Board of Health for the
Peterborough County-City Health Unit
AGENDA
Board of Health Meeting
4:45 p.m. Wednesday, May 8, 2013
(Council Chambers, Administration Building,
22 Wiinookeedaa Rd., Curve Lake First Nation)

1. Welcome and Opening Prayer

2. Call to Order

2.1. New Member – Councillor Trisha Shearer, Hiawatha First Nation

2.2. Reappointment – Jim Embrey, Provincial Appointee

3. Confirmation of the Agenda

4. Declaration of Pecuniary Interest

5. Delegations and Presentations

5.1. **Presentation: A Day In The Life – Access to Recreation/Physical Activity Program**
Janet Dawson, Health Promoter

5.2. **Presentation: Emerald Ash Borer – The Threat to the Urban Forest**
Wayne Jackson, Director of Utility Services & Deputy CAO, City of Peterborough

5.3. **Presentation: TreeAzin® Systemic Insecticide and Emerald Ash Borer Management**
Joe Meating, B.Sc., M.Sc. President, BioForest Technologies Inc.

5.4. **Delegation: Kasshabog Lake Dust and Noise Issues**
Bev MacLeod, Resident

6. Confirmation of the Minutes of the Previous Meeting

6.1. **April 10, 2013**

6.2. **April 24, 2013**

7. Business Arising From the Minutes

8. **Correspondence**

9. **New Business**

9.1. **Staff Report: Emerald Ash Borer**
Dr. Rosana Pellizzari, Medical Officer of Health

9.2. **Staff Report: Mandatory Re-Inspection of On-Site Sewage Systems**
Atul Jain, Manager, Inspection Services

9.3. **Staff Report: Cuts to Discretionary Benefits – Update to the Board of Health**
Larry Stinson, Director, Public Health Programs

9.4. **Q1 2013 Program Report**
Larry Stinson, Director, Public Health Programs

9.5. **Q1 2013 Financial Report**
Brent Woodford, Director, Corporate Services

9.6. **2013 Budget Approval – Healthy Babies, Healthy Children Program**
Brent Woodford, Director, Corporate Services

9.7. **2013-14 Budget Approval – Infant and Toddler Development Program**
Brent Woodford, Director, Corporate Services

9.8. **Reportable Diseases in Peterborough County-City 2012**
Dr. Rosana Pellizzari, Medical Officer of Health

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

9.10. **Resolutions for the alPHa Annual General Meeting (June 3 - 4, 2013)**
Dr. Rosana Pellizzari, Medical Officer of Health

9.11. **Strategic Plan Update**
Dr. Rosana Pellizzari, Medical Officer of Health
Larry Stinson, Director, Public Health Programs

10. **In Camera to Discuss Confidential Personal and Property Matters**

11. **Date, Time, and Place of the Next Meeting**
4:45 p.m. Wednesday, June 12, 2013; Council Chambers, Lower Hall, Administration Building, 123 Paudash Street, Hiawatha First Nation

12. **Adjournment**

Emerald Ash Borer (EAB)

THE THREAT TO THE URBAN FOREST

MAY 2013

City of Peterborough

Peterborough It's a Natural.

What is Emerald Ash Borer?

- An invasive species commonly referred to as EAB
- Imported from Asia and discovered in Michigan and Windsor, Ontario in 2002
- Attacks and kills all species of ash tree
- Millions of ash trees killed in North America since then

Peterborough
It's a Natural.

How does it Kill the tree?

- Adult females lay individual eggs distributed over the bark of tree
- Eggs hatch out –larvae bore through the bark and feed on the cambium
- Unchecked numbers obstruct flow of water and nutrients

Adult EAB

- Adult females emerge leaving characteristic D-shaped emergence hole

Symptoms on the tree

- Canopy becomes thin with weak, smaller foliage
- Epicormic shoots produced on trunk and branches
- Tree succumbs and rapidly dies

Peterborough
It's a Natural.

Symptoms on the tree

- Tree succumbs and rapidly dies

Insect build-up & Ash tree death

- One adult female = 1 Trillion insects in year 9 (increase by factor of 50/year)
- Losses are exponential once populations build up

Peterborough It's a Natural.

Impact of EAB

- Toledo, Ohio

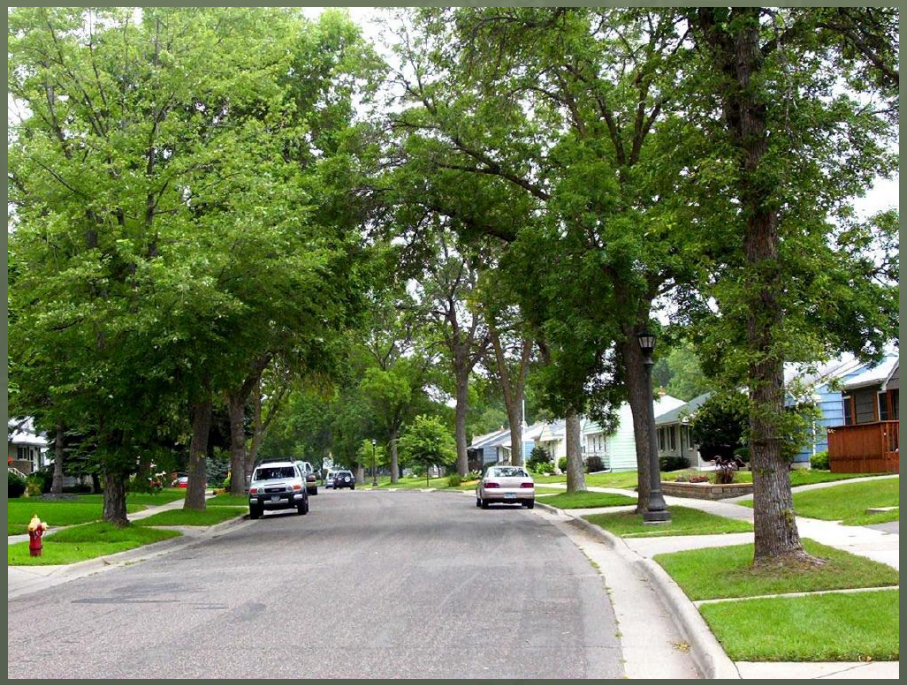
- 2005

- 2009

Peterborough
It's a Natural.

Impact of EAB

- Loss of tree cover



- Aesthetic, environmental, property values

Peterborough
It's a Natural.

How rapidly is it spreading?

- Natural spread only about 20km/year
- Artificial spread by human actions (40+ km/year)
- Principal cause –movement of wood, especially firewood

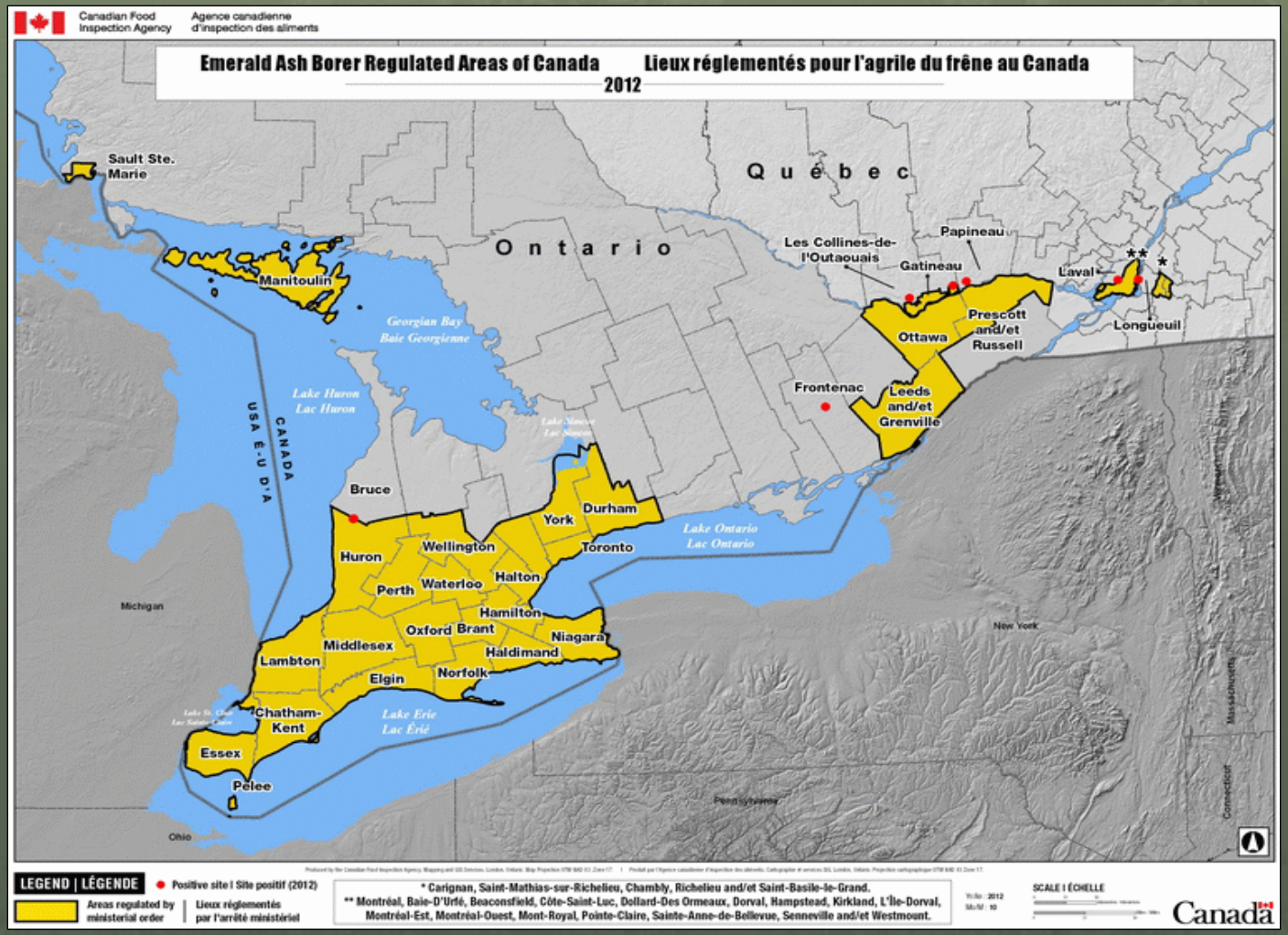
Peterborough
It's a Natural.

Where is it now?

- Pickering
- Ajax
- Whitby
- Oshawa
- Frontenac County

Peterborough
It's a Natural.

CFIA Regulated Areas



Where is next?

Likely to be found next in:

- Clarington
- Port Hope
- Cobourg
- Kingston

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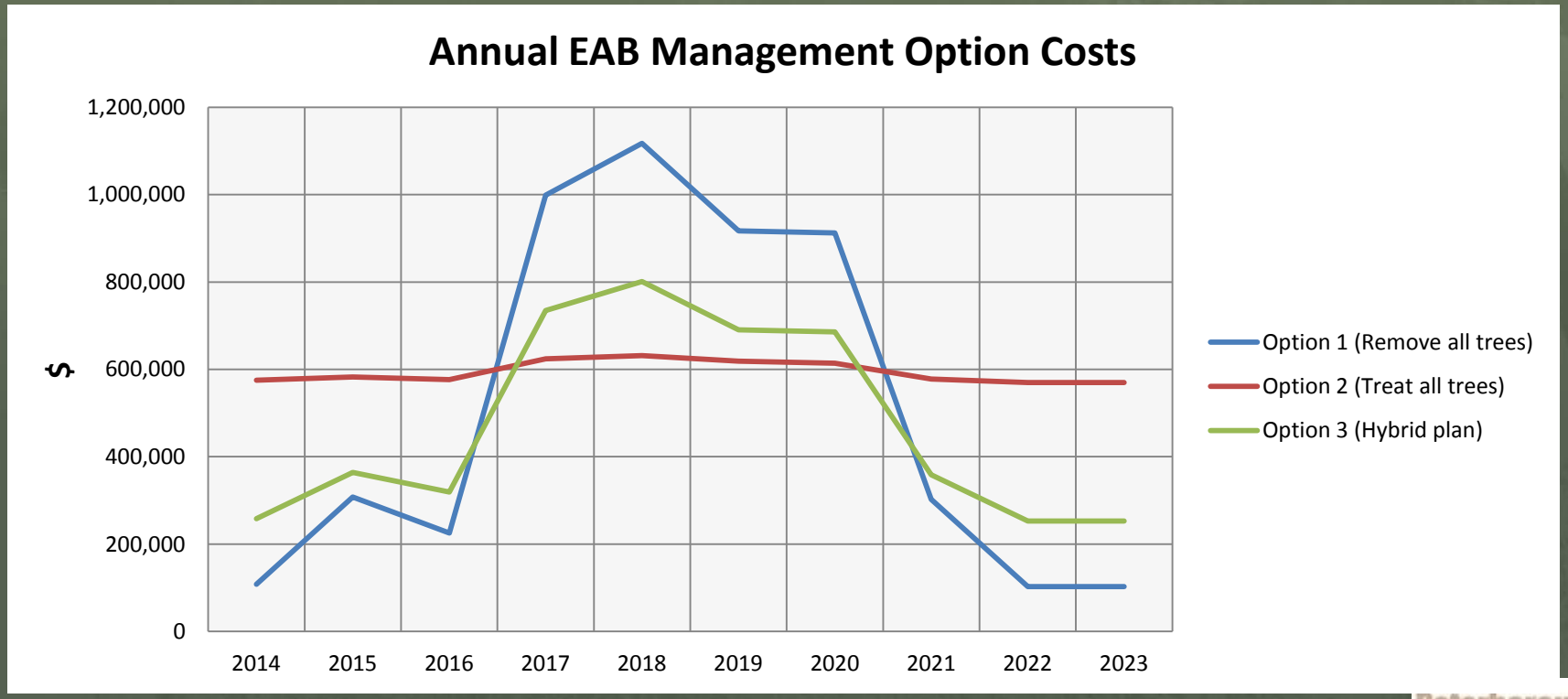
It's a Natural.

City of Peterborough

Management Strategies – Three Options

- Option 1: Remove all the Ash trees as they die
- Option 2: Treat all structurally sound ash trees
- Option 3: Combined treatment and removals program



Peterborough It's a Natural.

Costs

Option 3 – Hybrid plan ($4,900,000)

Year	Number of Trees Removed (1)	Inventory, Monitoring & Assessment ($)	Waste Disposal(2) ($)	Treatment Cost(3) ($)	Removal Cost(4) ($)	Replanting Cost(5) ($)	Public Education & Communications ($)	Yearly Totals ($)
2013	0	148,000	0	0	0	0	25,000	173,000
2014	0	98,000	0	150,000	0	0	10,000	258,000
2015	147	98,000	-1,800	150,000	92,610	18,400	10,000	367,210
2016	88	98,000	-1,100	150,000	55,440	10,800	10,000	323,140
2017	646	98,000	-8,100	150,000	406,980	80,000	10,000	736,880
2018	733	98,000	-9,200	150,000	461,790	91,200	10,000	801,790
2019	587	98,000	-7,300	150,000	369,810	72,800	10,000	693,310
2020	587	98,000	-7,300	150,000	369,810	72,800	5,000	688,310
2021	147	98,000	-1,800	150,000	92,610	18,000	5,000	361,810
2022	0	98,000	0	150,000	0	0	5,000	253,000
2023	0	98,000	0	150,000	0	0	5,000	253,000
Totals	**2,935**	**$1,128,000**	**-$36,600**	**$1,500,000**	**$1,849,050**	**$364,000**	**$105,000**	**$4,909,450**

Peterborough It's a Natural.

Treatments

- TreeAzin, Confidor 200 SL, IMA-Jet
- TreeAzin used most in Ontario municipalities (class 4 pesticide)
- Bio-pesticide derived from Neem Oils
- Treatments 98% effective
- Needed every 2 (possibly 3) years
- Alternatives will emerge over coming years

Application

- 5/16ths holes drilled in tree trunk (6” spacing)
- Nozzles inserted
- Pre-loaded canisters of product drawn up by the tree transpiration stream and distributed throughout the plant
- Chemical naturally purged over 2 year period

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Application

Application

Peterborough
It's a Natural.

Application

Peterborough
It's a Natural.

Application

Peterborough
It's a Natural.

EAB Strategic Management Summary

- Conduct City-wide tree inventory
- Determine ash tree numbers, sizes, condition and grading
- Monitor for EAB through branch sampling & trapping
- Conduct Public education & outreach
- Implement a proactive removals, treatments and replacement planting program

Peterborough
It's a Natural.

WHY ARE WE HERE TONIGHT

LOOKING FOR SUPPORT FROM THE HEALTH BOARD IN WHATEVER FORM YOU FEEL IS MOST APPROPRIATE.

TreeAzin® Systemic Insecticide and Emerald Ash Borer Management

Joe Meating
BioForest Technologies Inc.
May 8, 2013

Systemic Insecticide Research: Rationale

- Aerial spraying and traditional ground treatments are not always practicable or effective in some situations. Alternatives are needed for:
  - Urban/residential areas
  - Environmentally sensitive areas
  - Difficult to treat pests

TreeAzin® Systemic Insecticide

- Neem-based bio-insecticide;
- High toxicity to wide range of damaging insect pests;
- Very low mammalian and bird toxicity;
- TGAI:
  - Commercially available in NA;
  - Registered in >40 countries;
  - "Organic" Listing (OMRI).

OMRI® Listed
Organic Materials Review Institute

TreeAzin® Systemic Insecticide

- 5% technical systemic formulation
  - Rapid uptake and translocation
  - Effective in deciduous and conifer species
- IP developed and owned by the CFS
- Under worldwide license to BioForest Technologies

TreeAzin: 2013 Status

- Emergency Registration 2008-2012
- Full registration by PMRA: 2012
- US EPA registration 2008

TreeAzin: Ontario Classification

- *TreeAzin is a Class 4 Pesticide: "Less or Least Hazardous"
- Azadirachtin is a Class 11 active - Biopesticide or "lower risk" pesticide
- Must be applied by licensed pesticide applicator
- All service providers are trained by BioForest

*Pesticide Classification Guideline for Ontario, MOE, February 24, 2009

Regulatory Compliance: Toxicity Studies

Skin Sensitization	Not a dermal sensitizer
Acute Oral Toxicity	LD50 > 2000 mg/kg
Acute Nose Inhalation	LC50 >2.070 mg/L
Acute Dermal Irritation	No dermal irritation
Acute Dermal Toxicity	LD50 > 2000 mg/kg
Acute Eye Irritation	Non-irritant to eyes

EcoJect® System for Tree Injections

US Patent: March 2007

EcoJect: USDA APHIS Trial Rankings 2004

Ease of use	8
Consistent volume	10
Sound construction	8
Durability in field	8
Compatibility with USDA tip	8
Minimal damage to tree	8
Worker safety	10
Protection of environment	8
Weighted score	8.5/10

EcoJect II


NITRILE POWDER-FREE
GLOVES
SYSTEM
ECOJECT
1-888-236-7378
www.BioForest.ca
BioForest

Questions?

Treated 2008 & 2010; Photo 2011

Board of Health for the
Peterborough County-City Health Unit
Minutes
Wednesday, April 10, 2013
(Council Chambers, County Court House
County of Peterborough, 470 Water Street)

Present:

Board Members: Councillor Andrew Beamer
Councillor Henry Clarke
Mr. Jim Embrey
Mayor John Fallis
Councillor Lesley Parnell
Deputy Mayor Andy Sharpe
Mayor Mary Smith
Chief Phyllis Williams
Mr. David Watton, Chair

Staff: Ms. Leisa Baker, Public Health Nurse
Ms. Brittany Cadence, Supervisor, Communications Services
Ms. Jane Hoffmeyer, Health Promoter
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
Mr. Brent Woodford, Director, Corporate Services

1. Call to Order

Mr. Watton called the meeting to order at 4:45 p.m.

2. Confirmation of the Agenda

Moved by Mayor Fallis — Seconded by Chief Williams

That the agenda be approved as circulated.

- Carried (M-13-48)

3. Declaration of Pecuniary Interest

There were no declarations of pecuniary interest.

4. Delegations and Presentations

4.1 Presentation: A Day in the Life – Child Health
Presenter: Leisa Baker, Public Health Nurse

Mayor Smith expressed concern about the Famliy *Health*Line and that the name may be confused with Family Health Teams. She suggested that the Health Unit should potentially consider renaming the line, or assess how it is being advertised. It was also asked whether the Health Unit could poll the public to see determine awareness of the line. Dr. Pellizzari responded that polling in general is quite expensive and likely not a feasible option at this time.

4.2 Presentation: Let's Start a Conversation About Health
Presenter: Brittany Cadence, Supervisor, Communications Services

Deputy Mayor Sharpe and Councillor Parnell recommended a presentation of this video to City and County Councils , and potentially to First Nations Band Councils if appropriate. Dr. Pellizzari advised she would follow up on this request.

5. Confirmation of the Minutes of the Previous Meeting

Moved by Councillor Parnell — Seconded by Mayor Smith

That the minutes of the Board of Health meeting held on March 13, 2013, be approved.
- Carried (M-13-49)

6. Business Arising From The Minutes

6.1 Briefing Note: Follow-Up to March 2013 Casino Expansion Report

As a follow-up to the March 2013 casino expansion report, a briefing note citing the relevant evidence for harm reduction recommendations was provided. The resolution on gambling expansion and provincial revenue generation which will be submitted by Toronto Public Health for the Association of Local Public Health Agencies (alPHa) Annual General Meeting was not ready for circulation, however, this will be provided to the Board at its May meeting, along with other resolutions to be voted on at the alPHa AGM in June.

7. Correspondence

Moved by Andrew Beamer — Seconded by Councillor Clarke

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

1. Letter dated March 12, 2013 from Minister Matthews regarding one-time funding.
2. Letter received March 13, 2013 from Minister Aglukkaq, in response to Dr. Pellizzari's original letter dated January 11, 2013, regarding the Canadian Prenatal Nutrition Program.
3. Resolutions/Letters from other local public health agencies:
   Hastings & Prince Edward Counties
   - Nicotine Replacement Therapy

   Ottawa
   - Healthy Kids Panel

   Windsor Essex County
   - Oral Health

- Carried - (M-13-50)

8. Program Reports

Nil.

9. New Business

9.0 Mandatory Baby-Friendly Designation for All Ontario Hospitals with Birthing Units

A copy of a proposed resolution for the alPHa June AGM was circulated to Board members at the meeting. The resolution was amended with a correction to the last paragraph.

Moved by Councillor Parnell — Seconded by Councillor Clarke

That the Board of Health for the Peterborough County-City Health Unit approve the resolution "Mandatory Baby-Friendly Designation for All Ontario Hospitals with Birthing Units", as amended, for submission to alPHa for their Annual General Meeting in June 2013.

- Carried - (M-13-51)

9.1 Staff Report: Summary of Media Relations Activities 2010-2012

Brittany Cadence, Supervisor, Communications Services

Ms. Cadence provided an overview of the Health Unit's media relations activities from 2010 to 2012.

9.2 Presentation: Built Environment & Public Health: An Update on PCCHU Activity

Jane Hoffmeyer, Health Promoter

Ms. Hoffmeyer outlined the public health role as it relates to the built environment. She presented information about activities the Health Unit is currently involved with, and identified future local and provincial initiatives.

9.3 Presentation: Chief Medical Officer of Health 2011 Annual Report

Dr. Rosana Pellizzari, Medical Officer of Health

Moved by	Seconded by
Councillor Clarke	Mayor Fallis

That the Board of Health for the Peterborough County-City Health Unit receive the following reports for information:

- Staff Report: Summary of Media Relations Activities 2010-2012
- Presentation: Built Environment & Public Health: An Update on PCCHU Activity
- Presentation: Chief Medical Officer of Health 2011 Annual Report

- Carried - (M-13-52)

9.4 alPHa Winter Symposium Update

David Watton
Chief Phyllis Williams

Mr. Watton and Chief Williams provided an oral update on the alPHa Winter symposium to the Board.

Moved by	Seconded by
Councillor Parnell	Mayor Fallis

That the Board of Health for the Peterborough County-City Health Unit receive the oral report on the alPHa Winter Symposium for information.

- Carried - (M-13-53)

9.5 2013- Budget Approvals

Brent Woodford, Director, Corporate Services

Moved by	Seconded by
Mr. Embrey	Mayor Smith

That the Board of Health for the Peterborough County-City Health Unit approve the following 2013 budgets for the Ministry of Health and Long-Term Care:

- Healthy Smiles Ontario, $427,260
- Chief Nursing Officer, $119,104
- Infection Prevention and Control Nurses, $86,569
- Infectious Diseases Control, $222,233

- Public Health Nurses, $176,945
- Enhanced Safe Water, $15,501
- Enhanced Food Safety (Haines), $25,000
- Healthy Communities Fund (Partnership Stream), $47,100
- Needle Exchange Program, $21,121
- Infection Prevention and Control Week, $8,000
- Sexually Transmitted Infections Week, $7,000
- World Tuberculosis Day, $2,000
- Children in Need of Treatment (CINOT) Expansion, $49,000
- Small Drinking Water Systems, $92,631
- Vector Borne Diseases, $76,105
- Smoke-Free Ontario , $300,800

- Carried - (M-13-54)

Moved by Mr. Embrey | Seconded by Mayor Smith

That the Board of Health for the Peterborough County-City Health Unit send a letter to both City and County Councils, with copies to MPP Jeff Leal and Minister Deb Matthews, to express concern over the potential impact of the loss of discretionary benefits on the Healthy Smiles Ontario program, and that this issue must be resolved through adequate provincial funding.

- Carried - (M-13-55)

9.6 <u>2013 Cost-Shared Public Health Budget – Approval for Increased Occupancy Cost</u>

Brent Woodford, Director, Corporate Services

Moved by Mr. Embrey | Seconded by Mayor Smith

That the Board of Health for the Peterborough County-City Health Unit revise the approval of the 2013 cost-shared budget for public health programs and services from $7,225,542 to $7,502,875 to reflect the true costs of occupancy.

- Carried - (M-13-56)

9.7 <u>2013 One-Time Funding Requests</u>

Brent Woodford, Director, Corporate Services

Moved by Mayor Smith | Seconded by Mr. Embrey

That the Board of Health for the Peterborough County-City Health Unit approve in principle the following supplemental budgets for one-time funding:

- Server Room Emergency Repair, $91,000
- Data Security Project, $55,000

- Server Virtualization Project, $131,500
- Public Health Awareness Campaign, $23,000
- Office Equipment Replacement, $170,390
- Vaccine Refrigerator, $5,000

- Withdrawn -

Due to in camera discussions which could impact a decision on this item, the motion was withdrawn and the item was deferred for consideration until after the in camera session.

9.8 <u>Strategic Plan Update</u>

David Watton

A draft version of strategic directions was provided to the Board in their meeting package. Mr. Watton advised that a draft plan would be sent out to Health Unit staff, Board Members, partners and the general public for further input. This input would be collated and reviewed by the Strategic Planning Working Group at its next meeting, and presented to the Board at its May meeting. The plan will then proceed for final review by the Governance Committee, and presented for final approval by the Board at the June meeting.

Moved by — Seconded by
Councillor Clarke — Mayor Fallis
That the Board of Health for the Peterborough County-City Health Unit receive the strategic plan update for information.

- Carried - (M-13-57)

9.9 <u>Committee Report: Governance</u>

Chief Phyllis Williams, Chair, Governance Committee

Moved by — Seconded by
Mayor Fallis — Mayor Smith
That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Governance Committee for February 1, 2013, approved by the Committee on March 13, 2013

- Carried - (M-13-58)

Moved by — Seconded by
Mr. Embrey — Deputy Mayor Sharpe
That the Board of Health for the Peterborough County-City Health Unit:

- approve the following documents referred by the Committee at the March 13, 2013 meeting:
  - 2-120 – By-Law Number 3, Calling and Proceedings at Meetings (revised)
  - 2-170 – By-Law Number 8, Building Code Act, Sewage Systems (revised)
  - 2-185 – By-Law Number 10, Open and In Camera Meetings (revised)

- 2-300 – Policy, Medical Officer of Health (new)
- 2-342 – Policy, Medical Officer of Health, Selection (new)
- 2-343 – Procedure, Medical Officer of Health, Selection (new)
- 2-345 - Procedure, Medical Officer of Health, Absence (new); and

- approve the following document, included with permission from the Committee Chair and Board Chair:
  - 2-110 – By-Law Number 2, Banking and Finance (revised)

- Carried - (M-13-59)

9.10 Minister of Finance - Update

Mr. Watton received an invitation to attend a pre-budget consultation meeting from the Minister of Finance which took place on Thursday, April 4th in Peterborough. His presentation at that meeting covered a number of topics including:

- support for socio- economically disadvantaged citizens (e.g., Healthy Smiles Ontario, cuts to social assistance benefits, food security, school breakfast programs);
- expansion of gambling in Ontario; and,
- capital funding for public health facilities

Mr. Watton noted that he would circulate his presentation and notes to Board Members after the meeting.

10. By-Laws

Nil.

11. In Camera to discuss Confidential Personal Matters

Moved by Councillor Clarke — Seconded by Councillor Parnell

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

- Carried - (M-13-60)

Moved by Councillor Parnell — Seconded by Councillor Clarke

That the Board of Health rise from In Camera

- Carried - (M-13-61)

Motions for Open Session

Nil.

The Board re-considered item 9.7, 2013 One-Time Funding Requests, which had been deferred earlier in the meeting.

Moved by	Seconded by
Mayor Smith	Councillor Parnell

That the Board of Health for the Peterborough County-City Health Unit approve in principle the following supplemental budgets for one-time funding:

- Server Room Emergency Repair, $91,000
- Data Security Project, $55,000
- Server Virtualization Project, $131,500
- Public Health Awareness Campaign, $23,000
- Office Equipment Replacement, $170,390
- Vaccine Refrigerator, $5,000

- Carried - (M-13-62)

12. <u>Date, Time, and Place of the Next Meetings</u>

4:45 p.m., Wednesday, May 8, 2013; Council Chambers, Administration Building 22 Wiinookeedaa Road, Curve Lake First Nation

13. <u>Adjournment</u>

Moved by	Seconded by
Councillor Parnell	Mr. Embrey

That the meeting be adjourned.

- Carried - (M-13-63)

The meeting adjourned at 8:50 p.m.

_____	_____
Chairperson	Medical Officer of Health

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Special Board of Health Meeting
5:00 p.m., Wednesday, April 24, 2013
(Board Room, 10 Hospital Drive, Peterborough)

Present:

Board Members:	Councillor Henry Clarke Mr. Jim Embrey Mayor John Fallis Councillor Lesley Parnell Deputy Mayor Andy Sharpe Mayor Mary Smith Mr. David Watton, Chair
Regrets:	Councillor Andrew Beamer Chief Phyllis Williams Councillor Trisha Shearer
Staff:	Dr. Rosana Pellizzari, Medical Officer of Health Mrs. Alida Tanna, Administrative Assistant (Recorder) Mr. Brent Woodford, Director, Corporate Services

1. Call to Order

Mr. Watton called the meeting to order at 5:00 p.m.

2. In Camera to Discuss Confidential Property Matters

Moved by	Seconded by
Mayor Smith	Councillor Clarke

That the Board of Health go In Camera to discuss confidential property matters.
- Carried - (M-13-64)

Moved by	Seconded by
Councillor Clarke	Mayor Smith

That the Board of Health rise from In Camera

- Carried - (M-13-65)

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

4:45 p.m. Wednesday, May 8, 2013; Council Chambers, Administration Building
22 Wiinookeedaa Rd., Curve Lake First Nation

4. Adjournment

Moved by	Seconded by
Councillor Parnell	Mr. Embrey

That the meeting be adjourned.

- Carried - (M-13-66)

The meeting adjourned at 6:00 p.m.

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

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **Correspondence**

Date: May 8, 2013

Recommendation:

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

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1. Letter dated April 17, 2013 from the Board Chair to Minsters Piruzza, Matthews and Sandals regarding student nutrition programs. **REF: P. 2 - 3**

2. Letter dated April 17, 2013 from the Board Chair to Premier Wynne and Minister Leal regarding student nutrition programs. **REF: P. 4 - 5**

3. Letter dated April 17, 2013 from the Board Chair to Mr. Paul Godfrey, Ontario Lottery and Gaming Corporation regarding support for problem gambling. **REF: P. 6 - 7**

4. Letter dated April 17, 2013 from the Board Chair to Premier Wynne and Ministers Sousa and Matthews regarding the public health impact of casino expansion. **REF: P. 8 - 9**

5. Resolutions/Letters from other local public health agencies:

   Middlesex London
   - Artificial Tanning **REF: P. 10 - 13**

   Niagara
   - Artificial Tanning **REF: P. 14 - 15**

   North Bay Parry Sound
   - Healthy Kids Panel **REF: P. 16 - 17**

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

April 17, 2013

Hon. Teresa Piruzza, Minister of Children and Youth Services
Hon. Deb Matthews, Minister of Health and Long-Term Care
Hon. Liz Sandals, Minister of Education

Dear Ministers:

At its February 13, 2013 meeting, the Board of Health for the Peterborough County-City Health Unit reviewed the current status of the Student Nutrition Programs in local elementary and secondary schools. Subsequently, the Board of Health endorsed the enclosed report entitled "Student Nutrition Programs: Best Practices, Actions for Sustainability and Call to Action for Food For Kids Peterborough and County.

Student Nutrition Programs (SNP) supported by Food For Kids Peterborough and County are recognized as an initiative with positive results and a direct impact on the health and learning capacity of children and youth, serving over 1.8 million breakfasts and snacks in the 2012-13 school year. With support from over 175 local community partners who donate food, funding, supplies, space and volunteer time, it is a true community collaboration.

The Board of Health also endorsed the vision of Food for Kids Peterborough and County, that all students attend school well-nourished and ready to learn and that the creation of healthy school nutrition environments is supported. We also endorsed the 17 recommended actions.

The Board of Health learned that despite a decade of evidence supporting the need for universal student nutrition programs, funding for local programs does not meet existing need and is tenuous from year to year. Increasing student need, the growth of the program, increasing food costs and decreased funding from foundations traditionally supporting SNPs, mean that Food For Kids Peterborough and County programs are vulnerable.

The financial support in the form of grants from the Ministry of Children and Youth Services, administered for the Central East Student Nutrition Program is highly valued. The Board of Health urges the provincial government to increase the level of support for local SNPs to ensure this is truly a universal program. This is in line with recommendations outlined in the recently released report, "No Time to Wait: The Healthy Kids Strategy".

Your attention to this critically important public health strategy is appreciated.

Yours in health,

Original signed by

David Watton
Chair, Board of Health
Peterborough County-City Health Unit

/at

Encl.

cc: Jeff Leal, MPP Peterborough

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

April 17, 2013

Hon. Kathleen Wynne, Premier and Minister of Agriculture and Food
Hon. Jeff Leal, Minister of Rural Affairs

Dear Ministers:

At its February 13, 2013 meeting, the Board of Health for the Peterborough County-City Health Unit reviewed the current status of the Student Nutrition Programs in local elementary and secondary schools. Subsequently, the Board of Health endorsed the enclosed report entitled "Student Nutrition Programs: Best Practices, Actions for Sustainability and Call to Action for Food For Kids Peterborough and County.

The Board of Health also endorsed the vision of Student Nutrition Programs (SNP), delivered in Peterborough County and City schools by Food For Kids Peterborough and County, that all students who would benefit can achieve the positive health, learning and behavioural outcomes that result from this key nutrition strategy and sound public policy.

Student Nutrition Programs (SNP) including breakfast and snack programs are supported by Food For Kids Peterborough and County with additional support from over 175 local community partners who donate food, funding, supplies, space and/or volunteer time. In the 2012-13 school year, over 1.8 million breakfasts and snacks were served to local students through breakfast programs.

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

One action area included in the Food For Kids Peterborough and County Sustainability Plan is to increase the amount of local food being used in programs and to encourage local food partnerships. The Board of Health expressed interest in a pilot of "Farms to Schools" that would link local producers to schools. This initiative was developed by British Columbia from an initial pilot project in 2006. To date, comprehensive Farm to School programs have spread to over 50 schools across that province ensuring that more than 20,000 students have access to a variety of healthy and local foods in their school lunch programs - much arriving from nearby farms.[i]

Recently, Food For Kids Peterborough and County was a regional partner of the Ontario Farm to School Challenge and as a result of a grant from Sustain Ontario and Ontario Greenbelt Fund, were able to purchase approximately 1,200 pounds of locally grown carrots. Funding to support this type of work is needed. We hope that the recently re-introduced Bill 36: Local

Food Act, 2013 includes funding opportunities for Food For Kids Peterborough and County to build on this important work.

In closing, we look forward to working with you, as well as our active community partners to address the need for increased funding and use of locally grown foods in Student Nutrition Programs. We will be contacting Minister Leal's local constituency office to seek an opportunity to discuss the potential for a Peterborough pilot of Farms to School in more details.

Thank you for your immediate attention to this matter.

Yours in health,

Original signed by

David Watton
Chair, Board of Health
Peterborough County-City Health Unit

/at

Encl.

[i] Public Health Association of BC, A Fresh Crunch in School Lunch: The BC Farm To School Guide – 2nd Edition, 2012. Accessed on April 17, 2013: http://www.phabc.org/files/farmtoschool/home/F2Sguide-2nd-edition-singles.pdf

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

April 17, 2013

Mr. Paul Godfrey, Chair
Ontario Lottery and Gaming Corporation
4120 Yonge Street, Suite 500
Toronto, ON M2P 2B8

Dear Mr. Godfrey:

Re: Providing Greater Support to the Prevention, Treatment and Research of Problem Gambling

At its March 13, 2013 meeting, the Board of Health for the Peterborough County-City Health Unit reviewed the potential health impacts of having a casino in our community. Based on this review, the Board of Health asks that the Ontario Lottery and Gaming Corporation (OLG) direct a greater proportion of provincial revenues from gambling to:

a) prevention, treatment and research; and
b) public awareness initiatives to increase the numbers of individuals seeking assistance.

This is particularly crucial given the province's plan to expand access to gambling.

Currently, just under 1.5% of all gambling revenue is administered to prevention, treatment and research. Research shows that only 1 to 2% of problem gamblers are seeking treatment and that those individuals seeking treatment are not the typical problem gambler (older, more educated vs. younger, less educated). We are concerned that many problem gamblers are falling through the cracks. Since such a small proportion of problem gamblers seek treatment, we believe that a more comprehensive and effective strategy should be funded. Such a strategy would:

- reduce the stigma of gambling addiction;
- raise awareness of problem gambling signs and symptoms;
- prevent more gamblers from developing an addiction; and
- promote treatment services to a wider audience.

We ask that OLG and the Ministry of Finance develop a comprehensive plan and direct adequate revenue to the prevention, treatment, research and public awareness campaigns to reduce the stigma of gambling addiction and increase the number of individuals seeking assistance.

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

Yours in health,

Original signed by

David Watton
Chair, Board of Health
Peterborough County-City Health Unit

/at

cc Mr. Ron Phillips, President and CEO, OLG
Honourable Charles Sousa, Minister of Finance

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

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

April 17, 2013

Hon. Kathleen Wynne, Premier of Ontario
Hon. Charles Sousa, Minister of Finance
Hon. Deb Matthews, Minister of Health and Long-Term Care

Dear Premier Wynne and Ministers:

Re: The Potential Health Impacts of a Casino in Peterborough

At its March 13, 2013 meeting, the Board of Health for the Peterborough County-City Health Unit reviewed the potential health impacts of having a casino in our community. Given the negative consequences to the financial, mental and physical health of problem gamblers, the Board of Health is asking the provincial government to:

a) reconsider its plan to expand gambling throughout the province;

b) direct the Ontario Lottery and Gaming Corporation to implement stronger harm reduction policies and criteria, including the use of tools such as a casino social contract; and,

c) plan to commit a larger percentage of its gaming revenues for public awareness, prevention and treatment of gambling disorders and research.

Problem gamblers suffer financially, mentally and physically as do their families, friends, co-workers and the community. These costs need to be fully considered in any decision to increase access to gambling throughout the province.

With a problem gambling prevalence rate in the County and City of Peterborough already between 2.7% and 6.3%, we are very concerned that greater proximity and access to a casino will lead to even greater harm. Peterborough youth between the ages of 18 and 24 years already have a prevalence rate of problem gambling similar to youth living in Las Vegas. We also know that older adults are more vulnerable to problem gambling and Peterborough has more seniors per capita than any other jurisdiction in Canada. In addition, we are aware that there is a positive correlation between problem gambling and excess alcohol consumption. Since our region already experiences higher than average alcohol consumption rates, increased gambling in our community may exacerbate an already troubling trend.

If the province continues with its plan to support the expansion of gambling opportunities, we propose the province direct the Ontario Lottery and Gaming Corporation to develop, implement and enforce more harm reduction policies and establish criteria to mitigate harms

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known to be associated with gambling. We also encourage the province to consider the introduction of casino social contracts between the provincial government, the Ontario Lottery and Gaming Corporation and casino operators. These contracts could include a number of strategies that support the community and contribute to the prevention or the mitigation of harms related to problem gambling.

Though we are concerned with the health and social impact in Peterborough, gambling addiction and the expanded access to gambling is a province-wide public health issue that must be considered within the broader deliberations of revenue generation. We ask therefore that you ensure that the recommended actions approved by our Board are given full attention.

Yours in health,

Original signed by

David Watton
Chair, Board of Health
Peterborough County-City Health Unit

/at

cc: Eleanor Meslin, Board Chair, Alcohol and Gaming Commission of Ontario
MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

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

April 22, 2013

Right Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Room 281
Queen's Park
Toronto, ON M7A 1A1

RE: Support for Bill 30 – An Act to Regulate the Selling and Marketing of Tanning Services and Ultraviolet Light Treatments

Dear Right Honourable Premier Wynne;

The Middlesex-London Board of Health wishes to commend you on your announcement March 7, 2013 introducing Bill 30, *An Act to Regulate the Selling and Marketing of Tanning Services and Ultraviolet Light Treatments.* This comprehensive legislation will help protect youth from skin cancer by primarily banning access and use of tanning beds by those under the age of 18 years.

In July 2009, the World Health Organization's International Agency for Research on Cancer (IARC) classified ultraviolet radiation (UVR) from tanning beds as a Group 1 Carcinogen - "carcinogenic in humans". Skin cancer accounts for approximately one-third of all cancers diagnosed in Ontario, and this cancer was estimated to result in an economic burden of more than $344 million in 2011. Melanoma skin cancer, the most deadly form of skin cancer, is one of the most common cancers in young Ontarians aged 15-29 years and is largely preventable.

There is significant public support for Ontario legislation with regard to tanning beds. An Ipsos Reid poll commissioned by the Canadian Cancer Society in June 2011 showed that:

- 83% of Ontarians support a ban on indoor tanning by youth under 18 years;
- 77% said youth should be prevented from using tanning beds;
- 73% of Ontarians polled said the tanning industry cannot be trusted to regulate itself and government legislation is needed; and
- 80% of Ontarians support legislation to regulate the tanning industry.

Studies show that using artificial tanning equipment before the age of 35 raises the risk of melanoma by 75%. Since most people receive 80% of their lifetime exposure to ultraviolet radiation by the age of 18, it is crucial that the use of indoor tanning equipment by youth be reduced and eliminated if possible.

..2

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health@mlhu.on.ca

Strathroy Office - Kenwick Mall
51 Front St. E., Strathroy ON N7G 1Y5
tel: (519) 245-3230 • fax: (519) 245-4772

The Middlesex-London Board of Health supports this important legislation, commends you for introducing it, and encourages you to enact Bill 30 without delay. Ontario will then join leaders in Canada like Nova Scotia, British Columbia and Quebec in protecting youth from the harmful effects of ultraviolet radiation, including skin cancer.

Sincerely,

Bryna Warshawsky, MDCM, CCFP, FRCPC
Secretary-Treasurer, Middlesex-London Board of Health

cc:
Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services
The Honourable Deb Matthews, Ontario Minister of Health and Long-Term Care
Ms. Siu Mee Cheng, Executive Director, Ontario Public Health Association
Mr. Gordon Fleming, Manager, Public Health Issues, Association of Local Public Health Agencies
Ms. Teresa J. Armstrong, MPP London-Fanshawe
Mr. Chris Bentley, MPP London West
Mr. Monte McNaughton, MPP Lambton-Kent-Middlesex
Mr. Jeff Yurek, MPP Elgin-Middlesex-London

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 053-13

TO: Chair and Members of the Board of Health

FROM: Bryna Warshawsky, Acting Medical Officer of Health

DATE: 2013 April 18

ARTIFICIAL TANNING LEGISLATION UPDATE: GOVERNMENT BILL 30 INTRODUCED TO BAN YOUTH UNDER 18 FROM ACCESS TO TANNING BEDS

Recommendations

It is recommended:

1. ***That the Board of Health endorse Report No. 053-13 re: "Artificial Tanning Legislation Update: Government Bill 30 Introduced to Ban Youth Under 18 from Access to Tanning Beds"; and further***
2. ***That the Board of Health send a letter, attached as Appendix A, to the Right Honourable Premier Kathleen Wynne; the Honourable Deb Matthews, Minister of Health and Long Term Care; and local Members of Provincial Parliament (MPPs) to commend the Ontario Government for introducing Bill 30, An Act to Regulate the Selling and Marketing of Tanning Services and Ultraviolet Light Treatments; and further***
3. ***That the Board of Health request that the Health Unit demonstrate support for Bill 30 by participating in any public hearings held on Bill 30; and further***
4. ***That the Board of Health forward Report No. 053-13 and copies of the letter in Appendix A to all Boards of Health, the Ontario Public Health Association and the Association of Local Public Health Agencies.***

Key Points

- There have been three Private Member's Bills introduced to the provincial government since 2009 to regulate the tanning industry and to protect youth; none of them have been successful.
- Melanoma skin cancer, the most deadly form of skin cancer, is the second most common cancer in young Ontarians aged 15-34 years, and is largely preventable. The risk of skin cancer, particularly melanoma, increases by 75% when tanning beds are used prior to the age of 35.
- The World Health Organization has classified overexposure to UV radiation from the sun and artificial sources as a significant public health concern. Tanning beds are particularly concerning because of the size of the artificial tanning industry, as indicated by the number of commercial sunbeds and the number of people using them, as well as the significant lack of regulation.
- Eighty-three percent (83%) of Ontarians support a ban on indoor tanning by youth under 18 years.

Background

On March 7, 2013, the Ontario Government introduced Bill 30 (Appendix B) "*An Act to Regulate the Selling and Marketing of Tanning Services and Ultraviolet Light Treatments"*. The Bill prohibits persons who sell artificial tanning services or treatments from providing ultraviolet light treatments to persons under the age of 18. Under this legislation, it would also be illegal to advertise or market artificial tanning or ultraviolet light treatments to persons under the age of 18. Businesses or individuals who sell such services or treatments to adults would be

required to notify their local Medical Officer of Health that they intend to do so, and to post signs in their businesses about the health effects of the services or treatments.

Skin cancer accounts for approximately one-third of cancers diagnosed in Ontario, and it is estimated to result in an economic burden of more than $344 million in 2011. With most people receiving much of their lifetime exposure of ultraviolet radiation (UVR) during childhood and adolescence, it is imperative that they avoid the additional burden of artificial UVR from tanning equipment. UVR from tanning equipment is an established human carcinogen. The World Health Organization, International Agency for Research on Cancer, Ontario Medical Association, Canadian Medical Association, Canadian Pediatric Society, and Canadian Dermatology Association all support legislation that would prohibit the use of artificial tanning equipment by people younger than 18 years of age.

Tanning Bed Use in Ontario

Young women and youth continue to use indoor tanning equipment despite the risks of UVR exposure from this equipment. Canadian Cancer Society (CCS) surveys reported that between 2006 and 2012, the prevalence of tanning equipment use more than doubled, from 7% to 16 % among Ontario students in grades 11 and 12. In 2012, CCS conducted another survey that showed 1% of grade 7 students, 9% of grade 10 students and 21% of grade 12 students reported ever having used a tanning bed. The main reasons students gave for using this tanning equipment were: feeling like they looked better with a tan (females=66%, males=53%); to build a base tan (females=57%, males=44%); to be tanned before going on vacation (females=51%, males=44%); and to be tanned for a special occasion (females=45%, males=27%). As well, 39% of female students and 33% of male students reported that they used tanning equipment because their friends used them. The tanning industry has failed to demonstrate the ability or willingness to self-regulate, despite the existence of Health Canada's Guidelines for Tanning Owners, Operators and Users.

Public Support for Provincial Legislation

There is significant public support for Ontario legislation with regard to tanning beds. An Ipsos Reid poll commissioned by the CCS in June 2011 showed that:

- 83% of Ontarians support a ban on indoor tanning by youth under 18 years;
- 77% said youth should be prevented from using tanning beds;
- 73% of Ontarians polled said the tanning industry cannot be trusted to regulate itself and government legislation is needed; and,
- 80% of Ontarians support legislation to regulate the tanning industry.

Conclusion/Next Steps

Overexposure to ultraviolet radiation (UVR) from the sun and artificial sources is a significant public health concern. With most people receiving much of their lifetime exposure of UVR during childhood and adolescence, it is imperative that children and youth be protected from the additional burden of artificial UVR from tanning equipment. Just as the Ontario government has taken legislative action to protect youth from the promotion of and access to alcohol and tobacco products, it is very important to support Bill 30 (Appendix B) in order to protect children and youth from melanoma skin cancer and other health risks from the use of artificial tanning equipment.

This report was prepared by Ms. Kaylene McKinnon, Public Health Nurse and Ms. Linda Stobo, Manager, Chronic Disease Prevention & Tobacco Control Team.

Bryna Warshawsky, MDCM, CCFP, FRCPC
Acting Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Foundations: Principles-1, 2, 4; Foundational Standard: 3, 8, 9, 10, 11, 12, 13; Chronic Disease Prevention – Ultraviolet Radiation Exposure: 1, 6, 7, 11

OFFICE OF THE REGIONAL CHAIR
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May 1, 2013

The Honourable Deb Matthews
Minister of Health and Long Term Care
Minister's Office
Hepburn Block - 10th Floor
80 Grosvenor St
Toronto ON M7A2C4

Dear Minister:

Re: Call for Provincial Action on Youth Access to Tanning Beds

On behalf of Niagara Region, I would like to commend you and your government on your recent acknowledgement and commitment to action on the issue of youth access to tanning beds. Niagara Region's Board of Health approved report PHD 29-2012, which called for regulatory action to be taken with the tanning bed industry. We echo your concerns for health and thank your government for taking action to regulate the tanning bed industry by prohibiting marketing and selling tanning bed services to youth under 18, via Bill 30, which is before the legislature at this time.

The World Health Organization (WHO) has classified tanning beds as known carcinogens. Skin cancer is the most commonly diagnosed cancer in Canada. According to Cancer Care Ontario, the associated costs were over $344 million dollars in 2011. The evidence is clear that tanning bed use increases the risk for skin cancers including melanoma; this risk is higher with increased use and for those who use tanning beds at a young age.

Although the tanning industry and Health Canada have voluntary guidelines for salon owners, we are concerned that they are not stringent enough and are not being followed. In June 2011, an IPSOS Reid survey commissioned from the Canadian Cancer Society showed that:

- 83% of Ontarians support a ban on indoor tanning by youth under 18
- 73% of Ontarians polled said the tanning industry cannot be trusted to regulate itself and that government legislation is required.

Niagara Region's Board of Health is committed to protecting the heath of its youth from overexposure to ultraviolet radiation (UVR). We recognize that a ban will not reduce outdoor UVR exposure; however it could have tremendous impact by reducing the overall exposure to UVR. We cannot estimate the social norms impact of this legislation, but can anticipate that it will add consistency and reinforce messages around the importance of sun safety.

A recent review of tanning salons in Niagara indicated that there are over 80 tanning salons within our region and 3,500 across the province. These salons are not currently routinely licensed or routinely inspected. Tanning salons are currently part of an unregulated industry that is permitted to provide a service classified as a known carcinogen to youth. To help protect the health of youth, provincial regulation is essential, and we hope that this will happen without delay.

Yours truly,

Gary Burroughs
Regional Chair

C: The Honourable Jim Bradley, Minister of the Environment, MPP St. Catharines
Tim Hudak, Leader of the Official Opposition, MPP Niagara West-Glanbrook
Kim Craitor, MPP Niagara Falls
Cindy Forster, MPP Welland
Dr. Arlene King, Chief Medical Officer of Health
Kate Manson-Smith, ADM, Health Promotion Division
Provincial Boards of Health
Mike Trojan, Chief Administrative Officer, Niagara Region
Dr. Valerie Jaeger, Medical Officer of Health, Niagara Region

GBs047-13

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

North Bay • Parry Sound
1-800-563-2808 • www.healthunit.biz

April 25, 2013

The Honourable Deborah Matthews
Minister – Minister's Office
Ministry of Health and Long-Term Care
Hepburn Block
10th Floor, 80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister:

I am writing, on behalf of the Board of Health for the North Bay Parry Sound District, to endorse the Healthy Kids Panel report: *No Time to Wait: The Healthy Kids Strategy*, and to urge the inter-ministerial working group to develop a comprehensive action plan to implement The Healthy Kids Strategy.

The Board of Health commends you for appointing the Healthy Kids Panel, which has developed a comprehensive strategy to reduce childhood obesity in Ontario by 20 per cent over five years.

Successfully meeting the target will require partnership across all sectors of healthcare, non-profit organizations and industry. Consequently, the Board of Health for North Bay Parry Sound district is committed to advancing these initiatives. As a first step, our Healthy Schools & Families team reviewed the strategy and will be working with community partners on local initiatives to address many of the recommendations within the report.

On behalf of our Board of Health, I commend you for taking critical steps in addressing childhood obesity in our province and look forward to the development of a comprehensive action plan to implement The Healthy Kids Strategy.

Yours sincerely,

Original signed by

Daryl Vaillancourt, Chairperson
Board of Health for North Bay Parry Sound District Health Unit

c: The Honourable Teresa Piruzza, Minister, Ministry of Children and Youth Services
Victor Fedeli, Member Provincial Parliament, Nipissing
Ontario Boards of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies

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April 25, 2013

The Honourable Teresa Piruzza
Minister – Minister's Office
Ministry of Children and Youth Services
14th Floor, 56 Wellesley Street West
Toronto, ON M5S 2S3

Dear Minister:

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Yours sincerely,

Original signed by

Daryl Vaillancourt, Chairperson
Board of Health for North Bay Parry Sound District Health Unit

c: The Honourable Deborah Matthews, Minister, Ministry of Health and Long-Term Care
Victor Fedeli, Member Provincial Parliament, Nipissing
Ontario Boards of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies

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Staff Report

Emerald Ash Borer

Date:	May 8, 2013
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Shawn Telford, Public Health Inspector

Recommendations

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

- receive this report for information; and,
- express its support for the City of Peterborough's Emerald Ash Borer (EAB) program.

Financial Implications and Impact

There are no direct financial implications for the Board of Health arising from this report.

Decision History

The Board of Health has not previously made a decision with regards to this matter.

Background

Emerald ash borer (EAB) is an exotic beetle that was discovered in southeastern Michigan near Detroit in the summer of 2002. Emerald ash borer probably arrived in the United States on solid wood packing material carried in cargo ships or airplanes originating in its native Asia. The Emerald Ash borer is a non-native pest to Ontario, and will attack all species of True Ash, not Mountain Ash trees. The adult beetles nibble on ash foliage. The larvae (the immature stage)

feed on the inner bark of ash trees, disrupting the tree's ability to transport water and nutrients.

Unfortunately, it is extremely difficult for a homeowner to ascertain whether one of their trees is infested with EAB. Without cutting the tree down and skinning off most of the bark, it can be difficult to determine whether a tree is infested. A lot of the symptoms associated with EAB, such as shoots (suckers), cracking bark, D-shaped holes and thinning crowns only become evident after two or more years of infestation. One or more of these symptoms may appear even without the presence of EAB.

All ash trees in Peterborough are at risk of dying from this infestation. Mortality may occur in as short a period as one year, however, death normally occurs within 2-3 years of a tree becoming infested. The emerald ash borer has **killed millions of ash trees** in southwestern Ontario, Michigan and surrounding states. It poses a major economic and environmental threat to urban and forested areas in both countries.

Management of the EAB in Canada and the United States has largely focused on slowing the spread of the emerald ash borer through establishment of quarantined and regulated areas; restrictions on movement of live ash trees and all types of firewood; detection surveys in high-risk areas such as campgrounds, parks, and nurseries; and communication strategies to educate the public about the pest. Control of invasive tree-boring insect pests, particularly when they occur in environmentally sensitive or urban areas, represents a unique challenge because conventional methods of insecticide application via broadcast foliar/ bark sprays or soil injection may be publicly unacceptable or environmentally inappropriate. Current pest management trends advise that the preferred method of treating insect pest problems in the urban landscape is with either soil or trunk injection of systemic insecticides; traditional broadcast spraying methods are no longer acceptable by pesticide regulators, environmental advocates and most importantly, homeowners and the public at large.

In Canada, the most effective pesticide available to control EAB is the trunk-injectable TreeAzin Systemic Insecticide. BioForest Technologies Inc. is the registrant of this insecticide. In Canada, TreeAzin is registered by Health Canada's Pest Management Regulatory Agency (PMRA). Ontario's Ministry of the Environment (MOE) scheduled TreeAzin as a class 4 pesticide or "less and least hazardous commercial or restricted", with a class 11 active ingredient (ingredients contained in pesticide products that are biopesticides or certain lower risk pesticides). Pesticide products are classified on the basis of their toxicity, environmental or health hazard, persistence of the active ingredient or its metabolites, concentration, usage, federal class and registration status. TreeAzin is exempt from Ontario's Cosmetic Pesticide Ban Act.

TreeAzin is injected under a tree's bark, directly into the conductive tissues, and moves upwards with the flow of water and nutrients. It is formulated to inject quickly into the ash tree and move rapidly throughout the tree. TreeAzin kills EAB larvae feeding on the tree's tissues by regulating growth and disrupting normal molting and in addition reduces EAB fertility and egg viability when adult females feed on the tree's foliage. TreeAzin is found throughout the tree at

effective levels through the summer and provides two years of protection against EAB. Because TreeAzin is injected under a tree's bark, directly into the conductive tissues, it does not pose a health risk to applicators, bystanders, or the environment. Tree injections significantly reduce the risk of exposure to applicators and bystanders compared to other methods of treatment such as topical applications using sprayers. TreeAzin can only be applied by professionals.

Since 2008, the number of communities in Ontario using TreeAzin has steadily grown. Our neighbours in Oshawa have treated 3000 trees, Toronto has treated upwards of 12,000 trees, and fourteen other southern Ontario cities have used this treatment. In total, approximately 40,000 trees in total were treated last year with no incidents being reported to either BioForest or the PMRA.

Canadian Forest Centre (CFS) scientists are working to understand the environmental fate and effects of TreeAzin on non-target organisms. To date, studies show that the pesticide has a very low toxicity to mammals and birds, has low to moderate persistence in water, soils and foliage, and does not pose a significant risk to bees or other non-target species.

Rationale

Trees are major capital assets in cities and towns. Just as streets, sidewalks, sewers, public buildings and recreational facilities are a part of a community's infrastructure, so are publicly owned trees. Trees and, collectively, the urban forest are important assets that require care and maintenance the same as other public property.

Trees and other plants make their own food from carbon dioxide (CO_2) in the atmosphere, water, sunlight and a small amount of soil elements. In the process, they release oxygen (0_2) for us to breathe. Trees:

- Help to settle out, trap and hold particulate pollutants (dust, ash, pollen and smoke) that can damage human lungs.
- Absorb CO_2 and other dangerous gases and, in turn, replenish the atmosphere with oxygen.
- Produce enough oxygen on each acre for 18 people every day.
- Absorb enough CO, on each acre, over a year's time, to equal the amount you produce when you drive your car 26,000 miles.

Trees remove gaseous pollutants by absorbing them through the pores in the leaf surface. Particulates are trapped and filtered by leaves, stems and twigs, and washed to the ground by rainfall. Air pollutants injure trees by damaging their foliage and impairing the process of photosynthesis (food making). They also weaken trees making them more susceptible to other health problems such as insects and diseases. The loss of trees in our urban areas not only intensifies the urban "heat-island" effect from loss of shade and evaporation, but we lose a principal absorber of carbon dioxide and trapper of other air pollutants as well.

A recent survey of attitudes of urban residents towards urban forests tells us that the vast majority (84 percent) thinks the presence of trees in their local community is very important. This includes trees on private property and those on public property such as streets and parks. Almost no one thinks trees are unimportant, and most believe strongly that trees play a very important role in urban areas, while having a major impact on their own personal health and well being.

Strategic Direction

The *Identification, Investigation and Management of Health Hazards Protocol* falls under the *Health Hazard Prevention and Management Standard* in the *Ontario Public Health Standards*, 2008. The protocol promotes consistent best practices for addressing health hazards in the environment across the province in order to prevent or reduce the burden of illness from such hazards. Support for the City of Peterborough's EAB program supports the Board of Health strategic directions of *Continuing to Meet our Mandate* as well as *Expanding Existing and Building New Strategic Partnerships.*

Contact:

Shawn Telford, Public Health Inspector
Health Hazards Prevention and Management
(705) 743-1000, ext. 287
stelford@pcchu.ca

References:

1. http://www.ontarionature.org/discover/resources/PDFs/factsheets/urban_forest.pdf

2. McKenzie, N. et al. (2010). Azadirachtin: An Effective Systemic Insecticide for Control of *Agrilus planipennis* (Coleoptera: Buprestidae). *J. Econ. Entom.*103 (3): 708-717.

3. http://www.bioforest.ca/index.cfm?fuseaction=content&menuid=34&pageid=1062#q07

Staff Report

Mandatory Re-Inspection of On-Site Sewage Systems

Date:	May 8, 2013
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Atul Jain, Manager, Inspection Services

Recommendations

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

- receive this report for information; and
- direct staff to bring forward a draft County by-law for approval in Fall 2013, confirming the Health Unit as the principal authority and proposing the Health Unit conduct the mandatory re-inspection of on-site sewage systems from January 1, 2014 to December 31, 2016 (3 years).

Background

Under Part IV of the Clean Water Act, the principal authority is required to conduct inspections of on-site sewage systems located in "vulnerable areas" as outlined in source protection plans.

In our Health Unit area, the Otonabee Region Conservation Authority working with the Lower Trent Conservation Source Protection Committee has identified, mapped and geocoded these vulnerable zones in its source protection plans and has provided the Health Unit with the number and location of sewage systems that require mandatory re-inspection.

There are a total of 116 systems that require re-inspection in Peterborough County and two (2) in the City of Peterborough. (Attachment A)

Financial Implications and Impact

The sewage system inspection program currently offered by the Peterborough County-City Health Unit (PCCHU) is a full cost-recovery program as fees generated by applications, file searches, etc. are put back into the program for payment of its expenses (i.e., staffing, allocated administrative and occupancy costs, materials and supplies, etc.).

Currently, there is no fee associated with re-inspection of on-site sewage systems. The fee will be established based on an estimate of the most effective and efficient means for program delivery.

Decision History

The Building Code (Ontario Regulation 350/06) was recently amended by Ontario Regulation 315/10. This Regulation establishes and governs mandatory sewage system maintenance inspection programs. These programs must be administered in certain areas by principal authorities – defined by the Act as a municipality, a board of health or a conservation authority, depending on the location in Ontario.

These amendments largely came into force on January 1, 2012. The balance of the Regulation, pertaining to certain areas around the Lake Simcoe shoreline and watershed, will come into effect January 1, 2016.

The Board of Health has not previously made a decision with regards to this matter.

Rationale

The rationale for proposing the Health Unit conduct the mandatory re-inspection of on-site sewage systems is that the Health Unit:

- is currently the principal authority;
- has successfully conducted sewage system inspections for the past 25 years;
- houses the historical files and corporate memory on the locations of systems identified for mandatory re-inspection; and
- will ensure cost neutral, professional delivery of service.

Strategic Direction

Although this program is not part of the Ontario Public Health Standards, it is consistent with the goals of population health protection and environmental health and therefore supports us in our efforts to "Continue to Meet Our Mandate".

The delivery of this program also supports our efforts to "Build on our Leadership Role" and "Expand Existing and Build New Strategic Partnerships" in the area of environmental health.

Contact:

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Attachments:

Attachment A – List of properties for mandatory re-inspection on-site sewage systems (as of January 7, 2013)

ActivitySiteArea_Municipality	System	LandownerContact_Municipality	Property_Address	Mailing_Address
Alnwick/Haldimand	Grafton	Alnwick-Haldimand	432-434 Edwardson Rd.	P.O. Box 70, Grafton, ON K0K 2G0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	148 PARK LANE	PO Box 481 Hastings ON K0L 1Y0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	154 PARK LANE	154 Park Lane PO Box 575 Hastings ON K0L 1Y0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	156 PARK LANE	156 Park Lane Hastings ON K0L 1Y0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	160 PARK LANE	PO Box 331 Hastings ON K0L 1Y0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	150 PARK LANE	PO Box 159 Hastings ON K0L 1Y0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	1163 ROGERS LANE	1163 Rogers Lane PO Box 114 Hastings ON K0L 1Y0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	1161 ROGERS LANE	4705 Reid Street Orono ON L0B 1M0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	1159 ROGERS LANE	29 Kennedy Drive Courtice ON L1E 2H2
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	1157 ROGERS LANE	273 East 28th St Hamilton ON L8V 3J2
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	1153 ROGERS LANE	40 Waymount Ave Richmond Hill ON L4S 2G5
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	1149 ROGERS LANE	39 Twelve Oaks Drive Aurora ON L4G 6J5
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	164 PARK LANE	164 Park Lane PO Box 261 Hastings ON K0L 1Y0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	166 PARK LANE	PO Box 613 Hastings ON K0L 1Y0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	1147 ROGERS LANE	24 Lochleven Dr Scarborough ON M1M 3S1
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	1161 MCCARTHY'S PNT RD	PO Box 193 Hastings ON K0L 1Y0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	NA	24 Lochleven Dr Scarborough ON M1M 3S1
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	168 PARK LANE	168 Park Lane Hastings ON K0L 1Y0
Asphodel-Norwood	Hastings	ASPHODEL-NORWOOD TOWNSHIP	174 PARK LANE	174 Park Lane Hastings ON K0L 1Y0
Cavan-Monaghan	Fraserville	Cavan Monaghan	2401 Lansdowne Street W.	2401 Landsdowne Street W. PO Box 1602 Station Main, Peterborough, ON, K9J 7S4
Cavan-Monaghan	Fraserville	Cavan Monaghan	2435 Lansdowne Street W.	2435 Lansdowne Street W. RR#3 Peterborough, Ontario, K9J 6X4
Cavan-Monaghan	Fraserville	Cavan Monaghan	2422 Lansdowne Street W.	2422 Lansdowne Street West. RR #3 Peterborough, Ontario, K9J 6X4
City of Peterborough	Peterborough	City of Peterborough	1297 Dafoe Dr.	1297 Dafoe Drive, Ptbo, ON K9J 6Y1
City of Peterborough	Peterborough	City of Peterborough	1300 Dafoe Dr.	RR 9 Station Main Peterborough, ON, K9J 6Y1
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	632 Alpine Lake Road	632 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	697 Alpine Lake Road	697 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	701 Alpine Lake Road	701 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	657 Alpine Lake Road	657 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	738 Alpine Lake Road	738 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	732 Alpine Lake Road	732 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	730 Alpine Lake Road	730 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	724 Alpine Lake Road	724 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	729 Alpine Lake Road	729 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	707 Alpine Lake Road	707 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	711 Alpine Lake Road	711 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	626 Alpine Lake Road	626 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	1621 Alpine Cres	59 Alpine Cres, RR 3, Bobcaygeon ON, K0M 1AO
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	1625 Alpine Cres	1625 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	656 Alpine Lake Road	656 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	640 Alpine Lake Road	640 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	636 Alpine Lake Road	636 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	4 Pinewood Drive	4 Pinewood Drive, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	725 Alpine Lake Road	725 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	720 Alpine Lake Road	720 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	716 Alpine Lake Road	716 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	1628 Cedar Cres	69 Sir Raymond Drive, Scarborough ON, M1E 1C1
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	618 Alpine Lake Road	618 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	4 Swiss Cres	11608-30 Carabob Court, Toronto ON, M1T 3N2
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	1621 Cedar Cres	444 Lawson Road, Scarborough ON, M1C 2K1
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	1629 Cedar Cres	3356 Juanita Court, Mississaugua ON, L5A 3J6
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	686 Alpine Lake Road	686 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	684 Alpine Lake Road	684 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	1624 Alpine Cres	1624 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	645 Alpine Lake Road	127 Duvernet Ave, Toronto ON, M4E 1V5
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	651 Alpine Lake Road	651 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	653 Alpine Lake Road	653 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	1620 Cedar Cres	PO Box 274, Stn Main, Lindsay ON, K9V 4S1
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	735 Alpine Lake Road	735 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0

Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	737 Alpine Lake Road	737 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	637 Alpine Lake Road	637 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	641 Alpine Lake Road	641 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	643 Alpine Lake Road	643 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	715 Alpine Lake Road	77 Greybeaver Trail, Scarborough On, M1C 4N7
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	3 Pinewood Drive	3 Pinewood Drive, RR 3, Bobcaygeon ON , K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	5 Pinewood Drive	39 Pinewood Cres, Bobaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	719 Alpine Lake Road	719 Alpine Lake Road, RR3, Bobcaygeon ON K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	663 Alpine Lake Road	663 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	654 Alpine Lake Road	578 Walsh Drive, Port Perry ON, L0L 1K9
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	660 Alpine Lake Road	660 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	6 Pinewood Drive	6 Pinewood Drive, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	1624 Cedar Cres	1624 Cedar Cres, RR 3, Bobcaygeon ON K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	8 Swiss Cres	24 Cresswell Drive, Toronto ON, M1G 3L8
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	667 Alpine Lake Road	667 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	681 Alpine Lake Road	681 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	685 Alpine Lake Road	685 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Alpine Village	Galway-Cavendish & Harvey	687 Alpine Lake Road	687 Alpine Lake Road, RR 3, Bobcaygeon ON, K0M 1A0
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	245 Sumcot Drive, Buckhorn Lake Estates	245 Sumcot Drive, RR 1 Stn Delivery Centre, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	235 Sumcot Drive, Buckhorn Lake Estates	235 Sumcot Drive, RR 1 Stn Delivery Centre, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	239 Sumcot Drive, Buckhorn Lake Estates	239 Sumcot Drive, RR 1 Stn Delivery Centre, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	797 Cedar Circle, Buckhorn Lake Estates	144 Evans Ave, Etobicoke ON, M8Z 1H9
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	795 Cedar Circle, Buckhorn Lake Estates	795 Cedar Circle, RR 1, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	793 Cedar Circle, Buckhorn Lake Estates	28 Summerfield Cres, Etobicoke ON, M9C 3X3
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	186 Sumcot Drive, Buckhorn Lake Estates	54 Holden Drive, PO Box 62, Nobleton ON, LOG 1NO
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	240 Sumcot Drive, Buckhorn Lake Estates	240 Sumcot Drive, RR 1 Stn Delivery Centre, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	236 Sumcot Drive, Buckhorn Lake Estates	236 Sumcot Drive, RR 1 Stn Delivery Centre, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	193 Sumcot Drive, Buckhorn Lake Estates	193 Sumcot Drive, RR 1 Stn Delivery Centre, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	210 Sumcot Drive, Buckhorn Lake Estates	210 Sumcot Drive, RR 1 Stn Delivery Centre, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	196 Sumcot Drive, Buckhorn Lake Estates	196 Sumcot Drive, RR 1 Stn Delivery Centre, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	190 Sumcot Drive, Buckhorn Lake Estates	49 Major Willliam Sharpe Drive, Brampton ON, L6X 3H9
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	796 Cedar Circle, Buckhorn Lake Estates	2462 Linwood St, Pickering ON, L1X 2N8
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	794 Cedar Circle, Buckhorn Lake Estates	97 Stuart St, Stouffville ON, L3A 4S4
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	792 Cedar Circle, Buckhorn Lake Estates	792 Cedar Circle, RR 1, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	228 Sumcot Drive, Buckhorn Lake Estates	228 Sumcot Drive, RR 1 Stn Delivery Centre, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	224 Sumcot Drive, Buckhorn Lake Estates	224 Sumcot Drive, RR 1 Stn Delivery Centre, Peterborough ON, K9J 6X2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	218 Sumcot Drive, Buckhorn Lake Estates	8 Vantage Circle, Mississauga ON, L5M 2L2
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	Concession 15, PtL1, Plan M7 Lot 48	1505 Kenilworth Cres, Oakville ON, L6H 3G1
Galway-Cavendish and Harvey	Buckhorn Well Supply	Galway-Candish & Harvey	216 Sumcot Drive, Buckhorn Lake Estates	32 Sherbo Crescent, Brampton ON, L7A 2A1
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	718 Belmont Twp Conc 8	718 Belmont TWP CON 8 RR3 Havelock ON K0L 1Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	692 Bell TWP Con 8	RR # 3 Havelock ON K0L1Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	134 County Rd 46	326-1099B Clonsilla Ave Peterborough On K9J 8L7 Canada
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	717 Bel TWP Con 8	RR 2 Havelock ON K0L 1Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	4 Mary St	8 Mary Steet RR 3 Havelock ON K0L 1Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	8 Mary St	8 Mary Street RR 3 Havelock ON K0L 1Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	9 County Rd 48	PO Box 94 Trent River ON K0L 2Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	116 County Rd 48	PO Box 94 Rent River ON K0L 2Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	26 Mary St	Box 443 Havelock On K0L 1Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	10 County Rd 48	PO Box 94 Trent River ON K0L 2Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	28 MARY ST	28 Mary St., Box 32, Havelock, ON, K0L 1Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	47 Mary St	Box 175 Havelock ON K0L 1Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	45 Mary St	PO Box 898 Havelock ON K0L 1Z0
Havelock-Belmont-Methuen	Havelock	Municipality of Havelock-Belmont-Methuen	49 Mary St	PO Box 353 Havelock ON K0L 1Z0
Otonabee-South Monaghan	Crystal Springs	Township of Otonabee-South Monaghan	1745 Base Line, RR 6 Station Main	1745 Base Line, RR 6 Station Main, Peterborough, ON K9J 6X7
Otonabee-South Monaghan	Crystal Springs	Township of Otonabee-South Monaghan	1744 Base Line, RR 6 Station Main	1745 Base Line, RR 6 Station Main, Peterborough, ON K9J 6X7
Otonabee-South Monaghan	Crystal Springs	Township of Otonabee-South Monaghan	1754 Base Line, RR 6 Station Main	1745 Base Line, RR 6 Station Main, Peterborough, ON K9J 6X7
Otonabee-South Monaghan	Crystal Springs	Township of Otonabee-South Monaghan	1762 Base Line, RR 6 Station Main	1762 Base Line, RR6 Station Main, K9J 6X7
Otonabee-South Monaghan	Keene	Township of Otonabee-South Monaghan	42 Pinecrest Avenue, Keene	1994 Fisher Drive, PO Box 7190 Peterborough, ON K9J 7A1
Smith-Ennismore-Lakefield	Lakefield	Township of Smith-Ennismore-Lakefield	44 Water Street, Lakefield	PO Box 597, Lakefield, ON K0L 2H0

Staff Report

Cuts to Discretionary Benefits: Update to the Board of Health

Date:	May 8, 2013
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Christine Post, Health Promoter

Recommendations

That the Board of Health for the Peterborough County-City Health Unit receive the report, *Cuts to Discretionary Benefits: Update to the Board of Health*, for information.

Financial Implications and Impact

Reduced funding to discretionary benefits for social assistance clients could impact funding for the Peterborough County-City Health Unit (PCCHU) dental program, and particularly the dentures component of the program. It could also dramatically increase demand for funds administered by the Health Unit through the Dental Treatment Assistance Fund (DTAF), and the Healthy Babies, Healthy Children (HBHC) Equipment and Supplies Fund.

Decision History

The Board of Health received a staff report and presentation on "Cuts to Social Assistance Benefits: A Public Health Perspective" on September 12th, 2012. Shortly afterwards, letters were sent to John Milloy, Minister of Community and Social Services, Eric Hoskins, Minister of Children and Youth, Kathleen Wynne, Minister of Municipal Affairs and Housing, and Deb Matthews, Minister of Health and Long-Term Care, with copies to MPPs Jeff Leal and Laurie Scott, Ontario Boards of Health and the Association of Local Public Health Agencies (alPHa), to request enhanced provincial funding of discretionary benefits for people receiving social

assistance, and continued support for housing retention, moving, and home maintenance expenses.

The report was also shared with members of the City of Peterborough Joint Services Steering Committee and member of Peterborough City and County Councils.

Background

The 2012 Ontario Provincial Budget removed approximately $133 million annually from benefits to people on social assistance:

- Discretionary health and non-health related benefits lost about $20 million provincially as a result of a new cap which took effect on July 1, 2012.

- $110 million was lost provincially through the elimination of the Community Start Up and Maintenance Benefit (CSUMB) as of January 1, 2013.

In Peterborough, the City and County covered the shortfall in provincial funding for discretionary benefits at 2012 levels from July, 2012 – April 30, 2013. One-time grant funding of $1.5 million was also made available locally from the province to help with the transition to the new Community Homelessness Prevention Initiative (CHPI) for homelessness prevention programs and services.

On April 29, 2013 the City of Peterborough Council voted on a plan for the use of the one-time grant funding and a plan for the provision of discretionary benefits after May 1st, 2013.

Benefit levels will be reduced from a level of more than $20 per case/month to between $14 and $15 per case per month. There will be significant changes to many of the benefits formerly provided to social assistance recipients. The municipality has spread the impact of the new cuts over several benefits, by reducing individual allocations as well as the total amounts available within a particular category. Unfortunately, there is no room in the budgets of social assistance recipients to absorb the cost of the cuts. Individuals and families may suffer, as they may be forced to make impossible choices between dentures, baby equipment, recreation, transit and the basics of food, clothing and housing.

In terms of the Peterborough County-City Health Unit, cuts are a significant concern from a variety of perspectives. They undermine our efforts to address the social determinants of health for a large number of our most vulnerable community members. They will increase hardship for many direct clients of our public health programs (e.g., HBHC, Nobody's Perfect, oral health services, and food security programs). In the case of our dental programs, they could more broadly affect our program delivery. Cuts can be expected to increase demand for some support funds we administer (e.g., HBHC Equipment and Supplies Fund, DTAF) and could affect the accessibility of some of our programs to clients (through their impact on transit

subsidies). Cuts will also undermine some of our broader public education and policy efforts in injury prevention (through a loss of funding for safety equipment), the built environment (through a reduction in transit subsidies), and access to recreation (through a reduction in recreation subsidies for children). The overall expected impact is a reduction in the physical and mental health of many of the priority populations we are asked to address in the Ontario Public Health Standards.

Rationale

Changes to Emergency Housing Benefits (formerly Community Start-Up and Maintenance Benefit):

The total amount of funding allocated to the Housing Stability Fund for 2013 is now $1.7 million, which is a significant reduction from the $2.8 million needed and expended in 2012.

Furthermore, the recent City staff report on the one-time grant funding (March 28, 2013) points out that after the 2013 grant is expended, for 2014 and 2015, "it is expected that the current CHPI budget will not be sufficient to properly support our community".

These emergency funds provide people with the direct assistance they need to retain their housing and prevent homelessness. It can help families pay for the initial costs of establishing a new home (last month's rent deposit, heat/hydro deposits, moving costs, furniture and other necessities) or it can pay costs to prevent eviction or disconnection of heat or utilities.

Social assistance clients in our community have extremely low incomes, no extra resources to deal with a housing crisis, and few options to turn to. The "Shelter Allowance" for OW and ODSP is dramatically below the true cost of housing. Without emergency housing supports, people will be forced to cut into budgets for food and other essential items, and to live in unsafe and insecure housing, which will in turn make them more susceptible to poor physical and mental health. In the worst case, they may face the prospect of homelessness, at very high personal and community cost.

Changes in Discretionary Benefits:

The discretionary benefits schedule will be amended to reduce the level of benefits effective May 1, 2013. Outlined below are some of the key decisions from a public health perspective:

Basic Dental Services and Dentures ($579,431 for Basic Dental and $183,288 for Dentures in 2012):

The range of basic dental procedures covered under the Ministry of Community and Social Services Dental Schedule of Fees for OW adults will continue to be provided. ODSP clients will continue to be covered as a mandatory benefit under that program.

Support for dentures will be reduced to one third of the funding made available in 2012. Dentures will be supported once in a five year period, up to $750 each for upper or lower dentures, to a maximum of $60,000 per year. The amount eligible for each client has not changed, but the cap for total allowable expenses has decreased by two-thirds for each year.

Dentures can be absolutely essential for health and wellbeing. They relieve pain, help people with speech, affect nutrition, support people in finding and keeping employment and play a huge role in self esteem and social interactions. With the budget for dentures reduced by two-thirds, it can be expected that many people in our community will now go without that vital support.

Vision Care ($160, 591 in 2012) and Hearing Aids ($8,142 in 2012):
The vision benefit will continue to cover a maximum of $250 for vision care in a 24-month period for OW adults. Hearing aids will be covered up to $500 for a hearing aid.

Baby Supplies and Equipment ($70,536 in 2012):
This benefit will be removed from the schedule of discretionary benefits and less than 50% ($30,000) will be made available from an existing Social Services budget line. In 2012, it covered infant car seats (up to $125), booster seats (up to $50), cribs (up to $200), and the purchase or rental of a breast pump, based on over 240 requests.

The baby items covered by this discretionary benefit are absolutely essential. Parents may be forced to use older and unsafe equipment, with an increased risk of injuries to infants and young children.

Recreation and Social Activities Subsidy for Children ($162,699 in 2012):
The social and recreation subsidy will be reduced to $100 per year, to a maximum of $100,000 over-all, whereas last year approximately 800 families received $200 per year for a total of $163,000. This is a significant cut for our community's children.

Participating in recreation programming decreases emotional problems, school drop-out rates, smoking, drug and alcohol abuse, and it reduces long term health costs. These programs can be the only opportunity for children to be active, expressive and to meet other kids from a variety of social groups. Cutting the recreational subsidy by more than 50% will have significant health and social impacts on vulnerable children living in Peterborough City and County.

For those children that do receive the $100 subsidy, a quick survey of programs in the City revealed that registration in the Youth Soccer League is $125, a week of summer day camp at the Wellness Centre is $110 - $150, and even Scouts and Brownies ranges from $135 - $150. The $100 limit doesn't go very far, and in some cases it will prevent children from participating at all unless families access some other subsidy as well.

Unfortunately, there are few alternative sources of funding for recreation. While the City of Peterborough offers a separate recreational subsidy program, used by 382 non-social assistance

children in 2011, the needs of children on social assistance could not be met by these limited funds. There is no recreation subsidy program offered by the County of Peterborough.

Paternity Testing, Birth Verification ($4,080 in 2012):
The paternity testing fund covered the cost of DNA testing to establish paternity in order to pursue child support. It will no longer be funded. It is believed Social Services staff may be able to use OW administration costs to fund this when necessary.

Birth verification covered the cost of obtaining a birth certificate from the Ontario Office of the Registrar General for dependent children of OW or ODSP recipients. This will no longer be funded, and parents will be expected to use their child tax benefit, or be considered under a "Helping Hand Fund". Currently, clients of our programs take advantage of this benefit and apply jointly for a live birth registration and birth certificate as soon as the child is born. A birth certificate is required for a child to enter school. Without the benefit, it is felt that parents likely won't apply for a birth certificate until just before the child enters school, and it may result in delays to their entry. Health Unit staff emphasize that even the relatively low $30 fee is a significant barrier to these families.

Travel and Transportation ($453,957 in 2012):
The transit subsidy will decrease from $34 in 2012 to a level of $30. The amount an individual will have to pay will go up from $21 per month for a $55 pass in 2012, to $30 per month for a $60 pass (the cost has already increased to $26 per month). This will mean an increase of over $100 per year to obtain access to community and social services, grocery stores, food programs and social support networks.

Over the last several years, PCCHU has increasingly recognized the importance of the built environment in supporting a healthy community, including public transportation that is accessible, affordable, efficient and effective in supporting the needs of the community. Access to affordable and accessible public transportation has particular importance to low income people on social assistance, who have very few alternatives for transportation.

Strategic Direction

Supporting continued funding for discretionary benefits and emergency housing benefits will contribute to the strategic direction of continuing to meet our mandate through delivery of a wide variety of programs and initiatives. It also allows us to build on our leadership role at both the municipal and provincial level.

Contact:
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PETERBOROUGH COUNTY-CITY HEALTH UNIT
Q1 2013 PROGRAM REPORT
(January 1 – March 31, 2013)

Definitions
Frequently Used Acronyms

Mandatory Programs

Child Health
Chronic Disease Prevention
Food Safety
Foundational Standard
Health Hazard Prevention and Management
Infectious Diseases Prevention and Control
Prevention of Injury and Substance Misuse
Public Health Emergency Preparedness
Rabies Prevention and Control
Reproductive Health
Safe Water
Sexual Health, Sexually Transmitted Infections and Blood Borne Infections
Tuberculosis Prevention and Control
Vaccine Preventable Diseases

Other

Communications
Genetics
Infant and Toddler Development Program
Sewage Disposal Program

Board of Health Quarterly Reporting Definitions

✓ = **Compliant**	Have met the requirements of this standard for the operating year. No further action required.
↑ = **On Target**	Completion of operational plans will result in full compliance. Some activities may have taken place, but not all have been completed. Applies to requirements that do not have quarterly expectations.
Ø = **Partially Compliant**	Completion of operational plans will result in partial compliance of requirements. Some elements within this requirement have been achieved.
🛈 = **Compliant to Date**	Completion of operational plans will result in full compliance. For requirements that have quarterly expectations, these expectations have been met.
✖ = **Not Compliant**	Not able to meet most elements within this requirement.

Frequently Used Acronyms

BOH	Board of Health
CE-LHIN	Central East Local Health Integration Network
CINOT	Children In Need of Treatment
CFK	Care For Kids
CME	Continuing Medical Education
GIS	Geographic Information Systems
HBHC	Healthy Babies, Healthy Children
HCF	Healthy Communities Fund
HCO	Healthy Communities Ontario
HKPR	Haliburton, Kawartha, Pine Ridge
iPHIS	Integrated Public Health Information System
KPRDSB	Kawartha Pine Ridge District School Board
MCYS	Ministry of Children and Youth Services
MHP	Ministry of Health Promotion
MOE	Ministry of the Environment
MOH	Medical Officer of Health
MOHLTC	Ministry of Health and Long-Term Care
NBP	Nobody's Perfect
NRT	Nicotine Replacement Therapy
OAHPP	Ontario Agency for Health Protection and Promotion
PCCHU	Peterborough County-City Health Unit
PHAC	Public Health Agency of Canada
PHI	Public Health Inspector
PHN	Public Health Nurse
PRHC	Peterborough Regional Health Centre
PVNCCDSB	Peterborough Victoria Northumberland and Clarington Catholic District School Board

Child Health Q1 2013

(Managers: Karen Chomniak for Child Health, Nobody's Perfect; and Healthy Babies Healthy Children; Patti Fitzgerald/Sarah Tanner for Oral Health)

Goal: To enable all children to attain and sustain optimal health and developmental potential.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current), in the areas of: • Positive parenting; • Breastfeeding; • Healthy family dynamics; • Healthy eating, healthy weights, and physical activity; • Growth and development; and • Oral health.	 ✓ ✓ ✓ ✓ ✓ ✓	 ↑ ↑ ↑ ↑ ↑ ↑				Staff participated in a teleconference with other partners in the International Parenting Survey Canada. Learnings and next steps were discussed. Staff reviewed provincial family health status reports, local child and youth reports, and the availability of local child health data. Staff reviewed provincial family poverty reports that were provided through the Social Determinants of Health list-serves and networks. Data collection was completed for a six month telephone breastfeeding survey (200 surveys were completed).
2. The board of health shall conduct surveillance of children in schools and refer individuals who may be at risk of poor oral health outcomes in accordance with the *Oral Health Assessment and Surveillance Protocol, 2008* (or as current), and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				1205 students were screened this quarter in elementary schools throughout Peterborough County and City, and of those, 111 were referred for urgent dental treatment.
3. The board of health shall report oral health data elements in accordance with the *Oral*	✓	↑				Please see Oral Health Report requirement #3.

Status Legend: ✓ = Compliant ↑ = On Target Ø = Partially Compliant 🛈 = Compliant to Date × = Non Compliant

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Health Assessment and Surveillance Protocol, 2008 (or as current).						
Health Promotion and Policy Development						
4. The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and the creation or enhancement of supportive environments to address: • Positive parenting; • Breastfeeding; • Healthy family dynamics; • Healthy eating, healthy weights, and physical activity; • Growth and development; and • Oral health These efforts shall include: a. Conducting a situational assessment in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); and b. Reviewing, adapting, and/or providing behaviour change support resources and programs.	✓ ✓ ✓ ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑				Information on *Mother Matters*, an online support group run by the Mental Health Program at Women's College Hospital was shared with Family Health staff and Perinatal Mood Disorder Collaborative members. Materials to promote the Family HEALTH*line* were distributed to health care providers. Fifty percent of Family Physicians and Nurse Practitioners have received an 18-Month Well-Baby Visit Information session. A Speech and Language promotion campaign was inititated in partnership with the Haliburton Kawartha Pine Ridge District Health Unit and Five Counties Children's Centre. Staff worked with Peterborough Triple P Positive Parenting Program (TP) Steering Committee members towards the development of Terms of Reference and a local TP strategic plan. The Nobody's Perfect (NBP) parent education and support program Appreciation Event was held at the Health Unit to honour sponsors, partners and volunteers. Staff provided a workshop on the 18-Month Well-Baby Visit. Staff communicated with Breastfeeding Committee for Canada regarding the intent to formally begin the Baby-Friendly Initiative re-designation process. Child Health and Nutrition staff developed and delivered internal training for Family Health titled *Supporting Women Using Breastmilk Substitutes.* Staff collaborated with Peterborough Breastfeeding Coalition to update the *Breastfeeding Care Map* (a best-practice tool for health care providers to support breastfeeding in the early days). Staff monitored the Social Assistance Review information and its relevance to public health, and local progress regarding the funding of discretionary benefits.

Status Legend: ✓ **= Compliant** ↑ **= On Target** Ø **= Partially Compliant** 🛈 **= Compliant to Date** × **= Non Compliant**

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
						Staff completed a report of the child poverty focus groups held in 2012 and have initiated a priority setting process. Staff assisted in arranging a focus group with low income mothers through *Young Mom's Working Out* (YMWO).
5. The board of health shall increase public awareness of: • Positive parenting; • Breastfeeding; • Healthy family dynamics; • Healthy eating, healthy weights, and physical activity; • Growth and development; and • Oral health These efforts shall include: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓ ✓ ✓ ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑				Staff participated in the Prenatal Health Fair, providing displays for breastfeeding, skin-to-skin, and the *Circle of Support During and After Pregnancy*. Information regarding Perinatal Mood Disorders was discussed with expectant families.
6. The board of health shall provide, in collaboration with community partners, parenting programs, services, and supports, which include: a. Consultation, assessment, and referral; and b. Group sessions.	✓	↑				Three NBP group series and five NBP one-on-one series were provided in collaboration with community partners. Staff provided 11Triple P Parenting consultations and collaborated with the Ontario Early Years Centre, to provide a Triple P seminar in Lakefield on the Power of Positive Parenting.
7. The board of health shall provide advice and information to link people to community programs and services on the following topics:						Staff completed 112 telephone consultations on the Family HEALTH*line*, on a variety of child health related topics. See also #6, regarding positive parenting.

Status Legend: ✓ **= Compliant** ↑ **= On Target** Ø **= Partially Compliant** 🛈 **= Compliant to Date** × **= Non Compliant**

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
• Positive parenting; • Breastfeeding; • Healthy family dynamics; • Healthy eating, healthy weights, and physical activity; • Growth and development; and • Oral health.	✓ ✓ ✓ ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑				
8. The board of health shall provide, in collaboration with community partners, outreach to priority populations to link them to information, programs, and services.	✓	↑				Staff continued to collaborate with the YMCA to promote and support the YMWO group. Weekly incentives such as food boxes, gently-used runners, and T-shirts promoting smoking cessation were distributed to participants. Staff held an education session for YMWO participants on the topic of Early Childhood Speech, Language (S&L) and Literacy. Staff also arranged a session on the topic of Stress Management. Staff worked with the YWCA Crossroads Shelter and the Youth Emergency Shelter to support the provision of NBP. Staff participated in the Neighbours in Action Committee through the Peterborough Poverty Reduction Network. Staff delivered a presentation to child care service providers through the City of Peterborough's Children's Services and linked child care providers to the Peterborough Poverty Reduction Network. Staff provided support for the development of *Housing as a Social Determinant of Health* report that was submitted for the City of Peterborough's Housing and Homelessness consultations.
Disease Prevention						
9. The board of health shall provide all the components of the Healthy Babies Healthy Children Program in accordance with the *Healthy Babies Healthy Children Protocol, 2008* (or as current) (Ministry of Children and Youth Services).	Ø	Ø				See Reproductive Health report.

Status Legend: ✓ **= Compliant** ↑ **= On Target** Ø **= Partially Compliant** 🛈 **= Compliant to Date** × **= Non Compliant**

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
10. The board of health shall conduct oral screening in accordance with the *Oral Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				
11. The board of health shall facilitate access and support for families to complete screening tools to monitor their child's health and development, and provide a contact for families to discuss results and arrange follow-up.	✓	↑				The Nipissing District Developmental Screen (NDDS) for early identification of developmental delays was disseminated through NBP series and by partner agencies. Physicians and nurse practitioners ordered parent packages and board books to be used during a child's enhanced 18-month well-baby visit.
12. The board of health shall provide the Children in Need of Treatment (CINOT) Program in accordance with the *Children in Need of Treatment* (CINOT) *Program Protocol, 2008* (or as current). For CINOT-eligible children, the board of health shall provide referrals to oral health care providers and monitor the action taken.	✓	🄸				Please see Oral Health Report requirement #12.
13. The board of health shall provide or ensure the provision of the essential clinical preventive oral health services at least annually in accordance with the *Preventive Oral Health Services Protocol, 2008* (or as current).	✓	🄸				Please see Oral Health report requirement #13.
Health Protection						
14. The board of health shall review drinking water quality reports for its municipal drinking water supply(ies) where fluoride is added. These reports shall be reviewed at least monthly and, where necessary, action shall be taken in accordance with the *Protocol for the Monitoring of Community Water Fluoride Levels, 2008* (or as current).	✓	🄸				Please see Oral Health Report requirement #14.

Status Legend: ✓ **= Compliant** ↑ **= On Target** Ø **= Partially Compliant** 🄸 **= Compliant to Date** × **= Non Compliant**

Chronic Disease Prevention Q1 2013

(Manager: Hallie Atter; Donna Churipuy)

Goal: To reduce the burden of preventable chronic diseases of public health importance.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current), in the areas of: • Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; and • Exposure to ultraviolet radiation.	 ✓ ✓ ✓ ✓ ✓ ✓	 ↑ ↑ ↑ ↑ ↑ ↑				**Cancer Prevention** A literature search was initiated to evaluate interventions and strategies used to address the issues of ultra violet radiation exposure and tobacco use amongst outdoor workers. **Nutrition** Updated the Food Program Community Maps for the County of Peterborough with County Geographic Information System (GIS) staff.
2. The board of health shall monitor food affordability in accordance with the *Nutritious Food Basket Protocol, 2008* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				**Nutrition** Responded to inquiries from other Health Units regarding implementation of the Nutritious Food Basket (NFB) protocol. Completed the Ontario Public Health Association (OPHA) NFB survey regarding cost of feeding specific gender/age groups for a provincial research project they are conducting. Participated in NFB Task Group to create a set of province-wide recommendations for the 2013 reports.

Status Legend: ✓ = Compliant ↑ = On Target Ø = Partially Compliant 🛈 = Compliant to Date × = Non Compliant

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Health Promotion and Policy Development						
3. The board of health shall work with school boards and/or staff of elementary, secondary, and post-secondary educational settings, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies, and the creation or enhancement of supportive environments to address the following topics: • Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; and • Exposure to ultraviolet radiation. These efforts shall include: a. Assessing the needs of educational settings; and b. Assisting with the development and/or review of curriculum support.	✓ ✓ ✓ ✓ Ø ✓	↑ ↑ ↑ ↑ Ø ↑				**Tobacco Use Prevention** School-based cessation/connectedness program phase 1 & 2 evaluation report and summaries were completed. Staff continued implementation of program at three schools (Adam Scott, St. Peter's and Lakefield High Schools). Staff met with Peterborough Alternative Continuing Education (PACE) and School for Young Moms (SFYM) staff to facilitate integration of cessation programming. The school-based cessation/connectedness Coordinating Group (representation from Kawartha Pine Ridge District School Board (KPRDSB) and Haliburton Kawartha Pine Ridge Health Unit (HKPRDHU)) met twice. Staff provided a letter in support of Adam Scott's nomination for the Ministry of Education's Premier's Award for Accepting Schools in regards to two initiatives, the School-Based Cessation/Connectedness Pilot Project and the Challenges, Beliefs and Changes Program. Staff met with Health Services Managers of Trent University and Fleming College to enhance cessation services. Staff provided cessation support and resources at a Fleming College Health Fair. A consultation meeting with the Family Health Team (FHT) representative was held to improve access to the Centre for Addiction and Mental Health Centre (CAMH) Nicotine Replacement Therapy (NRT). **Cancer Prevention** Staff made contributions to the School Health Matters newsletter. Staff collaborated with a Trent University Nursing student on the development of workshop on UV radiation risks and sun safe behaviors for elementary students. Staff participated in the Fleming College Health Fair with interactive display on ultra violet radiation.

Status Legend: ✓ **= Compliant** ↑ **= On Target** Ø **= Partially Compliant** 🄸 **= Compliant to Date** × **= Non Compliant**

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
						Youth Engagement Staff delivered iThink training to 120 Student Nurses at Trent University and demonstrated how this PCCHU resource could be used in their placement. **Nutrition** Presented Nutrition Tools for Schools to Ministry of Health and Long-term Care staff. Provided feedback to the Ministry of Education on their Foundations for a Healthy School. Submitted Nutrition Tools for Schools as a topic and provided feedback on PCCHU priorities for Public Health Ontario's Locally Driven Collaborative Projects (LDCP). Presented on comprehensive school health and Nutrition Tools for Schools to second year nursing students at Trent University. Participated in meetings exploring licensing and curriculum writing, on behalf of the Ontario Society of Nutrition Professionals in Public Health (OSNPPH), of *Sip Smart BC,* focused on increasing awareness of sugar-sweetened beverages. Prepared and presented staff report on Student Nutrition Programs at the February Board of Health (BOH) meeting. Assisted with the organization and promotion of the Great Big Crunch nutrition event in schools. Reviewed Food for Kids (FFK) funding, donations, and distribution of funding to school programs **Physical Activity (including the Built Environment and Access to Recreation)** Planned implementation of Spring Swim to Survive program for seven Grade 3 Peterborough Victoria Northumberland Clarington Catholic District School Board (PVNCCDSB) classes. **Alcohol** See Prevention of Injury and Substance Misuse Standard Requirement #2.

Status Legend: ✓ **= Compliant** ↑ **= On Target** Ø **= Partially Compliant** 🛈 **= Compliant to Date** × **= Non Compliant**

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
						Healthy Schools Staff preceptored four Trent University nursing students who completed school curriculum-linked projects. Staff provided support to Rhema Christian School Healthy Schools project through six student and parent initiatives, as well as support for the Queen Mary Public School Healthy Schools Committee. Staff coordinated: • a presentation of public health resources and overview to 120 Community nursing students at Trent University; • public health resource showcase to new/occasional KPRDSB teachers; • resources for School Board kindergarten registration programs; and • a healthy schools presentation to PVNCCDSB Peterborough principals.
4. The board of health shall use a comprehensive health promotion approach to increase the capacity of workplaces to develop and implement healthy policies and programs, and to create or enhance supportive environments to address the following topics: • Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; • Work stress; and • Exposure to ultraviolet radiation. These efforts shall include: a. Conducting a situational assessment in accordance with the *Population Health Assessment and Surveillance Protocol,*	✓ ✓ Ø ✓ ✓ ✓ x	↑ ↑ ↑ ↑ x ↑ x				**Cancer Prevention** Staff collaborated with the City of Peterborough Health and Safety and Disability Management Coordinators and Health Services Managers at Fleming College and Trent University in the enhancement of cancer prevention strategies for workers and students. **Tobacco Use Prevention** Staff promoted National Non Smoking Week and cessation supports available via Health@Work website. **Nutrition** Prepared an article for Health@work on nutrition month theme. **Workplace Health** Updated the *Health at Work* website and promoted this new content in the January and March e-Bulletin. Met with the local representative from Public Services Health and Safety Association to discuss how the four Health and Safety Associations in Ontario can support workplaces in our area.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
2008 (or as current); and b. Reviewing, adapting, and/or providing behaviour change support resources and programs.						**Physical Activity (including the Built Environment and Access to Recreation)** Attended planning meeting for Shifting Gears 2013; booked Mayor Bennett and Board of Health Chair, David Watton, to speak at launch.
5. The board of health shall collaborate with local food premises to provide information and support environmental changes through policy development related to healthy eating and protection from environmental tobacco smoke.	Ø	↑				**Nutrition** Worked with childcare agencies on food preparation skills and Healthy Eating policies.
6. The board of health shall work with municipalities to support healthy public policies and the creation or enhancement of supportive environments in recreational settings and the built environment regarding the following topics: • Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; and • Exposure to ultraviolet radiation.	✓ ✓ ✓ ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑				**Tobacco Use Prevention** Staff provided support for the: • Township of Cavan Monaghan to develop a bylaw respecting smoking in certain public places in the township (By-law No. 2012-100); • amendment of Selwyn Township's bylaw respecting smoking in certain public spaces (By-law No. 2013-016) to include Ennismore Waterfront Park Beach and Playground and a nine meter radius at all entrances and exits of municipally owned and operated buildings; and • development of the City of Peterborough's by-law to prohibit the use of water pipes in enclosed public places and in certain other places in the City of Peterborough (By-law No. 12-169). **Cancer Prevention** Staff are partnering with Fleming College Geographic Information System (GIS) students and the City of Peterborough to enhance the Shade Audit Protocol that was developed in 2012 to include mapping and spatial analysis of tanning salons in Peterborough. **Nutrition** Participated in the Food and Farming Summit. Support the Peterborough Community Garden Network (PCGN) and their work which supports the City of Peterborough's Community Garden Policy. **Physical Activity** Held three planning meetings with Douro-Dummer and Selwyn Townships to discuss

Status Legend: ✓ = Compliant ↑ = On Target Ø = Partially Compliant 🄸 = Compliant to Date × = Non Compliant

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
						Access to Recreation project. Hired a consultant to support the Access to Recreation project with these two Townships. Participated in the City of Peterborough's active bylaw review public meeting. Submitted a letter and presented to County Council regarding their Transportation Master Plan. Submitted letter to Ontario Cycling Strategy review and shared with municipal partners. **Alcohol** See Prevention of Injury and Substance Misuse Standard Requirement #2.
Disease Prevention						
7. The board of health shall increase the capacity of community partners to coordinate and develop regional/local programs and services related to: • Healthy eating, including community-based food activities; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; and • Exposure to ultraviolet radiation. These efforts shall include: a. Mobilizing and promoting access to community resources; b. Providing skill-building opportunities; and c. Sharing best practices and evidence for the prevention of chronic diseases	✓ ✓ ✓ ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑				**Tobacco Use Prevention** Staff partnered with the Peterborough Drug Strategy to host a *PotTalk: Better than Tobacco? Marijuana and Tobacco: Lung Health and Cancer Risk* with guest speaker Dr. Vlasschaert. Approximately 50 people attended. A Locally Driven Collaborative Project (LDCP) idea was submitted for the School-Based Cessation/Connectedness project. Held meetings with the Ontario Tobacco Research Unit staff to modify evaluation tools for group cessation. **Youth Engagement** Staff completed focus groups with three groups of youth and program staff at local agencies to inform the updates needed to complete the Youth Service Providers Information (YSPI), PCCHU's Smartphone directory of Youth Service Providers. **Nutrition:** Prepared a presentation for the Medical Officer of Health (MOH) to give to the Peterborough Medical Society on the *No Time to Wait: Healthy Kids Strategy* report. Submitted a successful application for $4500 to Foodland Ontario to use locally grown

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
						and produced food in our Collective Kitchens. Submitted Healthy Communities funding requests for the Sustainable Peterborough Food and Farming Working Group and the Nourish Food Hub activities. Presented to Family Health Staff on *Supporting Non-breastfeeding Families* Presented food security continuum and food program overview to the St. Vincent de Paul Food Pantry Committee. Partnered with YWCA on packing and delivery of 1,153 Just Food boxes to City and County. Provided and staffed Community Food Security display and resources at Seedy Sunday. Prepared a food security presentation for the Medical Officer of Health's conference in Gravenhurst Ontario. **Physical Activity (including the Built Environment and Access to Recreation)** Collaborated with Nutrition and Injury Prevention to complete a comprehensive scan of daycare policies and best practices via Trent Centre for Community-Based Education (TCCBE) regarding physical activity, healthy eating and injury prevention in childcare centres across Ontario and Canada. Provided funds for Access to Recreation Working Group partners to attend policy-related training. Planned and implemented a healthy eating and physical activity survey with local licensed daycares. Supported community partners to submit a funding application to the Ontario Sport and Recreation Communities Fund regarding the Active Together project. Co-chaired one teleconference with interested Health Units across Ontario to explore joint planning for daycare project.

Status Legend: ✓ **= Compliant** ↑ **= On Target** Ø **= Partially Compliant** 🄸 **= Compliant to Date** × **= Non Compliant**

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
						Alcohol See Prevention of Injury and Substance Misuse Standard Requirement #3.
8. The board of health shall provide opportunities for skill development in the areas of food skills and healthy eating practices for priority populations.	✓	↑				**Nutrition** Supported nine Collective Kitchens in the City and three Collective Kitchens in the County. Presented healthy eating recommendations for mothers attending ECHO Smoking Cessation program. Presented healthy eating recommendations to parents/caregivers via Peterborough Family Resource Centre (PFRC) hubs. Led 30 *Come Cook with Us* classes for 74 parents, seniors and single adults in the City of Peterborough and Apsley. Participated at the Canada Prenatal Nutrition Program (CPNP) Babies First by conducting nutrition assessments, answering nutrition questions, and conducting sessions on healthy eating and feeding your baby.
9. The board of health shall ensure the provision of tobacco use cessation programs and services for priority populations.	✓	↑				**Tobacco Use Prevention** Development of a Medical Directive for dispensing NRT at *STOP* workshops improving access to NRT for area residents was completed. Staff collaborated with CAMH to provide four *STOP on the Road* study workshops to dispense free NRT: three for the general public and one in partnership with the Peterborough Regional Health Centre (PRHC) Schizophrenic Clinic. Approximately 140 people participated. Provided cessation support and resources for individuals at the PRHC Wellness Fair and the Prenatal Health Fair. Provided ongoing provision of group cessation support for women who are pregnant and recently pregnant.
10. The board of health shall collaborate with community partners to promote provincially approved screening programs related to the early detection of cancers.	✓	↑				**Cancer Prevention** Staff attended a meeting with University of Toronto and Cancer Care Ontario to review results of focus groups with under/never screened population. The Executive Summary of focus group results was distributed to key local community stakeholders.

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Requirement	Status 2012	Status 2013				Comments
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						Staff attended a consultation meeting with the Victorian Order of Nurses (VON) 360 Degree Clinic to review focus group results, recommendations and next steps. Staff attended a consultation with Medical Centre staff to determine need and feasibility of hosting an integrated cancer screening day.
11. The board of health shall increase public awareness in the following areas: • Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; • Exposure to ultraviolet radiation; • Benefits of screening for early detection of cancers and other chronic diseases of public health importance; and • Health inequities that contribute to chronic diseases. These efforts shall include: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓ ✓ ✓ ✓ Ø ✓ ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑				**Tobacco Use Prevention** Promoted Smokers' Helpline services and fax referral program at *STOP* workshops. **Youth Engagement** Peer Leaders participated in the joint PCCHU/Peterborough Drug Strategy *Pot Talk* panel discussion. **Nutrition** Nutrition Month Campaign on planning, shopping and cooking with healthy eating in mind. Attended PRHC Health Fair with sodium reduction messaging. Participated in PCCHU Prenatal Health Fair. Planned and implemented Nutrition Month 2013 campaign. **Alcohol** See the Prevention of Injury and Substance Misuse Standard Requirement #4.
12. The board of health shall provide advice and information to link people to community programs and services on the following topics: • Healthy eating; • Healthy weights; • Comprehensive tobacco control; • Physical activity; • Alcohol use; • Screening for chronic diseases and early	✓ ✓ ✓ Ø Ø ✓ ✓	↑ ↑ ↑ ↑ ↑ ↑ ↑				**Tobacco Use Prevention** Responded to public inquires regarding tobacco cessation supports and multi-unit dwelling smoking complaints. Provided tobacco cessation information and resources via social media and print media. **Nutrition** See Requirement# 11 regarding Nutrition Month Campaign.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
detection of cancers; and • Exposure to ultraviolet radiation.						Supported Dietetic Intern at two presentations for children and youth in Peterborough and at Hiawatha First Nation. **Alcohol** See the Prevention of Injury and Substance Misuse Standard Requirement #4. **Physical Activity (including the Built Environment and Access to Recreation)** Presented to the Fitness and Health Promotion students at Fleming College regarding access to recreation. Supported PRHC with roll-out of local Heart Wise program. Provided 400 County of Peterborough trails maps for participants of OFSAA gymnastic competition in Peterborough.
13. The board of health shall implement and enforce the Smoke-Free Ontario Act[8] in accordance with provincial protocols, including but not limited to the *Tobacco Compliance Protocol, 2008* (or as current).	✓	↑				**Tobacco Use Prevention** 46 workplaces and public places were inspected. 17 tobacco vendors were tested for compliance to youth access regulations under the *Smoke Free Ontario Act.* Two vendors were charged. 21 vendors were inspected for compliance with tobacco vendor display and promotion regulations.

Status Legend: ✓ **= Compliant** ↑ **= On Target** Ø **= Partially Compliant** 🛈 **= Compliant to Date** × **= Non Compliant**

Food Safety Q1 2013 (Manager: Atul Jain)

Goal: To prevent or reduce the burden of food-borne illness.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall conduct surveillance of: • Suspected and confirmed food-borne illnesses; and • Food premises in accordance with the *Food Safety Protocol, 2008* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				Surveillance of Emergency Department visits were conducted and analyzed bi-weekly to identify unreported clusters of illnesses which could be food-related. The Health Unit investigated an outbreak of salmonella linked to a restaurant in Peterborough.
2. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				Reports from our existing database were reviewed for statistical data. This requirement needs additional IT and reporting capacity. This will be accomplished this year.
3. The board of health shall report Food Safety Program data elements in accordance with the *Food Safety Protocol, 2008* (or as current).	✓	↑				Accountability Indicator regarding High Risk Food Premises: first reporting period ends April 30, 2013. The Negative Performance Variant Report for High Risk Food Premise inspections for 2012 was completed and posted to the Ministry of Health and Long-Term Care's Directory of Networks (DoN) website.
Health Promotion and Policy Development						
4. The board of health shall ensure food handlers in food premises have access to	✓	↑				20 Food Handler courses were presented in the first quarter with 493 successful attendees certified.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
training in safe food-handling practices and principles in accordance with the *Food Safety Protocol, 2008* (or as current).						Year-to-date 2013: 20 courses, 493 certified. Year-to-date 2012: 11 courses; 225 certified *In Good Hands* on-line course: Year-to-date 2013: 10 certified Year-to-date 2012: 15 certified The County approved the by-law for mandatory Food Handler training at local food premises. The new by-law takes effect for high-risk food premises on January 1, 2014, and for moderate-risk food premises on January 1, 2015. An information package was mailed to all County food premises. The City of Peterborough also approved the by-law for mandatory Food Handler training at local food premises and this will take effect on the same dates as the County. Food Safety Training wallet size certificates have been produced and will be issued to all certified food handlers along with their certificates.
5. The board of health shall increase public awareness of food-borne illnesses and safe food-handling practices and principles in accordance with the *Food Safety Protocol, 2008* (or as current) by: a. Adapting and/or supplementing national and provincial food safety communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓	↑				There were 242 visits to the main Food Safety page on the PCCHU website and three requests for inspection reports. There were three tweets and three Facebook posts related to salmonella. As part of their routine inspections, Public Health Inspectors (PHIs) also distribute report cards for display in restaurants. Two presentations were held: *An Overview of Food Safety* presentation to a group of 30 and a *Farmers' Market* presentation to a group of 40. A new version of *Starting up a Food Premise* printable online pamphlet was posted to our website, as well as a link to Health Canada's *Safe Food Handling Tips*. The Health Unit issued a media release approving the reopening of a restaurant in Peterborough following an outbreak of lab-confirmed cases of Salmonella.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Disease Prevention/Health Protection						
6. The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to: • Suspected and confirmed food-borne illnesses or outbreaks; • Unsafe food-handling practices, food recalls, adulteration, and consumer complaints; and • Food-related issues arising from floods, fires, power outages, or other situations that may affect food safety in accordance with the Health Protection and Promotion Act; the *Food Safety Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); and the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑				13 food complaints were investigated. 51 high-risk premises (hospitals, long-term care facilities, daycares, etc.) were contacted concerning health hazard alerts relating to *Gourmet Meat Shoppe* and *The Butcher's Cut* brands of frozen beef burgers and various lettuce products from *Freshpoint* Toronto. See #5 above.
7. The board of health shall inspect food premises and provide all the components of the Food Safety Program within food premises as defined by the Health Protection and Promotion Act and in accordance with the Food Premises Regulation (O. Reg. 562); the *Food Safety Protocol, 2008* (or as current); and all other applicable Acts.	✓	↑				Accountability Indicator regarding High Risk Food Premises: first reporting period ends April 30, 2013.

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Foundational Standard Q1 2013 (Manager: Larry Stinson)

Goal: Public health practice responds effectively to current and evolving conditions, and contributes to the public's health and well-being.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Population Health Assessment						
1. The board of health shall assess current health status, health behaviours, preventive health practices, health care utilization relevant to public health, and demographic indicators in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				Completed preliminary analysis and data cleaning of PCCHU six month breastfeeding survey as well as analysis of PCCHU breastfeeding surveillance and prenatal mood disorders data (Requirements 2, 3, 6, 7). Provided analyses of gonorrhea and invasive Group A Strep Accountability Agreement indicators (Requirements 2, 5). Examined most current data for *Maternal Experiences – Breastfeeding* from the Canadian Community Health Survey (CCHS). Supported identification of local parenting, child health, oral health, and reproductive health data (Requirements 2-5). Data collection and analysis for a 2013 Reproductive Health report including healthy weights, birth/pregnancy rates, prenatal health, reproductive outcomes, etc. (Requirements 2, 3, 5). Data collection and analysis for a 2013 Oral Health report including oral health behaviours, Early Development visits, PCCHU clinical services, etc. (Requirements 2, 3, 5). Additional ad-hoc analyses and summaries of health status data included: chlamydia, gonorrhea, salmonella and tuberculosis statistics; Sudden Infant Death Syndrome; teenage pregnancies and Sexually Transmitted Infections; PCCHU demographic data; problem gambling; influenza vaccine coverage; International Parenting Survey summary; Chief Medical Officer of Health (CMOH) Annual Report data; and drinking in excess of the Low Risk Drinking Guidelines (LRDG).

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
2. The board of health shall assess trends and changes in local population health in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				With a few exceptions, all epidemiological analyses conducted involve the assessment of trends (see Requirements 1 and 6).
3. The board of health shall use population health, determinants of health and health inequities information to assess the needs of the local population, including the identification of populations at risk, to determine those groups that would benefit most from public health programs and services (i.e., priority populations).	✓	↑				The Foundational Standards team continued to support the development of the Board of Health strategic plan. A focus group with low income marginalized people was held at the Lighthouse Community Centre (13 participants). In collaboration with Fleming Geographic Information System (GIS) students, a Shade Audit has been planned for completion in the second and third quarter (Requirements 4, 5, 8-10).
4. The board of health shall tailor public health programs and services to meet local population health needs, including those of priority populations, to the extent possible based on available resources.	✓	↑				Procedures have been established to ensure that priority populations and health equity are key components of the annual planning process. This will be presented in the second quarter. The Health Promoter for Poverty and Health provided input to *Speak Up, Speak Out* youth leaders on the content and format for their rural youth outreach project. Submitted an application to the *Bell Let's Talk* fund on behalf of the Anti-Stigma Working Group for $15,000 to support local education, the development of a local strategy on anti-stigma, and local consumer survivors in sharing their stories through expressive arts.
5. The board of health shall provide population health information, including determinants of health and health inequities to the public, community partners, and health care providers, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				Made the Poverty Game available for Telecare training (six participants). Finalized the local version of the *Let's Start a Conversation about Health* video on the social determinants of health (SDOH) with Crestwood High School students. Developed a slide presentation on PCCHU's role in addressing the SDOH and our work with the Peterborough Poverty Reduction Network (PPRN). The presentation was delivered by Dr. Pellizzari at the *Central East Community Connections Count!* Regional gathering in Gravenhurst. Participated in an interview for the *Newcomers Bulletin* on English language literacy and access to public health services.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Surveillance						
6. The board of health shall conduct surveillance, including the ongoing collection, collation, analysis, and periodic reporting of population health indicators, as required by the Health Protection and Promotion Act and in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* or as current).	✓	↑				Surveillance activities conducted by the Health Unit included the following activities: • ongoing use of a syndromic surveillance system to monitor visits to local hospital emergency departments, in conjunction with local school boards, monitoring absences due to illnesses; • contacting sentinel physicians for reports on visits due to selected symptoms; • reviewed emergency department admissions for reportable communicable diseases; and • monitored outbreaks of communicable diseases in the community, region, Province and across the country. Statistics Canada, the Public Health Agency of Canada (PHAC), and academic journal newsfeeds were monitored for pertinent surveillance and research information which was then distributed to appropriate staff. Assisted in the salmonella outbreak investigation.
7. The board of health shall interpret and use surveillance data to communicate information on risks to relevant audiences in accordance with the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol, 2008* (or as current); and the *Risk Assessment and Inspection of Facilities Protocol, 2008* (or as current).	✓	↑				Relevant syndromic surveillance data was utilized to monitor the state of influenza and respiratory illness in Peterborough and it assisted in a community outbreak being declared. The following surveillance information was provided to the public and/or community partners: • bi-weekly surveillance data examining emergency department visits, school absenteeism due to illness, and community and facility outbreaks; and • monthly communicable disease reports distributed internally.
Research and Knowledge Exchange						
8. The board of health shall engage in knowledge exchange activities with public health practitioners, policy-makers,	✓	↑				See activities under Foundational Standard Requirement 13. Held consultations with Toronto Public Health and Centre for Addiction and Mental

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community partners, health care providers, and the public regarding factors that determine the health of the population and support effective public health practice gained through population health assessment, surveillance, research, and program evaluation.						Health during the preparation of the Technical Report on the Health Impacts of a Casino in Peterborough. Provided key findings to the Peterborough Social Planning Council so they could create an InfoNote and distribute to other community partners. Met with Family Practice Resident, Heather McLaughlin, to discuss SDOH and poverty and health initiatives at PCCHU. Hosted a teleconference with regional practitioners working on hoarding, squalor and other high-risk issues to share successes, challenges, and identify future opportunities to work together. Delivered a presentation to the Board of Health (BOH) on Mental Health Promotion, PCCHU's activities in this area, and our involvement with the Anti-Stigma Working Group.
9. The board of health shall foster relationships with community researchers, academic partners, and other appropriate organizations to support public health research and knowledge exchange.	✓	↑				Todd Barr from the Trent Centre for Community Based Education attended the March Research and Education Committee meeting to discuss future possibilities for collaboration.
10. The board of health shall engage in public health research activities, which may include those conducted by the board of health alone or in partnership or collaboration with other organizations.	✓	↑				PCCHU is engaged in two Cycle 2 Public Health Ontario (PHO) LDCP's: one related to injury prevention and the other related to substance misuse prevention. PCCHU submitted ten research ideas to PHO's LDCP Cycle 3 process. PCCHU also responded to PHO's Priority Setting process for LDCP Cycle. Assisted with the development of two surveys for external use: daycare policies survey; and a food handler evaluation.
Program Evaluation						
11. The board of health shall routinely monitor program activities and outcomes to assess and improve the implementation and effectiveness of programs and services, including collection, analysis, and periodic reporting of indicators related to inputs, resources, implementation processes, reach, outputs, and outcomes.	✓	↑				Staff provided consultation and support for the following activities: Grade 8 Maturation and Sexuality class feedback for Sexual Health program; Access to Recreation Working Group survey; PCCHU Student Placement Feedback form; Tobacco Youth Cessation Project meetings; Dental Health Clinics First Visit Feedback form; Food Safety Training Evaluation Survey; Condom Sense Campaign Survey; Childcare Provider Survey; and ongoing Fluid surveys support to program staff.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
12. The board of health shall conduct program evaluations when new interventions are developed or implemented, or when there is evidence of unexpected operational issues or program results, to understand the linkages between inputs, activities, outputs, and outcomes.	✓	↑				Working with the Evaluation Group of the Oral Health Team, staff are developing new evaluation tools for the dentures program and end of treatment. Worked with NOURISH partners to help determine appropriate evaluation tools for this initiative.
13. The board of health shall use a range of methods to facilitate public health practitioners' and policy-makers' awareness of the factors that contribute to program effectiveness.	✓	↑				Staff continue to attend and share web-based learning opportunities related to evaluation with PCCHU staff and partners.
FOUNDATIONAL STANDARDS PRINCIPLES: In addition to the Requirements outlined under the Foundational Standard, some activities are guided by the principles of "Impact," "Capacity," and "Partnership and Collaboration." These activities are outlined below:						
Impact: The Board of Health shall strive to influence broader societal changes that reduce health disparities and inequities.	✓	↑				Dr. Pellizzari presented key findings from the Technical Report on the Health Impacts of a Casino in Peterborough to the City's Planning Committee. Dr. Pellizzari's March article in the Peterborough Examiner focused on health impacts of gambling. The BOH approved sending letters to the Premier, Minister of Finance, Minister of Health and Long-Term Care and the Ontario Lottery and Gaming Corporation expressing concerns of the impact of gambling behaviour on health. Staff reviewed the *Healthy Kids Panel* report, and provided a response from a poverty and health perspective. A letter was drafted to the Peterborough Regional Health Centre (PRHC) expressing concern over their practice of charging parents to stay in the *Care by Parent* rooms. The letter was shared with community partners for their endorsement. Participated on an Association of Local Public Health Agencies (alPHa) - Ontario Public Health Association (OPHA) Health Equity Work Group team to draft a response to the provincial government on the recommendations of the Social Assistance Review. Worked with the Income Security Work Group of the PPRN to hold a community consultation on the recommendations of the Commission for the Review of Social Assistance (70 people attended).

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	4th	1st	2nd	3rd	4th	
						Submitted recommendations with supporting background for the City's Housing and Homelessness Plan after consultation with Health Unit staff from various programs. Families with young children were identified as a priority group.
Capacity-Building: The Board of Health shall provide on-going staff development and skill-building related to public health competencies.	✓	↑				Participated in a number of web-based learning opportunities and partnership/network building opportunities including: Five Good Ideas to Engage Donors; FoundationSearch Update Software Training; PHO Cycle 3 LDCPs; Starting a Social Enterprise; Ethical Implications of Diversity in Disaster Research; Planning at a Glance; Facilitators and Barriers to the Application of Health Equity Tools; Introduction to Foundation Fundraising; Introduction to Indicators; and Stories of Using Evaluation for Learning in Chronic Disease Prevention and Health Promotion. Attended a Best Start Train-The-Trainer Workshop on providing support to Healthy Babies, Healthy Children (HBHC) staff caring for clients with mental health issues. Organized three webinars for all staff on policy development.
Partnership and Collaboration: The Board of Health shall foster the creation of a supportive environment for health through community and citizen engagement in the assessment, planning, delivery, management and evaluation of programs and services.	✓	↑				A number of funding requests have been supported including: development of Dental Treatment Assistance Fund (DTAF)/Food for Kids (FFK) presentations to service clubs; Morton Community Health Centre applications for Tobacco and Family Health programs; City Grant proposal for DTAF; Ontario Ministry of Agriculture and Food proposal for Come Cook With Us; and Climate Change Proposal to the Public Health Agency of Canada. Staff continue to work with Executive Committee on policy and procedures related to grant writing and the organizational use of the FoundationSearch software. Staff led the development of a Trillium proposal and Collaborative Agreement for the PPRN to support *Building Community Capacity for Poverty Reduction in Peterborough*. A submission to the Healthy Communities Partnership Fund was developed to support continued activity on local policy initiatives.
ORGANIZATIONAL STANDARDS:						

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In addition to the Requirements outlined under the Foundational Standard, some activities are guided by the requirements found in the Organizational Standards. These activities are outlined below:						
3.1 The board of health shall provide governance direction to the administration and ensure that the board remains informed about the activities of the organization on the following:… research and evaluations, including ethical review.		↑				Through quarterly Board reports.
3.2 The board of health shall have a strategic plan…		↑				Members of the Foundational Standards team are involved with the Strategic Planning Work Group and have contributed to wording for the draft strategic directions.
5.2 The board of health shall ensure that the administration develops and implements a stakeholder engagement strategy which includes:… monitoring and evaluating these partnerships to determine their effectiveness and identify and address gaps.		↑				An update to the Staff and Partnership Inventory is underway and is expected to be completed in April 2013.
5.3 The board of health shall contribute to the development and/or modification of healthy public policy, as described in the Ontario Public Health Standards, 2008 (or as current), by facilitating community involvement and engaging in activities that inform the policy development process.		↑				The BOH sent a letter to MPP Jeff Leal, thanking him for his role in supporting additional one-time housing benefits for people on social assistance, and reminding him that discretionary benefits still face dramatic cuts.
6.1 The board of health shall ensure that the administration establishes an operational plan for the organization which: … Includes objectives, activities, timeframes, responsibilities, intended results, monitoring processes, an organizational chart and internal reporting requirements; Contains planned activities based on an assessment of its communities' needs; Demonstrates efforts to minimize barriers to access; and Describes the monitoring of key performance indicators to support continuous quality improvement and evidence-informed public health		↑				Staff supported the development of a child/youth framework as a member of the internal Steering Group. Debrief sessions about the 2013 planning process were held with all programs across the organization.

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practice…. shall be reviewed and updated at least annually… shall be monitored and reported in status reports on a quarterly basis to board members and staff.						
6.11 The board of health shall ensure that the administration develops an overall communication strategy that is complementary to the program specific communication strategies required in the OPHS and its Protocols, and addresses both external and internal audiences. The communication strategy shall include:…Dissemination plans to disseminate relevant research findings for each approved research project proposal…		↑				Research findings are disseminated throughout the year as required. No research results were reported by the Research and Education Committee this quarter.
6.13 The board of health shall ensure that the administration establishes, maintains and implements policies and procedures related to research ethics that reflect accepted standards of practice.		↑				A small group of Research and Education Committee members worked on redeveloping the policy and procedure related to Research and Education to be consistent with PHO's Ethical Framework.

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Health Hazard Prevention and Management Q1 2013 (Manager: Donna Churipuy)

Goal: To prevent or reduce the burden of illness from health hazards[32] in the physical environment.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
1. The board of health shall conduct surveillance of the environmental health status of the community in accordance with the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol 2008* (or as current); and the *Risk Assessment and Inspection of Facilities Protocol, 2008* (or as current).	✓	↑				The Peterborough County-City Health Unit received the final report analyzing results of air quality monitoring around Kasshabog Lake from the Ministry of the Environment.
2. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				The Peterborough County-City Health Unit requested support from Public Health Ontario to analyze air quality data received from the Ministry of the Environment.
Health Promotion and Policy Development						
3. The board of health shall increase public awareness of health risk factors associated with the following health hazards: • Indoor air quality;	✓	↑				Presentations to staff regarding the Air Quality Health Index were completed.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
• Outdoor air quality; • Extreme weather; • Climate change; • Exposure to radiation; and • Other measures, as emerging health issues arise. These efforts shall include: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.						
4. The board of health shall assist community partners to develop healthy policies related to reducing exposure to health hazards. Topics may include, but are not limited to: • Indoor air quality; • Outdoor air quality; • Extreme weather; and • Built environments.	✓	↑				Staff attended a meeting with Climate Change Working Group of Sustainable Peterborough.
Disease Prevention/ Health Protection						
5. The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to respond to and manage health hazards in accordance with the Health Protection and Promotion Act; the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol, 2008* (or as current); and the *Risk Assessment and*	✓	↑				24/7 on call system was maintained.

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<tr><th rowspan="2">Requirement</th><th>Status 2012</th><th colspan="4">Status 2013</th><th rowspan="2">Comments</th></tr>
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<tr><td>Inspection of Facilities Protocol, 2008 (or as current).</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>6. The board of health shall inspect and assess facilities where there is an elevated risk of illness associated with exposures that are known or suspected to be associated with health hazards in accordance with the Risk Assessment and Inspection of Facilities Protocol, 2008 (or as current).</td><td>Ø</td><td>↑</td><td></td><td></td><td></td><td>Staff inspected and assessed 13 arenas for air quality.

Staff inspected two migrant farm workers facilities.</td></tr>
<tr><td>7. The board of health shall implement control measures to prevent or reduce exposure to health hazards in accordance with the Identification, Investigation and Management of Health Hazards Protocol, 2008 (or as current) and the Risk Assessment and Inspection of Facilities Protocol, 2008 (or as current).</td><td>✓</td><td>↑</td><td></td><td></td><td></td><td>
<table>
<tr><th>Activity</th><th>Jan 2013</th><th>Feb 2013</th><th>March 2013</th><th>Total Q1 2013</th><th>2013 Year-to-Date</th></tr>
<tr><td>Air Quality – Arenas</td><td>-</td><td>7</td><td>6</td><td>13</td><td>13</td></tr>
<tr><td>Air Quality – Institutional</td><td>--</td><td>--</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Air Quality – Residential</td><td>1</td><td>3</td><td>2</td><td>6</td><td>6</td></tr>
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<tr><td>Asbestos Inquiry/Complaint</td><td>--</td><td>--</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Bedbug Identification</td><td>--</td><td>---</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Bedbug Investigation</td><td>1</td><td>2</td><td>3</td><td>6</td><td>6</td></tr>
<tr><td>Bird Complaints (geese, pigeons, etc.)</td><td>--</td><td>--</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Chemical Inquiry/Complaint</td><td>--</td><td>--</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Garbage Complaints</td><td>1</td><td>--</td><td>--</td><td>1</td><td>1</td></tr>
<tr><td>Heating Complaints</td><td>4</td><td>2</td><td></td><td>6</td><td>6</td></tr>
<tr><td>House Disrepair/Sanitation Complaints</td><td>--</td><td>1</td><td>2</td><td>3</td><td>3</td></tr>
<tr><td>Insect Complaints</td><td>--</td><td>--</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Lead Inquiry/Complaint</td><td>--</td><td>--</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Migrant Farm Worker</td><td>--</td><td>1</td><td>1</td><td>2</td><td>2</td></tr>
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Status Legend: **✓ = Compliant ↑ = On Target Ø = Partially Compliant 🛈 = Compliant to Date × = Non Compliant**

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<tr><th rowspan="2">Requirement</th><th>Status 2012</th><th colspan="4">Status 2013</th><th rowspan="2">Comments</th></tr>
<tr><th>4th</th><th>1st</th><th>2nd</th><th>3rd</th><th>4th</th></tr>
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<tr><td>Facility Inspection</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Mould Investigation</td><td>4</td><td>3</td><td>2</td><td>9</td><td>9</td></tr>
<tr><td>Noise</td><td>--</td><td>--</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Playground Inspections</td><td>--</td><td>--</td><td>--</td><td>--</td><td>--</td></tr>
<tr><td>Rodent Complaints</td><td>1</td><td>1</td><td>--</td><td>2</td><td>2</td></tr>
<tr><td>Sewage Complaints</td><td>--</td><td>1</td><td>--</td><td>1</td><td>1</td></tr>
<tr><td>Sharps</td><td>--</td><td>--</td><td>--</td><td>--</td><td>--</td></tr>
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<tr><td>8. The board of health shall develop a local vector-borne management strategy based on surveillance data and emerging trends in accordance with the Infectious Diseases Protocol, 2008 (or as current).</td><td>✓</td><td>↑</td><td></td><td></td><td></td><td>The annual report for the 2012 Vector-borne disease strategy was written.</td></tr>
<tr><td>9. The board of health shall maintain systems to support timely and comprehensive communication with all relevant health care and other community partners about identified health hazard risks.</td><td>✓</td><td>↑</td><td></td><td></td><td></td><td>Notification systems were updated to ensure timely communication with health care and community partners.</td></tr>
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Infectious Diseases Prevention and Control Q1 2013 (Manager: Edwina Dusome)

Goal: To prevent or reduce the burden of infectious diseases of public health importance.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall report infectious disease data elements in accordance with the Health Protection and Promotion Act and the *Infectious Diseases Protocol, 2008* (or as current).	✓	↑				Staff entered reportable disease data into the Integrated Public Health Information System (iPHIS) as per the protocol.
2. The board of health shall conduct surveillance of: • Infectious diseases of public health importance, their associated risk factors, and emerging trends; and • Infection prevention and control practices of inspected premises associated with risk of infectious diseases of public health importance in accordance with the *Infectious Diseases Protocol, 2008* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				Infection prevention and control practices were reviewed for selected premises by Public Health Inspectors (PHIs), i.e. hair salons, tattoo and body piercing parlours, group homes, etc. during inspections. Monthly surveillance reports were prepared by the Epidemiologist.
3. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				Epidemiological analysis of surveillance data was prepared and distributed to health care practitioners by the Epidemiologist.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Health Promotion and Policy Development						
4. The board of health shall work with community partners to improve public knowledge of infectious diseases of public health importance and infection prevention and control practices in the following areas: • Epidemiology of infectious diseases of public health importance that are locally relevant; • Respiratory etiquette; • Hand hygiene; • Vaccinations and medications to prevent or treat infectious diseases of public health importance; • Infection prevention and control core competencies, incorporating both Routine Practices (including personal protective equipment) and Additional Precautions (transmission-based precautions); and • Other measures, as new interventions and/or diseases arise. These efforts shall include: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓	↑				Staff consulted, upon request, with community partners (long-term care facilities, schools, hospital, day nurseries, pharmacies, and primary care practices) on infectious disease, vaccine related or infection control related issues. Staff organized an information session on tuberculosis for the physicians in March 2013.
5. The board of health shall participate on committees, advisory, bodies, or networks that address infection prevention and control practices of, but not limited to, hospitals and LTCHs, which shall include	✓	↑				Staff attended infection control meetings in long-term care homes and at the Peterborough Regional Health Centre (PRHC). They assisted organizations with the preparation of response plans for infectious diseases and offered information to local School Boards.

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Requirement	Status 2012	Status 2013				Comments
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consultation on the development and/or revision of: • Infection prevention and control policies and procedures; • Surveillance systems for infectious diseases of public health importance; and • Response plans to cases/outbreaks of infectious diseases of public health importance.						
6. The board of health shall work with appropriate partners to increase awareness among relevant community partners, including correctional facilities, health care and other service providers of: • The local epidemiology of infectious diseases of public health importance; • Infection prevention and control practices; and • Reporting requirements for reportable diseases, as specified in the Health Protection and Promotion Act.	✓	↑				Staff provided information to local partners on communicable diseases and the requirement to report diseases. They provided information on infectious disease and infection and prevention and control via the *For Your Information* newsletter. Staff worked with partners (long-term care, day nurseries, hospital, schools, etc.) to monitor and reduce the incidence of communicable diseases through regular inspections.
Disease Prevention						
7. The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to infectious diseases of public health importance in accordance with the Health Protection and Promotion Act; the Mandatory Blood Testing Act; the *Exposure of Emergency Service Workers to Infectious Diseases Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); the *Institutional/Facility*	✓	↑				The PCCHU has a 24/7 response plan in place.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Outbreak Prevention and Control Protocol, 2008 (or as current); and the *Public Health Emergency Preparedness Protocol, 2008* (or as current).						
8. The board of health shall provide public health management of cases and outbreaks to minimize the public health risk in accordance with the *Infectious Diseases Protocol, 2008* (or as current); the *Institutional/Facility Outbreak Prevention and Control Protocol, 2008* (or as current); and provincial and national protocols on best practices.	✓	↑				Staff provided management of outbreaks. The total number of outbreaks investigated this year to date is: 15.
9. The board of health shall ensure that the medical officer of health or designate receives reports of complaints regarding infection prevention and control practices and responds and/or refers to appropriate regulatory bodies in accordance with applicable provincial legislation and in accordance with the *Infection Prevention and Control Practices Complaint Protocol, 2008* (or as current).	✓	↑				Staff were available to receive and respond to infection prevention and control complaints regarding infection prevention and control practices to appropriate regulatory bodies. The total number of complaints received this year to date is: 1.
10. The board of health shall ensure that the medical officer of health or designate receives reports of and responds to complaints regarding infection prevention and control practices in settings for which no regulatory bodies exist, particularly personal services settings. This shall be done in accordance with the *Infection Prevention and Control in Personal Services Settings Protocol, 2008* (or as current) and the *Infection Prevention and Control Practices Complaint Protocol, 2008* (or as current).	✓	↑				Staff were available to receive and respond to infection prevention and control complaints in settings where no regulatory bodies exist. The total number of complaints received this year to date is: 0.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
11. The board of health shall respond to local, provincial/territorial, federal and international changes in disease epidemiology by adapting programs and services.	✓	↑				Staff adapted programs as directed by the Ministry of Health and Long Term Care (MOHLTC), such as providing more detailed follow-up for selected diseases such as influenza, salmonella, etc.
12. The board of health shall supplement provincial efforts in managing risk communications to the appropriate stakeholders on identified risks associated with infectious diseases of public health importance based on local epidemiology and epidemiological information.	✓	↑				Staff provided telephone consultation, presentations, and media releases to supplement provincial risk communication efforts. The *For Your Information* newsletter was distributed to health care providers. The *Important Health Notice* regarding a novel influenza was distributed to local health care providers.
13. The board of health shall communicate in a timely and comprehensive manner with all relevant health care providers and other partners about urgent and emerging infectious disease issues.	✓	↑				Staff disseminated information to health care providers through alerts, surveillance reports and the *For Your Information* Newsletter (salmonella, influenza, measles, etc.)
Health Protection						
14. The board of health shall inspect settings associated with risk of infectious diseases of public health importance in accordance with the *Infection Prevention and Control in Licensed Day Nurseries Protocol, 2008* (or as current); the *Infection Prevention and Control in Personal Services Settings Protocol, 2008* (or as current); and the *Risk Assessment and Inspection of Facilities Protocol, 2008* (or as current).	✓	↑				Staff inspected day nurseries and personal service settings as directed in the protocol. The number of personal service settings inspected this year to date: 42. The number of group homes, lodging houses, retirement homes and nursing homes and day cares inspected, for infection control purposes: 25

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Prevention of Injury and Substance Misuse Q1 2013

(Managers: Hallie Atter - Substance Misuse Prevention; Injury Prevention)

Goal: To reduce the frequency, severity, and impact of preventable injury and of substance misuse.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current), in the areas of: • alcohol and other substances; • falls across the lifespan; • road and off-road safety; and • other areas of public health importance for the prevention of injuries.	✓ ✓ Ø Ø	✓ ✓ Ø Ø				**Injury Prevention** Reviewed documents on helmet use and mandatory helmet legislation to inform official Health Unit comment on the Provincial Draft Cycling Strategy. **Substance Misuse Prevention** Obtained overdose data from the Emergency Management System (EMS). Compiled evaluations of *PotTalks* initiatives for funder and internal use.
Health Promotion and Policy Development						
2. The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs, and the creation or enhancement of safe and supportive environments that address the following: • Alcohol and other substances; • Falls across the lifespan; • Road and off-road safety; and may include	✓ ✓ Ø	✓ ✓ Ø				**Injury Prevention** Working with a variety of partners and stakeholders to influence both local and provincial policy: • *A Million Messages* (AMM) Steering Committee, AMM Locally Driven Collaborative Project (LDCP) and Evidence Based Messaging Working Group; • The Ontario Injury Prevention Practitioners Network (OIPPN); • The OIPPN – Motor Vehicle Crashes Subcommittee; and • Eastern Ontario Car Seat Coalition. Continued to collaborate with the Nutrition and Physical Activity programs on the Trent Centre for Community Based Education research project on daycare policies.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
• Other areas of public health importance for the prevention of injuries as identified by local surveillance in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	Ø	Ø				**Substance Misuse** Disseminated *Drug Early Warning System* to increase community capacity to monitor and respond to tainted drugs or illness outbreaks in the drug using population. Supported the Townships of Selwyn, Otonabee-South-Monaghan and Asphodel-Norwood in developing/updating their Municipal Alcohol Policies (MAPs). The workplan for 2014 has been revised to complete these three MAPs and direct efforts to increasing municipal staff readiness to invest in revised MAPs and to support strong alcohol harm prevention measures. Participated in LDCP to increase adherence to the Low Risk Drinking Guidelines (LRDG). Advised local police to advocate for increased control of narcotics diversion occurring in the pharmaceutical supply chain. Advocated for Naloxone, a drug to intervene in opioids overdoses, to be covered through the Ontario Drug Benefit Plan and organized/promoted overdose prevention/Naloxone training for physicians.
3. The board of health shall use a comprehensive health promotion approach to increase the capacity of priority populations to prevent injury and substance misuse by: a. Collaborating with and engaging community partners; b. Mobilizing and promoting access to community resources; c. Providing skill-building opportunities; and d. Sharing best practices and evidence for the prevention of injury and substance misuse.	 ✓ ✓ ✓ ✓	 ✓ ✓ Ø Ø				**Injury Prevention** Increased Partners In Aging Well (PIAW) membership/support by five new organizations, broadening the reach to priority populations, including future resource/education dissemination. Met with community partners to work on a comprehensive, population-based car seat safety strategy. This quarter, activities also included support to partners to organize a Car Seat Clinic. Participated in the work being conducted on a Public Health Ontario (PHO) funded LDCP that is examining the perceived facilitators and barriers in the development of a messaging strategy directed at parents/caregivers to prevent childhood injuries. Reviewed and provided evidenced-based referencing for nursing students regarding concussion prevention work.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
						Substance Misuse Prevention As the Chair of the Peterborough Drug Awareness Coalition, received notification that the Coalition attained $143,900 (Trillium funding) to support ongoing youth engagement around substances, particularly tobacco and marijuana. Developed community and internal capacity to deliver overdose prevention training. Organized local filming for a provincial video resource to increase understanding of overdose prevention amongst first responders. Supported the training of youth to tell their stories of overcoming problematic use of substances.
4. The board of health shall increase public awareness of the prevention of injury and substance misuse in the following areas: • Alcohol and other substances; • Falls across the lifespan; • Road and off-road safety; and may include • Other areas of public health importance for the prevention of injuries, as identified by local surveillance in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current). These efforts shall include: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	↑ ↑ Ø Ø	↑ Ø Ø Ø				**Substance Misuse Prevention** Organized community partners to attend the Prenatal Health Fair to discuss car seat safety and substance misuse. **Injury Prevention** Attended the Wellness Fair at the Peterborough Regional Health Centre (PRHC). **Substance Misuse Prevention** Supported peer to peer messaging in the schools (Challenges, Beliefs and Changes Program). Hosted a *PotTalk* session on the lung impacts of marijuana and tobacco. Promoted education tools regarding the LRDG and opioids safety in the *For Your Information* (for physicians) and workplace health newsletter.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Health Protection						
5. The board of health shall use a comprehensive health promotion approach in collaboration with community partners, including enforcement agencies, to increase public awareness of and adoption of behaviours that are in accordance with current legislation related to the prevention of injury and substance misuse in the following areas: • Alcohol and other substances; • Falls across the lifespan; • Road and off-road safety; and may include • Other areas of public health importance for the prevention of injuries as identified by local surveillance in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	 Ø Ø Ø Ø	 Ø Ø Ø Ø				**Injury Prevention** See Requirement #4 regarding the PRHC Wellness Fair. PHO has been asked to conduct a literature review on helmet use in adults.

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Public Health Emergency Preparedness Q1 2013 (Manager: Donna Churipuy)

Goal: To enable and ensure a consistent and effective response to public health emergencies and emergencies with public health impacts.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall identify and assess the relevant hazards and risks to the public's health in accordance with the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); and the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑				This is a fouth quarter activity.
Health Protection/Emergency Planning						
2. The board of health shall develop a continuity of operations plan to sustain the ongoing functioning of time-critical board of health services during business disruptions in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑				Business recovery strategies were reviewed with Management Committee.
3. The board of health shall develop its emergency response plan, in consultation with community partners and governmental bodies, to address the identified hazards for which the board of health and medical officer of health will	✓	↑				This is a second quarter activity.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
have a lead role in responding to, consistent with an Incident Management System and in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).						
Risk Communications and Public Awareness						
4. The board of health shall develop, implement, and document 24/7 notification protocols for communications with board of health staff, community partners, and governmental bodies to facilitate the sharing of information in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑				The contact list for 24/7 notification was updated. The 24/7 notification was reviewed with the Manager of Inspection Services. The 24/7 on call system was maintained.
5. The board of health shall, in collaboration with community partners, increase public awareness regarding emergency preparedness activities.	✓	↑				In January, a frostbite alert was issued providing the public with information on how to protect themselves from the health hazards associated with exposure to extreme cold.
Education, Training, and Exercises						
6. The board of health shall ensure the provision of emergency preparedness and response education and training for board of health staff in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑				This is a second quarter activity.
7. The board of health shall ensure that its officials are oriented on the board of health's emergency response plan in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑				This is a fourth quarter activity.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
8. The board of health shall exercise, in whole or in part, the continuity of operations plan, emergency response plan, and 24/7 notification procedures in accordance with the *Public Health Emergency Preparedness Protocol, 2008* (or as current).	✓	↑				This is a third quarter activity.

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Rabies Prevention and Control Q1 2013 (Manager: Atul Jain)

Goal: To prevent the occurrence of rabies in humans.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall liaise with the Canadian Food Inspection Agency to identify local cases of rabies in animal species.	✓	↑				No rabid animals were reported in the PCCHU's geographic area.
2. The board of health shall report rabies data elements in accordance with the Health Protection and Promotion Act and the *Rabies Prevention and Control Protocol, 2008* (or as current).	✓	↑				Information on five incidents where post-exposure prophylaxis was provided was entered into the Ministry of Health and Long Term Care (MOHLTC) database.
3. The board of health shall conduct surveillance of rabies in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current) and the *Rabies Prevention and Control Protocol, 2008* (or as current).	✓	↑				There have been no rabid animals reported for this Health Unit. The Ministry of Natural Resources (MNR) has not released their first quarter report.
4. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				There have been no cases of human rabies in the PCCHU's geographic area.
Health Promotion and Policy Development						
5. The board of health shall work with community partners to improve public knowledge of rabies and its prevention in the community by supplementing	✓	↑				Low cost rabies clinics have been held in Cavan-Millbrook and Otonabee-South-Monaghan. Clinics for other municipalities throughout the Health Unit are planned for April and May.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
national/provincial education/communications strategies and/or developing and implementing regional/local communications strategies[24] based on local epidemiology.						Developed and working with the Peterborough Regional Health Centre (PRHC) on a new rabies reporting form in order to change the On-Call system for receiving notification.
Disease Prevention/ Health Protection						
6. The board of health shall annually remind those individuals specified in the Health Protection and Promotion Act of their duty to report suspected rabies exposure.	✓	↑				This is a third quarter activity.
7. The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to suspected rabies exposures in accordance with the Health Protection and Promotion Act; the *Public Health Emergency Preparedness Protocol, 2008* (or as current); and the *Rabies Prevention and Control Protocol, 2008* (or as current).	✓	↑				33 incidents of possible transmission of the rabies virus were investigated. Five series of anti-rabies vaccine and globulin were distributed in the first quarter.
8. The board of health shall address the prevention and control of rabies threats as per a local Rabies Contingency Plan, as outlined in the *Rabies Prevention and Control Protocol, 2008* (or as current).	✓	↑				The Ministry of Health and Long Term Care (MOHLTC) has not requested development of a Rabies Contingency Plan.

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Reproductive Health and Healthy Babies Healthy Children; Q1 2013 (Manager: Karen Chomniak)

To enable individuals and families to achieve optimal preconception health, experience a healthy pregnancy, have the healthiest newborn(s) possible, and be prepared for parenthood.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current) in the areas of: • Preconception health; • Healthy pregnancies; • Reproductive health outcomes; and • Preparation for parenting.	✓	↑				Staff participated in the Social Determinants of Health Nurses teleconference to be aware of emerging trends and information. Staff provided feedback to the Ministry of Health regarding unmet needs in the Reproductive Health Guidance Document.
Health Promotion and Policy Development						
2. The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and the creation or enhancement of supportive environments to address: • Preconception health; • Healthy pregnancies; and • Preparation for parenting. These efforts shall include: a. Conducting a situational assessment in accordance with the *Population Health Assessment and Surveillance Protocol,*	✓	↑				The *Skin to Skin* campaign pamphlets and posters were distributed to community partners and healthcare agencies in the County and City to support healthy pregnancies and preparation for parenting. They have also been incorporated into the Health Unit's prenatal classes. The Prenatal Breastfeeding Class (adult series) was revised to meet new Baby Friendly Initiative (BFI) Outcome Indicators and recertification requirements. As a result of advocacy efforts the Ontario Public Health Association Supporting Normal Birth Task Group was successful in convincing the Provincial Council for Maternal and Child Health (PCMCH) and the Maternal-Newborn Advisory Committee (MNAC) to strike a workgroup for 2013-2014. Provincially, there is a need to develop and implement best practices that support physiological birth and reduce unnecessary medical interventions so that health outcomes for women and their babies can be

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2008 (or as current); and b. Reviewing, adapting, and/or providing behaviour change support resources and programs.						improved. Four teleconferences with provincial partners were attended.
3. The board of health shall increase public awareness of preconception health, healthy pregnancies, and preparation for parenting by: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓	↑				323 Your First Prenatal Visit packages were distributed to local physicians, nurse practitioners, and midwives to educate women and their support person about healthy pregnancy.
4. The board of health shall provide, in collaboration with community partners, prenatal programs, services, and supports, which include: a. Consultation, assessment, and referral; and b. Group sessions.	✓	↑				A Prenatal Health Fair was held at the Holiday Inn in February. 126 expectant women and their partners visited 35 displays. New to the Fair were: • the Lovesick Lake Native Women's Association representing the topic of Aboriginal Pre/Post Natal Health; and • Smith-Ennismore Community Policing Volunteers promoting infant car seat safety. 23 Adult Prenatal Classes were held. A meeting was held with the hospital's new Maternal Child Nurse Educator to identify ways we can work collaboratively.
5. The board of health shall provide advice and information to link people to community programs and services on the following topics: • Preconception health; • Healthy pregnancies; and • Preparation for parenting.	✓	↑				Consultations and referrals to community agencies were provided to callers seeking that information via the Family HEALTH*line*.
6. The board of health shall provide, in collaboration with community partners, outreach to priority populations to link them	✓	↑				A Teen Prenatal Supper Club series of seven classes was held. A meeting was held with administrators of the School for Young Moms to introduce

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<tr><td>to information, programs, and services.</td><td></td><td></td><td></td><td></td><td></td><td>them to the new Reproductive Health contact person, promote referrals to the Healthy Babies Healthy Children program, and identify smoking cessation supports.

Staff participated in the delivery of the ECHO Choose to be Smoke Free group program; and co-taught at four STOP on the Road sessions offered to members of the public committed to quitting smoking.

Staff facilitated two Young Moms Working Out sessions at the YMCA to promote physical activity and healthy eating to pregnant and postpartum women on limited incomes.</td></tr>
<tr><td colspan="7">Disease Prevention/ Health Protection</td></tr>
<tr><td>7. The board of health shall provide all the components of the Healthy Babies Healthy Children Program in accordance with the Healthy Babies Healthy Children Protocol, 2008 (or as current) (Ministry of Children and Youth Services).</td><td>Ø</td><td>Ø</td><td></td><td></td><td></td><td>
<table>
<tr><th>Healthy Babies, Healthy Children (HBHC) Program Activities</th><th>Q1 2013*</th><th>2013* Year to Date</th><th>2012 Year to Date</th></tr>
<tr><td>Number of prenatal screens received</td><td>131</td><td>131</td><td>143</td></tr>
<tr><td>Number of postpartum screens received</td><td>231</td><td>231</td><td>240</td></tr>
<tr><td>Number of postpartum contacts</td><td>253</td><td>253</td><td>239</td></tr>
<tr><td>Number of families receiving postpartum home visits</td><td>31</td><td>31</td><td>26</td></tr>
<tr><td>Number of In Depth Assessments completed</td><td>35</td><td>35</td><td>33</td></tr>
<tr><td>Number of joint home visits provided</td><td>21</td><td>21</td><td>12</td></tr>
<tr><td>Number of home visits provided – PHNs</td><td>242</td><td>242</td><td>210</td></tr>
<tr><td>Number of home visits provided – FHVs</td><td>96</td><td>96</td><td>82</td></tr>
</table>
* Figures to March 25, 2013, as the new HBHC Screen was implemented as of this date.

Training has been provided to Family Health staff, staff of the Maternal-Child Unit (Peterborough Regional Health Centre), and Midwives on the new HBHC Screen. The HBHC Screen replaces the previous prenatal and postpartum screens as it is designed for use prenatally, postpartum, and through the early childhood period.</td></tr>
</table>

Status Legend: ✓ **= Compliant** ↑ **= On Target** Ø **= Partially Compliant** 🄸 **= Compliant to Date** × **= Non Compliant**

Safe Water Q1 2013 (Manager: Atul Jain)

Goals: To prevent or reduce the burden of water-borne illness related to drinking water. To prevent or reduce the burden of water-borne illness and injury related to recreational water use.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall report Safe Water Program data elements in accordance with the *Beach Management Protocol, 2008* (or as current); the *Drinking Water Protocol, 2008* (or as current); and the *Recreational Water Protocol, 2008* (or as current).	✓	↑				Adverse notifications were reported in the Ministry of Health and Long-Term Care (MOHLTC) database.
2. The board of health shall conduct surveillance of drinking-water systems and of drinking water illnesses of public health importance, their associated risk factors, and emerging trends in accordance with the *Drinking Water Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				No clusters of illnesses related to drinking water were identified.
3. The board of health shall conduct surveillance of public beaches and public beach water illnesses of public health importance, their associated risk factors, and emerging trends in accordance with the *Beach Management Protocol, 2008* (or as current).	✓	↑				This is a second quarter activity.
4. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time,	✓	↑				No clusters of illnesses related to drinking water, recreational water, or beach use were identified.

Status Legend: ✓ = Compliant ↑ = On Target Ø = Partially Compliant 🛈 = Compliant to Date × = Non Compliant

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).						
5. The board of health shall conduct surveillance of recreational water facilities in accordance with the *Recreational Water Protocol, 2008* (or as current).	✓	↑				Six Class A year round pools received the first of four inspections in the first quarter. A total of 24 inspections of pools and spas were conducted.
Health Promotion and Policy Development						
6. The board of health shall provide information to private citizens who operate their own wells, cisterns, rain or lake water system to promote their awareness of how to safely manage their own drinking-water systems.	✓	↑				Inspectors provided 82 consultations with the public about sample result interpretation, maintaining and improving well water quality. Drinking water sample bottles, forms, and information provided by the Public Health Laboratory and distributed through: • the Health Unit office; • Municipal offices; and • other locations upon request (e.g. pharmacies). *How Well Is Your Well* (revised January 2013*)* and *Water Wells: Best Management Practices* were distributed through Municipal offices, the Public Health Lab, and the Health Unit.
7. The board of health shall provide education and training for owners/operators of drinking-water systems in accordance with the *Drinking Water Protocol, 2008* (or as current).	✓	↑				A Public Health Inspector (PHI) provided informal training and guidance to operators during Small Drinking Water Systems (SDWS) inspections and provided 17 consultations. 290 SDWS newsletters have been developed and will be mailed in the second quarter.
8. The board of health shall increase public awareness of water-borne illnesses and safe drinking water use by: a. Adapting and/or supplementing national and provincial safe drinking water communications strategies; and/or b. Developing and implementing	✓	↑				Blue Green Algae posters to be printed and distributed in the second quarter.

Status Legend: **✓ = Compliant ↑ = On Target Ø = Partially Compliant 🛈 = Compliant to Date × = Non Compliant**

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
regional/local communications strategies.						
9. The board of health shall provide education and training for owner/operators of recreational water facilities in accordance with the *Recreational Water Protocol, 2008* (or as current).	✓	↑				Operational materials will be made available to owners of recreational water facilities in the second quarter.
Disease Prevention/ Health Protection						
10. The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to: • Adverse events related to safe water, such as reports of adverse drinking water on drinking-water systems governed under the Health Protection and Promotion Act or the Safe Drinking Water Act; • Reports of water-borne illnesses or outbreaks; • Safe water issues arising from floods, fires, power outages, or other situations that may affect water safety; and • Safe water issues relating to recreational water use including public beaches in accordance with the Health Protection and Promotion Act; the *Beach Management Protocol, 2008* (or as current); the *Drinking Water Protocol, 2008* (or as current); the *Infectious Diseases Protocol, 2008* (or as current); the *Public Health Emergency Preparedness Protocol, 2008* (or as current); and the *Recreational Water Protocol, 2008*	✓	↑				Staff responded to six adverse drinking water reports. An Order was issued to a food premise as sewage was found on the ground surface.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
(or as current).						
11. The board of health shall provide all the components of the Safe Water Program in accordance with all applicable statutes and regulations, and the *Drinking Water Protocol, 2008* (or as current) to protect the public from exposure to unsafe drinking water.	✓	↑				The SDWS portion of the Safe Water program has conducted four risk assessments and nine re-assessments in the first quarter.
12. The board of health shall inform the public about unsafe drinking water conditions and provide the necessary information to respond appropriately in accordance with the *Drinking Water Protocol, 2008* (or as current).	✓	↑				Two Boil Water Advisories were issued.
13. The board of health shall reduce risks of public beach use by implementing a beach management program in accordance with the *Beach Management Protocol, 2008* (or as current).	✓	↑				Signs have been developed by the Health Unit advising users of public beaches about water quality safety and protection. They will be provided to municipalities which operate public beaches in the second quarter.
14. The board of health shall reduce the risks of recreational water facility use by implementing a management program in accordance with the *Recreational Water Protocol, 2008* (or as current).	✓	↑				As noted above, a total of 24 pools and spas were inspected.

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Sexual Health, Sexually Transmitted Infections, and Blood Borne Infections (including HIV) Q1 2013 (Manager: Patti Fitzgerald)

Goals: To prevent or reduce the burden of sexually transmitted infections and blood borne infections and to promote healthy sexuality.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall report data elements on sexually transmitted infections and blood-borne infections in accordance with the Health Protection and Promotion Act and the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008* (or as current).	✓	🛈				Reported cases of sexually-transmitted (STIs) and blood-borne infections (BBIs) are reported electronically, on a monthly basis, to the Ministry of Health and Long-Term Care (MOHLTC) via the Integrated Public Health Information Surveillance (iPHIS) system.
2. The board of health shall conduct surveillance of: • Sexually transmitted infections (STI); • Blood-borne infections (BBI); • Reproductive outcomes; • Risk behaviours; and • Distribution of harm reduction materials/equipment in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current) and the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008* (or as current).	✓	↑				Staff provided case management for 100 cases of sexually transmitted (STI) and blood-borne (BBI) infections, and provided follow-up for 25 contacts of reported cases. Staff performed 497 clinical assessments related to STIs/BBIs.
3. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time,	✓	🛈				The Epidemiologist provides reports on reportable diseases quarterly.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).						
Health Promotion and Policy Development						
4. The board of health shall increase public awareness of the epidemiology, associated risk behaviours, risk factors, and risk reduction strategies related to healthy sexuality, sexually transmitted infections, and blood-borne infections by: a. Adapting and/or supplementing national and provincial health communications strategies; and/or b. Developing and implementing regional/local communications strategies.	✓	↑				The current phase of the 'Use Condom Sense" Campaign concluded with the participation at the Fleming College Health Fair. Data will be gathered and contribute to the next steps planned for the next quarter.
5. The board of health shall use a comprehensive health promotion approach to increase the community capacity regarding the promotion of healthy sexuality, including the prevention of adolescent pregnancies, sexually transmitted infections, and blood-borne infections, by: a. Collaborating with and engaging community partners and priority populations; b. Mobilizing and promoting access to community resources; c. Providing skill-building opportunities; and d. Sharing best practices and evidence.	✓	↑				Public Health Nurses provided consultation to health care professionals to ensure that cases of STIs/BBIs were managed and treated as per current guidelines.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
6. The board of health shall collaborate with community partners, including school boards, to create supportive environments to promote healthy sexuality and access to sexual health services.	✓	↑				Provided maturation and sexuality classes to 40 Grade eight classes (within both local school boards). Attended the School for Young Mom (x3) to promote clinic services, education on sexual health, sexually transmitted infections and contraception. Provided four education sessions for Alternatives Community Program Services (for adults with developmental disabilities). Provided one educational session for an after school drop in for high risk youth. Provided three InTouch facilitated workshops at local high schools. Participated in the Fleming College Health Fair, promoting the *Use Condom Sense* Campaign. Outreach clinic services were offered bi-monthly at high schools in Lakefield and Norwood.
Disease Prevention/ Health Protection						
7. The board of health shall provide clinical services for priority populations to address contraception, comprehensive pregnancy counselling, sexually transmitted infections, and blood-borne infections. For further information, refer to the *Sexual Health Clinic Services Manual, 2002* (or as current).	✓	↑				Sexual Health Staff and physicians conducted 51 clinical assessments related to contraception and pregnancy and 131 clinical assessments related to testing and treatment for STI/BBIs. PHNs also investigated and followed-up all reported community cases of STI/BBIs (see # 2).
8. The board of health shall ensure that the medical officer of health or designate receives reports of sexually transmitted infections and blood-borne infections and responds in accordance with the Health Protection and Promotion Act and the *Sexual Health and Sexually Transmitted Infections*	✓	↑				The Emergency Service Worker (ESW) Protocol /Mandatory Blood Testing Act provides for risk assessment, advice and follow-up following potential occupational exposures to blood-borne infections. There were not any ESW reported exposures this quarter. One community needlestick injury was followed up. All STI reports for Health Care Providers were reviewed and revised.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Prevention and Control Protocol, 2008 (or as current).						Staff reviewed, revised, and developed Policies and Procedures for case and contact follow up for HIV, Syphilis, Chlamydia and Gonorrhea.
9. The board of health shall provide or ensure access to provincially funded drugs for the treatment of sexually transmitted infections, at no cost to clients, in accordance with the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2008* (or as current).	✓	↑				Provincially-funded medications for the treatment of STIs were dispensed at the Sexual Health Clinic.
10. The board of health shall communicate and coordinate care with health care providers to achieve a comprehensive and consistent approach to the management of sexually transmitted infections and blood-borne infections.	✓	↑				Staff worked collaboratively with community Medical Doctors/Nurse Practitioners to ensure cases of STI/BBIs are managed and treated appropriately as per current guidelines.
11. The board of health shall engage community partners and priority populations in the planning, development, and implementation of harm reduction programming.	✓	↑				To increase awareness of the importance of access to and use of condoms in preventing transmission of STIs, 13,802 condoms were distributed through clinic, youth-serving agencies, and organizations that interface with priority populations. Harm Reduction Works, operated by PARN - Your Community AIDS Resource Network on behalf of the Peterborough County-City and Haliburton, Kawartha, Pine Ridge Health Units, has five fixed sites, two of which are in Peterborough: PARN and Four Counties Addictions Services Team (4CAST).
12. The board of health shall ensure access to a variety of harm reduction program delivery models which shall include the provision of sterile needles and syringes and may include other evidence-informed harm reduction strategies in response to local surveillance.	✓	↑				Peterborough City and County residents have access to needles, syringes, condoms, and other harm reduction supplies through a number of venues.

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Tuberculosis Prevention and Control Q1 2013 (Manager: Edwina Dusome)

Goal: To prevent or reduce the burden of tuberculosis.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall report TB data elements in accordance with the Health Protection and Promotion Act and the *Tuberculosis Prevention and Control Protocol, 2008* (or as current).	✓	↑				Staff entered data into the Integrated Public Health Information System (iPHIS).
2. The board of health shall conduct surveillance of active tuberculosis as well as individuals with LTBI in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current) and the *Tuberculosis Prevention and Control Protocol, 2008* (or as current).	✓	↑				Staff investigated 0 reports of active and five reports of latent tuberculosis (TB) infections.
3. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				All suspected and confirmed cases were entered into iPHIS. Due to the few staff investigating and the few cases of active TB occurring, staff are cognizant of the mode of transmission and closely monitor for trend and priority populations.
Health Promotion and Policy Development						
4. The board of health shall engage in health promotion and policy development activities with community partners, policy-makers, and health care providers that have clients/contacts from priority populations based on local epidemiology.	✓	↑				World TB Day funds were used to promote TB awareness to the community and health care providers. Staff arranged for a local respirologist to conduct a presentation on TB for physicians and nurse practitioners at Grand Rounds in March 2013.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Disease Prevention/ Health Protection						
5. The board of health shall facilitate timely identification of active cases of TB and referrals of persons with inactive TB through immigration medical surveillance in accordance with the *Tuberculosis Prevention and Control Protocol, 2008* (or as current).	✓	↑				Staff responded to 0 reports of active TB and three immigration medical surveillance reports, provided follow-up and made recommendations to minimize public health risk (i.e. isolation, medication, Mantoux testing).
6. The board of health shall provide management of cases to minimize the public health risk in accordance with the *Tuberculosis Prevention and Control Protocol, 2008* (or as current).	✓	↑				Staff distributed anti-tuberculosis medication to five individuals and/or health care providers for distribution to appropriate clients. In some instances, directly observed therapy was required.
7. The board of health shall provide or ensure access to TB medication at no cost to clients or providers.	✓	↑				Five clients were initiated and received anti-tuberculosis medication.
8. The board of health shall provide or ensure the provision of the identification, assessment, and public health management of contacts of active cases in accordance with the *Tuberculosis Prevention and Control Protocol, 2008* (or as current).	✓	↑				Staff conducts follow-up of contacts of active TB if required. None were required in the first quarter.
9. The board of health shall provide or ensure the provision of the identification and effective public health management of individuals with LTBI in accordance with the *Tuberculosis Prevention and Control Protocol, 2008* (or as current), with a particular focus on people at highest risk of progression to active TB.	✓	↑				Year to date is five latent tuberculosis infection cases.
10. The board of health shall respond to local, provincial/territorial, federal, and international changes in disease epidemiology by adapting programs and services.	✓	↑				No changes were required this quarter.

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Vaccine Preventable Diseases Q1 2013 (Manager: Edwina Dusome)

Goal: To reduce or eliminate the burden of vaccine preventable diseases.

Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
Assessment and Surveillance						
1. The board of health shall assess, maintain records and report, where applicable, on: • The immunization status of children enrolled in licensed child care programs as defined in the Day Nurseries Act; • The immunization status of children attending schools in accordance with the Immunization of School Pupils Act; and • Immunizations administered at board of health-based clinics as required In accordance with the *Immunization Management Protocol, 2008* (or as current) and the *Infectious Diseases Protocol, 2008* (or as current).	✓	↑				The percent of day nursery attendees adequately immunized for their age is 72%. The percent of students in elementary and secondary schools adequately immunized for their age is 87%. The number of immunizations administered at the PCCHU Immunization Clinic was 308.
2. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Infectious Diseases Protocol, 2008* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).	✓	↑				Staff reviewed monthly reports of communicable diseases and identified risk factors. The Epidemiologist provided quarterly communicable disease reports.
Health Promotion and Policy Development						
3. The board of health shall work with community partners to improve public	✓	↑				Staff offered telephone consultation on immunization to the general public and health care providers. Immunization information was posted on the PCCHU web site.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
knowledge and confidence in immunization programs by: a. Supplementing national and provincial health communications strategies, and/or b. Developing and implementing regional/local communications strategies. Topics to be addressed shall include: • The importance of immunization. • Diseases that vaccines prevent. • Recommended immunization schedules for children and adults and the importance of adhering to the schedules; • Introduction of new provincially funded vaccines; • Promotion of childhood and adult immunization, including high-risk programs; • The importance of maintaining a personal immunization record for all family members; • The importance of reporting adverse events following immunization; • Reporting immunization information to the board of health as required; • Vaccine safety; and • Legislation related to immunizations.						Staff visited health care providers to offer information on immunization and vaccine safety during cold chain inspections and sent information to parents of students and day care attendees. Information on immunization was included in the *For Your Information* newsletter for health care providers.
4. The board of health shall promote the reporting of adverse events following immunization by health care providers to the local board of health in accordance with the Health Protection and Promotion Act.	✓	↑				Health care workers were reminded, via the *For Your Information* newsletter, to report adverse vaccine reactions.
5. The board of health shall provide a comprehensive information and education	✓	↑				The number of cold chain inspections conducted this year to date: 13.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
strategy to promote optimal vaccine management, including storage and handling practices, among health care providers in accordance with the *Vaccine Storage and Handling Protocol, 2008* (or as current). This shall include: • One-on-one training at the time of cold chain inspection; • Distributing information to new health care providers who handle vaccines; and • Providing ongoing support to existing health care providers who handle vaccines.						
6. The board of health shall provide consultation to community partners to develop immunization policies (e.g., workplace policies) based on local need and as requested.	✓	↑				No requests were received this quarter.
Disease Prevention/ Health Protection						
7. The board of health shall promote and provide provincially funded immunization programs to any eligible person in the health unit, including: • Board of health-based clinics; • School-based clinics (including, but not limited to, hepatitis B and meningococcal immunization); • Community-based clinics, and • Outreach clinics to priority populations.	✓	↑				NOTE: The data below is for the current year and not by school year: Staff immunized Grade 7 students with Hepatitis B: first dose 23; second dose 149; third dose 0. Staff immunized Grade 7 students with the Meningitis vaccine: 56 Staff immunized Grade 8 females with the HPV vaccine: first dose 21; second dose 153; and third dose 85. Staff have conducted a partial cleansing of the Immunization Record Information System in preparation for the Panorama (new Ministry of Health immunization and reportable disease database).
8. The board of health shall, as part of the Public Health Emergency Preparedness Program Standard, have a contingency plan to deploy	✓	↑				The Health Unit mass vaccination plan (as part of the PCCHU Pandemic Plan) is available on the Health Unit website.

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
board of health staff capable of providing vaccine preventable disease outbreak management control such as mass immunization in the event of a community outbreak.						
9. The board of health shall provide or ensure the availability of travel health clinics.	✓	↑				Travel clinic services were offered on Tuesdays, Wednesdays and Thursdays by appointment. The following provides the statistics on the clinic (year-to-date): # of clients seen: 38. # of phone consults: 738. # of yellow fever immunizations: 13. # hep A and hep B high risk: 0. # immunizations covered by the Ontario Government Pharmacy (OGP): 124. # other immunizations: 503. Total immunizations administered: 1,062.
Health Protection						
10. The board of health shall ensure the storage and distribution of provincially funded vaccines including to health care providers practicing within the health unit in accordance with the *Vaccine Storage and Handling Protocol, 2008* (or as current).	✓	↑				Distributed vaccines to community partners and facilities. Total amount of doses of government funded vaccine distributed this quarter: 9,434.
11. The board of health shall promote vaccine inventory management in all premises where provincially funded vaccines are stored in accordance with the *Vaccine Storage and Handling Protocol, 2008* (or as current).	✓	↑				Promotion was conducted during inspection of premises through telephone consultation, *For Your Information* newsletter, and through investigation of cold chain incidents. All premises storing these vaccines are inspected once yearly.
12. The board of health shall health shall monitor, investigate, and document all suspected cases of adverse events following immunization that meet the provincial reporting criteria and promptly report all cases	✓	↑				The number of adverse events reported and investigated this year to date is: 7.
13. The board of health shall comply with the Immunization Management Protocol, 2008 (or	✓	↑				In January, staff initiated the collection of immunization information for children/students in day nurseries and schools and suspended, if necessary, for those

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Requirement	Status 2012	Status 2013				Comments
	4th	1st	2nd	3rd	4th	
as current), that specifies the process for the assessment of the immunization status of children in licensed day nurseries as defined in the Day Nurseries Act and the enforcement of the Immunization of School Pupils Act.						with no or inadequate immunization information on file.

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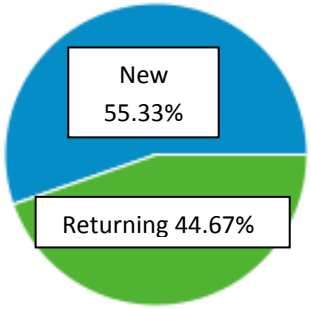
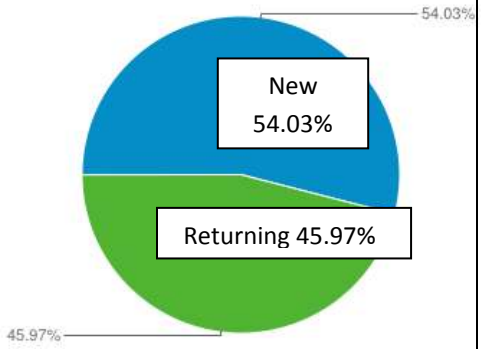
Communications 2013 Q1 (Supervisor, Communications Services: Brittany Cadence)

Media Relations:

Activity	Q1		Year To Date	
	2013	2012	2013	2012 (whole year)
Press releases issued	24	33	24	134
Media interviews	36	41	36	150
Number of media stories directly covering PCCHU activities (print and TV only, and some radio when stories posted online)	102	66	102	334

Website Statistics:

Q1 Comparisons	2013	2012	Year To Date	
			2013	2012
Website Traffic	56,461 page views	62,480 page views	56,461 page views	62,480 page views
% change in website traffic	9.6% -			
New/Returning visitors				
Pages/Visit	3.01	N/A		N/A
Average Visit Time	2:36	N/A		N/A
Visits from Mobile Phones	2,640	N/A		N/A

PCCHU Website:

Maintenance and functionality enhancements continued to be a priority for this quarter. Although the number of page views decreased this quarter compared to Q1 2012 there has been a significant increase in traffic to specific health promotion campaign web pages that are cross-promoted through social media (content and advertising) and media releases. For example, the media release issued regarding the closure of Ming's restaurant (December 14, 2012) received 198 hits the day it was released and a total of 525 hits in nine days. This is very substantial traffic/interest to any page but especially for a media release. This increased traffic was directly related to the message spreading via social media.

Social Media:

Activity	Q1		Totals	
	2013	2012	2013	2012 (whole year)
Twitter (@PCCHU):				
Tweets	121	N/A	288 (total carried over from 2012)	167
Re-tweets (re-posting of content from others, i.e. Health Canada)	22	N/A	22	16
New Followers	142	N/A	482 (total carried over from 2012)	340
Facebook (search: Peterborough County-City Health Unit):				
New Likes	18	N/A	34 (carried over from 2012)	16
Events Promoted	0	N/A	0	3
Posts	73	N/A	73	47
Ad Campaigns	1	0	1	8

Twitter

There was a rapid spike in the number of Twitter followers this quarter (142). This was a result of a few things:

- The Health Unit started following @Ptbo_Canada (with 7000+ followers), one of the leading local Twitter accounts. In return they followed us and have begun promoting the PCCHU Twitter account (see below) and re-tweeted several PCCHU messages thus resulting in many new followers.
- By utilizing the @Ptbo_Canada handle in place of Ptbo or Peterborough in tweets this increases PCCHU reach to @Ptbo_Canada's followers and opportunity for re-tweets.
- Focusing tweets on engaging and useful content which is generating more followers as @PCCHU is being seen as a great resource for information via social media. It takes time to develop and build a social media presence and after 8 months @PCCHU is now starting to yield very positive results.

Another point of interest is the increase in "twitter chatter" this quarter. This means that more people are talking about @PCCHU in conversations via Twitter. Topics of interest have been mostly regarding: casino, possible PCCHU move, frostbite alerts, gonorrhea, and closure of Ming's

Facebook:

In Q1 more content was posted more frequently to the PCCHU Facebook page, almost doubling the number of fans ("likes") this quarter. Now that the PCCHU Facebook page has surpassed 30 likes staff can now access more detailed analytics/insights regarding our fans and our posts which will allow for more effective evaluation of our campaigns. The most popular post this quarter (Chlamydia campaign) received 46 views (26 via post shares).

Social Media Content This Quarter:

- Chlamydia – provincial awareness campaign utilizing engaging and youth friendly video content and images to drive people to http://findoutthewholestory.ca and the new Public Health Ontario website http://www.sexualhealthontario.ca – Tweets/post including interesting facts and stats and catchy taglines
- Dentists on Wheels- promoting our new video about the mobile dental clinic services
- Supermarket Tours
- Nutrition Month
- Prenatal Health Fair
- National Non-Smoking Week
- Stop on the Road Workshops (Tobacco Use Prevention)
- RFP-Dental Cleaning
- #QuitChat- first twitter chat by Smokers Helpline
- Frostbite Alert
- All media releases

Q1 Graphic Design Projects:

Administration
- Templates (x3)
- Presentations (x3)
- Signage (x5)
- Personal Safety Handbook

Cancer Prevention
- 2013 Golfers Sun Safety Poster

Dental
- Mobile DHC Flow Chart
- 2013 First Visit Feedback Form
- Dental Commercial Screen Image
- Mobile DHC Schedule (x2)
- HSO Qualify & Apply – pamphlet

Family Health
- How to Bottle Feed - Sterilize
- What's Available 2013 – DRAFT
- Breastfeeding Care Map
- PSL Growth Chart

Healthy Babies, Healthy Children
- HBHC Flowchart
- HBHC Quick Reference Guide
- HBHC Pen

HCP Correspondence
- FYI Newsletter (x3)
- Advisory (x1)

Health Hazards
- Air Quality Index
- Health Hazards Display

Injury Prevention
- Simply Safer 2013 – CD's
- Swim to Survive – Flyer

Inspection
- Guide to Opening a Restaurant DRAFT
- HOLD Under Investigation stickers
- Sewage System – PowerPoint Presentation
- Small Drinking Water Systems Newsletter DRAFT
- Mandatory Food Handler Certification – POSTER
- Food Handler Certification CARDS & Template
- Six Steps to Handwashing – POSTER update
- How Well is Your Well – Update
- 2013 Rabies Clinic – stickers

Infant and Toddler Development
- Joy of Toys – Brochure
- Floortime – Pamphlet updated

Nutrition
- Food for All – Update
- FFK Flowchart
- 2013 Service Club Presentation

Sexual Health
- You and the Pill – DRAFT Pamphlet
- Clinic Philosophy
- Use Condom Sense – AD Fleming Student Handbook
- Sexual Health – Day in the Life PowerPoint

Substance Misuse
- Bad Drugs or an Outbreak

Tobacco
- Choose to be – pamphlet update
- Tenant Survey
- STOP Study – Posters

Triple P
- Triple P - AD, Peterborough Kids
- Triple P – Poster
- Triple P – Seminar Series WEB
- Triple P – Programs WEB

Infant and Toddler Development Q1 2013 (Manager: Karen Chomniak)

Infant and Toddler Development (ITDP) Program Activities	Q1 2013	2013 Year-to-Date	2012 Year-to-Date
New referrals	31	31	23
Children discharged from program	44	44	29
Children on current caseload	89	89	92
Home/agency visits	207	207	186
Visits provided in group settings	0	0	18

The Infant and Toddler Development Program (ITDP) has received a higher-than-usual number of new referrals during the first quarter. Infant Development Workers have also:

- met with staff of the Family and Youth Clinic, and the Pediatric Out-Patient Clinic at Peterborough Regional Health Centre; and Five Counties Children's Centre for professional development; and
- participated in external committee meetings: Speech Language Hearing Association of Peterborough.

Staff reviewed the report *Kids Count Too… Social Inclusion for Children and Youth with Intellectual Disabilities,* an issue paper from the Developmental Services Network-Haliburton Kawartha Pine Ridge, May 2011. This report recommends a centralized service model to enhance a family's capacity to support their children with special needs. It also recommends that the community provide:

a) a continuum of support;
b) family support based on the child's needs;
c) services based on need; and
d) local services and respite/residential options.

The Board of Health has shown a commitment to families and children with special needs by continuing as the host for our local ITDP. The program provides direct, family-centred service to families and children with developmental delays, as recommended in the report. The Health Unit has an important role as part of the continuum of support, and in its involvement with local and regional planning tables and meetings with government representatives.

Sewage Disposal Program Q1 2013 (Manager: Atul Jain)

	Jan 2013	Feb 2013	Mar 2013	Total Q1 2013	2013 Year-to-Date	2012 Year-to-Date
Applications for Sewage System Permits	4	11	22	37	37	42
Permits Issued	4	9	20	33	33	40
Applications for Severance	0	1	4	5	5	25
Applications for Subdivision (# of Lots)	0	0	0	0	0	0
Existing Systems and Complaints	5	6	11	22	22	19

Staff Report

Q1 2013 Financial Update

Date:	May 8, 2013
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Pellizzari, M.D.	Bob Dubay, Accounting Supervisor

Recommendations

That the Board of Health for the Peterborough County-City Health Unit receive the report, *Q1 2013 Financial Update*, for information.

Financial Implications and Impact

This report provides a look at results from first quarter 2013 financial operations.

Most budgets have been or will soon be submitted to the Province for approval. Until the Provincial approvals are received, we are comparing the actual results to the 2013 budgets approved by the Board of Health or to the amounts that management intend to request for the Board to approve.

On a whole all programs have operated within budget. The CINOT Expansion program budget was approved by the Province in 2011 of $49,000. In 2012, the Province approved a significantly lower amount of $26,473. The Board has approved the 2013 budget of $49,000 and based on the first quarter operations the program is slightly over the board approved amount.

The Mandatory Public Health Program line appears to be significantly under budget but this is due in large part by the additional approved funding of $277,233 for Occupancy on April 10, 2013. To date, no costs have been incurred relating to this approved increase.

Background

Operations in 2012, all came within budget approvals.

Strategic Direction

The financial operations for 2013 will continue to allow the Health Unit to contribute to the strategic goal to meet our mandate by addressing the needs of identified priority populations and ensure access within both the City and County of Peterborough.

The successful financial operations will allow the Board of Health to meet its mandate to better achieve the Ontario Public Health Standards.

Contact:

Bob Dubay, Accounting
Corporate Services
(705) 743-1003, ext. 286
bdubay@pcchu.ca

Attachments:

Attachment A – Financial Update March 31, 2013

Financial Update Q1 2013 (Accounting Supervisor: Bob Dubay)

ATTACHMENT A

Programs funded January 1 to December 31, 2013	Type	2013	Approved By board	Approved By Province	Expenditures to Mar. 31	% of Budget	Funding	Comments
Mandatory Public Health Programs	Cost Shared	7,361,244	11/14/2012 and 04/10/2013	submitted	1,681,175	22.8%	MOHLTC	Operating within budget.
Vector- Borne Disease (West Nile Virus)	Cost Shared	76,105	10-Apr-13	submitted	0	0.0%	MOHLTC	West Nile Virus measures and students start in May.
One-time cost request	Cost Shared	470,890	10-Apr-13	submitted	0	0.0%	MOHLTC	Capital expenditures waiting for approvals.
Infectious Disease Control	100%	222,263	10-Apr-13	submitted	48,714	21.9%	MOHLTC	Expected to operate within budget.
Infection Prevention and Control Nurses	100%	86,584	10-Apr-13	submitted	21,642	25.0%	MOHLTC	Operating within budget.
Small Drinking Water Systems	Cost Shared	92,631	10-Apr-13	submitted	22,754	24.6%	MOHLTC	Operating within budget.
Healthy Smiles Ontario	100%	427,260	10-Apr-13	submitted	105,465	24.7%	MOHLTC	Operating within budget.
One-time cost - Vaccine Fridge	100%	5,500	10-Apr-13	submitted	0	0.0%	MOHLTC	Capital expenditures waiting for approval.
Enhanced Food Safety	100%	25,003	10-Apr-13	submitted	165	0.7%	MOHLTC	Operating within budget.
Enhanced Safe Water	100%	15,501	10-Apr-13	submitted	0	0.0%	MOHLTC	Operating within budget.
Needle Exchange Initiative	100%	21,121	10-Apr-13	submitted	4,713	22.3%	MOHLTC	Operating within budget.
Infection Prevention and Control Week	100%	8,000	10-Apr-13	submitted	0	0.0%	MOHLTC	Operating within budget.
Sexually Transmitted Infections Prevention week	100%	7,000	10-Apr-13	submitted	1,531	21.9%	MOHLTC	Operating within budget.
Nurses Commitment	100%	176,945	10-Apr-13	submitted	44,283	25.0%	MOHLTC	Operating within budget.

Programs funded January 1 to December 31, 2013	Type	2013	Approved By board	Approved By Province	Expenditures to Mar. 31	% of Budget	Funding	Comments
Smoke Free Ontario - Control	100%	100,000	10-Apr-13	submitted	23,755	23.8%	MOHLTC	Operating within budget.
Smoke Free Ontario - Enforcement	100%	120,724	10-Apr-13	submitted	27,149	22.5%	MOHLTC	Operating within budget.
Youth Engagement	100%	80,000	10-Apr-13	submitted	19,097	23.9%	MOHLTC	Operating within budget.
CINOT Expansion	Cost Shared	49,000	10-Apr-13	submitted	13,277	27.1%	MHPS	Operating within budget.
Healthy Babies, Healthy Children	100%	928,413	to BoH in May	waiting BoH approval	206,650	22.3%	MCYS	Operating within budget.
Healthy Communities Fund	100%	47,100	10-Apr-13	submitted	0	0.0%	MOHLTC	Operating within budget.
Chief Nursing Officer Initiative	100%	119,104	10-Apr-13	submitted	29,931	25.1%	MOHLTC	Operating at budget.
Ontario Works	100% from City	1,079,020	##	NA	231,129	21.4%	CITY OF PTBO	Budget based on 2012 actual expenditures

Programs funded April 1, 2012 to March 31, 2013	Type	2012 - 2013	Approved By Board	Approved By Province	Expenditures to Mar. 31	% of Budget	Funding	Comments
Infant Toddler and Development Program	100%	245,423	11-Jun-12	16-Oct-12	245,218	99.9%	MCSS	Budget spent in full.
Medical Officer of Health Compensation	100%	70,259	29-Nov-12	1-Dec-12	70,259	100.0%	MOHLTC	Budget spent in full.
Healthy Communities Fund	100%	38,400		19-Dec-12	38,400	100.0%	MOHLTC	Budget spent in full.
Speech		13,084		2-Apr-12	13,084	100.0%	FCCC	Budget spent in full.

Funded Entirely by User Fees January 1 to December 31, 2013	Type	2013	Approved By Board	Approved By Province	Expenditures to Mar 2012	% of Budget	Funding	Comments
Sewage Program		343,388	13-Apr-11	NA	57,564	16.8%	FEES	Expenditures are within budget; **Revenue from User Fees are also under budget resulting in a net deficit of $30,534. During the summer months, as building activity picks up, revenues should be sufficient to balance the budget . The accumulated reserve available to offset any deficit is $67,865.**

Staff Report

2013 Budget Approval - Healthy Babies, Healthy Children Program

Date:	May 8, 2013
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

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

Recommendations

That the Board of Health for the Peterborough County-City Health Unit approve the 2013 budget for the Healthy Babies, Healthy Children Program in the total amount of $828,413.

Financial Implications and Impact

The 2013 budget has been completed in accordance with MCYS guidelines and is based on the approved provincial funding allocation of $828,413. This allocation does not include new base funding under the 9,000 Nurses Commitment of $100,000 for one Public Health Nurse (PHN) full-time equivalent (FTE). The provincial base allocation has not been increased since 2008.

In 2007, the program had 5.2 FTE PHNs. The 2013 base funding allocation provided by MCYS will allow for only 4.5 FTE PHNs; however the new funding allocation under the 9,000 Nurses Commitment will permit one additional FTE PHN for a total of 5.5 FTE PHNs. Significant financial impact will continue to be exerted on our program due to the fact that three PHNs will each complete a pregnancy/parental leave of absence, each returning between June and September 2013. Costs include "the supplement or 'top up' of the Human Resources Development Canada benefits payable to employees who are absent from work on pregnancy, parental or adoption leave" (Ontario Nurses Association Collective Agreement, 11.04 (h)) projected to be $18,389, as well as the employer share of benefit costs.

To aid in balancing the budget in 2013, the program has included funding or $22,190 from deferred revenue and this will cover 0.39 FTE Family Home Visitor (FHV). This will maintain the program's FHV complement at 2.8 FTE.

Decision History

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

Background and Rationale

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

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

HBHC has established itself as a valuable program in the community and has worked to build strong working relationships with the Children's Aid Society, Ontario Early Years Centre, Peterborough Regional Health Centre, Family Health Teams, addictions and mental health agencies, housing and social services agencies, and adult education and pre-employment agencies.

In an effort to build a "more robust provincial early years system", MCYS implemented a number of significant changes during the latter part of 2012 and first part of 2013:

- The revised HBHC Protocol and the Guidance Document to support protocol requirements, and new performance targets were released.
- The new HBHC Screen was introduced with the intent to more quickly and effectively identify and support pregnant women and vulnerable children and families so those who need help the most can access services and supports more quickly.
- The HBHC Liaison Nurse position was funded through the 9,000 Nurses Commitment. The role of this PHN is to provide training and support to staff of hospital maternal-child units, prenatal clinics, midwifery practices, and other family-serving agencies to

effectively administer the HBHC Screen, and in turn to facilitate referral of families who could benefit from HBHC services.

- HBHC home visiting has been enhanced to more effectively support at-risk families through standardized best practice guidelines and provincial training for HBHC staff to help ensure the effectiveness of home visiting.
- Strategies will continue to promote the Enhanced 18-Month Well-Baby Visit to physicians and parents.
- Two new pamphlets were developed and the provincial website was revised to provide parents with information regarding early years programs and services. These resources complement the information package provided to all new parents developed jointly by the Peterborough Regional Health Centre and our HBHC program.

2013 will be a transition year to determine whether our HBHC program will have sufficient resources to meet projected achievements based on performance targets established by MCYS. In the past, inadequate funding and staffing resources have diminished the capacity of our Health Unit to achieve targets and provide necessary services.

Strategic Direction

The HBHC program is identified as a requirement under both the Reproductive Health and Child Health Standards in the Ontario Public Health Standards 2008. Approval of the budget will maintain the program and the Health Unit's ability to continue to meet our mandate.

Contact:

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

Attachments:

Attachment A: HBHC Budget Summary 2013

Healthy Babies Healthy Children
Child and Youth Development Branch
Strategic Policy and Planning Division
Ministry of Children and Youth Services
2013 Request for Funding Schedule
January 1, 2013 - December 31, 2013

Public Health Unit: **Peterborough County-City Health Unit**

	Previous Year Approved FTE	Previous Year Approved Budget	Previous Year Actual FTE	Previous Year Actual Costs	Current Year Request FTE	Current Year Request	Current Year Approved Request Ministry Use
Salaries & Wages: Staff	10.3	617,867	9.4	573,131	10.0	618,894	
Employee Benefits		166,771		161,428		167,644	
Employee Benefits as % of S&W Staff		27.0%		28.2%		27.1%	
Contracted Services	-	28,000	-	28,000	-	28,000	
Operating Costs		37,965		34,340		36,065	
TOTAL REQUEST FROM MCYS	10.3	850,603	9.4	796,899	10.0	850,603	
Adjustments	-	(22,190.0)	-	-	-	(22,190.0)	
One-Time Grant Request	-	-	-	-	-	-	
GRAND TOTAL	10.3	828,413	9.4	796,899	10.0	828,413	

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

Signature: _____

Name: Dr. Rosana Pellizzari, Medical Officer of Health

Date: _____

Public Health Unit: Peterborough County-City Health Unit

	Previous Year Approved FTE	Previous Year Approved Request	Previous Year Actual FTE	Previous Year Actual Costs	Current Year Request FTE	Current Year Request	Current Year Approved Request Ministry Use
1a. Salaries & Wages - Unionized							
Management							
Public Health Nurses	4.50	295,973	3.67	253,271	4.50	303,001	
Lay Home Visitors	2.80	123,805	2.73	120,888	2.80	128,293	
Social Workers							
Administration: Program Support	1.00	36,867	1.00	36,867	0.70	27,637	
Administration: ISCIS Data Entry Support	0.40	14,142	0.40	14,142	0.38	11,844	
Administration: ISCIS Release Support	0.30	18,543	0.30	18,087	0.30	18,927	
Other Professional (specify)							
Other Non-Professional (specify)							
Total Salaries & Wages - Unionized	9.00	489,330	8.10	443,255	8.68	489,702	
Employee Benefits - Unionized		**132,966**		127,271		133,667	
1b. Salaries & Wages - Non unionized							
Management	1.30	128,537	1.30	129,876	1.30	129,192	
Public Health Nurses							
Lay Home Visitors							
Social Workers							
Administration: Program Support							
Administration: ISCIS Data Entry Support							
Administration: ISCIS Release Support							
Other Professional (specify)							
Other Non-Professional (specify)							
Total Salaries & Wages - Non unionized	1.30	128,537	1.30	129,876	1.30	129,192	
Employee Benefits - Non unionized		33,805		34,157		33,977	
Total Salaries & Wages	10.30	617,867	9.40	573,131	9.98	618,894	
Employee Benefits		166,771		161,428		167,644	
2. Contract Services							
Other Professional : PHN		28,000		28,000		28,000	
Other Non-Professional (specify)							
Lay Home Visitors							
Administration: ISCIS Release Support							
Total Contract Services	-	28,000	-	28,000	-	28,000	
3. Operating Costs							
Office Supplies		5,500		5,500		5,500	
Office Equipment							
Professional Development &Training		2,500		2,091		2,500	
Travel		16,000		14,300		15,000	
Public Awareness/Promotion							
Program Resources		5,165		5,165		5,165	
Computer costs for ISCIS							
Audit		3,800		2,300		2,800	
Other : Telephone and communication		5,000		4,984		5,100	
Other (specify)							
Total Operating Costs		37,965		34,340		36,065	
Total Request from MCYS (1+2+3)	10.30	850,603	9.40	796,899	9.98	850,603	
4. Adjustments							
Contributions from Cost Sharing Programs		(22,190)		-		(22,190)	
Gapping							
Total (1+2+3+4)	10.30	828,413	9.40	796,899	9.98	828,413	
5. One-Time Grant Request					-	-	
Grand Total	10.30	828,413	9.40	796,899	9.98	828,413	

Staff Report

2013-14 Budget Approval - Infant and Toddler Development Program

Date:	May 8, 2013
To:	Board of Health
From:	Dr. Rosana Pellizzari, Medical Officer of Health

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

Recommendations

That the Board of Health for the Peterborough County-City Health Unit approve the 2013-14 budget for the Infant and Toddler Development Program (ITDP) in the total amount of $242,423.

Financial Implications and Impact

As directed by the Board of Health, the budget submitted to the Ministry of Children and Youth Services (MCYS) reflects the actual needs for full program delivery ($374,241). Operating costs continue to be limited to the approved funding level of $242,423, so there is no financial risk to the health unit.

The attached budget (Appendix A) and supporting documentation has been delivered to MCYS. If the budget is not approved by the Board, the Ministry will not fund the program.

Decision History

The Board of Health has operated the ITDP Program since 1981. There have been no funding increases to the program since 2003. Since 2008, the Board has annually reviewed the impact of funding shortfalls and communicated to the funder the resulting challenges. The Board has

committed to continuing to operate the program for the 2013-14 fiscal year and has directed staff to continue to communicate with MCYS regarding funding requirements.

Background and Rationale

The ITDP is funded 100% by the MCYS. The Infant and Toddler Development Program (ITDP) is for families with infants and young children who may become delayed in their development because of prematurity, social, or economic concerns; are diagnosed with special needs, such as Down syndrome, cerebral palsy, or spina bifida; or are found to be delayed in development. An approved budget is required to continue to operate this program and offer these important supports to families in Peterborough County and City.

Strategic Direction

Although not part of the OPHS, the ITDP assists PCCHU in continuing to meet its mandate through coordinated efforts with the Healthy Babies Health Children Program and the Child Health Program. It also assists in building on our leadership role by developing important linkages in our community and providing a valued service.

Contact:

Karen Chomniak, Manager, Family Health
Infant Toddler and Develolpment Program
(705) 743-1000, ext. 242
kchomniak@pcchu.ca

Attachments:

Attachment A: ITDP Budget Summary, 2013-14

Service / Budget Submission
Budget Summary

Budget Year
2013-14

Organization Name Peterborough County-City Health Unit					Contract/Approval # & Date		Amendment # & Date		
	TPBE #		41808						**TPR #**
	IFIS Line - Subline #		B078-B200						**23673**
	Legislation		CFSA						
	Detail Code		**A476**						
	Service Name		SCS - Children Infant Development						**TOTAL** Page 1 of 1
	Description	Allocated Central Administration							
	FISCAL EXPENDITURES								
A	Salaries/Benefits	34,283	309,458						343,741
F	Other Expenditures	1,300	29,200						30,500
	Gross Expenditures (A+F)	**35,583**	**338,658**						**374,241**
G	Total In-Year Adjustments								
H	Offsetting Revenue (-)								
I	**Adjusted Service Expenditures (A+F+G+H)**	35,583	338,658						374,241
J	**Allocated Central Administration**	(35,583)	35,583						(0)
K	**Adjusted Gross Expenditures (I + J)**		**374,241**						**374,241**
L	Less: Revenue (Legislated Share) (-)								
M	**Net Expenditures (K less L)**		**374,241**						**374,241**
	Allocated Central Administration - $		35,583						35,583
	Allocated Central Administration - %		9.51%						9.51%
P	Total Fiscal Funding (From Revenue Worksheet)		242,423						242,423
Q	**Net (P Less M)**		**(131,818)**						(131,818)

Expenditures Worksheet

Organization Name	Peterborough County-City Health Unit	TPR #	TPBE#
		23673	41808

Q4/Year-End/TPAR Report	
Service/Budget Submission	x

Detail Code A476

		2012-13 Actual (Or Estimated Actual)	2013-14 Budget Year Estimate (Service/Budget Submission Only)	2013-14 Year-End Actual (For Q4/ Year End / TPAR Report Only)
	Service Name SCS - Children Infant Development			
	Description			
	Expenditures	**Total**	**Total**	**Total**
A1	Salaries	168,298	243,728	
A2	Benefits	50,069	65,730	
A	**Salaries/Benefits (Subtotal : A1 + A2)**	**218,367**	**309,458**	
	TRANSPORTATION AND COMMUNICATION			
B1	Travel	6,500	7,000	
B2	Communication	1,656	1,800	
B	**SUB-TOTAL Transportation and Communication**	**8,156**	**8,800**	
	SERVICES			
C1	Rent/ Lease/ Mortgage Interest	2,500	15,400	
C2	Mortgage Principal			
C3	Utilities			
C4	Staff Training	1,120	1,000	
C5	Advertising and Promotion			
C6	Services related to Repairs and Maintenance			
C7	Professional/Contracted-out Services			
C8	Professional/Contracted-out IT Services			
C9	Purchased Client Services			
C10	Purchased Client Services - OPR			
C11	Insurance			
C12	Other Services			
C	**SUB-TOTAL Services**	**3,620**	**16,400**	
	SUPPLIES AND EQUIPMENT			
D1	Supplies, Equipment related to Repairs and Maintenance			
D2	IT - Supplies and Equipment			
D3	Other Supplies and Equipment	3,600	4,000	
D	**SUB-TOTAL Supplies and Equipment**	**3,600**	**4,000**	
E	**OTHER TRANSACTIONS**			
	Please provide description for the above			
F	**SUB-TOTAL Other Expenditures (B + C + D + E)**	**15,376**	**29,200**	
	Gross Expenditures (A + B + C + D + E)	**233,743**	**338,658**	
G1	Adjustments / Recoveries:			
G2	Adjustments / Recoveries:			
G3	Adjustments / Recoveries:			
G4	Adjustments / Recoveries:			
G5	Adjustments / Recoveries:			
G	**TOTAL IN-YEAR ADJUSTMENTS**			
H	**Offsetting Revenue (-)**	**(7,995)**		
I	**Adjusted Service Expenditures (Subtotal : A to H)**	**225,748**	**338,658**	
J	Allocated Central Administration	**16,675**	**35,583**	
K	**Adjusted Gross Expenditures (Total : A to J)**	**242,423**	**374,241**	

Notes:

To: All Members
Board of Health

From: Dr. Rosana Pellizzari, Medical Officer of Health

Subject: **2013-14 Membership Fee – Association of Local Public Health Agencies (alPHa)**

Date: May 8, 2013

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit approve the 2013-14 annual membership fee for the Association of Local Public Health Agencies (alPHa) in the amount of $6,855.36.

		Increase
2008 – 2009 Membership Fee approved by the Board of Health	$5,716.26	$64.25 *(+ 1.1%)*
2009 – 2010 Membership Fee approved by the Board of Health	$5,836.30	$120.04 *(+ 2.0%)*
2010 – 2011 Membership Fee approved by the Board of Health	$5,964.70	$128.40 *(+ 2.2%)*
2010 – 2011 Membership Fee approved by the Board of Health	$6,534.70	$570.00 *(+ 8.7%)*
2012 – 2013 Membership Fee approved by the Board of Health	$6,665.40	$130.70 *(+ 2.0%)*
2013 – 2014 Membership Fee requested by alPHa:	$6,855.36	$189.96 *(+ 2.7%)*

Correspondence from alPHa is attached.

alPHa
Association of Local
PUBLIC HEALTH
Agencies

alPHa's members are the public health units in Ontario.

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

ANDSOOHA - Public Health Nursing Management

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Society of Nutrition Professionals in Public Health

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

April 15, 2013

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

Dear Dr. Pellizzari: Rosana

RE: alPHa 2013-14 Membership Fees

In January 2012, Minister Deb Matthews released *Ontario's Action Plan for Health Care – Better patient care through better value from our health care dollars*. Despite the strong patient care focus, a foundational goal of the plan is "to make Ontario the healthiest place in North America to grow up and grow old". The first priority of the plan is "keeping Ontario healthy". As a result, 2012-13 has been a year of opportunity for public health.

To respond to this opportunity, alPHa's Board of Directors engaged in a strategic planning process to determine the best positioning of alPHa as we move forward. Strategic planning will continue into 2013-14 as the broader health system transformation and public health sector strategic plan continues to evolve. The next year promises to bring further challenges and opportunities. alPHa is well positioned to represent public health with seats on the Health System Strategy Council, the Public Health Leadership Council, the Funding Review Working Group, the Public Health Performance Management Working Group, and the Joint Ministries/Boards of Health Accountability Agreement Committee.

During 2012-13, we were very pleased to provided alPHa members with a number of professional development and networking opportunities. We were able to deliver the following four conferences for you, your Board members, and your staff:

1. *Changing the Conversation. A conference on moving to a new way of thinking and talking about health,* Niagara Falls - 2012 Annual Conference, June 10-12;
2. *Who's Who in 2012,* Mississauga – 2012 November 7 & 8;
3. *Public Health Administrative Assistant's Conference* – Toronto, 2013, February 13; and
4. *2013 Winter Symposium,* Toronto – 2013 February 14 & 15.

alPHa also shared in the development of the 3rd annual Ontario Public Health Convention (TOPHC) with partner organizations, Public Health Ontario and the Ontario Public Health Association.

Enclosed is an invoice for the 2013-14 annual membership renewal for your public health agency with alPHa. Your continuing membership helps us to build on our successes and deliver strong supports for public health agencies across Ontario.

. . . . /2

I would like to thank you for your ongoing support of alPHa. Please accept the enclosed I ♥ PH sweatshirt as a token of appreciation. It has been a privilege to work with you this past year and I look forward to facing next year's challenges together.

Sincerely,

Linda Stewart
Executive Director

enclosure

alPHa
Association of Local PUBLIC HEALTH Agencies

INVOICE

Invoice No.: 24 MF 2013-14
Invoice Date: 03/31/2013

Sold to:

Peterborough County-City

Health Unit
10 Hospital Drive
Peterborough, Ontario K9J 8M1

Business No.: 127380822RT0001

Item No.	Description	Tax	Tax amount	Unit Price	Amount
2013-14 alPHa MF	2013-14 alPHa Membership - April 1, 2013 - March 31, 2014	H1	788.67	6,066.69	6,066.69
	Subtotal:				6,066.69
	H1 - HST 13% HST				788.67

Payable to Association of Local Public Health Agencies (alPHa)

1306-2 Carlton Street
Toronto M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030

Association of Local Public Health Agencies HST: #127380822 RT0001

Total Amount 6,855.36

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Fax: (416) 595-0030
E-mail: info@alphaweb.org

Providing leadership in public health management

MEMO

To: Chairs and Members of Boards of Health
Medical Officers of Health
alPHa Board of Directors
Presidents of Affiliate Organizations

From: Linda Stewart, Executive Director

Subject: ***alPHa Resolutions for Consideration at June 2013 Conference***

Date: April 30, 2013

Please find enclosed a package of the resolutions to be considered at the Resolutions Session which takes place at the Radisson Admiral Toronto Harbourfront Hotel on June 3, 2013 from 8:00 to 10:00 AM as part of alPHa's 2013 annual conference, *Keeping People Healthy.*

These resolutions were received prior to the deadline for advance circulation and have been reviewed for recommendation by the alPHa Executive Committee. The Executive Committee's recommendations serve as a guide; delegates will vote on the question before them, not on the recommendations.

Sponsors of resolutions should be prepared to have a delegate present to speak to their resolution(s) during the session.

IMPORTANT NOTE FOR LATE RESOLUTIONS:

Late resolutions (i.e. those brought by the floor) will be accepted, but please note that any late resolution must come from a health unit, the Boards of Health Section, the Council of Medical Officers of Health, the Board of Directors or an Affiliate Member Organization of alPHa. They may not come from an individual acting alone.

Also, in order to have a late resolution considered it must be first submitted in writing to an alPHa staff member **by 7:00 AM the day of the Resolutions Session (Monday, June 3, 2013)** so that it may be prepared for review by the membership. Before presentation to the membership, it must be reviewed by the Resolutions Chair appointed by the Executive Committee. The Chair will quickly review the resolution to determine whether or not it meets the criteria of a proposed resolution as per the "Procedural Guidelines for alPHa Resolutions" found at www.alphaweb.org/resolutions.asp. If the resolution meets these guidelines, it proceeds to the membership to vote on whether or not there is time to consider it. A successful vote will garner 2/3 majority support. If this is attained, it will be displayed on the screen and read aloud by its sponsor followed by a discussion and vote.

Each late resolution will go through this process. We value timely and important resolutions and want to ensure that there is a process to consider them.

Cont'd

IMPORTANT NOTE FOR VOTING DELEGATES:

Members must register to vote at the Resolutions Session. A registration form is attached. Health Units must indicate who they are sending as voting delegates and which delegates will require a proxy vote. Only one proxy vote is allowed per person.

Eligible voting delegates include Medical Officers of Health, Associate Medical Officers of Health, Acting Medical Officers of Health, members of a Board of Health and senior members in any of alPHa's Affiliate Member Organizations. Each delegate will be voting on behalf of their *health unit/board of health.*

Delegates are asked to obtain their voting card and proxy (if applicable) from the registration desk during the conference. They will be asked to sign off verifying that they did indeed receive their card(s). This is done so that we have an accurate record of who was present and voted during the meeting.

To help us keep paper costs down, **please bring your enclosed copy of the resolutions with you** to the Resolutions Session.

Attached is a list describing the number of votes for which each Health Unit qualifies. Please note that we have updated this list based on population statistics taken from the 2011 Statistics Canada Census data "Census Profile".

If you have any questions on the above, please feel free to contact Susan Lee, Manager, Administrative and Association Services, at 416-595-0006 ext. 25 or via e-mail at susan@alphaweb.org

Enclosures:

- Resolutions Voting Registration Form
- Number of Votes Eligible for alPHa Resolutions Session Per Health Unit
- June 2013 Resolutions for Consideration

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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E-mail: info@alphaweb.org

Providing leadership in public health management

2013 alPHa Resolutions Session
June 3, 2013 – 8:00 to 10:00 AM
Admiral Ballroom, Radisson Admiral Toronto Harbourfront, Toronto, ON

REGISTRATION FORM FOR VOTING

Health Unit _____

Contact Person & Title _____

Phone Number & E-mail _____

Name(s) of Voting Delegate(s):

Name	**Proxy*** (Check this box if the person requires a proxy voting card. Only one proxy is allowed per delegate.)	**Is this person registered for the June 2-4 Conference? (Y/N)**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Fax this form to 416-595-0030 or
email it to susan@alphaweb.org **on or before May 27, 2013**

* Each voting delegate may carry their own vote plus one proxy vote for an absent delegate. For any health unit, the total number of regular plus proxy votes cannot exceed the total number of voting delegates allotted to that health unit.

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Providing leadership in public health management

Number of Votes Eligible for Resolutions Session Per Health Unit

HEATLH UNITS	*VOTING DELEGATES*
Toronto*	**20**
POPULATION OVER 400,000	**7**
Durham	
Halton	
Hamilton	
Middlesex-London	
Niagara	
Ottawa	
Peel	
Simcoe-Muskoka	
Waterloo	
York	
POPULATION OVER 300,000	**6**
Windsor-Essex	
POPULATION OVER 200,000	**5**
Wellington-Dufferin-Guelph	
POPULATION UNDER 200,000	**4**
Algoma	
Brant	
Chatham-Kent	
Eastern Ontario	
Elgin-St.Thomas	
Grey Bruce	
Haldimand-Norfolk	
Haliburton, Kawartha, Pine-Ridge	
Hastings-Prince Edward	
Huron	
Kingston, Frontenac, Lennox and Addington	
Lambton	
Leeds, Grenville and Lanark	
North Bay-Parry Sound	
Northwestern	
Oxford	
Perth	
Peterborough	
Porcupine	
Renfrew	
Sudbury	
Thunder Bay	
Timiskaming	

* total number of votes for Toronto endorsed by membership at 1998 Annual Conference

Health Unit population statistics taken from: Statistics Canada. 2011 Census. *Census Profile.*

alPHa
Association of Local
PUBLIC HEALTH
Agencies

June 2013

RESOLUTIONS FOR CONSIDERATION

.....

at the

alPHa Resolutions Session, 2013 Annual Conference
Monday, June 3, 2013
Admiral Ballroom, Third Floor
Radisson Admiral Toronto Harbourfront
249 Queen's Quay West, Toronto, Ontario

DRAFT RESOLUTIONS FOR CONSIDERATION
at June 2013 alPHa Annual Conference

TITLE: **Banning the Sale and Distribution of All Tobacco Products in the Province by the Year 2030**

SPONSOR: **Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit**

WHEREAS smoking, along with other forms of tobacco use, remains the leading cause of illness and death in Ontario; and

WHEREAS tobacco use is responsible for three times as many deaths as the combined total of alcohol, drugs, suicide, homicide, injuries sustained from car crashes, and AIDS[1]; and

WHEREAS scientific studies have concluded that cigarette smoking causes chronic lung disease, coronary heart disease, stroke, cancer of the lungs, larynx, esophagus, mouth, and bladder, and contributes to cancer of the cervix, pancreas, and kidneys[2]; and

WHEREAS the use of cigars is known to cause lung, larynx, esophageal, and oral cancer[3]; and

WHEREAS there is no safe level of exposure to second hand smoke and over the past three decades, a substantial body of research has confirmed that exposure to tobacco smoke among children and adults causes a range of adverse health effects[4]; and

WHEREAS smoking during pregnancy not only affects the health of a mother, but also her unborn and newborn baby[5], including: a higher risk of miscarriage and complications during birth; having an infant with low birth weight;[6] more prone to illnesses (e.g. asthma[7] or sudden infant death syndrome8); and a higher chance of death at birth or shortly after;[2] and

1 Holowaty E, Cheong SC, Di Cori S, Garcia J, Luk R, Lyons C, Therialt ME. Tobacco or health in Ontario: Tobacco attributed cancers and deaths over the past 50 years... and the next 50. Toronto, ON: Cancer Care Ontario, 2002. Available at: http://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=14456

2 U.S. Department of Health and Human Services. The health consequences of smoking: A report of the Surgeon General. Atlanta, GA: U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004. Available at: http://www.cdc.gov/tobacco/data_statistics/sgr/2004/index.htm

3 U.S. Dep't of Health and Human Services, Centers for Disease Control and Prevention, *Annual Smoking – Attributable Mortality, Years of Potential Life Lost, and Economic Costs – United States 1995-1999 (*2002) MORBIDITY AND MORTALITY WEEKLY REPORT. Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm

4 U.S. Department of Health and Human Services. The health consequences of involuntary exposure to tobacco smoke: A report of the Surgeon General. Atlanta, GA: U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006. Available at: http://www.surgeongeneral.gov/library/secondhandsmoke/report/index.html

5 Health Canada. The Facts About Tobacco. Available at: http://www.hc-sc.gc.ca/hecssesc/tobacco/facts/health_facts/pre_postnatal.html

6 US Department of Health and Human Services. Reducing the Health Consequences of Smoking: 25 years of progress. A Report of the Surgeon General, Rockville, Maryland: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1989.

7 U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.

WHEREAS second-hand smoke exposure causes children to suffer from lower respiratory tract infections, such as pneumonia and bronchitis, exacerbates childhood asthma, and increases the risk of acute, chronic, middle ear infection in children[16]; and

WHEREAS smokeless tobacco has over 3,000 chemicals including 28 known carcinogens, is not a safe substitute for cigarettes and increases the risk of having a fatal heart attack, fatal stroke and certain cancers;[9] and

WHEREAS the World Health Organization (WHO) estimates that by 2030, tobacco will account for 10 million deaths per year, making it the greatest cause of death worldwide;[10] and

WHEREAS more than 13,000 people die in Ontario from tobacco-related diseases every year, making it the number one cause of death and disease in Ontario;[11] and

WHEREAS in 2002, in Ontario, the direct cost for health care related to tobacco was $1.6 billion rising to the equivalent of $1.93 billion in 2009 when inflation and population growth are considered; [13, 7] and

WHEREAS the economic value of labour productivity lost to tobacco related illness was $4.4 billion in 2002, with the 2009 equivalent calculated to be $5.8 billion;[12]

WHEREAS Ontario law acknowledges the harms of tobacco use by prohibiting the sale or furnishing of cigarettes, tobacco products or smoking paraphernalia to minors; and

WHEREAS Ontario law prohibits public school students from smoking or using tobacco products on school property, including parking lots; and

WHEREAS some Ontario jurisdictions prohibit smoking in playgrounds and recreational facilities;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies request the Ministry of Health and Long Term Care and its stakeholders to provide for the public health, safety, and welfare of all Ontario citizens by banning the sale and distribution of all tobacco products in Ontario by 2030, and by continuing to implement the recommendations made by the Smoke-Free Ontario – Scientific Advisory Committee as a means of achieving a tobacco-free Ontario;

AND FURTHER that the Premier of Ontario, the Minister of Finance, the Chief Medical Officer of Health, the Ontario Public Health Association and Ontario Boards of Health be so advised.

Backgrounder attached (1) – see next 2 pages

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

8 California Environmental Protection Agency. Health Effects of Exposure to Environmental Tobacco Smoke. Final Report. Sacramento: California Environmental Protection Agency, Office of Environmental Health Hazard Assessment, 1997.
9 Piano MR, Benowitz NL, FitzGerald GA, Corbridge S, Heath J, Hahn E, et al. Impact of smokeless tobacco products on cardiovascular disease. Implications for policy, prevention and treatment. *Circulation* 2010;122:1520-44.
10 U.S. Dep't of Health and Human Services, Centers for Disease Control and Prevention, *Reducing Tobacco Use: A Report of the Surgeon General*, 437 (2001).
11 Rehm J, Baliunas D, Brochu S, Fischer B, Gnam W, Patra J, et al. The costs of substance abuse in Canada 2002: Highlights. Ottawa, Canada: Canadian Centre on Substance Abuse, 2006. Available at: http://www.ccsa.ca/2006%20CCSA%20Documents/ccsa-011332-2006.pdf
12 Based on 2002 data as reported, adjusted for 22.1% increase in median individual income and 8.1% population growth from 2002-09 (Ontario, all ages) during the same period (Statistics Canada, CANSIM Table 111-0008 and CANSIM, Estimates of population growth by province).

BACKGROUNDER FOR A13-1

BACKGROUND

Smoking and other forms of tobacco use remain the leading cause of preventable illness and death in Ontario. Smoking and exposure to tobacco smoke have been clearly established as the cause of a large number of diseases and health conditions. Tobacco use costs the Ontario economy billions of dollars annually in health care and lost productivity costs[13].

In October 2010, the Tobacco Strategy Advisory Group to the Minister of Health Promotion and Sport, released its report "*Building On Our Gains, Taking Action Now; Ontario's Tobacco Control Strategy for 2011-2016*. **Their vision statement is: A tobacco-free Ontario by 2030[14].**

Much success has been achieved to date. Since 1992, research, legislation and public education have increased awareness of the dangers of smoking and second hand smoke which in turn has increased public acceptance and demand for smoke-free policies. In 2004, the Smoke-Free Ontario Act (SFOA) replaced the Tobacco Control Act (1994), providing comprehensive provincial legislation which addresses enclosed public places and workplaces, tobacco display bans and strengthens restrictions on selling tobacco products to young people. The SFOA also provides additional support to smokers trying to quit and creates and funds programs designed to prevent youth from starting to smoke14.

Municipal governments have played a key role as well, enacting no-smoking policies governing restaurants and bars (prior to the SFOA) and more recently, no-smoking policies for outdoor public spaces such as public parks, beaches and children's playgrounds.

In 2009, the Ontario government also banned smoking in vehicles when children under 16 are present, and passed legislation to allow the government to sue tobacco companies to recover health care costs due to tobacco-related illness and to address the supply of flavoured cigarillos to young people[14].

The results have been impressive:

- More than 99 percent of Ontario bars, restaurants and other enclosed workplaces are now smoke-free
- Ninety-eight (98) percent of tobacco retail outlets are in compliance with the ban on retail displays of tobacco products
- According to 2006 Health Canada figures, legal sales of Ontario cigarettes fell by 31.8 percent since 2003[14]
- National youth smoking rates (age 15-19) have been reduced by 15% from 27% in 1985 to 12% in 2011[15]

13 Smoke-Free Ontario – Scientific Advisory Committee. *Evidence to Guide Action: Comprehensive Tobacco Control in Ontario.* Toronto, ON: Ontario Agency for Health Protection and Promotion, 2010
14 Tobacco Strategy Advisory Group. *Building on our Gains, Taking Action Now: Ontario's Tobacco Control Strategy for 2011-2016.* Toronto, ON: Ministry of Health Promotion and Sport, 2010.
15 Canadian Tobacco Use Monitoring Survey (CTUMS), 2011. Accessed at http://www.hc-sc.gc.ca/hc-ps/tobactabac/research-recherche/stat/ctums-esutc_2011-eng.php March 2013

However, the tobacco industry, both legal and illegal, persists as a supplier of products responsible for the leading cause of preventable disease and death among Ontarians. Tobacco related diseases cost the Ontario economy approximately $1.6 billion in health care annually, more than $4.4 billion in productivity losses and accounts for at least 500,000 hospital days each year14. In contrast, revenue from tobacco taxes in Ontario was only $1.236 billion in the 2006/07 fiscal year[16]. This is not a deficit the Ontario government, nor our health care system, can sustain.

One key document that directs the work of public health tobacco prevention, protection, cessation and equity is *Evidence to Guide Action: Comprehensive Tobacco Control in Ontario, (2010)*. This document acknowledges that, despite many successes, challenges remain and there is much room for improvement. The document also acknowledges that tobacco control needs to be comprehensive and requires the adoption and implementation of a combination of effective programs and policies. There are several factors to be considered, including confronting the tobacco disease vector (the tobacco industry), addressing prevention, protection, cessation and the system enablers in tobacco control[13].

[16] Smoke-Free Ontario Act, as of May 31, 2006. Fact Sheet – costs of Tobacco Use and Tax Revenues. Ministry of Health Promotion. Accessed at http://www.mhp.gov.on.ca/en/smoke-free/factsheets/Tobacco_Revenue-120208.pdf March 2013

TITLE: **The Healthy Smiles Ontario Program and the Overall Inequity within the Oral Health Care System**

SPONSOR: **The Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit**

WHEREAS OHIP pays to provide medical care to every part of the body except the mouth and one in four Ontarians do not visit a dentist because of cost; and

WHEREAS working adults and seniors on fixed incomes do not have a government program to assist them with any dental care expenses; and

WHEREAS there are four provincial dental programs for children aged 0-17 each with a different set of eligibility criteria and fee guide, making access to them confusing to dental offices, administrators and families; and

WHEREAS children from families with partial insurance that cannot afford to pay the uninsured portion of their dental treatment do not qualify for these programs; and

WHEREAS Healthy Smiles Ontario, the preventive and early dental treatment program, is underutilized provincially and locally; and

WHEREAS there are different models of assisting in the delivery of provincially funded oral health programs including Community Health Centres; and

WHEREAS a number of recent provincial reports and initiatives have indicated the urgent need to move forward to transform the current oral care health system;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies request the Government of Ontario to:

1. Increase the Healthy Smiles Ontario (HSO) income cut-off threshold, which is currently adjusted family net income of $20,000 or less;
2. Remove the 'no dental insurance' eligibility criterion from the HSO program;
3. Streamline children's dental treatment programs to make them more efficient, effective and equitable as recommended in *Oral Health – More Than Just Cavities. A Report by Ontario's Chief Medical Officer of Health, April 2012;*
4. Extend provincial programs to include adults who need and cannot afford emergency dental care.
5. Continue to facilitate the partnerships between local health units and community health centres to assist with the delivery of provincially funded oral health programs;

AND FURTHER that the Premier of Ontario, the Minister of Health and Long-Term Care, Chief Medical Officer of Health, the Association of Municipalities of Ontario and Ontario boards of health are so advised.

Backgrounder attached (1) – see next 3 pages

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

BACKGROUNDER FOR A13-2

Background
The Healthy Smiles Ontario Program and the Overall Inequity within the Oral Health Care System

Healthy Smiles Ontario

As the second phase of Ontario's Poverty Reduction Strategy, the Healthy Smiles Ontario (HSO) program was launched across the province in October 2010. Healthy Smiles Ontario is a preventive and early dental treatment program for children 17 and under from families with no form of dental insurance (or social assistance) and an adjusted family net income of $20,000 or less. It is 100% funded by the Ministry of Health and Long Term Care (MOHLTC).

Prior to the launch of HSO, each health unit was asked to work with its local community to develop a proposal that would make the most of the current resources and improve local capacity to provide access to community dental services for children from low income populations. Depending on what was asked for and approved, each health unit received varying levels of funding for infrastructure and operational costs. This funding was used for things such as building or expanding dental clinics within health units or community health centres and/or hiring new clinical, health promotion or administrative staff. As a result there are several different HSO models in place across the province.

The launch of the HSO program took place around the time that a number of Community Health Centres (CHCs) were being established or expanded across the province. Community Health Centres without dental health clinics were ideal partners for health units to work with when preparing their HSO proposals as CHCs cater to the needs of high risk and low income groups and value the importance of access to dental care.

Programs for children 17 and under

In addition to HSO there are three additional programs for children 17 and under:
1. Children In Need of Treatment Program (CINOT), an urgent dental care program administered by health units
2. Ontario Works (OW) Dental Program, a basic dental care program for dependents of OW recipients, administered by some health units
3. Ontario Disability Support Program (ODSP), a basic dental care program for dependents of ODSP recipients, not administered by health units.

Most children from low income families are eligible for at least one of these programs. An exception to this would be a child from a family that has partial or limited dental insurance and cannot afford to pay for the uninsured portion of their child's treatment. Another problem with the current set of children's programs is that each program has its own set of eligibility criteria and fee guide making them confusing for administrators, dental offices and families. The CINOT program only sees children with urgent problems (i.e. large cavities). The HSO program, which includes preventive and early dental treatment that potentially prevents urgent and more costly dental issues from occurring in the first place, is underutilized provincially.

CONT'D

Adults (aged 18 and over)

Adults on OW are eligible for limited discretionary coverage mostly to get them out of pain, and adults on ODSP are eligible for basic dental care and limited discretionary coverage for dentures. Working adults and seniors on fixed incomes however, have no government program to assist them with any dental care expenses. In particular, it is of some concern that while most children from low income families can access at least one of the above dental care programs, their parents and grandparents are still left with very limited or no access to dental care, even when suffering from dental pain and infection.

Concerns with HSO and overall inequity related to access to dental care

With HSO being underspent provincially, a number of specific concerns have been raised regarding the eligibility of the program including:

- The income cut off being too low
- The 'No dental insurance' eligibility criterion
- Adults (aged 18 + years) are excluded

Across the province, a number of health officials, leaders in the field and community groups have come forward to discuss the situation regarding HSO and oral health programs in general and to offer solutions. All are in agreement that there is an urgent need to take the steps necessary to transform the current oral health system into one that is efficient, effective and equitable.

Chief Medical Officer of Health (CMOH) Report[1]

Ontario's CMOH, Dr. Arlene King, released a report in April 2012 titled *Oral Health- More Than Just Cavities.* Dr. King has called on the province to:

- ensure access to fluoridated water
- review how publicly funded oral health programs are monitored and evaluated
- improve access to oral health care available to First Nations in Ontario
- review Ontario's low income dental programs and consider integrating them to improve the ease with which families can access the care they need for their children when they need it.

Ontario Oral Health Alliance Postcard Campaign

The Ontario Oral Health Alliance (OOHA) is an Ontario wide group of dental coalitions, agencies and members of the public concerned with the lack of access to equitable and affordable dental care for Ontarians. In June 2012, OOHA launched a provincial postcard campaign to bring attention to the fact that thousands of adults live in pain and infection because they cannot afford dental care. Over 50,000 postcards have been distributed across Ontario in at least 76 out of the 108 electoral districts. The campaign is currently wrapping up as participants meet with their local MPPs and ask them to present signed postcards to the Legislature.

Staying Ahead of the Curve: A Unified Public Oral Health Program for Ontario?[2]

Released in October 2012, *Staying Ahead of the Curve: A Unified Public Oral Health Program for Ontario?,* was compiled by a group of individuals who care about the health of Ontarians. Each of the authors participated in an expert panel debate at the Ontario Public Health Convention in April 2012, which led to the formulation of three overall recommendations including combining the current patchwork of public oral health care programs in Ontario and implementing the recommendations made by the CMOH in her report.

Brighter Prospects: Transforming Social Assistance in Ontario[3]

The recently released Social Assistance Review (Brighter Prospects: Transforming Social Assistance in Ontario) recognized the link between oral health and employment. It called for the province to look at ways to make discretionary benefits like dental care available to all low income Ontarians, not only those on social assistance. In addition, the report recommended that special health benefits such as adult dental care be streamlined and provided consistently to social assistance recipients in all municipalities.

1 Oral Health - More Than Just Cavities (Report by Ontario's CMOH, April 2012)
2 Staying ahead of the curve: A unified public oral health program for Ontario?, October 2012
3 Commission for the Review of Social Assistance in Ontario. Brighter Prospects: Transforming Social Assistance in Ontario. A Report to the Ministry of Community and Social Services. October 2012

TITLE: **Mandatory Baby-Friendly Designation for all Ontario Hospitals with Birthing Units**

SPONSOR: **Board of Health, Peterborough County-City Health Unit**

WHEREAS breastfeeding supports optimal health and developmental outcomes in infants and young children, as supported by research; and

WHEREAS the Canadian Paediatric Society (CPS) recommends that breastfeeding should be protected, promoted, and supported as breast milk is the ideal form of nutrition for all infants and young children; and

WHEREAS that World Health Organization's Baby-Friendly Initiative (BFI) is an evidence-based program to protect, promote, and support breastfeeding, as outlined in the Breastfeeding Committee for Canada's BFI 10 Steps and Practice Outcome Indicators (2012); and

WHEREAS the Ministry of Health and Long-Term Care (MOHLTC) has identified BFI designation as a requirement for Family Health programs for all Health Units in its Accountability Agreements; and

WHEREAS the provincial Healthy Kids Panel it its report titled *No Time to Wait: The Healthy Kids Strategy (2013)* on reducing the incidence of childhood overweight and obesity, recommends that all hospitals with labour and delivery units and all paediatric hospitals to be designated Baby-Friendly; and

WHEREAS the CPS recommends that "provincial/territorial ministries of health should mandate the development of a strategy for the implementation of the BFI in all health care facilities providing maternal/child health services, including hospitals, public health units, community health centres and physicians' offices"; and

WHEREAS the Government of Canada has endorsed the WHO's *International Code on the Marketing of Breastmilk Substitutes*, (WHO Code) which protects breastfeeding by restricting the marketing of infant formula, in particular through the health care system; and

WHEREAS despite Canada's adoption of the WHO Code the formula industry continues to violate the WHO Code, and market formula through the health care system, specifically by providing free formula to hospitals;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies urges the Minister of Health and Long Term Care, Deb Matthews, to make it mandatory for all Ontario hospitals with birthing units to implement the BFI 10 Steps, and work to achieve Baby-Friendly designation.

Backgrounder attached (1) – see next 2 pages

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

Breastfeeding unfriendly in Canada?

Beverley Chalmers DSc(Med) PhD

More than 20 years ago, the Baby-Friendly Hospital Initiative,[1] which is supported by substantial evidence,[2] was launched by the United Nations Children's Fund and the World Health Organization.[1] Today, only 9 of Canada's about 350 maternity hospitals are accredited as Baby Friendly.[3] The Public Health Agency of Canada's Maternity Experiences Survey found that only 14.4% of mothers achieve the Canadian and global standard of breastfeeding exclusively at 6 months.[4] Our breastfeeding rates are unbecoming of a country that prides itself as a leading perinatal care provider globally.

Almost every province and territory has extensive documentation, programs and resources endorsing breastfeeding.[3] Canadian rates of breastfeeding initiation are praiseworthy, ranging from 72.2% in Prince Edward Island to 97.0% in British Columbia, with a 90.3% national average.[4] However, exclusive breastfeeding rates at 6 months are unimpressive in the provinces, ranging from 5.8% in Newfoundland and Labrador to 19.2% in BC. Interestingly, the Yukon's rates of 6-month exclusive breastfeeding are strikingly superior (34.2%), and those of the Northwest Territories (18.7%) and Nunavut (19.7%) are also among the best.[4]

We customarily attribute failure to breastfeed to social determinants of health, such as income and education, and then ascribe our failures to these relatively unchangeable influences. A review of 45 articles from 16 countries (including one Canadian paper) outlined barriers to implementing the Baby-Friendly Hospital Initiative.[5] These included inadequate endorsement from local administrators and government policymakers, ineffective change leadership, lack of training of health care workers, lack of integrated hospital and community services, and the influence of marketing for formula.[5]

The Canadian Maternity Experiences Survey found that although at least 90% of Canadian women intended to start, and started, breastfeeding, 21% added liquids other than breastmilk within 1 week of delivery and 25.2% within 2 weeks, which suggests that hospital breastfeeding support practices are failing about a quarter of all breastfeeding women.[4] Calculations based on 372 724 births in 2007 indicated that 335 452 women started breastfeeding, thereby expressing their desire to breastfeed, and 84 534 gave up exclusive breastfeeding within 1–2 weeks of giving birth.[6] Similarly, a 2009 survey of all Ontario births during a 1-year period found that only 61.6% of mothers were exclusively breastfeeding at discharge from hospital.[7] The Canadian Maternity Experiences Survey clearly showed that few of the in-hospital breastfeeding supportive practices recommended by the Baby-Friendly Hospital Initiative as necessary to support breastfeeding were being appropriately implemented by hospitals in Canada.[4] For instance, only 26.6% of women put their baby to the breast for the first time during the most optimal period (30 min to 2 h) after birth; 28.1% of mothers whose babies were not admitted to a neonatal intensive care unit or special care unit held their babies within 5 minutes of birth; 31.1% of mothers held their babies skin-to-skin on first contact; 35.8% of mothers were offered or given free formula; 35.0% of women whose babies were not admitted to a neonatal intensive care unit or special care unit had rooming-in for the recommended 23–24 hours per day; 50.2% of mothers did not follow the recommended demand-feeding schedule; and 44.4% of babies were given a pacifier within the first week of life.[4] These figures suggest that hospital practices (and therefore training of health care workers) probably contribute more to breastfeeding failure than social determinants of health, which are unlikely to have changed or influenced these in-hospital practices.

If exclusive breastfeeding were classified as a topic of patient safety (which it surely is, consid-

Key points

- A national survey by the Public Health Agency of Canada showed that although about 90% of Canadian women started breastfeeding, 21% added liquids other than breastmilk within 1 week of delivery and 25.2% within 2 weeks.
- The same study found that exclusive breastfeeding rates in Canada were less than optimal, with only 14.4% of mothers adhering to the global recommendations of 6 months of exclusive breastfeeding.
- Few maternity hospitals (9 of about 350) in Canada are accredited as Baby Friendly.
- Training of health care workers in practical breastfeeding skills is needed.

Competing interests: Beverley Chalmers has served as co-chair of the Maternity Experiences Survey for the Canadian Perinatal Surveillance System at the Public Health Agency of Canada and has served as a master trainer for the Baby-Friendly Hospital Initiative.

This article has been peer reviewed.

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ering the multiple health benefits that accrue to breastfeeding mothers and their babies), such numbers would be quickly acknowledged as requiring urgent attention.

Possible explanations

We are succeeding in promoting the start of breastfeeding. Why are we not able to support continued breastfeeding?

One of the possible explanations is lack of appropriate instruction of health care workers. Good policies and breastfeeding documentation are available, but how much time is dedicated to instruction in the skill of breastfeeding in medical, nursing and other health care provider programs? The provision of more than a 1- or 2-hour session on breastfeeding for medical students (including potential family doctors, obstetricians and pediatricians) is probably unusual. Although the current level of training can emphasize the benefits of breastfeeding, it can do little to teach how to position and, most importantly, latch a newborn correctly onto the breast. In-service training is also required.

Few comprehensive studies about breastfeeding have been conducted in Canada. The Maternity Experiences Survey[4] is the only national Canadian survey to simultaneously and extensively monitor the following: breastfeeding rates in the first 6 months of life, the contribution of most of the 10 steps of the Baby-Friendly Hospital Initiative, details regarding obstetric care and mother–infant contact at birth, and social determinants of health. Few national or local perinatal surveys are similarly comprehensive.

Monitoring of breastfeeding in hospital may be lacking. Do all caregivers observe mothers breastfeeding? And can they identify a successful latch? A maternal count of "pees and poops" is not an appropriate proxy indicator of successful feeding.

Information given to mothers in hospital may promote use of formula. For example, a public health document entitled "Feeding Your Baby Infant Formula" is displayed in some Ontario hospitals.[8] Its first line is "Feed your baby only formula for the first six months of life" and it fails to mention anywhere — as required by the International Code of Marketing of Breast-milk Substitutes[9] — that breastmilk is best. Happy bouncing infants are depicted in the document — also against code recommendations. Such documents are contrary to the Baby-Friendly Hospital Initiative and give official credibility to formula feeding of infants.

Inadequate support is given to mothers who have had cesarean deliveries. We downplay the breastfeeding challenges faced by the 27.8% of women in Canada who give birth by cesarean delivery.[6] Although the rates of breastfeeding initiation among mothers who have had cesarean and vaginal deliveries do not differ, mothers who have had cesarean deliveries have less optimal mother–infant contact after birth and lower rates of continued breastfeeding.[10] They are more likely to be given free formula samples, use pacifiers and not feed their babies on demand, factors that reduce success in breastfeeding[10] and are indicative of inappropriate breastfeeding support.

Federal support for breastfeeding is poor. The Breastfeeding Committee for Canada is no longer funded by the Public Health Agency of Canada; the agency's only involvement now is to facilitate some teleconferencing of its volunteer committee members.[3]

The way forward

A few hours of appropriate education of health care workers, and just 3 hours of hands-on clinical instruction, as required by the Baby-Friendly Hospital Initiative[1] and supported by the Promotion of Breastfeeding Intervention Trial,[2] could help many tens of thousands more women who currently stop exclusive breastfeeding within 1–2 weeks of giving birth to achieve their goal of breastfeeding, with its considerable maternal and infant health benefits.

I appeal to research funding bodies such as the Canadian Institutes of Health Research to dedicate resources to the practical implementation of the Baby-Friendly Hospital Initiative in Canada. As required by the initiative, we need a concerted effort to ensure that all caregivers (including obstetricians,[1] pediatricians, family doctors, nurses and midwives) are trained on the basic and simple skills of breastfeeding that, judging from our less than ideal outcomes, is lacking at present.

Responsibility for breastfeeding can no longer be shifted from obstetrician to nurse, midwife, family doctor or pediatrician: it is a shared responsibility. We need all our maternity hospitals to become "baby friendly," as the most efficacious means of improving rates of breastfeeding.[2] Most important, we need to make a concerted commitment to remedy this gap in Canadian health care services. It is not mothers who are failing to breastfeed, but we who are failing mothers.

For references, see Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.121309/-/DC1.

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alPHa DRAFT RESOLUTION A13-4

TITLE: **Gambling Expansion and Provincial Revenue Generation**

SPONSOR: **Toronto Public Health**

WHEREAS the Ontario government directed the Ontario Lottery and Gaming (OLG) Corporation in 2010 to modernize commercial and charitable gaming through a comprehensive strategic review; and

WHEREAS OLG's report*: Modernizing Lottery and Gaming in Ontario: Strategic Business Review* (approved by the Ontario Ministry of Finance in March 2012) includes recommendations that will result in increased access to gambling in Ontario including through: increasing the 27 legal gambling sites to 29 sites, launching internet gaming, expanding lottery sales and allowing bingo halls to host electronic games; and

WHEREAS The Ontario 2012 budget includes provisions for gambling expansion to increase provincial revenues; and

WHEREAS gambling expansion has been identified as a significant public health issue in Ontario and internationally due to its links to the prevalence of problem gambling and associated health and social impacts; and

WHEREAS an estimated 36 percent of Ontario gambling revenue Is derived from people with moderate and severe gambling problems; and

WHEREAS problem gambling has serious adverse health impacts on individuals, families and communities; and

WHEREAS the impacts of problem gambling are not evenly distributed in the community - males, youth, older adults, Aboriginal peoples, individuals and families with low income are disproportionately affected; and

WHEREAS certain types of gambling, such as electronic gaming machines are the most addictive forms of gambling; and

WHEREAS increased availability and accessibility of gambling, including new casinos or slot machines, is strongly associated with increases in the prevalence of problem gambling; and

WHEREAS a broad range of policies and strategies that focus on prevention are needed to minimize the probability of problem gambling occurring and to reduce health and social impacts for problem gamblers and their families;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies call for the Province of Ontario to refrain from expanding gambling availability as a way to address budget shortfalls in Ontario;

AND FURTHER that the Association of Local Public Health Agencies partner with health units and other stakeholders to strengthen and develop strategies that prevent or mitigate gambling-related harm in Ontario, promote awareness of treatment options, and protect vulnerable populations.

Backgrounder attached (1) – see next 3 pages

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

BACKGROUNDER FOR A13-4

Gambling and Health Backgrounder (DRAFT)

Over the past two decades, gambling expansion has been identified as a significant public health issue in Ontario and internationally due to its links to the prevalence of problem gambling and associated health impacts.

OLG Modernization Plan

In 2010, the Province directed the Ontario Lottery and Gaming (OLG) Corporation to modernize lottery and gaming operations.[1] There are many recommendations in the OLG report that will result in increased access to gambling in Ontario. In particular, OLG intends to increase the 27 legal gambling sites in Ontario (consisting of slots, casinos and resort casinos) to 29 sites, launch online gaming, expand lottery sales options to multi-lane retailers and expand charitable gaming to allow bingo halls to deliver electronic games.

The Ontario 2012 budget, building on recommendations from the Commission on the Reform of Ontario's Public Services (the Drummond report) and the OLG Modernization Plan, subsequently included provisions for gambling expansion to increase provincial revenues. [2]

Increased availability and accessibility of gambling in Ontario, including through new casinos or slot machines, will likely result in an increase in the prevalence of problem gambling in Ontario.

What is Problem Gambling?

Problem gambling is defined as gambling behaviour which includes continuous or periodic loss of control over gambling; preoccupation with gambling and money with which to gamble; irrational thinking; and continuation of activity despite adverse consequences.[3] Problem gambling can include a continuum of gambling behaviour that creates negative consequences for the gambler, others in his or her social network, or for the community.

Problem gambling is an issue of significant public health concern. Researchers estimate that the prevalence of problem gambling in Ontario was 1.2%[4] in 2011.

Problem gambling has adverse health impacts on individuals, families and communities. Problem gambling is associated with a range of negative impacts on physical and mental health, including ill health, fatigue, co-related substance use and addiction, depression and suicide among others. These impacts occur alongside others such as alcohol-related traffic fatalities, financial difficulties, family breakdown, divorce and compromised child development that also affect the health and well-being of family, friends, colleagues and communities.[5] [6] [7] [8] [9] [10] [11] [12] [13] [14] [15] [16] [17] [18] [19] [20] [21]

The impacts of problem gambling are not evenly distributed in the community. Problem gambling affects some groups disproportionately, including males, youth, older adults, Aboriginal peoples, and individuals and families with low incomes, and therefore contributes to poverty and socioeconomic inequalities. [5] [8] [16] [22] [23] [24]

Electronic gaming machines, such as slot machines, are the most addictive form of gambling. Certain gambling modalities carry a higher risk that their users will develop gambling problems or that existing gambling problems will be exacerbated. Evidence points to continuous forms of gambling, such as EGMs

including slot machines and video lottery terminals (VLTs), as most harmful. (VLTs are not currently permitted in Ontario.) The high-risk nature of EGMs is theorized to be related to the fast speed of play and the promotion of small wins, false beliefs and dissociative states. 7 [25]

Much remains unknown about Internet gambling, including who is most likely to gamble online, who is vulnerable to negative impacts of Internet gambling, and whether Internet gambling is creating a new market of gambling customers. The prevalence of Internet gambling is low and it is the least common form of gambling among adult Canadian gamblers.[26] However, research from Quebec, where the government operates online gambling sites, indicates that problem gambling rates are significantly higher among those who gamble online.[27] Available research also suggests that there may be some distinguishing features associated with those who partake in Internet gambling, including demographic characteristics, motivations and behaviours.[28] While there is certainly overlap between Internet and non-Internet gamblers, researchers hypothesize that Internet gambling, to some extent, opens up a new market of gamblers who may not frequent fixed gambling venues such as casinos.[26 28]

More must be done to explore the long-term effectiveness of interventions and to ensure problem gamblers undergo treatment. There are currently gaps in evidence on how to effectively counter the negative health and social impacts of problem gambling. It is an invisible addiction which has implications for prevention and treatment. While problem gambling is amenable to intervention and some treatment modalities achieve success, there is still a low uptake; only a minority of problem gamblers (1-2% per year) seeks or receives treatment. 5 8 [29 30 31]

A broad range of strategies and policies that focus on prevention are needed to minimize the probability of problem gambling occurring and to reduce health impacts to problem gamblers and their families. Given the current evidence base on treatment effectiveness, simply treating problem gambling will not adequately address the issue of problem gambling. A public health approach calls for prevention, research and awareness interventions, which focus on **preventing exposure to gambling** in order to minimize the probability of problem gambling from occurring. In the context of gambling expansion, a comprehensive program of harm mitigation measures should be put in place to minimize the risks associated with problem gambling.7 [32]

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TITLE: **Provincial Legislation to Prohibit the Use of Waterpipes in Enclosed Public Places and Enclosed Workplaces**

SPONSOR: **Simcoe Muskoka District Health Unit**

WHEREAS the emerging use of waterpipes in enclosed public places and enclosed workplaces has the potential to undermine the success of the Smoke-Free Ontario Act; and

WHEREAS tobacco-free ("herbal") waterpipe smoke has been demonstrated to have concentrations of toxins comparable to tobacco waterpipe smoke [1]; and

WHEREAS the environmental smoke from waterpipe use in indoor public places and workplaces has been demonstrated to contain toxins at harmful concentrations [2]; and

WHEREAS the alleged "herbal" preparations are poorly regulated and often contain tobacco even when they are labelled tobacco free [3]; and

WHEREAS the Tobacco Strategy Advisory Group report recommends an amendment of the Smoke-Free Ontario Act, with "the addition of controls on the indoor use of water-pipes such as hookahs";

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) advocate for provincial legislation to be enacted to prohibit the use of waterpipes (regardless of the substance being smoked) in all enclosed public places and enclosed workplaces.

Backgrounders attached (2) – see next three pages

alPHa Executive Committee Recommendation to the Membership: This resolution to go forward for discussion at the Resolutions Session at the June alPHa conference.

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BACKGROUNDER FOR A13-5

Waterpipe Smoking

Update: New **Date:** March 20, 2013

Issue:

The use of waterpipes, also known as hookahs, is an emerging trend that is gaining popularity among youth and young adults. A number of reasons for this increasingly popular phenomenon include: flavourings added to make it more palatable, misperceptions that the water filters nicotine and other harmful substances from the smoke negate the serious health effects, relative ease of access, and appeal of the social interaction that accompanies its use.

Recommendations:

THAT the Board of Health receive the waterpipe smoking briefing note for information.

AND FURTHER THAT the Board of Health write to the councils of Simcoe and Muskoka municipalities to identify the health concerns associated with the use of waterpipes and to provide a copy of a model bylaw similar to the City of Peterborough's bylaw (Appendix A) prohibiting the use of waterpipes, for consideration by municipal councils.

AND FURTHER THAT the Board of Health write to the Ontario Minister of Health recommending provincial legislation prohibiting waterpipe use regardless of the substance being smoked in all indoor public places and workplaces, with a copy to be sent to the Chief Medical Officer of Health, all Ontario Boards of Health, and the local Members of Provincial Parliament in Simcoe Muskoka.

AND FURTHER THAT the Board of Health direct Simcoe Muskoka District Health Unit (SMDHU) staff to create and submit for the alPHa conference in June a resolution for such legislation.

Current Facts:

In 2012, a small sandwich shop in Bradford decided to provide waterpipes for their customers in the enclosed area of their premises. The shop subsequently has closed.

In February of this year, a small café in Barrie began to provide waterpipes for customers to smoke in the enclosed area of the café.

Both businesses identified that they were offering herbal smoking material in the waterpipes. By claiming their product is herbal and contains no tobacco, proprietors can skirt the Smoke-Free Ontario Act (SFOA) and allow customers to smoke indoors. This undermines the SFOA which was created in part to protect Ontarians from smoke in enclosed public places and workplaces. Smoking waterpipes indoors confuses the public about the existing laws and undermines the denormalization of tobacco use to date since the more visible smoking behaviour is the more socially acceptable it appears.

The City of Toronto has approximately 80 premises providing waterpipes in enclosed areas. York Region has seven waterpipe lounges.

The City of Peterborough has taken the proactive step of passing a bylaw to address this trend.

Background:

Waterpipes, also known as hookah pipes, are an alternative smoking device. Waterpipes are used to smoke both tobacco and herbal (marketed as tobacco-free) products, called shisha. These products, usually sweetened and flavoured are heated by charcoal to create smoke. The smoke is then cooled by a water-filled chamber before being inhaled through a hose and a mouthpiece. Many waterpipes have multi hoses allowing multiple people to sit around a single pipe and smoke together.

There is inadequate regulation of the manufactured products smoked in waterpipes so often the ingredients are unknown. Determining whether or not a product has tobacco in it requires testing that is currently cost prohibitive.

Tobacco Enforcement Officers (TEOs) enforce the SFOA which prohibits the indoor smoking of tobacco products in waterpipes. However, due to the poor regulation and packaging of the product, TEOs working in other jurisdictions confirm that they face many difficulties in identifying a product as having tobacco in it and consequently that an offence has occurred.

The value of a written position from local boards of health and medical officers of health calling for provincial legislation prohibiting waterpipe use (regardless of the substance being smoked) in all indoor public places and workplaces was recently expressed to the SMDHU medical officer of health. Resolutions for the alPHa AGM are due for submission on April 12th. The timing of this request did not allow for the creation of a resolution before the March 20th Board meeting, however it does allow for its creation before the April 12th deadline (which is before the Board meeting on April 17th).

Health Risks:

The following health risks are associated with waterpipes:

- Waterpipe smoke created by heating herbal or tobacco products exposes people to carbon monoxide and particulate matter. It can cause decreased lung function, lung cancer, respiratory illness, gum disease, heart disease, and low birth weight.[1]
- The non-tobacco components of the waterpipe itself (including the charcoal) can expose the user to metals and cancer-causing chemicals. There have been case reports of carbon monoxide poisoning after waterpipe smoking.[2]
- Infectious Diseases – the use of publicly shared waterpipes increases the risk of contracting viruses and infectious diseases such as tuberculosis, hepatitis, or herpes from the reusable hose/mouthpiece.[3]

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BACKGROUNDER #2 FOR A13-5

Hazardous Air Quality Levels Inside and on Patios of Toronto Waterpipe Cafés

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OBJECTIVE

- To measure air quality in Toronto waterpipe cafés, using multiple methods.

BACKGROUND

- Flavoured herbal & tobacco waterpipe smoking increased exponentially in recent decades, particularly among young people
- Waterpipe smoking is wrongly believed safer than cigarette smoking, even though both have similar exposure and health risks
- Waterpipe smoking is exempted from bans in jurisdictions where only tobacco smoke is banned because of difficulty in differentiating herbal from tobacco product.
- Ambient nicotine can combine with nitrous acid to form new carcinogens adding to hazards

METHODS

- 12 indoor venues and 5 patio venues sampled in Toronto, Canada Aug-Oct 2012
- Real-time measurements of particulate matter < 2.5 microns in diameter ($PM_{2.5}$), carbon monoxide (CO), and air nicotine collected in 2-hour sessions
- Breath CO and carboxyhemoglobin (COHb) measured in non-smoking field staff
- Occupant behaviour, temperature, relative humidity, CO_2, and venue area/volume recorded
- Employed descriptive and mixed model analysis

RESULTS

Figure 1. Real-time air quality measures of $PM_{2.5}$ and CO in indoor waterpipe café with highest mean CO, Sept 21, 2012

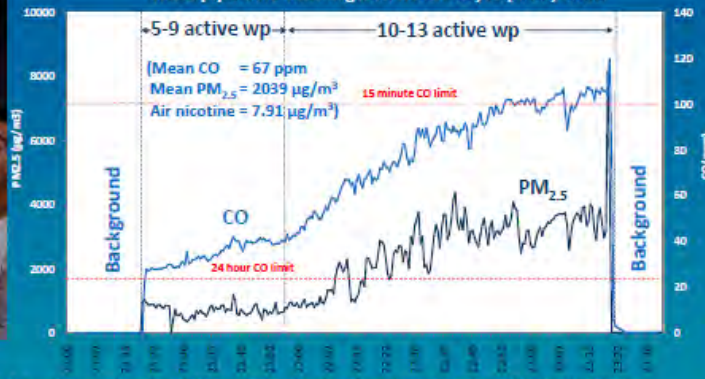

Table 1. Mean (SD) and maximum levels of $PM_{2.5}$, CO, air nicotine, breath CO and breath COHb

Location	Background	Patio	Indoors
	Mean (SD)/Max	Mean (SD)/Max	Mean (SD)/Max
$PM_{2.5}$ (µg/m³)	20.7 (23.7) / 295	80.5 (156.4) / 1711	1419.4 (2063.2)** / 17,211
CO (ppm)	0.2 (0.8) / 7.5	0.5 (0.7) / 7.3	17.7 (20.9)** / 120
Nicotine (µg/m³)	0 / 0	0.5 (0.3)* / 0.8	3.3 (2.7) ** / 7.9
Breath CO (ppm)	1.8 (0.4) / 2.5	2.4 (0.4) / 3	15.1 (21.0)* / 70.0
Breath COHb (%)	1.0 (0.1) / 1.1	1.2 (0.3) / 1.8	3.1 (3.4)* / 12.0

* p<0.05, ** p<0.01 for comparisons of indoor or patio and background measures.

- Indoor levels of $PM_{2.5}$ and CO increased significantly with number of active waterpipes (Figure 1)
- Breath CO and COHb among non-smoking field staff increased significantly after entering venues and reached "heavy smoker" levels
- Mean $PM_{2.5}$ of 81 µg/m³ on PATIO venues corresponds to "Unhealthy" EPA Air Quality Index (151-200)
- Mean $PM_{2.5}$ of 1419 µg/m³ in INDOOR venues corresponds to 3-times "hazardous" EPA Air Quality Index (301-500)
- In half of waterpipe venues, average ambient nicotine levels higher than average in smoky bars; significant levels of nicotine found in all venues

CONCLUSIONS

- Waterpipe café employees and patrons are exposed to very hazardous INDOOR levels of small particulates, CO, and nicotine, and hazardous levels of particulates on PATIOS
- Our study supports eliminating waterpipe smoking inside and on patios of hospitality venues

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