causing harms of their own.

…/2

- Focus needs to be not on criminalizing drug users, but on scaling up evidence-based drug treatment and harm reduction options.

  "Reorienting drug policies towards evidence-based approaches that respect, protect and fulfill human rights has the potential to reduce harms deriving from current policies and would allow for the redirection of the vast financial resources towards where they are needed most: implementing and evaluating evidence-based prevention, regulatory, treatment and harm reduction interventions." [2]

Some examples of evidence-based approaches [excerpted directly from [3, 4, 5, 6] and [7] below]

- A comprehensive four pillar approach comprising[3]
  - Health promotion and prevention
  - Treatment
  - Enforcement
  - Harm reduction

- Prevention programs for youth that focus on social skills and peer influences and are targeted at specific at-risk groups instead of broad "just say no" messages. Effective programs combine education and social support to prevent a proportion of youth from developing into regular or dependent drug users.[4]

- Expanded access to existing evidence-based drug treatment programs[5]
  - Medical and non-medical withdrawal programs
  - Programs to manage concurrent mental health problems and addictions
  - Ambulatory and residential treatment programs
  - Opioid substitution therapies

- Reorienting drug policies on addiction to consider addiction as a health issue rather than primarily a criminal justice issue[5]
  - Expand evidence-based community diversion programs for non-violent drug offenders to replace more costly and less effective incarceration efforts[5]
    E.g. In 2005, faced with a budget crisis, and realizing that alcohol and drugs are at the root of 80% of crime, rather than invest 2 billion dollars in new prisons which were needed for the prisoners anticipated, Texas invested just 300 million dollars in drug treatment programs, mental health centres, probation services and community supervision for prisoners out on parole[6]. According to the Texas Department of Corrections, the rate of incarceration, previously the highest in the world, fell 9 per cent between 2005 and 2010. In the same period, according to the FBI, the crime rate in Texas fell by 12.8 per cent. [6]
  - Avoid mandatory minimum sentences legislation for non-violent drug offences[5]
    E.g. Repeals of mandatory minimum sentences legislation were done in the states of New York, Michigan, Massachusetts and Connecticut with several others pending.[5] Mandatory minimum sentences fulfill the goal of punishment and retribution, but fail to meet broader objectives of deterrence of drug use and rehabilitation of offenders[7].
  - End the criminalization, marginalization and stigmatization of people who use drugs but who do no harm to others[4]
    E.g. Portugal decriminalized all drug use in 2001 and has seen no increases in drug-related harms, but instead, reductions in problematic use, drug-related harms and criminal justice overcrowding, with rates of drug use remaining among the lowest in the European Union[5]
    E.g. Jurisdictions across Australia, Europe and the Americas have decriminalized the possession of some or all illegal drugs[7]
  - Controlled regulation of illegal drugs. Substantial evidence from research on illicit drugs, tobacco and alcohol show how regulatory tools can more safely control drug availability while having the potential to positively influence cultural norms related to drug use[5]
    E.g. Rates of use of cannabis are higher in U.S. than in Holland[5]

- Harm reduction strategies [found in 93 countries worldwide][7]
  - Needle exchange programs[5]
  - Methadone maintenance therapy[5]
  - Supervised consumption facilities in urban areas with high concentrations of public drug use and related harms[5] [Sep 30, 2011 the Supreme Court of Canada ruled 9-0 in favour of maintaining legal exemption for Vancouver's Insite, the country's only supervised injection facility, declaring the facility an important health service][7]

Additional Information

- The Report of the Global Commission on Drug Policy (June 2011)[4] includes principles and recommendations such as
  - End the criminalization, marginalization and stigmatization of people who use drugs but who do no harm to others
  - Offer health and treatment services to those in need, including harm reduction measures
  - Invest in activities that can both prevent young people from taking drugs in the first place and also prevent those who do use drugs from developing more serious problems
  - Focus repressive actions on violent criminal organizations, but do so in ways that undermine their power and reach while prioritizing the reduction of violence and intimidation
  - Begin the transformation of the global drug prohibition regime…[to one] with fiscally responsible policies and strategies grounded in science, health, security and human rights
  - Break the taboo on debate and reform
  - Commissioners to the report include: César Gaviria, former President of Colombia; Ernesto Zedillo, former President of Mexico; Fernando Henrique Cardoso, former President of Brazil; George Papandreou, Prime Minister of Greece; George P. Shultz, former Secretary of State, United States; Kofi Annan, former Secretary General of the United Nations; and Louise Arbour, former UN High Commissioner for Human Rights, President of the International Crisis Group, Canada

- On March 28, 2012, the Urban Public Health Network (UPHN)[8], which comprises the chief medical health officers of the 18 largest municipalities in Canada, joined a growing list of Nobel Laureates, former heads of state, academic, political, law enforcement, health and religious leaders who have endorsed the Vienna Declaration.

References

1. Moses, J. (2012). *Starting the Conversation: A Report on Substance Abuse and Problem Gambling in Perth and Huron Counties.* Huron Perth Social Research and Planning Council. Retrieved from: http://socialresearchandplanning.ca/Welcome_Page_SRPC_files/Starting%20The%20Conversation.pdf

2. *The Vienna Declaration*. (2010). Retrieved from: www.viennadeclaration.com

3. Health Canada Drug Strategy and Controlled Substances Programme and Canadian Centre on Substance Abuse. *National framework for action to reduce the harms associated with alcohol and other drugs and substances in Canada.* 1st edition 2005. Retrieved from: http://www.nationalframework-cadrenational.ca/images/uploads/file/ccsa0113232005_e.pdf

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5. Wood, E. et al. (2012). *Improving community health and safety in Canada through evidence-based policies on illegal drugs.* Open Medicine, Vol. 6, No. 1. Retrieved from: http://www.openmedicine.ca/article/view/501/455

6. Milewski, T. (2011). *Texas conservatives reject Harper's crime plan.* CBC. Retrieved from: http://www.cbc.ca/news/politics/story/2011/10/17/pol-vp-milewski-texas-crime.html

7. Hyshka, E. et al. (2012). *Canada moving backwards on illegal drugs.* Canadian Journal of Public Health, Vol.103, No. 2. Retrieved from: http://journal.cpha.ca/index.php.cjph/article/view/2926

8. Urban Public Health Network. (2012). *Canada's Urban Public Health Network endorses global call for evidence-based drug policy.* Retrieved from: http://www.viennadeclaration.com/2012/03/canada%E2%80%99s-urban-public-health-network-endorses-global-call-for-evidence-based-drug-policy/

Staff Report

Date: November 23, 2011

To: Board of Health

From: Jane DeBlock

Subject: **The Vienna Declaration**

PURPOSE:
To give an understanding of what the Vienna Declaration is about and why the Perth District Health Unit should consider supporting it.

FINANCIAL IMPLICATIONS AND IMPACT STATEMENT:
Signing the Vienna Declaration would mean supporting the idea that Public Health systems are undermined when law enforcement drives drug users away from prevention and care services and into environments where the risk of infectious disease transmission, i.e., HIV, Hep C and other harms, is increased.

There is no financial burden to PDHU. It would be hard to predict the possible financial gains by improving access to health care and reducing harm.

RECOMMENDATIONS:
We recommend signing the Vienna Declaration which asks for the implementation of evidence-based policies that can meaningfully improve community health and safety by reducing the impact of drugs locally and globally.

BACKGROUND:
The Vienna Declaration is a call for evidence-based, public health approaches to drug policies prepared by an International Committee of leading scientists. The Vienna Declaration outlines the overwhelming evidence that drug law enforcement has failed to achieve its stated objectives, and has led to harmful consequences such as a massive illicit drug market worth an estimated $320 billion US. This money fuels crime, violence and corruption and is not taxable.

The evidence of the failure of drug prohibition to achieve its goals, as well as the severe negative consequences of these policies, is often denied by those with vested interests in maintaining the status quo.

The Supreme Court's decision in favour of Insite, Vancouver's safe injection site, demonstrated how scientific evidence won over ideology. The ruling makes the important distinction that those who use drugs are as worthy to receive care and treatment as those who choose abstinence. Recognizing the reality of addiction and meeting people where they are at, allows this program to offer a range of addiction interventions, helping the individuals gain control over their life and get on the path to becoming drug free.

COMMENTS:
Drug policies should be based on science, not ideology.

CONCLUSIONS:
Governments have an ethical and a legal responsibility to respond to this crisis and to seek evidence-based strategies to effectively reduce the harms of drugs without creating harms of their own. Signing the Vienna Declaration is one step toward this outcome.

…/2

CONTACT:

Name: Jane DeBlock
Title: Public Health Nurse
Perth District Health Unit
☎ 519-271-7600 ext 714
🖷 519-271-5368

LIST OF ATTACHMENTS:

The Vienna Declaration

The Vienna Declaration

The Vienna Declaration is a statement seeking to improve community health and safety by calling for the incorporation of scientific evidence into illicit drug policies. We are inviting scientists, health practitioners and the public to endorse this document in order to bring these issues to the attention of governments and international agencies, and to illustrate that drug policy reform is a matter of urgent international significance. We also welcome organizational endorsements .

The criminalisation of illicit drug users is fuelling the HIV epidemic and has resulted in overwhelmingly negative health and social consequences. A full policy reorientation is needed.

In response to the health and social harms of illegal drugs, a large international drug prohibition regime has been developed under the umbrella of the United Nations.[1] Decades of research provide a comprehensive assessment of the impacts of the global "War on Drugs" and, in the wake of the XVIII International AIDS Conference in Vienna, Austria, the international scientific community calls for an acknowledgement of the limits and harms of drug prohibition, and for drug policy reform to remove barriers to effective HIV prevention, treatment and care.

The evidence that law enforcement has failed to prevent the availability of illegal drugs, in communities where there is demand, is now unambiguous.[2,3] Over the last several decades, national and international drug surveillance systems have demonstrated a general pattern of falling drug prices and increasing drug purity—despite massive investments in drug law enforcement.[3,4]

Furthermore, there is no evidence that increasing the ferocity of law enforcement meaningfully reduces the prevalence of drug use.[5] The data also clearly demonstrate that the number of countries in which people inject illegal drugs is growing, with women and children becoming increasingly affected.[6] Outside of sub-Saharan Africa, injection drug use accounts for approximately one in three new cases of HIV.[7,8] In some areas where HIV is spreading most rapidly, such as Eastern Europe and Central Asia, HIV prevalence can be as high as 70% among people who inject drugs, and in some areas more than 80% of all HIV cases are among this group.[8]

In the context of overwhelming evidence that drug law enforcement has failed to achieve its stated objectives, it is important that its harmful consequences be acknowledged and addressed. These consequences include but are not limited to:

- HIV epidemics fuelled by the criminalisation of people who use illicit drugs and by prohibitions on the provision of sterile needles and opioid substitution treatment.[9,10]
- HIV outbreaks among incarcerated and institutionalised drug users as a result of punitive laws and policies and a lack of HIV prevention services in these settings.[11-13]
- The undermining of public health systems when law enforcement drives drug users away from prevention and care services and into environments where the risk of infectious disease transmission (e.g., HIV, hepatitis C & B, and tuberculosis) and other harms is increased.[14-16]
- A crisis in criminal justice systems as a result of record incarceration rates in a number of nations.[17,18] This has negatively affected the social functioning of entire communities. While racial disparities in incarceration rates for drug offences are evident in countries all over the world, the impact has been particularly severe in the US, where approximately one in nine African-American males in the age group 20 to 34 is incarcerated on any given day, primarily as a result of drug law enforcement.[19]
- Stigma towards people who use illicit drugs, which reinforces the political popularity of criminalising drug users and undermines HIV prevention and other health promotion efforts.[20,21]
- Severe human rights violations, including torture, forced labour, inhuman and degrading treatment, and execution of drug offenders in a number of countries.[22,23]
- A massive illicit market worth an estimated annual value of US$320 billion.[4] These profits remain entirely outside the control of government. They fuel crime, violence and corruption in countless urban communities and have destabilised entire countries, such as Colombia, Mexico and Afghanistan.[4]
- Billions of tax dollars wasted on a "War on Drugs" approach to drug control that does not achieve its stated objectives and, instead, directly or indirectly contributes to the above harms.[24]

Unfortunately, evidence of the failure of drug prohibition to achieve its stated goals, as well as the severe negative consequences of these policies, is often denied by those with vested interests in maintaining the status quo.[25] This has created confusion among the public and has cost countless lives. Governments and international organisations have ethical and legal obligations to respond to this crisis and must seek to enact alternative evidence-based strategies that can effectively reduce the harms of drugs without creating harms of their own. We, the undersigned, call on governments and international organisations, including the United Nations, to:

- Undertake a transparent review of the effectiveness of current drug policies.
- Implement and evaluate a science-based public health approach to address the individual and community harms stemming from illicit drug use.
- Decriminalise drug users, scale up evidence-based drug dependence treatment options and abolish ineffective compulsory drug treatment centres that violate the Universal Declaration of Human Rights.[26]
- Unequivocally endorse and scale up funding for the implementation of the comprehensive package of HIV interventions spelled out in the WHO, UNODC and UNAIDS Target Setting Guide.[27]
- Meaningfully involve members of the affected community in developing, monitoring and implementing services and policies that affect their lives.

Basing drug policies on scientific evidence will not eliminate drug use or the problems stemming from drug injecting. However, reorienting drug policies towards evidence-based approaches that respect, protect and fulfil human rights has the potential to reduce harms deriving from current policies and would allow for the redirection of the vast financial resources towards where they are needed most: implementing and evaluating evidence-based prevention, regulatory, treatment and harm reduction interventions.

**On August 19th, the Vienna declaration was modified to reflect the fact that the XVIII International AIDS Conference has passed. Reference to the UN Secretary General was also removed to enable UN organizations to endorse the Declaration. These modifications were approved without objection by the majority of the writing committee.*

British Columbia Centre for Excellence in HIV/AIDS

ICSDP

International AIDS Society Stronger Together

AIDS 2010

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Sign on now at www.viennadeclaration.com

Public Health

Head Office:
474 Wellington Road 18, Suite 100
RR #1 Fergus, ON N1M 2W3
T: 519.846.2715
1.800.265.7293
F: 519.846.0323
www.wdghu.org
info@wdghu.org

May 2, 2012

The Honourable Deborah Matthews
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Matthews:

Re: Immunization of School Pupils Act

Over the past 50 years vaccines have saved more lives than any other medical intervention in Canada. The goal of those advocating universal immunization is the elimination of vaccine preventable diseases. This is an achievable goal as illustrated by the eradication of small pox. The continued success of vaccines is dependent on continuing immunization programs with high vaccine coverage rates.

It is commendable that Ontario recently updated their publically funded vaccine schedule to include 14 vaccines that will protect the public from 17 different vaccine preventable diseases. Unfortunately, the Immunization of School Pupils Act 1990 does not reflect the current recommendations of the Ontario Vaccination Schedule. Legislation facilitates vaccine program success by supporting public health officials collecting immunization information for high risk groups, such as children attending school. The discrepancy in legislations and recommendation limits Public Health's ability to fulfill the Ontario Public Health Standard's goal to reduce or eliminate the burden of vaccine preventable diseases.

Additionally, in 2012, the MOHLTC introduced the Accountability Agreement Indicators that set performance targets specific to each health unit. These performance targets include vaccination rates for school age children for the following vaccine preventable diseases: hepatitis B, human papillomavirus and meningoccal disease-group C. Without the support of legislation the ability to meet these targets across the province is challenging at best.

...../2

Wellington-Dufferin-Guelph Public Health Board of Health respectfully requests that amendments be made to the Immunization of School Pupils Act 1990 to reflect the current Ontario Vaccine Schedule and provide Public Health with the tools necessary to ensure that school age children in Ontario are adequately protected from vaccine preventable diseases.

Sincerely,

Amanda Rayburn
Chair, WDGPH Board of Health

cc Dr. Arlene King, Chief Medical Officer of Health
Liz Sandals, MPP Guelph
Randy Pettapiece, MPP Perth-Wellington
Sylvia Jones, MPP Dufferin-Caledon
Ted Arnott, MPP Wellington-Halton Hills
Frank Valeriote, MP Guelph
David Tilson, MP Dufferin-Caledon
Gary Schellenberger, MP Perth-Wellington
The Honourable Michael Chong, MP Wellington-Halton Hills
All Ontario Public Health Units

PETERBOROUGH

DRUG STRATEGY

The Way Forward

The Peterborough Drug Strategy
Findings and Recommendations:
May 2012

The Peterborough Drug Strategy

The Peterborough Drug Strategy

- The Peterborough Drug Strategy is a collaboration amongst citizens, prevention, treatment, enforcement and harm reduction organisations to reduce the negative impacts of substance use.

The Peterborough Drug Strategy

- The Peterborough Drug Strategy is a collaboration amongst citizens, prevention, treatment, enforcement and harm reduction organisations to reduce the negative impacts of substance use.
- Initiative to mobilize collaborative action and strategic planning.

The Peterborough Drug Strategy

- The Peterborough Drug Strategy is a collaboration amongst citizens, prevention, treatment, enforcement and harm reduction organisations to reduce the negative impacts of substance use.
- Initiative to mobilize collaborative action and strategic planning.
- Four pillar partnership. Harm Reduction, Prevention, Treatment and Enforcement.

The Peterborough Drug Strategy

- The Peterborough Drug Strategy is a collaboration amongst citizens, prevention, treatment, enforcement and harm reduction organisations to reduce the negative impacts of substance use.
- Initiative to mobilize collaborative action and strategic planning.
- Four pillar partnership. Harm Reduction, Prevention, Treatment and Enforcement.
- Integrates fragmented responses, promotes intersectoral collaboration.

The Peterborough Drug Strategy

- The Peterborough Drug Strategy is a collaboration amongst citizens, prevention, treatment, enforcement and harm reduction organisations to reduce the negative impacts of substance use.
- Initiative to mobilize collaborative action and strategic planning.
- Four pillar partnership. Harm Reduction, Prevention, Treatment and Enforcement.
- Integrates fragmented responses, promotes intersectoral collaboration.
- Balances the health issues of the individual user with the public order issues of neighbourhoods and communities.

Guiding Principles

- Inclusion
- Collaboration
- Respect
- Sustainability
- Relevancy
- Evidence
- Innovation

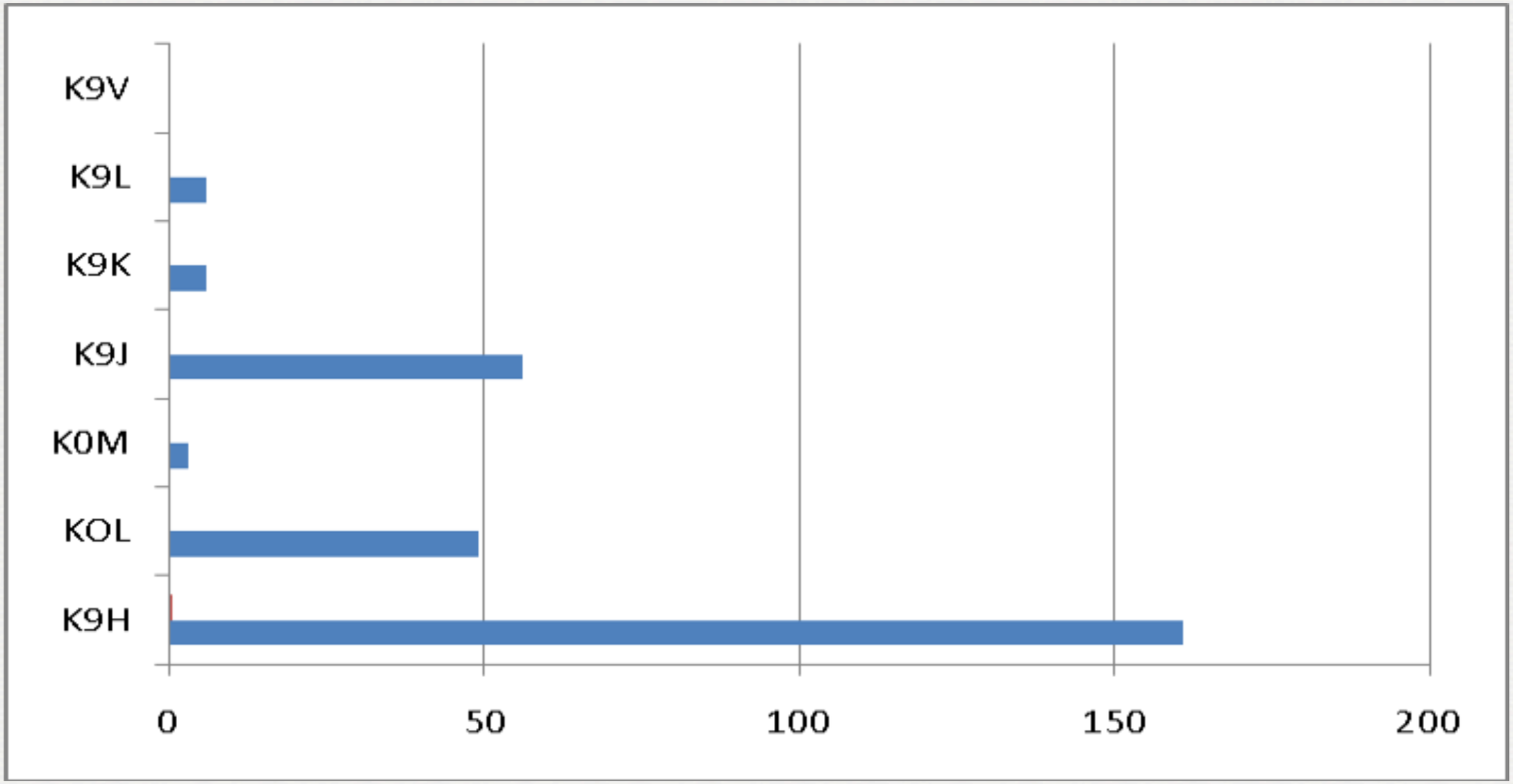
The Process

- Funding - Ontario Trillium Foundation 2011-2012
- Community consultation
- Analyze the data
- Research and evidence
- Compile and produce report
- Prioritize and implement

Community Consultation

- General Population
  - General Survey – 298 respondents
  - Focus Groups – 65 participants
- Youth
  - General Survey – 120 youth respondents (12-24)
  - Focus Groups – 440 participants
- "People with Lived Experience"
  - Survey – 122 respondents
  - Focus Groups – 55 participant
- Service Providers
  - Survey – 106 respondents
  - Focus Groups – 55 participants

PLACE OF RESIDENCE

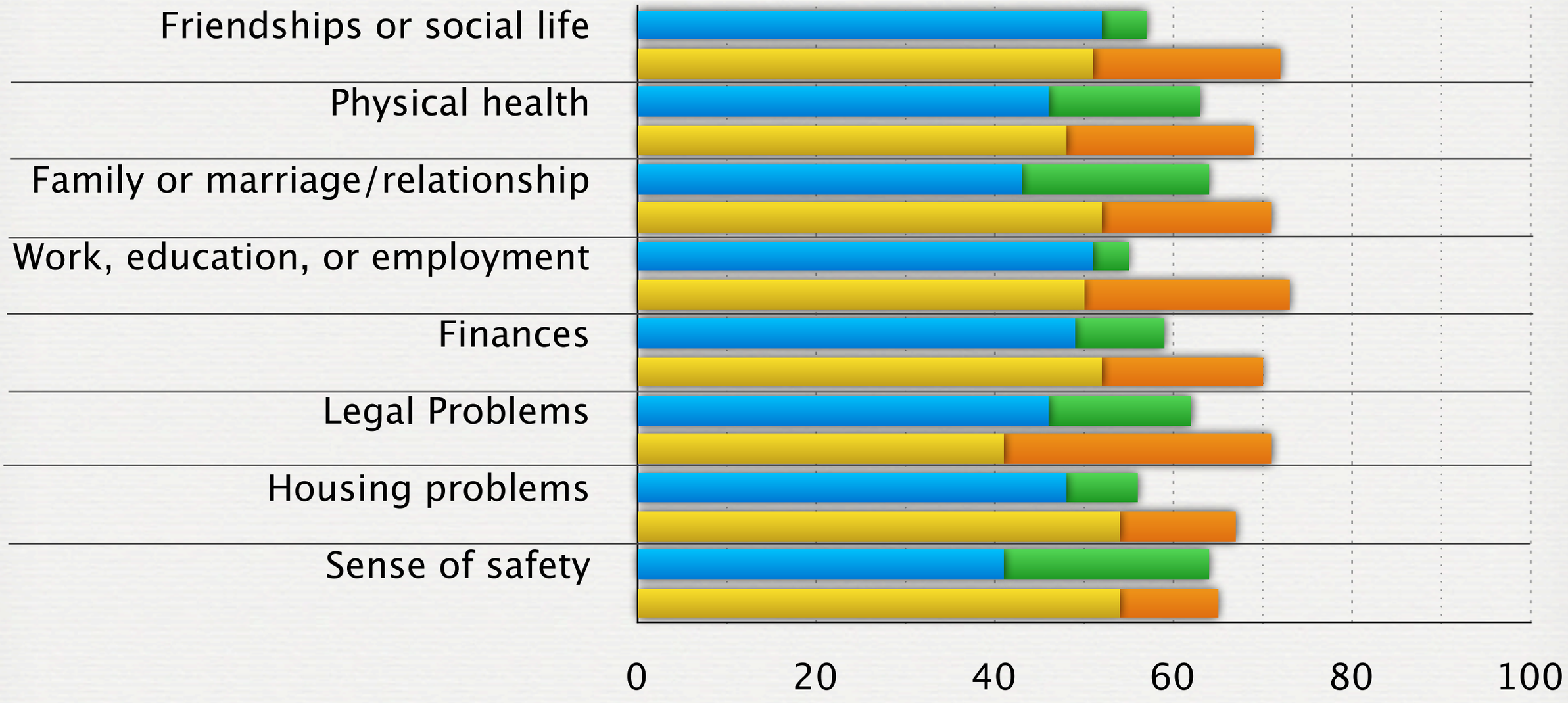


K9L, K9K, K9J, K9H - Peterborough

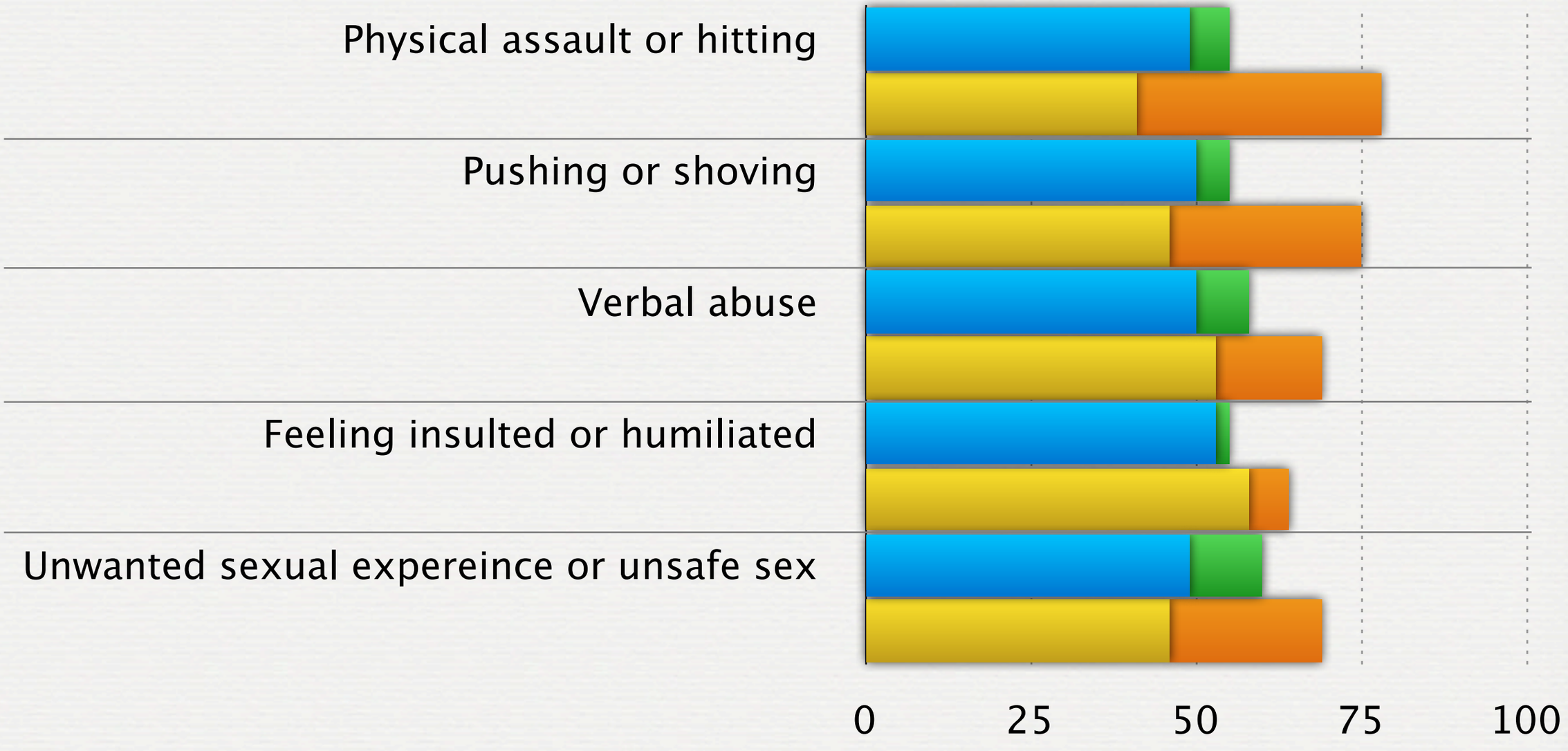
K0M - Bobcaygeon, Little Britain

K0L - Lakefield, Keene, Norwood, Warsaw, Havelock

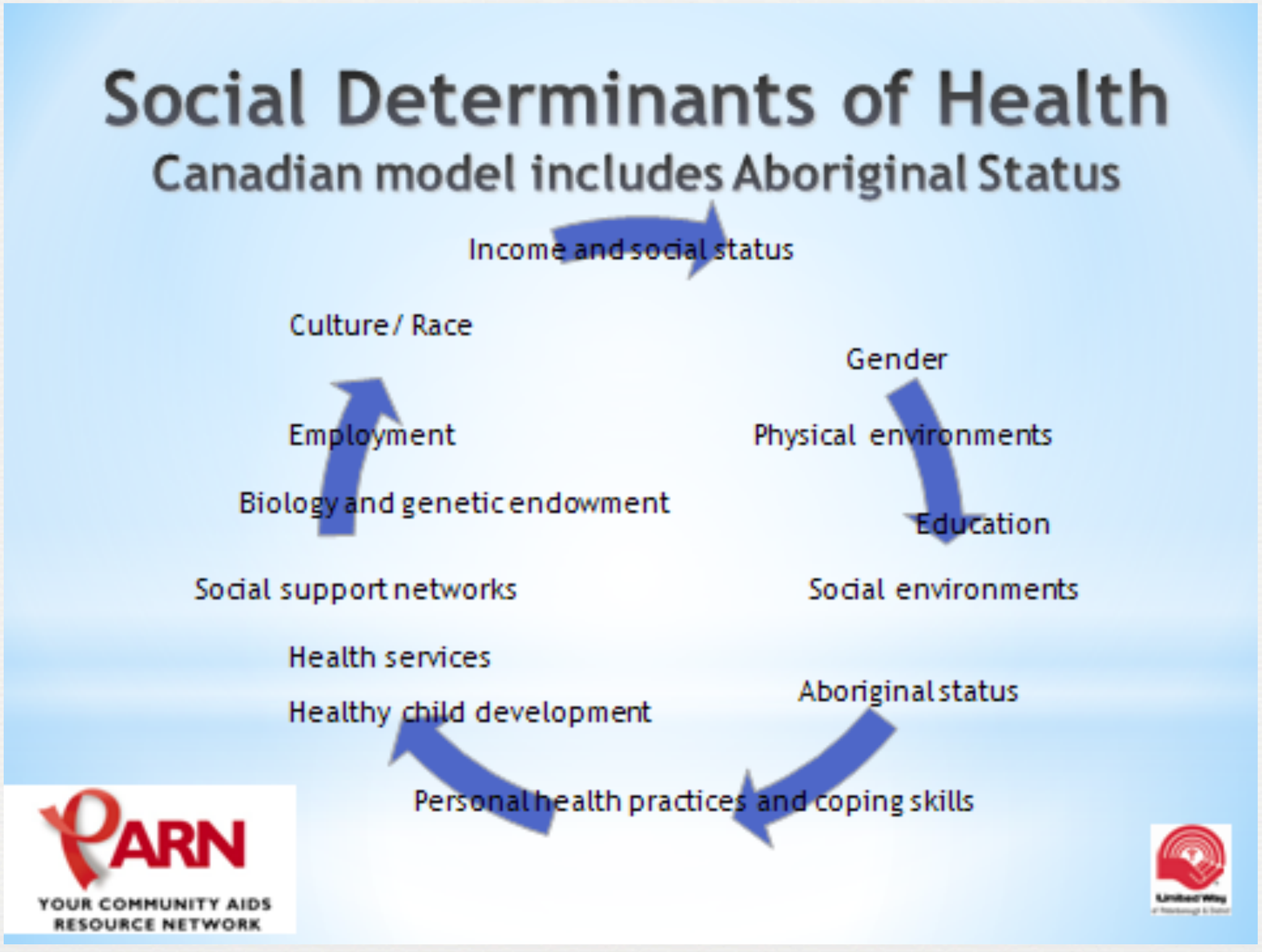
NEGATIVE IMPACTS OF SUBSTANCE USE
PETERBOROUGH DRUG STRATEGY SURVEY 2011



EXPERIENCES DUE TO OWN OR OTHERS' DRUG USE



SOCIAL DETERMINANTS OF HEALTH



Sectors

- Supportive Environments
- Education
- Housing
- Health and Social Services

Themes

- System Improvement
- Opportunities and Access
- Children Youth and Families
- Safety
- Stigma
- Beyond the Region of Peterborough

Emerging Priorities

- Stigma
- Public education and awareness raising.
- Conversation with youth about marijuana.
- Overdose Prevention
- Integrated service responses for addiction and mental health.
- Invest in the strength of families.

Questions?

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of health

Subject: **2011 Auditor's Report of the Consolidated Financial Statements**

Date: June 13, 2012

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit approve the 2011 Auditor's Report of the Consolidated Financial Statements of the Peterborough County-City Health Unit, as prepared by Collins Barrow Kawarthas LLP, Chartered Accountants.

Please refer to the attached.

Original signed by

Rosana Pellizzari, M.D.

Peterborough County-City Health Unit

Consolidated Financial Statements

At December 31, 2011

Peterborough County-City Health Unit

Consolidated Financial Statements

At December 31, 2011

Table Of Contents

The Peterborough County-City Health Unit

For The Year Ended December 31, 2011

Management Report

The accompanying consolidated financial statements of the Peterborough County-City Health Unit are the responsibility of management and have been approved by the Board of Health.

The consolidated financial statements have been prepared by management in accordance with Canadian generally accepted accounting principles. Financial statements are not precise since they include certain amounts based on estimates and judgements. When alternative accounting methods exist, management has chosen those it deems most appropriate in the circumstances, in order to ensure that the financial statements are presented fairly, in all material respects.

The Health Unit maintains systems of internal accounting and administrative controls of high quality, consistent with reasonable cost. Such systems are designed to provide reasonable assurance that the financial information is relevant, reliable and accurate and the Health Unit's assets are appropriately accounted for and adequately safeguarded.

The Board of Health is responsible for ensuring that management fulfills its responsibilities for financial reporting and is ultimately responsible for reviewing and approving financial statements.

The Board of Health reviews and approves the Health Unit's financial statements for issuance. The Board of Health meets periodically with management, as well as the external auditors, to discuss internal controls over the financial reporting process, auditing matters and financial reporting issues, to satisfy themselves that each party is properly discharging their responsibilities, and to review the consolidated financial statements and the external auditor's report.

The consolidated financial statements have been audited by Collins Barrow Kawarthas LLP in accordance with Canadian generally accepted auditing standards on behalf of the Health Unit. Collins Barrow Kawarthas LLP has full and free access to the Board of Health.

Chairman _____ Date _____

Medical Officer of Health _____ Date _____

INDEPENDENT AUDITORS' REPORT

To The Members Of The Board Of Health Of The Peterborough County-City Health Unit

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of the Peterborough County-City Health Unit which comprise the consolidated statement of financial position as at December 31, 2011 and the consolidated statements of operations and accumulated surplus, change in net financial assets, cash flows and the related schedules for the year then ended and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian Public Sector Accounting Standards, and for such internal controls as management determines are necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis of our audit opinion.

Opinion

In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Peterborough County-City Health Unit as at December 31, 2011, and the results of its operations and its cash flows for the year then ended in accordance with Canadian Public Sector Accounting Standards.

Chartered Accountants
Licensed Public Accountants

Peterborough, Ontario
June 13, 2012

Peterborough County-City Health Unit

Consolidated Statement of Financial Position
At December 31, 2011

	2011 $	2010 $
Financial Assets		
Cash	2,564,048	2,826,628
Accounts receivable		
Province of Ontario	-	8,048
Canada Revenue Agency	81,009	83,073
Health Canada	46,964	38,124
City of Peterborough - Ontario Works Program	111,886	248,096
Trade receivables	83,556	105,337
	2,887,463	3,309,306
Liabilities		
Accounts payable and accrued	1,121,768	1,112,881
Province of Ontario	344,143	-
Employee benefits payable (Note 5)	411,711	378,009
Deferred revenue (Note 6)	625,769	1,719,210
	2,503,391	3,210,100
Net Financial Assets	384,072	99,206
Non-Financial Assets		
Tangible capital assets (Note 3)	1,069,032	415,641
Prepaid expenses	60,255	405,531
	1,129,287	821,172
Accumulated Surplus (Note 4)	**1,513,359**	**920,378**

The accompanying notes are an integral part of this financial statement.

Peterborough County-City Health Unit

Consolidated Statement of Operations and Accumulated Surplus
For the year ended December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Revenue			
Province of Ontario	9,885,841	9,462,176	7,802,521
Health Canada	116,483	116,483	193,794
City and County of Peterborough and Curve Lake and Hiawatha First Nations	2,685,136	2,685,136	2,921,423
Fees for service	791,741	511,325	436,690
Other	248,581	225,886	105,920
Interest	22,000	25,095	15,381
	13,749,782	13,026,101	11,475,729
Expenses			
Salaries and wages	7,274,056	6,926,455	6,777,436
Benefits	1,772,111	1,756,721	1,593,575
Program costs	3,786,987	2,873,964	2,564,013
Administration and occupancy	916,628	744,954	561,948
Amortization	131,026	131,026	43,994
	13,880,808	12,433,120	11,540,966
Annual Surplus/(Deficit)	(131,026)	592,981	(65,237)
Accumulated Surplus, beginning of year	920,378	920,378	985,615
Accumulated Surplus, end of year	**789,352**	**1,513,359**	**920,378**

The accompanying notes are an integral part of this financial statement.

Peterborough County-City Health Unit

Consolidated Statement Of Changes In Net Financial Assets
For the year ended December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Annual Surplus/(Deficit)	(131,026)	592,981	(65,237)
Amortization	131,026	131,026	43,994
Change in prepaid expenses	-	345,276	(350,117)
Acquisition of tangible assets	-	(784,417)	-
Increase (Decrease) In Net Financial Assets	-	284,866	(371,360)
Net Financial Assets, beginning of year	99,206	99,206	470,566
Net Financial Assets, end of year	**99,206**	**384,072**	**99,206**

The accompanying notes are an integral part of this financial statement.

Peterborough County-City Health Unit

Consolidated Statement of Cash Flows
For the year ended December 31, 2011

	2011 $	2010 $
Operations		
Annual surplus/(deficit)	592,981	(65,237)
Items not involving cash		
Amortization	131,026	43,994
	724,007	(21,243)
Net change in working capital accounts related to operations		
(Increase) decrease in amounts receivable/payable to the Province of Ontario	352,191	344,243
(Increase) decrease in other accounts receivable	151,215	(114,146)
(Increase) decrease in prepaid expenses	345,276	(350,117)
Increase (decrease) in accounts payable	8,887	109,299
Increase (decrease) in deferred revenue	(1,093,441)	967,120
Increase (decrease) in employee benefits payable	33,702	40,549
Net increase (decrease) in cash from operations	521,837	975,705
Capital		
Acquisition of tangible capital assets	(784,417)	-
Increase (Decrease) in Cash	(262,580)	975,705
Cash, beginning of year	2,826,628	1,850,923
Cash, end of year	**2,564,048**	**2,826,628**

The accompanying notes are an integral part of this financial statement.

Peterborough County-City Health Unit

Notes to the Consolidated Financial Statements
For the year ended December 31, 2011

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1. **Purpose Of Organization**

The Peterborough County-City Health Unit strives to enable people and the community to be as healthy as possible. The Health Unit is a not-for-profit organization which provides accessible, community based programs and services that promote, protect and restore health.

2. **Significant Accounting Policies**

These consolidated financial statements have been prepared in accordance with generally accepted accounting principles for local governments and their boards as recommended by the Public Sector Accounting Board of the Canadian Institute of Chartered Accountants. Significant aspects of the accounting policies are as follows:

Reporting Entity

These consolidated financial statements reflect the assets, liabilities, revenue and expenditure and fund balances of the reporting entity.

The reporting entity is comprised of all programs and services administered by the Health Unit and coalition projects for which the Health Unit is contractually obligated as the sponsoring agency and accountable for the administration, financial affairs and resources of the coalition projects.

Tangible Capital Assets

Tangible capital assets are recorded at cost which includes all amounts that are directly attributable to acquisition, construction, development or betterment of the asset. The cost, less residual value, if any, of the tangible capital assets are amortized on a straight-line basis, over the expected useful life of the assets, as follows:

Buildings	-	3 to 60 years
Leasehold improvements	-	6 years
Equipment	-	2 to 5 years
Mobile dental unit	-	10 years

Capital acquisitions less than $25,000 are expensed during the year of acquisition.

Government Transfers

Government transfers are recognized in the financial statements as revenues in the period in which events giving rise to the funding occur, providing the funding is authorized, any eligibility criteria have been met, and reasonable estimates of the amounts can be made.

2. **Significant Accounting Policies** - (Continued)

Deferred Revenue

Deferred revenue consists of grants, contributions and other amounts are received from third parties pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or the completion of specific work. In addition certain fees are collected for which the related services have yet to be performed. Revenue is recognized in the period when the related expenses are incurred or the services are performed.

Non-financial Assets

Non-financial assets are not available to discharge existing liabilities and are held for the provision of services. They have useful lives beyond the current year and are not intended for sale in the ordinary course of operations. The change in non-financial assets during the year combined with the annual surplus provides the change in net financial assets for the year.

Realization of Revenue and Expenses

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the period in which the transactions or events have occurred that give rise to the revenue; expenses are recognized in the period the goods or services are acquired and a legal liability is incurred or transfers are due.

The Health Unit claims from the Ministry of Health and Long-Term Care, The Corporation of the City of Peterborough, The Corporation of the County of Peterborough, Curve Lake First Nation and Hiawatha First Nation revenue equivalent to its net costs for the public health programs. While these net claims for costs are recorded as revenue in the current year, the reimbursement for these costs is ultimately dependent upon their acceptance by the funding bodies.

For the Sewage Disposal Program, the Health Unit records inspection fee revenue as earned revenue based on the proportion of the completed inspection at the end of each year.

Management Estimates

The preparation of the financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting year.

Key areas where management has made complex or subjective judgments (often as a result of matters that are inherently uncertain) include, among others, accounts payable, revenue recognition, useful lives of capital assets and amortization. Actual results could differ from these and other estimates, the impact of which would be recorded in future periods.

Peterborough County-City Health Unit

Notes to the Consolidated Financial Statements
For the year ended December 31, 2011

2. **Significant Accounting Policies** - (Continued)

Financial Instruments

The Health Unit's financial instruments consist of cash, accounts receivable and accounts payable. Financial instruments are recorded at carrying value which approximates their fair value.

(a) Interest rate risk

Interest rate risk is the risk that the value of financial instruments will fluctuate due to changes in market interest rates. The Health Unit does not hold any financial instruments that are influenced by fluctuations in market rates.

(b) Credit risk

Credit risk arises from the potential that a counter party will fail to perform its obligations. The Health Unit has limited exposure to credit risk as the majority of the accounts receivable are due from government agencies. Trade receivables are made up of a number of various customers which minimizes concentration of credit risk.

(c) Foreign currency risk

Currency risk is the risk that the value of the financial instruments will fluctuate due to changes in foreign exchange rates. The Health Unit does not have any foreign currency and therefore they have no risk in this area.

3. **Tangible Capital Assets**

	2011		2010	
	Cost $	Accumulated Amortization $	Cost $	Accumulated Amortization $
Land	10,500	-	10,500	-
Buildings	879,407	530,491	879,407	516,534
Leasehold improvements				
- office	126,800	105,665	126,800	84,532
- clinic	262,417	43,736	-	-
Equipment	82,151	82,151	82,151	82,151
Mobile dental unit	522,000	52,200	-	-
	1,883,275	**814,243**	**1,098,858**	**683,217**
Net Book Value	**1.069,032**		**415,641**	

During 2011 and 2010 there were no disposals or write-downs related to tangible capital assets.

Peterborough County-City Health Unit

Notes to the Consolidated Financial Statements
For the year ended December 31, 2011

4. **Accumulated Surplus**

Accumulated surplus consists of the following:

	2011 $	2010 $
Surplus/(Deficit)		
. Invested in tangible capital assets	1,069,032	415,641
. Sewage disposal program	15,608	15,453
Total Surplus	1,084,640	431,094
Reserves		
Reserves set aside for specific purposes		
. occupancy/renovation	229,812	280,874
. local vaccination program	568	563
. genetics program - salaries	24,208	23,968
. genetics program - software	8,425	8,342
. Food security project	45,336	44,887
. Vector Borne Diseases	4,830	4,782
. Infant and Toddler Development program	15,198	15,048
	328,377	378,464
Contingency reserve	100,342	110,820
Total Reserves	428,719	489,284
Accumulated Surplus	**1,513,359**	**920,378**

Peterborough County-City Health Unit

Notes to the Consolidated Financial Statements
For the year ended December 31, 2011

5. **Employee Benefits Payable**

The Health Unit provides the following employee benefits that are fully funded and will require payment in future periods:

	2011 $	2010 $
. vacation and compensating pay entitlements	411,711	378,009

6. **Deferred Revenue**

Deferred revenue consists of:

	2011 $	2010 $
Specific and coalition projects	369,831	450,813
Ontario Works dental deposit	32,035	32,035
Sewage disposal program	223,903	232,158
Healthy Smiles Ontario	-	1,004,204
	625,769	1,719,210

7. **Pension Plan**

Substantially all the employees of the Health Unit are eligible to be members of the Ontario Municipal Employees Retirement Fund which is a multi-employer final average pay contributor pension plan. Employer contributions made to the Plan during the year by the Health Unit amounted to $509,903 (2010 - $439,775). These amounts are included in employee benefits expense in the consolidated statement of financial activities.

8. **Budget Figures**

Budget figures are compiled from budgets approved by the Board of Health, with subsequent adjustments for PSAB compliance. Budget figures are not subject to audit.

9. **Comparative Figures**

Certain comparative figures were restated to conform to the current year presentation.

Peterborough County-City Health Unit

Notes to the Consolidated Financial Statements
For the year ended December 31, 2011

10. **Commitments**

The Peterborough County-City Health Unit has committed to lease office space at O'Carroll Avenue until October 31, 2012 and clinic space at Peterborough Square until March 31, 2014. The estimated annual expense for the term of these leases is as follows:

2012	106,600
2013	28,941
2014	7,235

11. **Additional Financial Information**

	2011 $	2010 $
Medical Officer of Health Compensation		
The Health Unit provided the following compensation for the Medical Officer of Health:		
. Medical Officer of Health compensation - base salary	250,000	250,000
. Community Medicine stipend – 100% provincial	5,000	5,000
. Physician compensation – 100% provincial	37,263	27,063
. After hours availability – 2010 stipend	9,000	-
. After hours availability – 2011 stipend	12,000	-
	313,263	282,063
One Time Project Funding – Cost Shared		
. Project Manager	100,000	-
. Building and ground renovation	92,661	-
. Exterior signage upgrade	9,645	-
. Injury profile	19,047	-
. Text line	24,581	-
. Clinical services upgrade	13,180	-
	259,114	-
One Time Project Funding – 100%		
. Sexual health promotion	6,456	-
. Vaccine storage	15,551	-
	22,007	-
	281,121	**-**

Consolidated Schedule of Expenses by Program
For the Year Ended December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Public Health Programs and Services	7,855,757	7,761,243	7,364,191
Healthy Babies/Healthy Children	877,303	860,108	853,752
Infant Toddler Development Program	258,267	240,685	273,443
Sewage Disposal Program	343,500	300,750	320,516
Genetics Program	239,510	245,710	241,560
Smoke Free Ontario	300,724	304,208	310,809
Ontario Works Dental Program	1,024,277	955,020	1,200,872
Health for Life	-	-	15,706
Vector Borne Disease	76,101	37,249	79,107
Infectious Diseases Control	222,233	222,233	215,760
Five Counties Speech	13,884	14,152	13,580
Small Drinking Water Systems	104,300	102,495	104,300
Health Canada - Tobacco Control	116,483	116,483	193,794
Compensation Funding Adjustment	69,626	69,626	36,275
Stroke Prevention	-	-	64,113
Healthy Communities	50,141	50,141	116,837
Infection Prevention and Control Nurse Program	84,872	84,872	82,400
Nurses Initiative	170,040	86,958	-
Bed Bugs	34,806	24,983	-
Needle Exchange	27,147	27,147	-
World TB Day	2,000	834	2,000
Infection Prevention and Control Week	8,000	6,373	-
Enhanced Safe Drinking Water	27,125	27,125	-
Enhanced Food Safety - Haines	43,750	43,750	-
Healthy Smiles Ontario	1,970,140	1,696,174	225,819
OMAFRAH	60,291	60,291	20,000
ECHO Improving Women's Health	68,000	58,949	4,941
Breakfast Club and Food for Kids	29,000	17,696	20,175
Collective Kitchen	5,000	4,811	3,117
Workshops and miscellaneous	6,500	6,392	205
	14,088,777	13,426,458	11,763,272
Expenses capitalized as tangible capital assets	-	(784,417)	-
Expenses recovered from 100% funded programs	(207,969)	(208,921)	(222,306)
Total Consolidated Expenses	**13,880,808**	**12,433,120**	**11,540,966**

Schedule of Operations
Public Health Programs and Services
For the Year Ended December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Revenue			
Partner Contributions			
Ontario Ministry of Health and Long-Term Care	2,699,242	2,699,242	2,624,548
Ontario Ministry of Health Promotion	2,442,171	2,442,171	2,374,593
City of Peterborough	975,737	975,737	957,851
County of Peterborough	734,110	734,110	712,916
Curve Lake First Nation	8,170	8,170	7,938
Hiawatha First Nation	2,787	2,787	2,708
Transfer from occupancy/renovation reserve	82,882	53,871	-
Other			
Vaccine Reimbursement Programs (see page 15)	83,165	38,613	53,577
One Time Program Funding	279,245	278,652	-
Cinot Dental Program	36,750	36,750	33,981
Ontario Health Insurance Program	68,185	57,892	68,883
Student Nursing Graduate	-	-	69,542
Travel clinic		87,553	94,855
Recovery of administration and occupancy	207,969	208,921	222,306
Interest	22,000	20,047	12,476
Fee for service	132,706	29,428	23,052
Other income	45,548	108,650	43,152
	7,820,667	7,782,594	7,302,378
Expenses			
Salaries and wages	4,844,945	4,852,002	4,851,649
Employee benefits	1,190,028	1,240,933	1,134,321
Travel	86,272	89,704	76,878
Program materials and printing	379,967	344,445	319,619
Communication and public education	186,856	184,140	184,146
Dental consultant	19,375	23,500	6,956
Dental treatment assistant fund	-	8,828	-
Clinic doctor's fees and supplies	69,106	57,326	61,261
CINOT dental claims	153,604	124,212	157,660
Administrative	173,251	177,558	141,772
Occupancy	227,668	206,486	213,661
Liability insurance	43,015	43,298	41,477
Medical officer coverage	7,000	800	6,500
One-time	362,127	289,120	54,664
Staff education	39,785	35,819	31,355
Board costs	37,668	47,982	38,278
Amortization	35,090	35,090	43,994
	7,855,757	7,761,243	7,364,191
Annual Surplus / (Deficit)	(35,090)	21,351	(61,813)
Amount Due to Province of Ontario	-	(68,026)	-
Reduction in Invested in Tangible Capital Assets	35,090	35,090	43,994
(Decrease) / Increase in Contingency Reserve	**-**	**(11,585)**	**(17,819)**

Peterborough County-City Health Unit

Schedule of Operations
Vaccine Reimbursement Programs from Public Health Programs and Services
For the year ended December 31, 2011

	Universal Influenza Immunization Program $	Human Papilloma Virus Program $	Meningococcal C Program $	Actual 2011 $	Actual 2010 $
Revenue					
Ontario Ministry of Health and Long Term Care	19,955	10,668	7,990	38,613	53,577
Expenses					
Personal Services Expenses					
Salaries and wages	35,100	11,025	7,145	53,270	60,261
Employee benefits	2,665	1,207	1,320	5,192	7,481
	37,765	12,232	8,465	58,462	67,742
Other Operating Expenses					
Program materials and supplies	14,414	409	581	15,404	26,880
Travel	515	478	220	1,213	753
	14,929	887	801	16,617	27,633
	52,694	13,119	9,266	75,079	95,375
Annual Surplus/(Deficit) In Public Health Programs And Services	**(32,739)**	**(2,451)**	**(1,276)**	**(36,466)**	**(41,798)**

Peterborough County-City Health Unit
Schedule of Operations
Children In Need of Treatment Program from Public Health Programs and Services
For the year ended December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Revenue			
Ontario Ministry of Health Promotion	36,750	36,750	33,981
Local partners	12,250	7,678	-
	49,000	44,428	33,981
Expenses			
Purchased services	49,000	30,711	33,981
	49,000	30,711	33,981
Annual Surplus/(Deficit) In Public Health Program and Services	**-**	**13,717**	**-**

Peterborough County-City Health Unit
Schedule of Operations
Sewage Disposal Program
For the year ended December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Revenue			
Inspection fees	329,750	289,600	307,783
Lawyer research fees	13,750	11,150	11,000
Witness fee	-	-	53
Interest	-	155	92
	343,500	300,905	318,928
Expenses			
Salaries and wages	209,858	188,474	197,652
Employee benefits	51,392	54,344	49,053
Travel	44,000	26,075	39,035
Equipment, materials and supplies	6,500	1,618	4,410
Legal fees	1,650	-	-
Audit	2,000	2,000	2,000
Allocated costs	27,600	27,600	27,600
Staff education	500	639	766
	343,500	300,750	320,516
Annual Surplus / (Deficit)	-	155	(1,588)
Opening Fund Balance	-	15,453	17,041
Closing Fund Balance	**-**	**15,608**	**15,453**

Peterborough County-City Health Unit
Schedule of Operations
Healthy Babies/Healthy Children Program
For the year ended December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Revenue			
Ministry of Children and Youth Services	860,113	860,108	828,408
Student Nursing Graduate Program	-	-	25,344
Transfer from Public Health programs	17,190	-	-
	877,303	860,108	853,752
Expenses			
Personal Services Expenses			
Salaries and wages	623,449	605,623	630,963
Employee benefits	156,442	161,109	159,264
	779,891	766,732	790,227
Other Operating Expenses			
Universal screening	33,165	33,164	33,164
Program supplies	5,500	5,500	5,354
Professional development	2,500	2,406	2,381
Travel	15,747	13,414	15,587
Audit and legal	3,800	2,300	2,300
Telephone	5,000	4,892	4,739
	65,712	61,676	63,525
One-time expenses			
Salaries and wages	21,305	21,305	-
Employee benefits	4,895	4,895	-
N Cast - Parent Child Interaction Scale Kits	5,500	5,500	-
	31,700	31,700	-
	877,303	860,108	853,752
Amount Due to Province of Ontario	-	-	-

Peterborough County-City Health Unit
Schedule of Operations
Small Drinking Water Systems
For the year ended December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Revenue			
Ontario Ministry of Health and Long Term Care - Base	51,300	51,300	104,300
Ontario Ministry of Health and Long Term Care - One Time	53,000	53,000	-
	104,300	104,300	104,300
Expenses			
Personal Services Expenses			
Salaries and wages	75,883	79,400	75,898
Employee benefits	18,865	18,367	12,624
	94,748	97,767	88,522
Other Operating Expenses			
Legal fees	1,000	-	-
Materials and supplies	8,552	2,026	5,524
Professional development	-	-	1,625
Travel	-	2,702	8,629
	9,552	4,728	15,778
	104,300	102,495	104,300
Amount Due to Province of Ontario	-	**1,805**	-

Peterborough County-City Health Unit
Schedule of Operations
Infection Prevention and Control Nurse
For the year ended December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Revenue			
Ontario Ministry of Health and Long Term Care	84,872	84,872	82,400
Expenses			
Personal Services Expenses			
Salaries and wages	68,466	68,761	65,885
Employee benefits	16,406	16,111	16,515
	84,872	84,872	82,400
Amount Due to Province of Ontario	**-**	**-**	**-**

Peterborough County-City Health Unit
Schedule of Operations
Infectious Diseases Control
For the year ended December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Revenue			
Ontario Ministry of Health and Long Term Care	222,233	222,233	215,760
Expenses			
Personal Services Expenses			
Salaries and wages	140,083	154,641	135,862
Employee benefits	36,205	39,564	32,973
	176,288	194,205	168,835
Other Operating Expenses			
Materials and supplies	42,730	24,855	43,982
Travel	3,215	3,173	2,943
	45,945	28,028	46,925
	222,233	222,233	215,760
Amount Due to Province of Ontario	**-**	**-**	**-**

Peterborough County-City Health Unit
Schedule of Operations
Public Health Nurses Initiative - Social Determinants of Health
For the year ended December 31, 2011

	Budget 2011 $	Actual 2011 $
Revenue		
Ontario Ministry of Health and Long Term Care	170,040	88,131
Expenses		
Personal Services Expenses		
Salaries and wages	137,040	70,795
Employee benefits	33,000	16,163
	170,040	86,958
Amount Due to Province of Ontario	**-**	**1,173**

Peterborough County-City Health Unit
Schedule of Operations
Vector Borne Diseases
For the year ended December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Revenue			
City of Peterborough	10,870	6,018	13,043
County of Peterborough	8,155	3,294	4,380
Ontario Ministry of Health and Long Term Care	57,076	57,075	57,076
	76,101	66,387	74,499
Expenses			
Personal Services Expenses			
Salaries and wages	11,614	11,628	18,796
Employee benefits	2,887	1,530	2,250
	14,501	13,158	21,046
Other Operating Expenses			
Materials, communications and avian surveillance	4,300	3,429	3,931
Mosquito identification	8,150	6,434	4,929
Larviciding	46,150	12,724	46,371
Travel	3,000	1,504	2,830
	61,600	24,091	58,061
	76,101	37,249	79,107
Annual Surplus/(Deficit)	-	29,138	(4,608)
Amount From Vector Borne Disease Reserve	-	-	4,608
Amount Due to Province of Ontario	**-**	**29,138**	**-**

Peterborough County-City Health Unit
Schedule of Operations
Smoke Free Ontario Tobacco Program
For the year ended December 31, 2011

	Budget 2011 $	Smoke Free Local Capacity $	Smoke Free Tobacco Coordinator $	Smoke Free Youth Engagement $	Actual 2011 $	Actual 2010 $
Revenue						
Ontario Ministry of Health Promotion	300,724	120,724	100,000	80,000	300,724	313,159
Other income	-	16,800	-	-	16,800	-
	300,724	137,524	100,000	80,000	317,524	313,159
Expenses						
Personal Services Expenses						
Salaries and wages	193,257	70,669	80,479	37,272	188,420	207,211
Employee benefits	49,007	16,825	19,521	11,003	47,349	43,163
	242,264	87,494	100,000	48,275	235,769	250,374
Other Operating Expenses						
Administration, office expense, and accommodation	23,080	13,105	-	9,975	23,080	23,080
Audit	2,500	1,800	-	1,000	2,800	1,800
Program materials and supplies	18,081	2,114	-	15,128	17,242	12,143
Staff and community training	1,000	1,031	-	-	1,031	1,246
Purchased enforcement services - legal fees	6,699	16,000	-	-	16,000	16,000
Travel	7,100	6,269	-	2,017	8,286	6,166
	58,460	40,319	-	28,120	68,439	60,435
	300,724	127,813	100,000	76,395	304,208	310,809
Amount Due to Province of Ontario	-	**9,711**	-	**3,605**	**13,316**	**2,350**

Peterborough County-City Health Unit
Schedule of Operations
Enhanced Food Safety - Haines
For the year ending December 31, 2011

	Budget 2011 $	3 Months Jan - Mar 2011 $	9 Months Apr - Dec 2011 $	Total 2011 $
Revenue				
Ontario Ministry of Health and Long Term Care	43,750	25,000	18,750	43,750
Expenses				
Personal Services Expenses				
Salaries and wages	22,165	12,003	9,665	21,668
Employee benefits	5,003	3,117	2,403	5,520
	27,168	15,120	12,068	27,188
Other Operating Expenses				
Materials and supplies	16,374	9,813	6,574	16,387
Travel	208	67	108	175
	16,582	9,880	6,682	16,562
	43,750	25,000	18,750	43,750
Expenditure in excess of revenue in Public Health Programs and Services Operations	**-**	**-**	**-**	**-**

Peterborough County-City Health Unit
Schedule of Operations
Enhanced Safe Water
For the year ended December 31, 2011

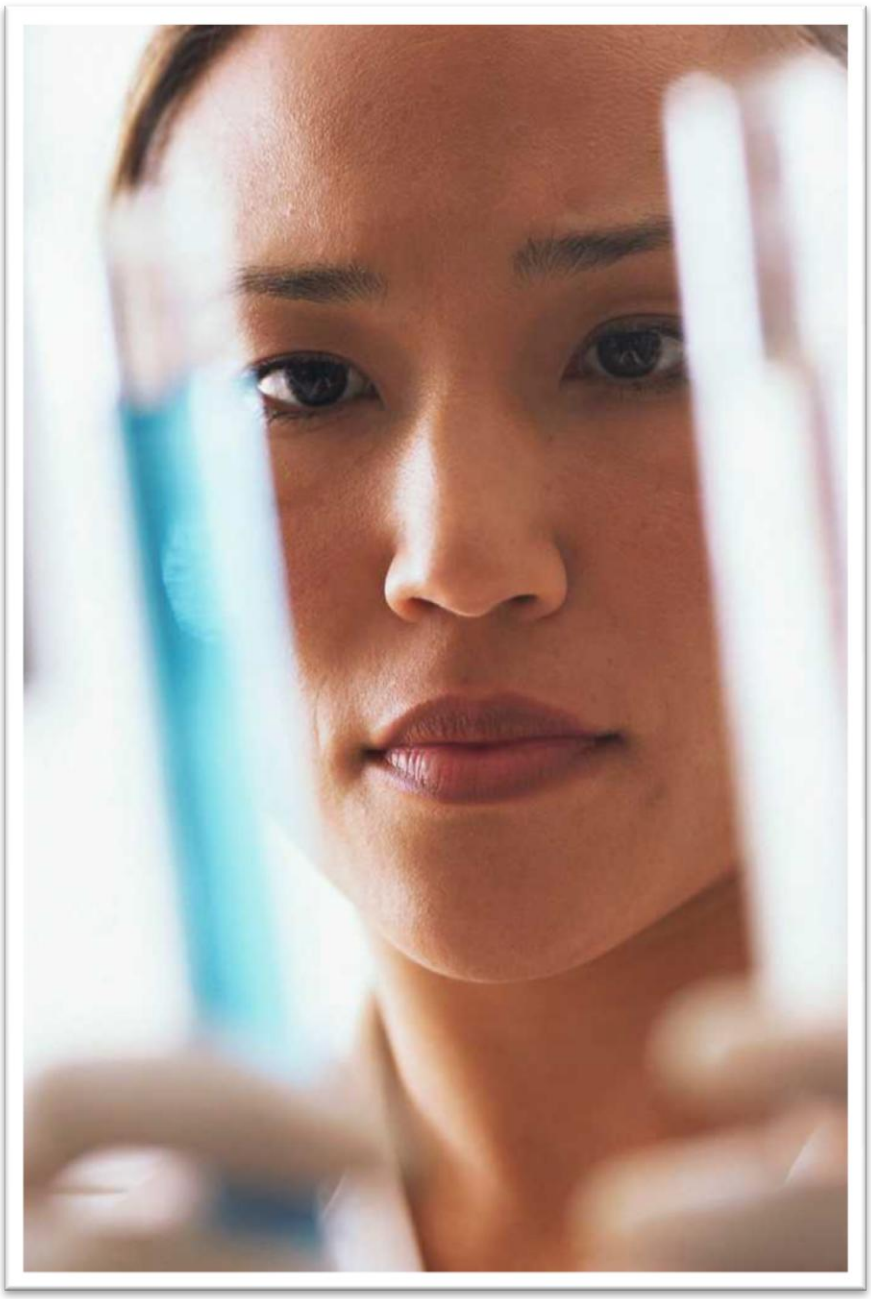
	Budget 2011 $	3 Months Jan - Mar 2011 $	9 Months Apr - Dec 2011 $	Total 2011 $
Revenue				
Ontario Ministry of Health and Long Term Care	27,125	15,500	11,625	27,125
Expenses				
Personal Services Expenses				
Salaries and wages	18,574	9,528	10,305	19,833
Employee benefits	4,231	2,376	917	3,293
	22,805	11,904	11,222	23,126
Other Operating Expenses				
Materials and supplies	3,900	3,596	-	3,596
Travel	420	-	403	403
	4,320	3,596	403	3,999
	27,125	15,500	11,625	27,125
Expenditure In Excess Of Revenue Over Expenses	-	-	-	-

Schedule of Operations
Healthy Smiles Ontario
For the year ending December 31, 2011

	Budget 2011 $	Actual 2011 $	Actual 2010 $
Revenue			
Ontario Ministry of Health and Long Term Care	1,558,669	1,558,670	228,843
Dental Treatment Fees	315,535	90,858	-
	1,874,204	1,649,528	228,843
Expenditure			
Operating Costs			
Salaries and wages	282,525	112,370	41,799
Employee benefits	70,236	20,758	8,664
Audit	3,000	3,000	3,000
Materials and supplies	38,604	60,014	18,772
Occupancy costs	29,001	28,258	-
Office supplies and equipment	8,005	6,408	-
Purchased services	224,041	214,215	39,388
Staff training and development	3,121	2,132	-
Travel	19,100	4,103	-
Allocated administration	40,231	40,231	19,459
Amortization	95,936	95,936	-
	813,800	587,425	131,082
One Time Start Up Operating Costs			
Salaries and wages	48,982	48,942	14,120
Employee benefits	12,502	7,014	2,923
Occupancy costs	27,203	27,203	2,412
Purchased services	-	-	33,057
Allocated administration	6,047	6,047	19,459
	94,734	89,206	71,971
One Time Capital Costs			
Mobile dental clinic	522,000	522,000	-
Leasehold improvements	118,417	118,417	-
One time - office equipment and furnishing	33,720	21,464	-
One time	387,469	357,662	22,766
	1,061,606	1,019,543	22,766
	1,970,140	1,696,174	225,819
Annual Surplus/(Deficit)	(95,936)	(46,646)	3,024
Reduction in Invested In Tangible Capital Assets	95,936	95,936	-
Amount Due to Province of Ontario	**-**	**49,290**	**3,024**

Reportable Diseases in Peterborough County-City

2011



Author: Andrew Kurc,
Epidemiologist

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Peterborough County-City HEALTH UNIT
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Lead Author:
Reportable Diseases in Peterborough County-City 2011 was written in principle by Andrew R. Kurc; Epidemiologist, Peterborough County-City Health Unit (PCCHU).

Reviewers
Edwina Dusome, Manager, Infectious Disease Programs; PCCHU
Simon Lee, Public Health Inspector, Infection Control; PCCHU
Diane Lockman, Public Health Nurse, Sexual Health; PCCHU
Marilyn Mitchell, Registered Nurse, Infectious Disease Programs; PCCHU
Jane Naylor, Secretary, Foundational Standards; PCCHU
Cathy Schofield, Secretary, Infections Disease Programs; PCCHU

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Comments, corrections and queries can be directed to:
Andrew R. Kurc, Epidemiologist
Peterborough County-City Health Unit
10 Hospital Drive
Peterborough, ON K9J 8M1
tel. 705-743-1000, Ext. 358
email. akurc@pcchu.ca

Table of Contents

Report Overview

Introduction

This Reportable Diseases in Peterborough County and City 2011 report summarizes the incidence of reportable diseases among Peterborough County and City residents, including members of the Curve Lake and Hiawatha First Nations, between 2005 and 2011.

Infectious diseases are caused by microorganisms (such as bacteria, parasites or viruses) or by the toxins they produce. These diseases are spread by: contact with infected persons or contaminated surfaces/articles, animals or insects; consumption of contaminated food or water; or exposure to airborne particles or other environmental sources.

In Ontario, there are over 60 diseases designated as reportable under the 1990 Health Protection and Promotion Act. Under this legislation, physicians, laboratories, hospitals, health departments, principals of schools, and superintendents of institutions are required to report these diseases to the local Medical Officer of Health. Reporting of diseases to the Health Unit is important for the follow-up of communicable diseases in order to prevent transmission to others, for the maintenance of surveillance data and for epidemiologic and program planning purposes. The list of reportable diseases can be found in Appendix A.

Data Sources

The data presented in this report was obtained from several Ontario Ministry of Health databases. Peterborough reportable disease data was retrieved from the Integrated Public Health Information System (iPHIS) in March, 2011. Only 'confirmed' or 'epidemiologically-linked' diseases with an accurate episode date[1] between January 1, 2005 and December 31, 2011 were included in this report. Aetiologic agent, subtype, age at illness, gender, exposure sources (e.g.: contaminated food) and exposure settings (e.g.: location such as farm, or travel) were also extracted, where available.

The Integrated Public Health Information System (iPHIS) is a centralized computer database system used to replace the Reportable Disease Information System (RDIS) and was implemented in PCCHU and in Health Units across Ontario in 2005. All suspect and confirmed reportable diseases are entered into iPHIS. However, specific case definitions as defined in the Ontario Public Health Standards (OPHS) Infectious Diseases Protocol have to be met before a disease is considered confirmed. Cases are usually confirmed based on laboratory test results (serology, microbiology cultures, etc.) and symptoms. Consistent application of the case definitions ensures that disease rates are comparable provincially.

[1] Accurate Episode Date corresponds to the earliest date on record for the case according to the iPHIS hierarchy Symptom Date > Clinical Diagnosis Date > Specimen Collection Date > Lab Test Date > Reported Date

Ontario data were retrieved through the Ontario Public Health Portal hosted by Public Health Ontario. Data includes counts from the *STI* and *Outbreak* modules of iPHIS for confirmed and probable cases of reportable diseases with an accurate episode date from January 1 to December 31, 2011 as of February 8, 2012. Please note that these data while relatively stable are subject to change on subsequent pulls. These data have not been cleaned extensively and may include duplicate cases; however, this information can be used to provide a general comparison for Peterborough rates and some demographic data of reportable illnesses. Ontario tuberculosis data will be posted after the completion of the annual TB data clean-up initiative. Data are available in aggregate form.

Incidence rates are produced using population estimates obtained from Statistics Canada, and are based on the 1986, 1991, 1996, 2001, and 2006 census counts adjusted for net undercoverage. Population estimates for 1986 to 2005 are final intercensal estimates that are interpolated using the adjusted census counts for the census years around the year that the estimates are for. Population estimates for 2006 onwards are extrapolated by applying the growth rates by age and sex of each census division (CD) to the census subdivisons that comprise that CD. Estimates are extracted using the Ontario Ministry of Health and Long-Term Care's IntelliHEALTH Ontario database system. Population projection data in are provided by the Ontario Ministry of Finance. The complete methodology used by the Ministry of Finance in calculating population projections for Ontario and the 49 census divisions can be found in a report released by the Ministry of Finance entitled, "Ontario Population Projections – 2010–2036 Ontario and its 49 Census Divisions".

Disease Categories and Reporting

The diseases in this report were classified into the following categories:

Food and Waterborne Diseases: Amebiasis; *Campylobacter* enteritis; Cryptosporidium; Cyclospora; Giardiasis; Hepatitis A; Listeriosis; Salmonellosis (non-typhoidal *Salmonella*); Shigellosis; Typhoid fever; Verotoxin-producing *E. coli* (VTEC); and Yersiniosis.

Sexually Transmitted Infections and Blood Borne Diseases: Chlamydia; Gonorrhea; Hepatitis B and C; HIV/AIDS; and Syphilis.

Diseases Spread by Direct Contact and Respiratory Routes: Influenza; Meningococcal disease, invasive; Streptococcal infections, Group A invasive (iGAS) and Group B neonatal (GBN); *Streptococcus pneumoniae*, invasive (iPD); Tuberculosis (TB)

Vaccine Preventable Diseases (VPDs): Chickenpox (Varicella Zoster virus); Diphtheria; *Haemophilus Influenza* type b (Hib disease); Measles; Mumps; Pertussis; and Rubella

Vector-borne and Zoonotic Diseases: Lyme disease; Malaria; West Nile Virus (WNV)

Other Reportable Diseases: This list includes rare diseases such as leprosy, plague, Q fever, etc.

Note: Some diseases may fall into two or more categories (i.e.: influenza, hepatitis A, measles, etc.); however, the aforementioned categories represent the typical or primary transmission route for each organism. In the case of VPDs, the following diseases have vaccines covered by the Ontario Ministry of Health for all, or eligible, individuals: chickenpox, diphtheria, hepatitis B, hepatitis A, rabies, Hib disease, human papillomavirus (not reportable), measles, mumps, pertussis, pneumococcal diseases, poliomyelitis, rubella, tetanus, and infections caused by meningococcal bacterium types A, C, Y and W135.

There may be considerable under-reporting of actual cases for some diseases. For instance, when an infected person has mild clinical symptoms (e.g.: salmonellosis, influenza) they may not seek medical care and/or laboratory testing may not be performed. Infections such as invasive group A streptococcus (iGAS), which tend to have more severe clinical presentations, are more accurately reflected in surveillance data. Conversely, diseases such as hepatitis B are under-reported because many individuals are asymptomatic. Additionally, diagnoses based on laboratory testing tend to be more accurately reported than those that rely on clinical diagnostic criteria.

Summary Data Table Report Format

Number of reported cases: Reflects the number of cases with an accurate episode date between January 1st and December 31st of a given year.

5-year mean: The mean yearly case count of a given disease with an accurate episode date between January 1st 2006 and December 31st 2010.

Incidence rates (per 100,000): The number of all new cases in the reporting period divided by the Peterborough population during that time period, multiplied by 100,000. Population estimates were extracted from intelliHEALTH data released by the Health Planning Branch at the Ministry of Health and Long-Term Care (MOHLTC).

Gender: The number and percent of cases that are male and female; five-year mean percentage of males and females also provided.

Mean age: Arithmetic mean (average) age of all cases in the reporting period; five-year mean age also provided.

Median age: The age that represents the midpoint for all case's ages of the reporting period; five-year median age also provided.

Age range: The ages of the youngest and oldest cases; age range over five years also provided. For cases under one year of age, less than one (<1) will be used.

Notes:

- For the purposes of this report, Peterborough County-City Health Unit will be "PCCHU" and the regions of Peterborough County and the City of Peterborough will be "Peterborough".
- Due to the small population size of Peterborough many diseases are reported infrequently. Due to confidentiality issues diseases with case counts of less than five will be reported as <5; rates and age/gender data will also be suppressed for these diseases. Similarly, to ensure confidentiality, where counts by age or gender are less than five, data will be suppressed.
- Updated provincial case definitions were released on April 28, 2009. As a result of this, some reclassification of iPHIS data was necessary. This is an ongoing process that PCCHU is addressing and may be reflected in case counts over the years.
- *Clostridium difficile* outbreaks in hospitals were reportable to Public Health as of 2010, and any incidences of these outbreaks are addressed in Section 5. Institutional Outbreaks.

Executive Summary

There were 710 confirmed cases of reportable diseases in Peterborough with an accurate episode date between January 1, 2010 and December 31, 2011 which results in a crude rate of 508.7 cases per 100,000 population. In 2010, there were 663 cases of reportable communicable diseases (474.3 per 100,000 population) representing a 7.2% increase in the number of cases between 2010 and 2011 – see Table I. There was an average of 59 incidences of reportable diseases each month in 2011 with the largest number reported in February (122) and the fewest in August (36). Just over one third (266 or 37.5%) of all cases in 2011 occurred in the first quarter (January through March) largely as a result of a number of institutional influenza outbreaks. Approximately two thirds (459 or 64.4%) of all the illnesses reported to PCCHU occurred in females. The average age of onset in 2011 was 35.8 years of age (median: 22) with a range of less than one (<1) to 102 years old. When excluding chlamydia, which accounted for over half (402 or 56.6%) of all reported illnesses to PCCHU, the average age increases to 53 years of age (median: 42) while the age range remains the same and 57.8% (n=178) of the reportable diseases occurred among females.

Table I. Number and proportion of communicable diseases by category in PCCHU; 2005-2011

Category	2011 n (%)	2010 n (%)	2009 n (%)	2008 n (%)	2007 n (%)	2006 n (%)
FW*	63 (8.9%)	98 (14.8%)	83 (10.7%)	89 (13.2%)	90 (16.2%)	87 (18.0%)
STI/BBI†	459 (64.7%)	505 (76.2%)	454 (58.4%)	395 (58.6%)	333 (59.8%)	315 (65.1%)
Direct and Respiratory	170 (23.9%)	52 (7.8%)	236 (30.4%)	171 (25.4%)	123 (22.1%)	52 (10.7%)
Other‡	18 (2.5%)	8 (1.2%)	4 (0.5%)	19 (2.8%)	11 (2.0%)	30 (6.2%)
Total	**710**	**663**	**775**	**676**	**559**	**486**

* food and waterborne
† sexually-transmitted infections and blood-borne infections
‡ includes vaccine preventable diseases, zoonotic diseases, and other rare diseases

Sexually-transmitted infections and blood-borne infections (STI/BBI) represented the largest category of reportable illnesses in 2011 with 64.7% of all cases reported to PCCHU. This category is a major contributor to the communicable disease burden due to the large numbers of chlamydia infections reported to PCCHU each year. However, for the first time since 2005 there was a reduction in the number of cases of chlamydia in Peterborough by 9.5%.

Influenza represents the largest contributor of respiratory illnesses, and the large increase in cases in 2011 over 2010 counts is the primary cause for the increased proportion (23.9%) of all reportable disease cases occurring by the direct and respiratory routes.

There was a decrease in the number and relative frequency of reportable diseases caused by food and waterborne routes, largely due to a reduction in the number of reported cases of giardiasis. An increase in the number of encephalitis/meningitis cases caused the increase of reported VPD, zoonotic, and rare diseases in Peterborough.

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1. Food and Waterborne Diseases

Foodborne diseases are illnesses acquired through the consumption of contaminated food or illnesses associated with consumption of a food infected by a specific bacterial, parasitic, or viral agent; similarly waterborne diseases are illnesses acquired through the consumption of contaminated water. Transmission of these illnesses can also occur via fecal-oral contact with an infected person. Cases and/or outbreaks are recognized by the occurrence of the illness within a generally short time frame among individuals who have consumed the contaminated substance or have been in contact with an infected person. Foodborne disease outbreaks are among the most common causes of acute illness; however, many outbreaks go unreported and single cases are often difficult to identify unless there is a distinct clinical syndrome and/or the affected individual seeks medical attention.

In 2011 in Peterborough there were 63 reported cases of food and waterborne diseases representing 8.9% of all reported diseases and a reduction of 35.7% from 2010 counts. With the exception of amebiasis the number of reported cases of all food and waterborne diseases decreased in 2011 compared to previous years and crude rates were the lowest in Peterborough since 2005 (Figure 1). The rank, number and proportions of each disease as proportion of all diseases reported to PCCHU in 2011 are listed in Table 1.

Table 1. Food and Waterborne diseases in Peterborough, 2010-2011

Rank	Disease	2011		2010	
		Number of Cases	Proportion of All Cases (%)	Number of Cases	Proportion of All Cases (%)
1	*Campylobacter enteritis*	27	3.8	36	5.5
2	Salmonellosis	18	2.5	27	4.1
3	Giardiasis	6	<1	21	3.2
4	Cryptosporidiosis	<5	<1	<5	<1
5	Verotoxin producing *E. coli*	<5	<1	<5	<1
6	Legionellosis	<5	<1	<5	<1
7	Listeriosis	<5	<1	<5	<1
8	Shigellosis	<5	<1	<5	<1
9	Amebiasis	<5	<1	<5	<1
10	Yersiniosis	<5	<1	<5	<1

1.1 *Campylobacter* enteritis

Campylobacteriosis is caused by the bacteria *Campylobacter jejuni* and, less commonly, *Campylobacter coli*. Symptoms can vary from mild to severe and are characterized by diarrhea, abdominal pain, malaise, fever, nausea and vomiting. Infection usually lasts from

several days to several weeks and occurs as a result of ingestion of the organism in under-cooked meat, contaminated food or water, or contaminated milk or poultry. Cattle are common reservoirs. Person-to-person transmission appears uncommon.

There was a significant reduction in the number of *campylobacter* enteritis cases reported to PCCHU in 2011 and a greater proportion of cases were male compared to the five-year average, though the patterns of the ages affected were similar to previous years (Table 2). With the exception of 2011, crude rates of *campylobacter* infections have been similar to the province, though the gender distribution is somewhat different. The majority of cases in 2011 (24 or 88.9%) were caused by *C. jejuni* while the remainder was caused by *C. coli* or an unspecified species, following similar patterns occurring between 2005 and 2010. Most exposure settings in 2011 were missing or unknown (16 or 59.3%). Where data was available, community exposure settings were implicated in most cases (7 or 25.9%). Exposure sources implicated with infections included birds, meat or poultry (6 or 22.2%) though most sources were unknown or missing. Similar exposure settings and sources were commonly implicated between 2006 and 2010.

Table 2. *Campylobacter* enteritis Summary Data

	2011	5-yr Mean (2006-10)	Ontario 2011
Number of Reported Cases	27	33.6	3,485
Incidence (per 100,00 population)	19.3	24.3	26.1
Males	18 (66.7%)	55.4%	44.0%
Females	9 (33.3%)	44.6%	56.0%
Age at Onset (Years)			
Mean	40.8	43.1	
Median	43	45	
Range	1 – 82	<1 – 87	

1.2 Salmonellosis

Salmonellosis is a bacterial infection that manifests itself as a sudden onset of headache, diarrhea, fever, abdominal cramps and sometimes vomiting. The infection may persist for several days but does not require treatment unless the patient becomes severely dehydrated or the infection spreads from the gastrointestinal tract to the bloodstream or other body sites. There are numerous species of *Salmonella* serotypes that are pathogenic to humans and can be transmitted by ingestion of foods contaminated with the organism including: raw or undercooked beef or poultry; milk and milk products; shellfish; and eggs. Person-to-person transmission can also occur if hands are not properly washed following bathroom use. Outbreaks have also been linked to the consumption of raw fruits and vegetables that were contaminated. Pet turtles, lizards, and snakes are other potential sources of exposure.

There were nine fewer cases of salmonellosis reported to PCCHU in 2011 compared to the 2006-2010 five year average and the crude rate of salmonellosis infections was somewhat lower than the province (Table 3). With the exception of 2005 when there was an outbreak linked to consumption of contaminated bean sprouts resulting in roughly double the number of expected cases, reported cases of salmonellosis to PCCHU has been consistent. In 2011, cases of salmonellosis tended to be younger than expected from the five-year average.

Numerous species of *Salmonella* were responsible for salmonellosis in 2011: *S. enteritidis* accounted for nearly a quarter of the cases (4 or 22.2%); *S. Heidelberg* and *S. typhimurium* each accounted for 11.1% (n=2 each). The remaining cases were unspecified, classified as 'other' or were made up of a variety of species (*infantis, javiana, Newport, telelkebir, Thomspon, and Uganda)*. The number of cases of *S. enteritidis* in Peterborough has varied since 2005, accounting for a minimum of 17.4% of salmonellosis cases in 2008 and a maximum of 40.7% in 2010 (Table 4).

The majority of exposure sources for cases of salmonellosis in 2011 were missing or unknown (16 or 88.9%). Community acquired and travel settings were implicated in just less than half of the cases reported to PCCHU in 2011 (4 or 22.2% each). Historically, community and travel settings as well as poultry and some other food products (i.e.: fish, fruit) have been implicated in salmonellosis, where data are available.

Table 3. Samonellosis Summary Data

	2011	5-yr Mean (2006-10)	Ontario 2011
Number of Reported Cases	18	24.8	2,560
Incidence (per 100,00 population)	12.9	17.9	19.1
Males	9 (50.0%)	42.8%	48.8%
Females	9 (50.0%)	57.2%	51.0%
Age at Onset (Years)			
Mean	26.8	39.5	
Median	28.5	40	
Range	1 – 51	<1 – 90	

Table 4. Relative frequency of *S. enteritidis* cases in PCCHU, 2005-2011

Year	2005	2006	2007	2008	2009	2010	2011
S. enteritidis (n %)	10 (23.3%)	5 (19.2%)	8 (36.4%)	4 (17.4%)	10 (38.5%)	11 (40.7%)	4 (22.2)
All Salmonellosis	**43**	**26**	**22**	**23**	**26**	**27**	**18**

1.3 Giardiasis

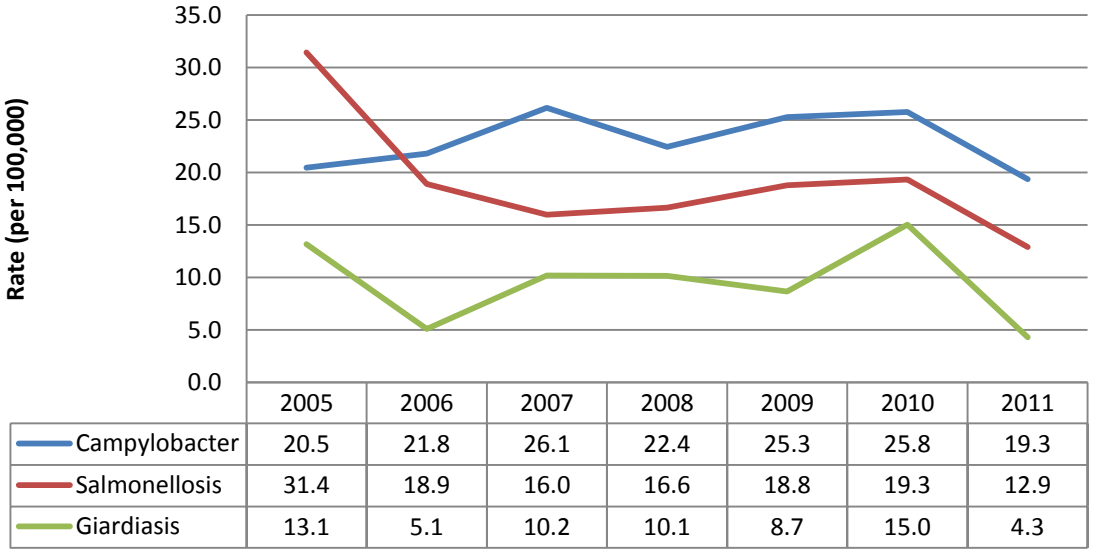
Giardiasis is an infection of the small intestine caused by the protozoa *Giardia lamblia*, *G. intestinalis* or *G. duodenalis*; however, only *Giardia lamblia* is reportable. Clinically, giardiasis can remain asymptomatic; bring on acute, self-limiting diarrhea; or lead to

intestinal symptoms such as chronic diarrhea, abdominal cramps, bloating, fatigue, malabsorption, and weight loss. Humans are the principle reservoir, though beavers and other wild and domestic animals are also reservoirs. Person-to-person transmission occurs by hand-to-mouth transfer of cysts from the feces of an infected individual; localized outbreaks also occur from ingestion of cysts in fecally contaminated drinking and recreational water.

There are typically a small number of giardiasis cases reported to PCCHU; in 2011 there were significantly fewer reported than would be expected and as a result the crude rate was less than half of that in Ontario (Table 5). In 2011, a few cases of giardiasis (2 or 33.3%) were associated with recreational water; this exposure source, along with drinking water, accounted for 14.3% of the giardiasis cases in Peterborough between 2006 and 2010. None of the exposure settings were known in 2011; among Peterborough cases travel accounts for 23.5% of reported giardiasis cases.

Table 5. Giardiasis Summary Data

	2011	5-yr Mean (2006-10)	Ontario 2011
Number of Reported Cases	6	13.6	1,253
Incidence (per 100,00 population)	4.3	9.8	9.4
Males	-	58.8%	60.8%
Females	-	41.2%	39.1%
Age at Onset (Years)			
Mean	31.7	41.8	
Median	32	38	
Range	<1 – 78	2 – 106	



	2005	2006	2007	2008	2009	2010	2011
Campylobacter	20.5	21.8	26.1	22.4	25.3	25.8	19.3
Salmonellosis	31.4	18.9	16.0	16.6	18.8	19.3	12.9
Giardiasis	13.1	5.1	10.2	10.1	8.7	15.0	4.3

Figure 1. Incidence of campylobacter, salmonellosis, and giardiasis in Peterborough, 2005-2011

2. Sexually Transmitted and Blood Borne Infections

Sexually transmitted infections (STIs) and blood borne infections (BBIs) are diseases caused by infectious agents in body fluids such as semen, vaginal secretions, anal fluids breast milk, saliva and blood. Transmission occurs primarily from person-to-person through sexual contact. Other routes of transmission include direct entry into the blood via shared needles or other drug equipment, transfusions, and perinatal transmission from mother to infant. In 2011 in Peterborough there were 459 cases of STIs and BBIs. This category represents the largest fraction of communicable diseases reported to PCCHU at 64.6%. The rank, number and proportions of each disease are listed in Table 6.

Table 6. STIs and BBIs in Peterborough, 2010-2011

Rank	Disease	2011		2010	
		Number of Cases	Proportion of All Cases (%)	Number of Cases	Proportion of All Cases (%)
1	Chlamydia	402	56.6	445	67.5
2	Hepatitis C	40	5.6	40	6.0
3	Gonorrhea	13	1.8	16	2.4
4	Syphilis (all)	<5	<1	<5	<1
5	Hepatitis B	<5	<1	<5	<1
6	HIV/AIDS	<5	<1	<5	<1

2.1 Chlamydia

Chlamydia is the most widespread bacterial STI in Canada and is most common among teenagers and young adults. It is transmitted through vaginal, anal and oral sex and can also be transmitted from mother to child during childbirth. In women, symptoms can include: vaginal discharge; burning sensation when urinating; pain in the lower abdomen, sometimes with fever and chills; pain during intercourse; and vaginal bleeding between periods or after intercourse. Approximately 70% of infected females have no symptoms and when left untreated can develop pelvic inflammatory disease (PID). PID can present with abdominal pain, fever, internal abscesses and long-lasting pelvic pain; effects also include scarring of the fallopian tubes, which can cause infertility and increase the chance of potentially life-threatening ectopic or tubal pregnancies. Symptoms of chlamydial infection in men can include: discharge from the penis; burning sensation when urinating; burning or itching at the opening of the penis; and pain and/or swelling in the testicles. Approximately 50% of infected males exhibit no symptoms. Lack of treatment in man can lead to scarring of the urethra, making urination difficult and occasionally causing infertility. Although rare, both sexes are at risk of a type of arthritis known as Reiter's Syndrome - an inflammation and swelling caused by the spread of the infection through the bloodstream into the joints. Easy access and consistent use of condoms is an effective measure in preventing chlamydia.

Chlamydia is the communicable disease most frequently reported to PCCHU, making up just over half (56.6%) of all reportable diseases and the large majority of STI/BBIs (87.6%) in 2011. It is important to note that while rates of chlamydia are high, each occurrence of the disease is captured, and there may be many individuals who are engaging in high risk behaviours resulting in multiple infections.

Between 2010 and 2011 the total number of chlamydia cases decreased by 9.5% from 445 to 402, representing the first time since 2005 that there had been a reduction in the number of cases in Peterborough. Still, since 2005 the number of cases has increased by 69.6% (Table 7); this increasing trend has been occurring in Ontario and across Canada since 1997. Some of the increase seen in Peterborough since 2005 may be a partially attributable to better screening programs and more sensitive testing procedures.

Chlamydia rates are highest among young adults: between 2006 and 2010, 82.8% of all cases among females were between the ages of 15 and 24 years of age; during the same time frame among males, 67.7% of all cases belonged to the same age cohort. In 2011, this trend among age groups continued, as teenagers and young adults made up the majority of new cases (77.9% of cases in females and 65.3% in males). The number of cases of chlamydia among all females was consistent between 2010 and 2011, though the number of cases among those aged 15 to 19 decreased by 27.5%; among males, the number of cases reported decreased across all age groups except among men 30 years of age and older (Figures 2 and 3).

Table 7. Chlamydia Summary Data

	2011	5-yr Mean (2006-2010)	Ontario 2011
Number of Reported Cases	402	329.4	36,286
Incidence (per 100,00 population)	288.0	237.8	271.4
Males	121 (30.1%)	33.0%	35.2%
Females	281 (69.9%)	67.0%	64.6%
Age at Onset (Years)			
Mean	22.9	22.2	
Median	21	21	
Range	13 – 64	<1 – 58	

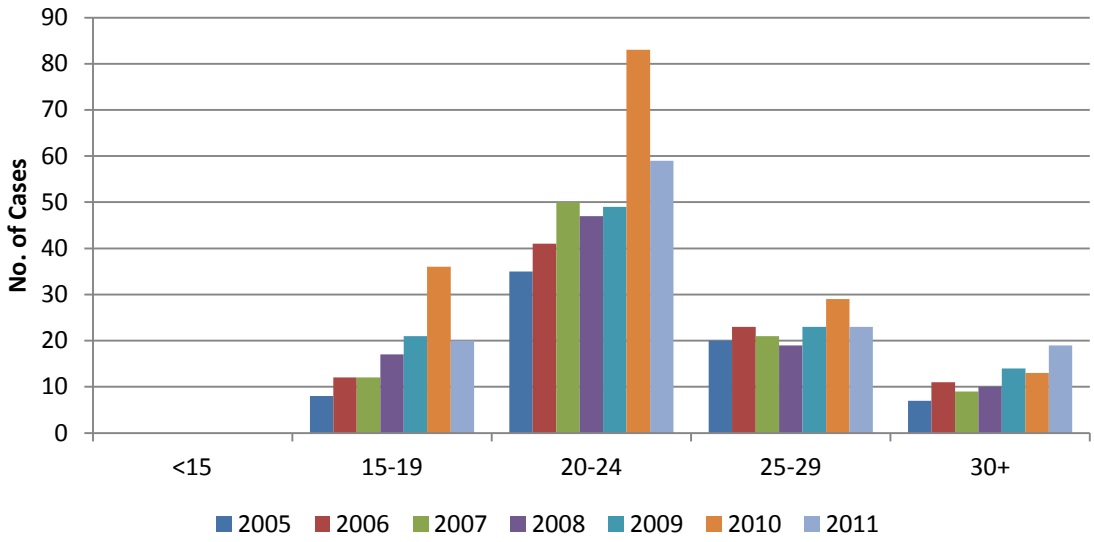


Figure 2. Number of cases of chlamydia in Peterborough males, 2005-2011

Note: data suppressed where counts <5

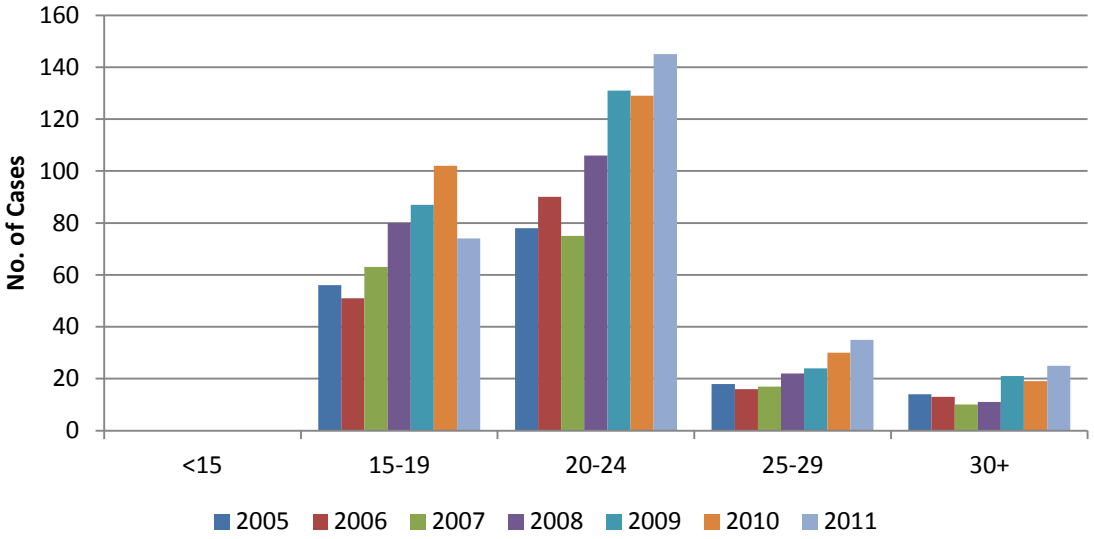


Figure 3. Number of cases of chlamydia in Peterborough females, 2005-2011

Note: data suppressed where counts <5

2.2 Hepatitis C

Hepatitis C is a chronic disease of the liver caused by the hepatitis C virus (HCV). Only 25% of people who acquire hepatitis C develop acute symptoms within the first six months, while 70-80% of people progress to chronic infection. These individuals become carriers of the virus and potentially transmit the infection to others. For those who experience symptoms, the most commonly reported include fatigue, lethargy, reduced appetite, sore muscles and joints, nausea, abdominal pain or jaundice. Individuals who progress to chronic hepatitis C can develop cirrhosis, leading to severe liver damage; a small number of people may get liver cancer. Transmission is primarily through contact with the blood of an infected person; transmission may also occur perinatally or through sexual contact, though these routes appear less common. High-risk groups for infection include people who share drug use equipment, health care workers, hemodialysis patients, and recipients of blood products or transfusions before 1992. Programs which exchange clean and sterile drug-using equipment are an effective method of preventing hepatitis C transmission among this group.

The number of hepatitis C cases in Peterborough was consistent between 2010 and 2011 and in general crude rates have decreased by 28.7% since 2005 (Figure 3.) Males represent an increasing proportion of cases (Table 8). Approximately two thirds (65.0%) of the hepatitis C cases diagnosed in 2011 were over the age of 40. The 40 to 54 age cohort has represented the age group most frequently diagnosed with hepatitis C since 2005.

Table 8. Hepatitis C Summary Data

	2011	5-yr Mean (2006-10)	Ontario 2011
Number of Reported Cases	40	45.6	4,072
Incidence (per 100,00 population)	28.7	33.0	30.5
Males	29 (72.5%)	59.2%	60.7%
Females	11 (27.5%)	40.8%	38.8%
Age at Onset (Years)			
Mean	44.9	43.4	
Median	47.5	45	
Range	17 – 65	<1 – 86	

2.3 Gonorrhea

Gonorrhea is a bacterial STI caused by *Neisseria gonorrhea* and differs in men and women in course, severity, and ease of recognition. In men, infection presents as acute purulent urethral discharge within two to seven days after exposure. In females, infection is often asymptomatic, though some women experience vaginal discharge and vaginal bleeding after intercourse. Transmission occurs through sexual contact and an infected individual can continue to transmit the disease for months if left untreated. Gonorrhea is treatable often with a single dose of antibiotics; however, some 32 strains of the bacteria have

become resistant to standard antibiotics. Treating patients with gonorrhea will become more difficult if resistant strains continue to increase. If left untreated, gonorrhea can cause serious complications including PID in women and infertility for both sexes.

After some years of increasing incidence in Peterborough, there has been a reduction of cases of gonorrhea since 2008 and correspondingly a reduction in the crude rate of gonorrhea infection (Figure 4). Male and female cases have been generally equally represented locally since 2005, however, the majority of cases in 2011 were female (Table 9). Typical of many STIs, youth are primarily affected, though there are incidents of older individuals also being infected. Crude rates of gonorrheal infection in Peterborough are a much lower than Ontario.

Table 9. Gonorrhea Summary Data

	2011	5-yr Mean (2006-10)	Ontario 2011
Number of Reported Cases	13	19.4	4,195
Incidence (per 100,00 population)	9.3	14.0	31.4
Males	-	49.5%	57.2
Females	-	50.5%	42.6
Age at Onset (Years)			
Mean	28	27.7	
Median	27	24	
Range	19 – 45	12 – 69	

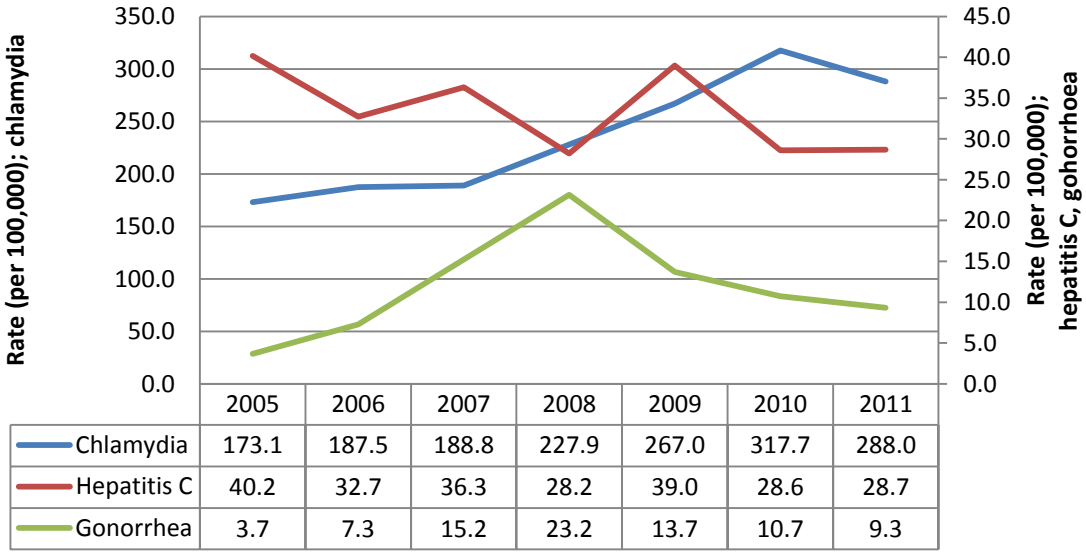


Figure 4. Incidence of chlamydia, hepatitis C, gonorrhea, and syphilis in PCCHU, 2005-2011

3. Diseases Spread by Direct Contact and Respiratory Routes

These are diseases caused by infectious agents transmitted through direct contact or airborne spread; transmission occurs via droplet contact – coughing or sneezing, or airborne transmissions, where the microorganism remains in the air for long periods of time. For the purpose of this report, this section refers to: influenza; meningococcal disease, invasive; streptococcal infections, group A invasive (iGAS) and group B neonatal (GBN); *Streptococcus pneumoniae*, invasive (iPD); and tuberculosis (TB). Other diseases may also be spread through this mode of transmission (e.g.: chickenpox, measles, etc.) but are not discussed here. In 2011 in Peterborough there were 170 cases of reportable diseases spread by direct contact or respiratory routes, representing 23.9% of the all reported diseases. The rank, number and proportions of each disease are listed in Table 10.

Table 10. Direct Contact and Respiratory diseases in Peterborough, 2010-2011

Rank	Disease	2011		2010	
		Number of Cases	Proportion of All Cases (%)	Number of Cases	Proportion of All Cases (%)
	Influenza	142	20.0	5	<1
1	Streptococcus pneumoniae, invasive (SPi)	19	2.7	28	4.2
2	Group A streptococcal disease, invasive (iGAS)	7	2.3	15	2.3
4	Group B streptococcal disease, neonatal	<5	<1	<5	<1
5	Tuberculosis	<5	<1	<5	<1

3.1 Influenza

Influenza is a respiratory infection caused by the influenza virus; slightly different strains circulate every year, resulting in predictable influenza 'seasons' that usually take place during winter months. Influenza typically starts with a headache, chills and cough, followed rapidly by fever, loss of appetite, muscle aches and fatigue, running nose, sneezing, watery eyes and throat irritation. Nausea, vomiting and diarrhea may also occur, especially in children. Most people recover from influenza within a week or ten days, however, some individuals – those over 65 years of age and adults and children with chronic conditions, such as diabetes and cancer – are at greater risk of more severe complications, such as pneumonia. Between 2,000 and 8,000 Canadians can die of influenza and its complications annually depending on the severity of the season and/or the match between the seasonal vaccine and the circulating strain.

The number of influenza cases reported to PCCHU in 2011 was significantly greater than in 2010. However, in mid-November 2009 in response to the pandemic H1N1 (pH1N1)

outbreak, the Ministry of Health and Long-Term Care indicated in a guidance document that "*testing is NOT generally recommended for patients in ambulatory care settings, except in unusual circumstances where testing is felt to affect the clinical management of those who are at high risk of complications*" which may have affected the number of cases reported to PCCHU: there were no cases of pH1N1 – or any influenza – reported after November 2009. In 2010, all cases occurred in the last quarter of the year, indicating they were part of the 2010-2011 influenza season. Of the 142 cases of influenza reported to PCCHU in 2011, the majority were female (109 or 76.8%) and nearly two thirds (89 or 62.7%) were 65 years of age or older (Table 13). Most cases of influenza reported to PCCHU in 2011 were influenza A (119 or 83.8%) and of those that were sub-typed the majority were H3N2 (87 or 73.1%). The crude rate on influenza infections in Peterborough was approximately 3 times that in Ontario.

Table 11. Influenza Summary Data

	2011	5-yr Mean (2006-10)	Ontario 2011
Number of Reported Cases	142	95.4	4,242
Incidence (per 100,00 population)	101.7	69.0	31.7
Males	33 (23.2%)	35.2%	45.2%
Females	109 (76.8%)	64.8%	54.6%
Age at Onset (Years)			
Mean	67.5	49.4	
Median	74	51	
Range	<1 – 102	<1 – 105	

3.2 *Streptococcus pneumoniae*, invasive

Pneumococcal disease is an infection caused by the bacterium *Streptococcus pneumonia* (*S. pneumoniae*) also known as pneumococcus. The most common types of pneumococcal infections include middle ear infections (otitis media), sinus infections, lung infections (pneumonia), blood stream infections (bacteremia), and meningitis; these infections are considered to be "invasive" when the bacteria is present in a normally sterile site (i.e.: blood). Only invasive infections are considered reportable. Invasive pneumococcal disease (iPD) most often presents as bacteremic pneumonia, meningitis and other clinical manifestations such as endocarditis or septic arthritis. Symptoms of pneumonia may include: a sudden onset with shaking chills, fever, shortness of breath or rapid breathing, chest pain and a productive cough.

Pneumococci are ubiquitous and usually colonize in the upper respiratory tract of healthy persons (carriers); the only reservoir is humans. Transmission occurs mostly through the spread of respiratory droplets from the nose or mouth, by direct oral contact or indirectly through articles freshly soiled with respiratory discharges from infected persons. The risk of disease is highest in persons 65 years of age and older, children less than 2 years of age,

and those persons with certain medical conditions that put them at increased risk for invasive pneumococcal disease.

There was little change in the number of cases and the proportion of males and females infected with iPD in Peterborough in 2011 compared to previous years though the cases reported to PCCHU were slightly older than expected (Table 11). Subtype 7F was the most frequently reported subtype in 2011 (5 or 29.4%); types 3, 34, 19A, 23A, 23B, 16F, 17F, and 9N were also reported to PCCHU. Crude rates of iPD are slightly higher than those in the province.

Table 12. iPD Summary Data

	2011	5-yr Mean (2006-10)	Ontario 2011
Number of Reported Cases	19	20.0	1,235
Incidence (per 100,00 population)	13.6	14.4	9.2
Males	8 (42.1%)	45.0%	52.6%
Females	11 (57.9%)	55.0%	47.3%
Age at Onset (Years)			
Mean	66.6	58.5	
Median	74	64	
Range	11 – 89	1 – 95	

3.3 Group A streptococcal disease, invasive (iGAS)

Invasive Group A streptococcal (iGAS) disease is caused by *Streptococcus pyogenes (S. pyogenes)*. The most common clinical presentations for iGAS are skin or soft tissue infections, bacteremia, pneumonia, streptococcal toxic shock syndrome (STSS) and necrotizing fasciitis (NF) – "flesh eating disease". *S. pyogenes* may colonize the throat of individuals (carriers) without causing symptoms and may be passed from person to person. Transmission generally occurs from person to person most commonly by: droplet spread when an infected individual coughs or sneezes; direct or indirect contact of the oral or nasal mucus membranes with infectious respiratory secretions; and sharing of contaminated needles.

Symptoms of the onset of iGAS may be non-specific and include pain, swelling, fever, chills, influenza-like symptoms, generalized muscle aches, generalized macular rash, nausea, vomiting, diarrhea, malaise or joint pain. Symptoms of NF include fever and a red painful swelling of tissue, which spreads rapidly; death may occur in 12 to 24 hours. NF, while less severe than STSS, still has a mortality rate of about 20%. Symptoms of STSS include infection of the primary site of iGAS and/or NF, plus hypotension, adult respiratory distress syndrome, renal impairment, rapid onset of shock and multi-organ failure; STSS has a mortality rate of up to 81%. Susceptibility to iGAS increases among individuals with underlying conditions including HIV infection, cancer, heart disease, diabetes, lung disease

and alcohol abuse. Older individuals, persons with chronic diseases, persons in institutions and pregnant women also appear to be at higher risk of iGAS.

Incidence of iGAS is generally low in Peterborough (Table 12); since 2005 there have been 58 cases of iGAS with and equal distribution of cases among men and women; the majority of cases (35 or 60.3.0%) have been under the age of 60. After experiencing and outbreak in quarter one (January to March) of 2010, the number of cases reported to PCCHU in 2011 returned to within the expected range and crude rates were on par with the province. Cases of iGAS reported to PCCHU in 2011 were slightly older than expected.

Table 13. iGAS Summary Data

	2011	5-yr Mean (2006-2010)	Ontario 2011
Number of Reported Cases	7	8.6	676
Incidence (per 100,00 population)	5.0	5.3	5.1
Males	-	50.0%	53.8%
Females	-	50.0%	46.2%
Age at Onset (Years)			
Mean	63.7	45.5	
Median	68	44.5	
Range	43 – 95	<1 – 95	

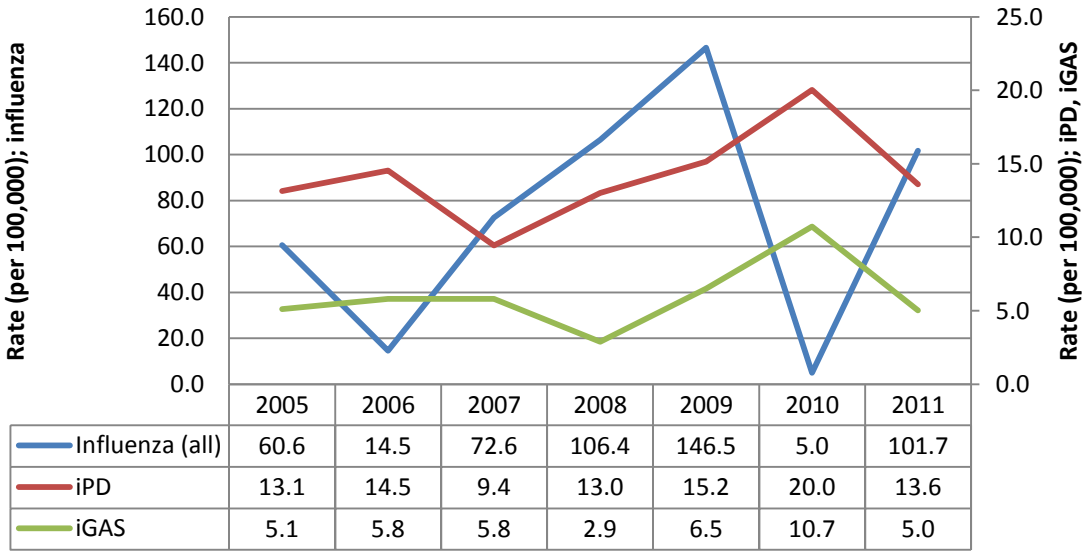


Figure 5. Incidence of influenza (all), iPD, and iGAS in PCCHU, 2005-2011

4. Vaccine Preventable Diseases (VPD); Vector-borne and Zoonotic Diseases; Other Reportable Diseases

Vaccine preventable diseases (VPD) are those communicable diseases that can be prevented by routine vaccination. As a result, these diseases are generally only seen in sporadic outbreaks in unimmunized populations or individuals who are not up to date with respect to their vaccination schedule; the schedule is available online (see Reference list). Up-to-date diphtheria, tetanus, polio, measles, mumps, and rubella vaccinations are required in order for children to attend Ontario schools as outlined in the Immunization of School Pupils Act and the Day Nurseries Act. Those immunizations plus *haemophilus influenzae* type B and pertussis immunizations are required for day care. There are also two publicly funded vaccines which confer protection against pneumococcal infection and disease; a summary of this disease can be found in Secion 3. Diseases Spread by Direct Contact and Respiratory Routes.

Any disease or infection that is naturally transmissible from vertebrate animals to humans and vice-versa is classified as a zoonosis; this can include infections from bacteria, viruses, fungi, parasites, or other agents such the prion responsible for variant Creutzfeldt-Jakob Disease (vCJD). Vector-borne diseases are transmitted to humans and animals through blood-feeding arthropods, such as mosquitoes, ticks and fleas; examples include Lyme disease and malaria. A list of vector-borne diseases of potential interest in Canada is presented in Appendix B.

In 2011 in Peterborough, the only reportable VPD, vector-borne, zoonotic, or rare/other disease which occurred at a frequency of greater than five cases were diseases classified as encephalitis/meningitis (EM). Encephalitis is an acute inflammatory disease involving parts of the brain, spinal cord and meninges caused by specific viruses such as: enteroviruses, coxsackie virus, arboviruses, St. Louis encephalitis virus (SLE), Western equine encephalitis virus (WEE), Eastern equine encephalitis (EEE) and California encephalitis (CE); encephalitis may also be caused by bacteria, fungi, and protozoa. Most viral encephalitis infections are asymptomatic; mild cases often occur as febrile headache; severe infections are usually marked by acute onset, with headache, high fever, meningeal signs, stupor, disorientation, coma, tremors, occasional convulsions and spastic paralysis Meningitis is a disease caused by the inflammation of the protective membranes covering the brain and spinal cord known as the meninges. The inflammation is usually caused by an infection of the fluid surrounding the brain and spinal cord. Bacterial meningitis is caused by the following bacteria: *Haemophilis influenza* (non-b types); *Staphlococcus aureus; E. coli; Enterobacter aerogenes; Proteus morganii* and *Klebsiella pneumonia*.
Viral meningitis may be caused by a variety of viruses, many of which are associated with other diseases that can cause the illness. These include: enteroviruses, coxsackievirus, echovirus, and arboviruses, measles, mumps, herpes simplex, varicella andlymphocytic choriomeningitis virus. Meningitis has a very sudden onset, usually with high fever, severe headache, vomiting, confusion, seizures, progressive lethargy, drowsiness, stiff neck, and skin rash.

Incidence of EM is generally low in Peterborough (Table 13); since 2005 there have been 43 cases of EM reported to PCCHU, ten of which (23.3%) occurred in 2011. The average age of cases was approximately 34 and just over half the cases were female (24 or 55.8%). Enterovirus was implicated in a few cases of EM in 2011 (3 or 30.0%) but the majority of cases had unspecified aetiologic agents.

Table 14. Encephalitis/meningitis Summary Data

	2011	5-yr Mean (2006-2010)	Ontario 2011
Number of Reported Cases	10	4.8	138
Incidence (per 100,00 population)	7.2	3.5	1.0
Males	-	33.3%	55.1%
Females	-	62.5%	44.2%
Age at Onset (Years)			
Mean	34.4	34.5	
Median	30	33.5	
Range	<1 – 71	<1 – 88	

There were no cases of the following diseases reported to PCCHU in 2011: anthrax; botulism; brucellosis; chancroid; cholera; cyclosporiasis; cytomegalovirus infection, congenital; diphtheria; hemorrhagic fevers; hepatitis A; hepatitis D; herpes, neonatal; Lassa fever; leprosy; malaria; measles; mumps; ophthalmia neonatorum; paratyphoid fever; pertussis; plague; poliomyelitis, acute; psittacosis/ornithosis; rabies; rubella; rubella, congenital syndrome; Severe Acute Respiratory Syndrome (SARS); tetanus; transmissible spongiform encephalopathies; trichinosis; tularemia; typhoid fever; and yellow fever.

5. Institutional Outbreaks

Institutional outbreaks, such as those occurring in a daycare, school, and health care or residential setting, require a public health response. There were 49 institutional outbreaks reported to PCCHU in 2011 compared to 33 in 2010 and most (27 or 55.1%) of these were enteric in nature (Table 15). On average, enteric outbreaks were larger than respiratory and were responsible for a much larger number of illnesses. Just under half (24 or 49.0%) of all institutional outbreaks reported to PCCHU in 2011 occurred in long-term care facilities (LTC); retirement residences (RR) and child care facilities (e.g.: daycares, nurseries) accounted for nine (18.4%) outbreaks each. Outbreaks in LTCs accounted for 691 (61.7%) of all illnesses associated with an institutional outbreak. One particular LTC accounted for eight (16.3%) outbreaks in 2011 while five outbreaks (10.2%) occurred at a second LTC. Seven deaths occurred among outbreak cases and, excluding hospital outbreaks, thirteen cases required hospitalization.

Table 15. Institutional Outbreaks Reported to PCCHU by Setting

		Enteric	Respiratory	Total
Outbreaks		27 (55.1%)	22 (44.9%)	**49**
Total Cases		676	444	**1,120**
Avg. Cases		25	20	**23**
Setting	**Hospital**	1 (3.7%)	-	**1 (2.0%)**
	LTC	9 (33.3%)	15 (68.2%)	**24 (49.0%)**
	RR	4 (14.8%)	5 (22.7)	**9 (18.4%)**
	School	3 (11.1)%	-	**3 (6.1%)**
	Child Care	7 (25.9)%	2 (9.1)	**9 (18.4%)**
	Community	3 (11.1)%	-	**3 (6.1%)**

A large number of institutional outbreaks (15 or 30.6%) were of unknown aetiologic agent; where available, Norovirus accounted for most of the outbreaks (10 or 20.4%) followed by rhinovirus (5 or 10.2%) – Table 15. There were also several outbreaks where two or more organisms were identified: respiratory syncytial virus (RSV) was identified in two influenza A outbreaks and one rhinovirus outbreak; metapneumovirus, RSV, and rhinovirus were all isolated during a single outbreak.

Table 16. Institutional Outbreaks Reported to PCCHU by Aetiologic Agent

Aetiologic Agent	Outbreaks	Total Illnesses	2010
C. difficile	1 (2.0%)	5	1 (3.0%)
Coronavirus	1 (2.0%)	53	-
ECHO virus	1 (2.0%)	9	-
Influenza A	3 (6.1%)	54	-

Influenza A; RSV	2 (4.1%)	57	-
Influenza B; RSV	1 (2.0%)	23	-
MPV	2 (4.1%)	58	1 (3.0%)
MPV; RSV; Rhinovirus	1 (2.0%)	13	-
Norovirus	10 (20.4%)	464	8 (24.2%)
Parainfluenza	2 (4.1%)	30	-
Rhinovirus	5 (10.2%)	105	-
Rhinovirus; RSV	1 (2.0%)	13	-
Rotavirus	3 (6.1%)	72	-
Salmonella javiana	1 (2.0%)	15	-
Unknown	15 (30.6%)	149	15 (45.5%)
TOTAL	**49**	**1,120**	**33**

Just over half of the institutional outbreaks in Peterborough occurred in the first few months of 2011: between January and April, 27 (55.0%) outbreaks were reported to PCCHU; a similar pattern occurred in 2010. There was an equal mix of enteric and respiratory outbreaks during this period (15 and 12, respectively).

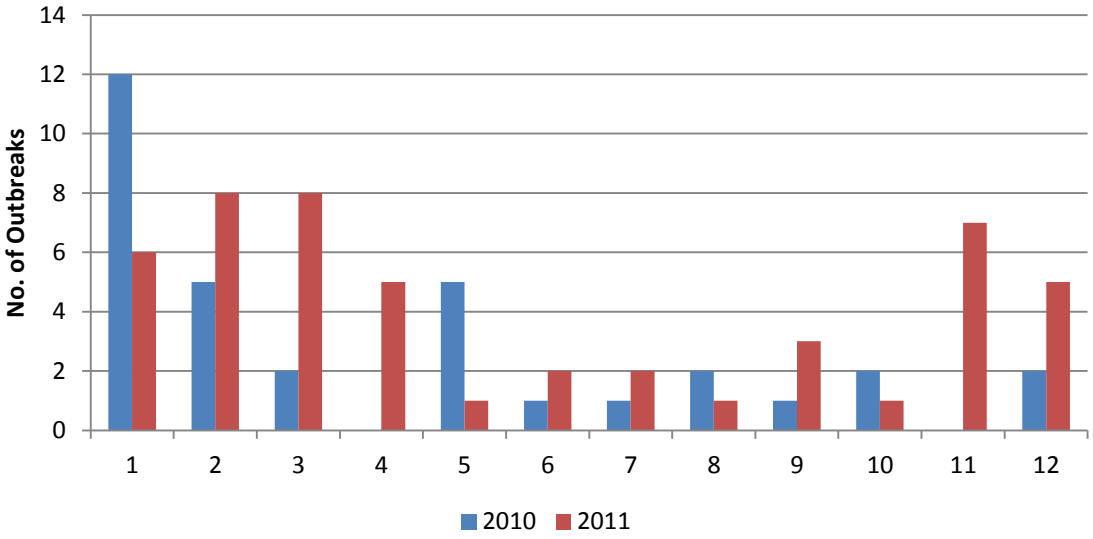


Figure 6. Time Series of Institutional Outbreaks Reported to PCCHU, 2010-11

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Appendices

Appendix A: Reportable Diseases

Acquired Immunodeficiency Syndrome (AIDS) Amebiasis *Anthrax *Botulism *Brucellosis Campylobacter enteritis Chancroid Chickenpox (Varicella) Chlamydia trachomatis infections *Cholera *Clostridium difficile* associated disease (CDAD) outbreaks in public hospitals *Cryptosporidiosis *Cyclosporiasis Cytomegalovirus infection, congenital *Diphtheria *Encephalitis, including: 1. *Primary, viral 2. Post-infectious 3. Vaccine-related 4. Subacute sclerosing panencephalitis 5. Unspecified *Food poisoning, all causes *Gastroenteritis, institutional outbreaks *Giardiasis, except asymptomatic cases Gonorrhea *Haemophilus influenzae b disease, invasive *Hantavirus Pulmonary Syndrome	*Hemorrhagic fevers, including: 1. *Ebola virus disease 2. *Marburg virus disease 3. *Other viral causes *Hepatitis, viral 1. *Hepatitis A 2. Hepatitis B 3. Hepatitis C 4. Hepatitis D (Delta hepatitis) Herpes, neonatal Influenza *Lassa Fever *Legionellosis Leprosy *Listeriosis Lyme Disease Malaria *Measles *Meningitis, acute 1. *Bacterial 2. Viral 3. Other *Meningococcal disease, invasive Mumps Ophthalmia neonatorum *Paratyphoid Fever Pertussis (Whooping Cough) *Plague *Poliomyelitis, acute Psittacosis/Ornithosis *Q Fever *Rabies *Respiratory infection outbreaks in Institutions *Rubella Rubella, congenital syndrome Salmonellosis	*Severe Acute Respiratory Syndrome (SARS) *Shigellosis *Smallpox *Streptococcal infections, Grp A invasive Streptococcal infections, Grp B neonatal *Streptococcus pneumoniae*, invasive Syphilis Tetanus Transmissible Spongiform Encephalopathy, including: i. Creutzfeldt-Jakob Disease, all types ii. Gerstmann-Straüssler- Scheinker Syndrome iii. Fatal Familial Insomnia iv. Kuru Trichinosis Tuberculosis *Tularemia *Typhoid Fever *Verotoxin-producing E. coli Infection indicator conditions including Hemolytic Uremic Syndrome *West Nile Virus illness, including: i. West Nile fever ii. West Nile neurological manifestations *Yellow Fever Yersiniosis

Source: Ontario Ministry of Health, 1996
Diseases marked * (and Influenza in institutions) should be reported **immediately** to the Medical Officer of Health by telephone.

Appendix B. Arthropod-borne diseases of potential interest to Canadians

Disease	Microbial category	Arthropod host	Distribution
Lyme disease	Bacterial	Tick	Southern Ontario, British Columbia, sporadic elsewhere, imported cases
Relapsing fever	Bacterial	Tick	British Columbia
Tularemia*	Bacterial	Tick	Canada wide
Plague	Bacterial	Flea	Western Canada
Bartonella*	Bacterial	Louse, flea	Potentially Canada-wide‡
Q fever*	Rickettsial	Tick	Canada-wide
Rocky Mountain spotted fever	Rickettsial	Tick	British Columbia, Alberta, Saskatchewan, Ontario, Nova Scotia
Human granulocytic ehrlichiosis	Rickettsial	Tick	Potentially in Canada‡, imported
Endemic (murine) typhus	Rickettsial	Flea	Potentially Canada-wide‡
California encephalitis	Viral	Mosquito	Canada-wide
Western equine encephalitis	Viral	Mosquito	Western Canada
Eastern equine encephalitis	Viral	Mosquito	Quebec, Ontario
Powassan encephalitis	Viral	Tick	Ontario, Quebec, New Brunswick
Colorado tick fever	Viral	Tick	Alberta, British Columbia
St Louis encephalitis	Viral	Mosquito	Ontario, Quebec, Manitoba, Saskatchewan
Cache Valley	Viral	Mosquito	Ontario, Manitoba, Saskatchewan, Alberta
Dengue	Viral	Mosquito	Imported
Exotic arboviral infections	Viral	Mosquito, tick, sandfly	Imported
Malaria	Parasitic	Mosquito	Imported

*The disease may have an arthropod-borne association, but it is not necessarily the main means of transmission to humans;
†Reflects speculation by H. Artsob
From: Paediatr Child Health. 2000 May–Jun; 5(4): 206–212.

Reportable Diseases in Peterborough County-City 2011

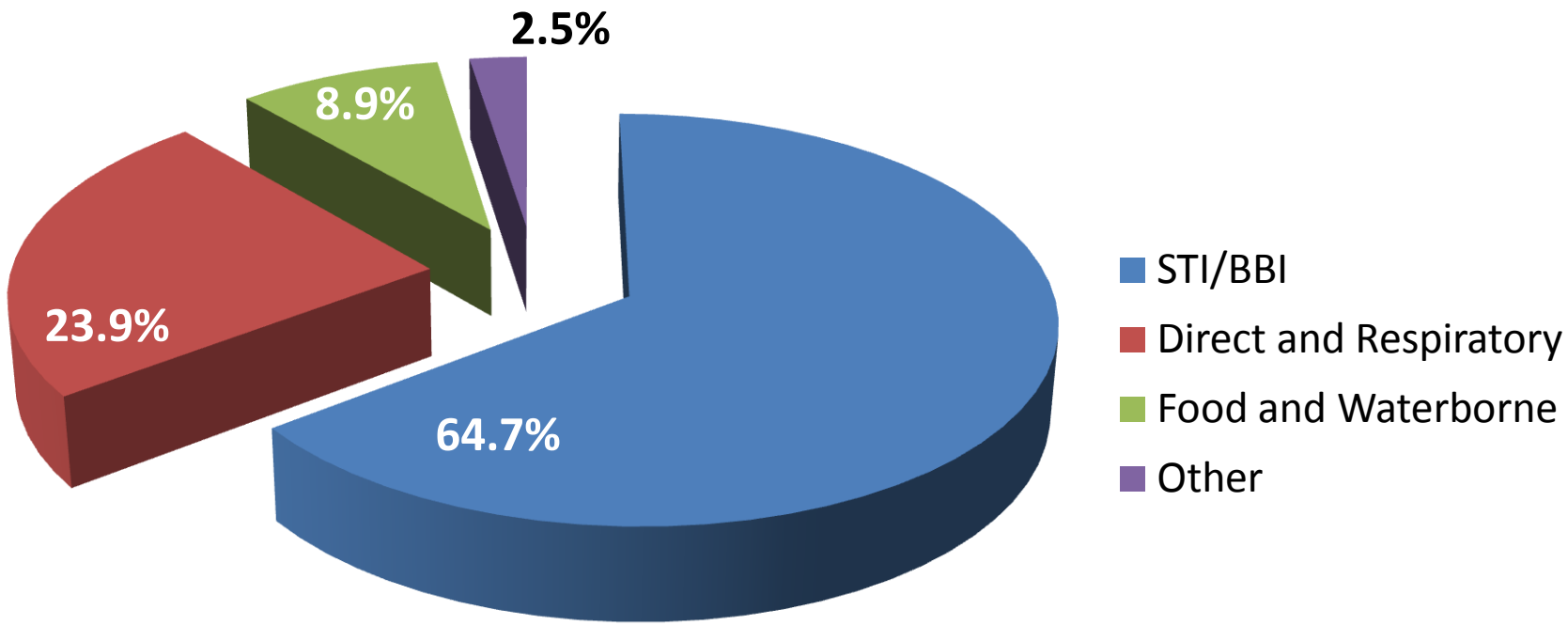
Highlights

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

Overview

- 710 total confirmed cases
  - 7.3% increase over 2010
- Average 59 cases per month
  - Most in February (due to influenza) with 122
- Most illnesses occurred among females (64.4%)

Diseases by type (transmission route)



Food and Water – Highlights

- Campylobacter (27), salmonella (18) and giardia (6) accounted for most cases (81%)
- Decreases in counts of each of those diseases, giardia most significantly (21 in 2010)
- Crude rates of these illnesses lower than PCCHU five-year mean, as well as Ontario 2011 rates

STI/BBI – Highlights

- Chlamydia (402), Hep C (40), and gonorrhea (13) made up large majority of STI/BBIs (99%)
- Chlamydia made up 88% of STI/BBI and 57% of all reportable illnesses in 2011
  - Chlamydia cases were ~10% less than 2010
  - 78% of cases in women and 65% of cases in men were aged 15 to 24
  - There was a decrease in the number of 15-19 female cases between 2010 and 2011, though increases in all other age cohorts

Hepatitis C

- Number of Hep C cases consistent
  - Increasing proportion of Hep C cases being diagnosed are males
  - Two-thirds of Hep C cases diagnosed are between 40 and 54

Direct/Respiratory – Highlights

- Influenza (142), invasive Strep pneumonia (19) and Group A strep (7) accounted for most cases (99%)
- Very large increase in influenza cases over 2010 (142 vs. 5)
- Of 142 cases in 2011:
  - Majority were female (76.8%)
  - Two-thirds were 65+ years
  - Most were influenza A (83.8%)
  - Of those sub-typed, majority were H3N2 (73.1%)

Other - Highlights

- Increase in number of encephalitis/meningitis cases
- Most (70%) were of an unknown etiologic agent

Institutional Outbreaks - Highlights

- Facilities are very good at reporting
- 49 reported to PCCHU (vs. 33 in 2010)
  - 55% enteric, 45% respiratory
- Most occurred in a LTC setting (49%) followed by retirement residence (18%) and child care settings (18%)
- Wide variety of agents
- Most outbreaks occurred Jan-Apr/Nov-Dec

Staff Report

Designation, Chief Building Official

Date:	June 13, 2012
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original signed by	**Original signed by**
Rosana Pellizzari, M.D.	Larry Stinson, Director, Public Health Programs

Recommendation

That the Board of Health for the Peterborough County-City Health Unit appoint Kathleen Shepherd as Chief Building Official, under section 6.2 (4) of the Building Code Act.

Financial Implications and Impact

At this time, there is no established wage differential for an Inspector who assumes the powers and duties of the Chief Building Official.

Decision History

Tom Cathcart, Manager, Inspection Services, has been designated as the Chief Building Official for the purposes of the Sewage Treatment Program since 2000. The Board has not previously considered the appointment of Ms. Shepherd, but has previously appointed her to act as a Sewage System Inspector under the Building Code Act.

Background

The role of the Chief Building Official is outlined in section 1.1 (6) of the Building Code Act as follows:

(a) to establish operational policies for the enforcement of this Act and the building code within the applicable jurisdiction;

(b) to co-ordinate and oversee the enforcement of this Act and the building code within the applicable jurisdiction;

(c) to exercise powers and perform the other duties assigned to him or her under this Act and the building code; and

(d) to exercise powers and perform duties in accordance with the standards established by the applicable code of conduct. 2002, c. 9, s. 3.

Kathleen Shepherd, Public Health Inspector with the Peterborough County-City Health Unit, has met the education and examination qualifications outlined in the regulation, and if appointed will submit the information required in section 3.1.6.1.(1) of the Code to the Ministry of Municipal Affairs and Housing Director.

This appointment will allow Ms. Shepherd to assume the powers and duties of the Chief Building Official, as well as continuing her work as an Inspector in the Sewage Disposal Program.

Rationale

The Manager of the Sewage Disposal Program has recently retired, and re-assignment of staff to the Chief Building Official role will be necessary to provide for the immediate continuation of the Sewage Disposal Program. While there are four Inspectors on staff with the Health Unit who have the qualifications specified in the Building Code, Ms. Shepherd has the most experience in the Sewage Disposal Program and has an excellent history of decisions and performance.

Strategic Direction

Through the continuing operation of the Sewage Disposal Program, the Health Unit builds on its record of cooperation and collaboration with its municipal partners.

Contact:

Larry Stinson,
Director, Public Health Programs
(705) 743-1000, ext. 255
lstinson@pcchu.ca

Residential Indoor Air Quality Trichloroethylene

Former OMCC Site

Donna Churipuy

June 13, 2012

Indoor Air Quality Program

- As a result of high some high results for TCE vapours in outdoor monitoring wells, 47 residences were sites selected by Ministry of Environment (MOE) on Romaine St and Brioux Avenue to test for potential impacts on indoor air quality
- Voluntary program
- Notifications sent and dropped off to 47 homeowners and tenants
- Indoor air quality testing completed in 26 homes
- 0ne control home

Results

- 23 homes had levels of TCE within normal range or non detect
- 3 homes had low level exceedances between 0.5 and 5 ug/m3

Communications to residents

- Results were shared by MOE staff with residents via telephone and letter
- Residents were offered a meeting with MOE and PCCHU staff, however at this time none have accepted the offer

Next Steps

- Ministry of Environment (MOE) Standards Development Branch is reviewing results
- MOE will resample indoor air in homes with exceedances under winter conditions next winter
- Public Meeting scheduled
  - June 26th, 6-8 p.m. Canadian Canoe Museum
  - Presenters include the MOE, Dr. Pellizzari, an Environmental Lawyer, and possibly MPAC

Public Meeting Agenda

- Ministry of the Environment
  - History of TCE Contamination, role of MOE and ongoing monitoring
  - Indoor air sampling results
  - Other e.g. soil sampling, removal of red flag on property deed, perceived delays
- Peterborough County-City Health Unit
  - Risk to health and health effects of exposure to TCE, including respiratory effects, cancer other medical problems
  - Safety of vegetable gardening
  - Safety of children playing with soil around homes
- MPAC - tentative
  - Impact on real estate/resale value
- Environmental Lawyer
  - To answer questions re liability and compensation for the costs of repairs

To: All Members
Board of Health

From: David Watton, Chair, Board of Health Governance Committee

Subject: **Governance Committee**

Date: June 13, 2012

Recommendation:

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

- receive for information, meeting minutes of the Governance Committee for April 4, 2012, approved by the Committee on May 28, 2012; and

- approve the following documents referred by the Committee at the April 4, 2012 meeting:

    - Revised Policy #2-20, Authority and Jurisdiction
    - Revised Procedure #2-281, Complaints, Public
    - Revised Policy #2-284, Correspondence
    - New Policy #2-350, Delegation of Authority
    - New Procedure #2-351, Delegation of Authority
    - New By-Law #10, By-Law Number 10, Open and In-Camera Meetings

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Please refer to the attached.

Original signed by

Rosana Pellizzari, M.D. *on behalf of*
Mr. David Watton, Chair,
Governance Committee

The Board of Health
for the
Peterborough County-City Health Unit
MINUTES
Governance Committee Meeting
April 4, 2012 – 3:00 p.m. to 6:00 p.m.
(Meeting Room 2 - 10 Hospital Drive, Peterborough)

Present: Mr. David Watton, Chair
Ms. Brittany Cadence *(joined at 4:00 p.m.)*
Mr. Tom Cathcart *(joined at 4:00 p.m.)*
Mr. Jim Embrey
Deputy Mayor Andy Sharpe
Reeve Mary Smith
Dr. Rosana Pellizzari
Mrs. Alida Tanna, Recorder

1. Call To Order

Mr. Watton called the meeting to order at 3:00 p.m.

2. Declaration of Pecuniary Interest

There were no declarations of pecuniary interest.

3. Delegations

Nil.

4. Approval of the Agenda

Moved by	Seconded by
Reeve Smith	Deputy Mayor Sharpe

That the agenda be approved as circulated.

Carried

5. Approval of the Minutes

Moved by	Seconded by
Mr. Embrey	Reeve Smith

That the minutes of February 29, 2012 be approved as written, and brought forward to the next Board of Health meeting.

Carried

6. Business Arising from the Minutes

6.1 Non-Union Forum

Discussion of this item was referred to the in camera session which would take place later in the meeting.

6.2 Accessibility for Ontarians With Disabilities Act Training

Dr. Pellizzari confirmed that Board members are required to complete this training to comply with the Act. Reeve Smith noted that County representatives have already completed this training, and it was likely that City representatives would have done the same. **ACTION: Mrs. Tanna will follow up with the City and County to confirm training and request documentation for municipal representatives. Training will be scheduled for other Board Members next month.**

6.3 Youth Representation on the Board

Dr. Pellizzari advised that an initial meeting was scheduled for April 23rd with Keith Beecroft (Youth Development Worker) and the Health Unit's peer leaders to explore ideas for engagement and discuss potential models for youth involvement with the Board. **ACTION: Dr. Pellizzari to update the Governance Committee on the outcome at the next Governance Committee meeting.**

Dr. Pellizzari also confirmed that all peer leaders are currently City residents.

6.4 Review Property Committee Terms of Reference

Draft Terms of Reference for the Property Committee were circulated to members based on input from the previous meeting, additional revisions were noted.

Moved by	Seconded by
Mr. Embrey	Deputy Mayor Sharpe

That the amended Terms of Reference for the Board of Health Property Committee be recommended for approval by the Board of Health.

Carried

6.5 Board Member Descriptions and Recruitment

Dr. Pellizzari noted that descriptions for the Board of Health which are provided to City and County Councillors was quite brief. **ACTION: Dr. Pellizzari to draft a new description which will be vetted with a City and County Board Member prior to submission to the respective clerk. This will be completed later in the year, Dr. Pellizzari will report back when this is done.**

A description on the Public Appointments Secretariat web site was discussed. Descriptions for all Boards of Health follow a consistent format without much

variance. It was decided that enhanced information about roles and responsibilities for Board Members would be included on the Health Unit's web site.

To this end, Mr. Watton provided additional narrative for the Health Unit's web site, based on similar changes he would propose to Board Policy 2-200 (addressed later in the meeting under item 7.1b). **DECISION: Members approved the revision to the web site. ACTION: Mrs. Tanna to forward revisions to Brittany Cadence for inclusion on the Health Unit's web site.**

6.6 By-Law Policy and Procedure Tracking

Alida Tanna shared a tracking document with Committee Members. The document included a list of all Board of Health by-laws, policies and procedures; noted dates when these documents were last reviewed; and, identified review dates. The tracking document will ensure that all by-laws, policies and procedures are reviewed at least every two years by the Committee.

7. New Business

7.1 By-Law, Policy and Procedure Review

a. 2-348, Policy - Governance Committee Terms of Reference

This item was deferred. The next review date for this document will be scheduled for June 2013.

b. 2-200, Policy - Duties and Responsibilities, Members of the BOH

Mr. Watton provided suggested changes for this document. Members were in agreement with the revisions proposed.

Moved by	Seconded by
Mr. Embrey	Deputy Mayor Sharpe

That the amended Policy 2-200 be recommended for approval by the Board of Health.

c. 2-270, Policy - Conduct, Members of the Board of Health

Additions to this policy were discussed and agreed upon in the meeting.

Moved by	Seconded by
Mr. Embrey	Deputy Mayor Sharpe

That the amended Policy 2-270 be recommended for approval by the Board of Health.

d. 2-280, Policy - Complaints, Public

A minor housekeeping change was made to this policy, this revision does not require Board approval.

e. 2-281, Procedure - Complaints, Public
Deferred. **ACTION: This item will be brought forward to the next meeting for further discussion.**

8. 2013+ Strategic Plan

8.1 Update on Consultant

Dr. Pellizzari advised that she had received two additional quotes related to consulting services for the development of the Board's strategic plan. Both quotes were higher than the quote received from Mr. Jonathan Bennett, Dr. Pellizzari was seeking consensus to proceed with Mr. Bennett. **DECISION: Members approved engaging Mr. Jonathan Bennett for consulting services in the fall to develop the Board of Health's new strategic plan. ACTION: Dr. Pellizzari to proceed as directed.**

9. In Camera/Closed Session to Discuss Personnel Matters

9.1 Non Union Discussions

Brittany Cadence and Tom Cathcart joined the meeting at 4:00 p.m.

Moved by	Seconded by
Reeve Smith	Deputy Mayor Sharpe

That the Governance Committee go In Camera to discuss confidential personnel matters.

Carried

Mrs. Tanna excused herself from this portion of the meeting.

Moved by	Seconded by
Reeve Smith	Jim Embrey

That the Governance Committee rise from In Camera

Carried

Mr. Cathcart and Ms. Cadence departed the meeting, Mrs. Tanna rejoined the meeting at 5:00 p.m.

10. Items to be referred to:

10.1 Board of Health

- Minutes, April 4, 2012
- 2-348, Policy - Governance Committee Terms of Reference
- 2-200, Policy - Duties and Responsibilities, Members of the BOH
- 2-270, Policy - Conduct, Members of the Board of Health

10.2 Other
Nil.

11. Agenda Items for Next Meeting

- Strategic Planning
- 2-281, Procedure - Complaints, Public
- Other policies and procedures as necessary for review

12. Date, Time and Place of Next Meeting

The next meeting for the Governance Committee will be scheduled for late May/early June 2012, or at the call of the Chair.

13. Adjournment

Moved by	Seconded by
Deputy Mayor Sharpe	Mr. Embrey
That the meeting be adjourned.	
	Carried

The meeting adjourned at 6:00 p.m.

c: Mr. Jim Embrey
Reeve Mary Smith
Deputy Mayor Andy Sharpe
Mr. David Watton
Dr. Rosana Pellizzari
Mr. Brent Woodford

Parked Items:
- *Board Liability Presentation (Woodford, Ref. Jan. 27/12)*
- *Revisions to By-Law # 9, Procurement of Goods and Services (Woodford, Ref. Jan. 27/12)*

Chair

Recorder

Board of Health
Policy

Section:	Number:	Title:	Page:
Board of Health	**2-20**	**Authority and Jurisdiction**	**1 of 2**

Approved by: **Board of Health**
Date: **December 9, 1986**

Housekeeping Revision
Approved by:
On:

Original:
Approved by: **Board of Health**
On: **December 9, 1986**

Revision:
Approved by:
On:

Reviewed:
By: **Governance Committee**
On: **May 28, 2012**

Next Review Date: June 2014

Reference:

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

1. The Board of Health for the Peterborough County-City Health Unit operates by authority of:

   a) The Health Protection and Promotion Act, and its Regulations; and

   b) Agreement between the County of Peterborough and the City of Peterborough signed January 22, 1965, establishing the Peterborough County-City Health Unit.

2. The Peterborough County-City Health Unit has jurisdiction over the geographical area of the County of Peterborough ~~which also includes~~ and the City of Peterborough (~~Ontario Regulation 236/84~~ R.R.O. 1990, Reg. 553, Sched. 30).

3. A Letter of Agreement dated March 26, 1999 between the Board of Health and Curve Lake First Nation Council, authorizes the Medical Officer of Health to make Health Unit programs and services available to Curve Lake First Nation.

4. A Letter of Agreement dated May 3, 2007 between the Board of Health and Hiawatha First Nation Council, authorizes the Medical Officer of Health to make Health Unit programs and services available to Hiawatha First Nation.

Board of Health
Procedure

Section:	Number:	Title:	Page:
Board of Health	**2-281**	**Complaints, Public**	**1 of 2**

Approved by: **Board of Health**
Date: **May 5, 1997**

Housekeeping Revision
Approved by:
On:

Original:
Approved by: **Board of Health**
On: **May 5, 1997**

Revision:
Approved by:
On:

Reviewed:
By: ~~**Medical Officer of Health**~~ **Governance Committee**
On: ~~**October 30, 2007**~~ **May 28, 2012**

Next Review Date: June 2014

Reference:

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

Objective:

To ensure that all non environmental complaints received by the Health Unit are dealt with in accordance with Board of Health By-laws, policies, and procedures.

Procedure:

1. The complainant will be requested to submit their complaint in writing. If assistance is required this will be provided by Health Unit staff.

2. One copy of the complaint is forwarded to the Director and another copy is forwarded to the Medical Officer of Health. The Director has fourteen days to investigate and prepare a

response to the complaint. A copy of the Director's response to the complaint is forwarded to the Medical Officer of Health.

3. If the response is not satisfactory to the complainant he or she will be directed to the Medical Officer of Health for follow-up.

4. Board members will forward all complaints received from the public, stakeholders, and partners to the Medical Officer of Health.

5. The Medical Officer of Health will investigate the complaint and issue a report to the Board member within two weeks.

6. If the issue is not resolved to the satisfaction of the Board member, the issue will be brought to the attention of the Chairperson of the Board of Health.

7. The Chairperson of the Board of Health, in consultation with the board member who received the complaint and the Medical Officer of Health, will attempt to resolve the issue.

8. If the issue is not resolved, the Chairperson of the Board of Health will refer the matter to the Board of Health for a final decision. The parties involved would be invited to present their concerns to the Board of Health.

9. The Medical Officer of Health will produce an annual summary report of complaints for the Board of Health. This report will be provided at the first meeting of the Board in the following year.

Board of Health
Policy

Section:	Number:	Title:	Page:
Board of Health	**2-284**	**Correspondence**	**1 of 1**

Approved by: Board of Health **Date: September 14, 2011** **Housekeeping Revision** **Approved by:** **On:**	**Original** **Approved by: Board of Health** **On: September 14, 2011** **Revision** **Approved by:** **On:** **Reviewed** **By: ~~By Laws, Policies Procedures Committee~~ Governance Committee** **On: ~~May 18, 2011~~ May 28, 2012** **Next Review Date: June 2014**
Reference:	

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

All paper and electronic correspondence addressed, or copied, to the Chair of the Board of Health will be reviewed by the Chair of the Board of Health and the Medical Officer of Health to determine what correspondence is to be included in Board of Health agenda packages.

Correspondence must be received no later than two weeks prior to the scheduled Board of Health meeting to be eligible for consideration. Any correspondence received after this deadline may be carried forward to the following meeting.

All correspondence requested or directed to be sent on behalf of the Board of Health is to be documented (in the minutes of Board of Health meetings and sent by the Secretary of the Board of Health).

Board of Health
Policy

Section:	Number:	Title:	Page:
Board of Health	**2-350**	**Delegation of Authority**	**1 of 1**

Approved by: Board of Health **Date:** **Housekeeping Revision** **Approved by:** **On:**	**Original:** **Approved by: Board of Health** **On:** **Revision:** **Approved by:** **On:** **Reviewed:** **By: Governance Committee** **On: May 28, 2012** **Next Review Date: June 2014**
Reference:	

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

Policy Statement:

The Board of Health is responsible by legislation to provide and ensure the provision of public health programs and services.

The Board delegates the day-to-day administration and oversight of the Health Unit to its Medical Officer of Health. The Medical Officer of Health may re-delegate certain functions as required.

Standard:

The Delegation of Authority also means the delegation of accountability and responsibility.

Board of Health
Procedure

Section:	Number:	Title:	Page:
Board of Health	**2-351**	**Delegation of Authority**	**1 of 2**

Approved by: Board of Health **Date:** **Housekeeping Revision** **Approved by:** **On:**	**Original:** **Approved by: Board of Health** **On:** **Revision:** **Approved by:** **On:** **Reviewed:** **By: Governance Committee** **On: May 28, 2012** **Next Review Date: June 2014**

Reference:

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Procedure:

Except as otherwise noted, all administrative authority is delegated to the Medical Officer of Health. This includes (but is not limited to):

- Developing, recommending and implementing Policies and Procedures;
- Interviewing, checking the references of, hiring and orienting Senior Managers;
- Authorizing purchases, disbursements and signing cheques to the financial level delegated by the Board;
- Supervising the day-to-day operations of the Peterborough County-City Health Unit;
- Maintaining records as required by law;
- Providing information and participating at Board of Health meetings;

- Terminating all employees below the level of Medical Officer of Health. It is anticipated the Medical Officer of Health will consult the Board Chair before an employee is terminated.

Board of Health
Policy

Section:	Number:	Title:	Page:
Board of Health	**2-185**	**By-Law Number 10, Open and In-Camera Meetings**	**1 of 3**

Approved by: Board of Health **Date:** **Housekeeping Revision** **Approved by:** **On:**	**Original:** **Approved by: Board of Health** **On:** **Revision:** **Approved by:** **On:** **Reviewed:** **By: Governance Committee** **On: May 28, 2012** **Next Review Date: June 2014**

Reference: Municipal Act, 2001, S.O. 2001

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

By-Law Number 10
A By-law for the Conduct of Open and In-Camera Meetings

Section 1 – Interpretation

1.1 In this By-law:

(1) "Act" means the Municipal Act, 2001;

(2) "Board" means the Board of Health for the Peterborough County-City Health Unit;

(3) “Chairperson” means the presiding officer at a meeting;

(4) "Chairperson of the Board" means the Chairperson elected under the Health Protection and Promotion Act;

(5) "Committee" means an assembly of two or more members that must meet together to transact business;

(6) “In-camera Meeting” means a meeting or portion of a meeting that is closed to the public;

(7) "Meeting" means any regular, special or other meeting of The Board or of a Committee of the Board;

(8) "Member" means a person who is appointed to the Board by a Council or the Lieutenant Governor-in-Council or a person who is appointed to a Committee by the Board;

(9) "Motion" means a formal proposal by a member in a meeting that the Board or a Committee take certain action;

(10) “Open Meeting” means a meeting of the Board or a Committee that is open to the general public; and

(11) “Resolution" means a motion that is carried at a meeting by a majority vote in the affirmative of the members present;

Section 2 - General

2. 1 The rules in this By-law shall be observed in the calling of and the proceedings at all Meetings of the Board and Committees.

2.2 Notice of all Meetings will publically posted. If the Meeting is to be held In-camera, this will be noted on the public posting and a general nature of the matter to be considered will be noted.

Section 3 – In-Camera Meetings

3.1 The Board or Committee shall approve a resolution that the Board or Committee go In-camera and state the general nature (legal/personal/property) of the matter to be considered.

3.2 The Board or a Committee shall go In-camera to discuss:

(1) Security of Board property;

(2) Personal matters about an identifiable individual, including Board employees;

(3) A proposed or pending acquisition or disposition of land by the Board;

(4) Labour relations or employee negotiations;

(5) Litigation or potential litigation, including matters before administrative tribunals affecting the Board;

(6) Advice that is subject to solicitor-client privilege;

(7) Personal information, personal health information and sensitive information about non-personal entities (eg: schools);

(8) Subject matter that relates to the consideration of a request under the Municipal Freedom of Information and Protection of Privacy Act;

(9) A matter in respect of which the Board, Committee or other body may hold a closed meeting under another Act;

(10) A meeting may be closed if it is held for the purpose of educating or training the Members, so long as no Member discusses or otherwise deals with any matter during the closed meeting in a way that materially advances the business or decision-making of Board or Committee.

Section 4 – Voting and Minutes

4.1 Minutes of In-camera meetings will be kept securely by the Medical Officer of Health, without comment, recording all resolutions, decisions and other proceedings.

4.2 Voting in an In-camera meeting is permitted if the In-Camera meeting is otherwise authorized and the vote is for a procedural matter or for giving directions or instructions to officers, employees or agents of the Board or of a Committee of the Board; or to persons retained by or under a contract with the Board.

Section 5 - Miscellaneous

In this By-law, whenever the masculine pronoun and the singular are used, it shall include the feminine pronoun and plural, respectively, where the content so requires it.

This By-law shall be deemed to have come in to force on the XXth day of Month 2012 by resolution passed by the Board of Health on Month XXth, 2012.

Dated at the City of Peterborough the XXth day of Month, 2012.