ALGOMA PUBLIC HEALTH

BOARD OF HEALTH MEETING

OCTOBER 26, 2016

5:00 - 7:00 PM

SAULT STE MARIE ROOM , 1ST FLOOR

294 WILLOW AVE, SAULT STE MARIE, ON

www.algomapublichealth.com

Meeting Book - October 26, 2016 - Board of Health Meeting

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ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
OCTOBER 26, 2016 @ 5:00 PM
SAULT STE MARIE ROOM A&B, SSM
A*G*E*N*D*A

1.0 Meeting Called to Order — Mr. Lee Mason, Board Chair

- **a. Declaration of Conflict of Interest**

2.0 Adoption of Agenda Items — Mr. Lee Mason, Board Chair

Resolution
THAT the agenda items dated October 26, 2016 be adopted as circulated; and
THAT the Board accepts the items on the addendum.

3.0 Adoption of Minutes of Previous Meeting — Mr. Lee Mason, Board Chair

- **a. September 28, 2016**

Resolution
THAT the Board of Health minutes for the meeting dated September 28, 2016 be adopted as circulated.

4.0 Delegations/Presentations.

- **a. Special Needs Strategy – Coordinated Service Planning** — Ms. Leslie Wright, Program Manager
- **b. Five over Five Equals One** — Ms. Janet Allen, Tobacco Control Coordinator
  - i. **Presentation**
  - ii. **5 in Five Infographic – Presentation Attachment**

5.0 Business Arising from Minutes

6.0 Reports to the Board

- **a. Medical Officer of Health and Chief Executive Officer Report** — Dr. Tony Hanlon, Chief Executive Officer

Resolution
THAT the report of the Medical Officer of Health and CEO for the month of October 2016 be adopted as presented.

- **b. Draft Financial Statements for the Period Ending August 31, 2016** — Mr. Justin Pino, Chief Financial Officer

Resolution
THAT the Financial Statements for the Period Ending August 31, 2016 be approved as presented.

7.0 New Business/General Business

- **a. Legalization of Cannabis – Provincial Collaboration** — Dr. Alex Hukowich, Associate MOH
  - i. Briefing Note
  - ii. Toward the Legalization, Regulation and Restriction of Access to Marijuana: Submission to Federal Task Force
  - iii. Resolution: A Public Health Approach to the Legalization of Cannabis

Resolution
WHEREAS Algoma Public Health is committed to prevent disease and promote the health of individuals and communities in the Algoma District; and

WHEREAS the Government of Canada has indicated the intention to legalize, regulate, and restrict access to marijuana; and

WHEREAS within the current criminalization context, 49.12 % of individuals in Algoma indicated that they have used cannabis in their lifetime compared to 40.22% in Ontario; and

WHEREAS cannabis also ranks 3rd on the list of top drugs presented at intake in both North and East Algoma according to Algoma Public Health's Community Alcohol/Drug Assessment Program; and

THEREFORE BE IT RESOLVED THAT the Board of Health for the District of Algoma Health Unit continue to support staff in their alignment with the "Provincial Marijuana Collaborative" on cannabis, with the purpose of forwarding public health recommendations to the Federal Task Force reviewing the legalization, enforcement and regulation of cannabis; and

FURTHER THAT this resolution be shared with the Honourable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-Term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

8.0 Correspondence Mr. Lee Mason, Board Chair

- **a.** Food Security
  - i. Letter to Ontario Ministers from Peterborough Public Health dated September 30, 2016
  - ii. Letter to Federal Ministers from Peterborough Public Health dated September 30, 2016
  - iii. Letter to Premier Wynne and Minister Ballard from Chatham-Kent Public Health dated September 27, 2016
- **b.** Changes to the HPV Immunization Program (support for APH resolution 2016-50)
  - i. Letter to Minister Hoskins from Peterborough Public Health dated October 6, 2016

9.0 Items for Information Mr. Lee Mason, Board Chair

- **a.** alPHa 2016 Fall Symposium – November 17& 18, 2016
- **b.** alPHa Information Break – October 13, 2016

10.0 Addendum

11.0 That The Board Go Into Committee — Mr. Lee Mason, Board Chair

Resolution
THAT the Board of Health goes into committee.

Agenda Items:

a. Adoption of previous in-committee minutes dated September 28, 2016
b. Labour Relations and Employee Negotiations

12.0 That The Board Go Into Open Meeting — Mr. Lee Mason, Board Chair

Resolution
THAT the Board of Health goes into open meeting

13.0 Resolution(s) Resulting from In-Committee Session — Mr. Lee Mason, Board Chair

14.0 Announcements: — Mr. Lee Mason, Board Chair

Next Committee Meetings:
November 9, 2016
Finance and Audit Committee 4:30-5:30 pm
Governance Standing Committee 5:30-6:30 pm
Prince Meeting Room

Next Board Meeting:
November 23, 2016 at 5:00pm
Sault Ste. Marie, Room A&B, Sault Ste. Marie

15.0 Board Meeting Evaluation — Mr. Lee Mason, Board Chair

October Board Meeting Evaluation

16.0 That The Meeting Adjourn — Mr. Lee Mason, Board Chair

Resolution
THAT the Board of Health meeting adjourns

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Special Needs Strategy
Coordinated Service Planning

Leslie Wright, R.N., B.Sc.N
Program Manager
Health Babies Healthy Children
Preschool Speech and Language
Infant and Child Development

Background

October 2014 (four ministries):

- Ministry of Child and Youth Services, Ministry of Community and Social Services, Ministry of Education, Ministry of Health and Long-Term Care

- To provide support for long-standing concerns expressed by parents needing to access special needs services

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APH Supporting Special Needs Strategy

Through our Infant Child Development Program (ICDP) and Preschool Speech and Language (PSLS) program we work with children with special needs. Children involved with ICDP and PSLS include children:

- Born premature or with low birth weight where developmental issues can arise
- With Genetic conditions such as Down Syndrome
- Diagnosed with or there is a query for Autism
- With a speech delay that has trouble producing sounds.
- With a language delay that has difficulty understanding or putting words together to express ideas.

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Three Elements to the Strategy:

- Developmental Screen
- Coordinated Service Planning
- Integrated Delivery of Rehabilitation Services

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Algoma Special Needs Strategy

- Partner Agencies involved :
  - APH Infant and Child Development Program
  - Child and Community Resources
  - Children's Rehabilitation Centre Algoma
  - Community Care Access Center
  - Community Living Algoma
- Many Affiliate agencies-Algoma Family Services, School Boards, First Nation Communities…

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Vision for Algoma Special Needs Strategy

- Seamless coordinated service planning approach in order to improve Algoma's families of children and youth with multiple or special needs
- Family-centered approach with one single coordinated plan

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Coordinated Service Planning

- Children with multiple or complex special needs
- Three components:
  - single coordinating agency
  - dedicated service planning coordinators
  - one coordinated plan of care

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Current Status

- Response from the Ministries: our model was one of 9 (34) in "category 1" in which we were designated as early implementer.
- Oversight committee meets every two weeks and started in May
- Frontline staff presentations April 20 and Oct 12
- Phased in approach to start January 2017 with full implementation April 2017

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Next Steps

- Planning of pilot project
- Hiring of project staff
- Training of frontline staff

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Questions?

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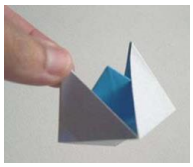
Five over Five Equals One

One Big, Incredibly Innovative, Integrated, Collaborated, Comprehensive Strategy to Get Algoma Smokers to Quit

Janet Allen
Tobacco Control Coordinator
Chronic Disease Prevention Program

How Did This Strategy Unfold?



2015 Prevention System Quality Index report shows tobacco use rates of decline have slowed, and two million Ontarians are still addicted to tobacco products

2015 Algoma Cancer Report identifies significantly higher lung cancer/smoking rates in Algoma

The report identified a Call to Action to reduce smoking rates by 5% over five years across the district

Tobacco cessation and cancer prevention strongly supported in the OPHS

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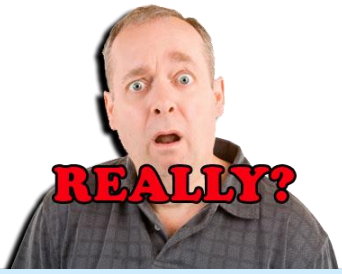
What Does a 5% in Five Years Goal Mean?

Rough estimates suggest that 100,000 cumulative quit attempts by the approximately 22,000 smokers in Algoma are needed to achieve a five percentage point reduction in prevalence over a five year period.



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How Did APH Run With This?

- Organized an onsite consultation with the Ontario Tobacco Research Unit (OTRU)
- Designated 2015 as a partnership strategy planning year
- Partnered with OTRU to submit a research proposal to the MOHLTC
- Gathered over 30 partner letters of support for the proposal
- Once notified in 2016 that the MOHLTC would not be funding any new programs began exploring other potential avenues for funding

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How Did APH Run With This?

- Algoma Board of Health passed a resolution supporting the call to action
- Similar supportive resolutions passed by 19 municipalities and townships across Algoma

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How Did APH Run With This?

- Established a district-wide 5% in five year partnership collaborative to move the strategy forward
- Surveyed partners to determine consensus on strategy and communication initiatives for year one
- Coordinated 5 meetings to date of the partnership
- Assumed responsibility for coordinating the strategy's communication campaign

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How Did APH Run With This?

- Developed a strategy backgrounder and infographic for the partners and media

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How Did the Partnership Run with it?

The partnership from across the district:

- met 5 times to work on developing a work plan and communication plan for year one
- decided on 4 collaborative initiatives for 2016

1) a social media/communications campaign
2) promoting the Canadian Cancer Society's new First Week Challenge contest
3) creating opportunities for Mobile Smoking Cessation Clinic Services for Worksites
4) Quit Smoking Facilitated Groups

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How Did the Partnership Run with it?

ESSAR STEEL

SAULT COLLEGE

THE ONTARIO TOBACCO RESEARCH UNIT / UNITÉ DE RECHERCHE SUR LE TABAC DE L'ONTARIO
Generating knowledge for public health

Group Health Centre

Superior Family Health Team

North Channel Nurse Practitioner-Led Clinic

Blind River District Health Centre
Pavillon Santé du District de Blind River

ÉQUIPE SANTÉ FAMILIALE ELLIOT LAKE FAMILY HEALTH TEAM

LADY DUNN HEALTH CENTRE
Centre de santé Lady Dunn

RICHMONT

St. Joseph's General Hospital
Elliot Lake

N'Mninoeyaa
Aboriginal Health Access Centre

SAULT AREA HOSPITAL
HÔPITAL DE SAULT-STE-MARIE

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How Did the Partnership Run with it?

L-R: Jennifer Jeffries, Dr. Chris Stamler (WFHT), Emma Blanchet (APH), Kasey Wright (WFHT), Melanie Rail (APH), Dr. Julie Weinstein (WFHT), Tina Heilioran (WFHT), Amanda Gauthier (APH) and Yvan Bazner (Council).

Algoma Public Health launches quit-smoking program

Goal to get 22,000 in Algoma to kick habit in five years

By KEVIN McGUFFREY, Of The Standard

After years of being addicted to nicotine many strive to quit smoking, but quitting on your own can be one of the most difficult tasks they will ever do.

Last month, Algoma Public Health launched a program to help people kick the smoking habit. The program, called Five In 5, is aimed at reducing the number of smokers in Algoma by five per cent over five years, said Jenna Dickson, of Algoma Public Health (APH) in Elliot Lake.

The APH launched the program at Elliot Lake's St. Joseph's General Hospital (SJGH) on Jan. 26, Weedless Wednesday, during National Non-smoking Week.

"If we can get 100,000 attempts, we should be able to get 22,000 smokers in Algoma to achieve this five per cent reduction over the five years," explained Dickson.

She added that Algoma also has the highest rate of lung cancer in Ontario.

Partners in the program

However, APH is not alone in its quest to get people to quit their smoking addiction. A coalition of 32 organizations and individuals across the district have partnered to help people quit.

The partners also committed to creating an initiative within the organization that would contribute to the smoking reduction this year.

Of the 32 partners involved in the Five In 5, 15 are municipalities, including Elliot Lake. Others include Family Health Teams, hospitals and private sector businesses.

Dickson said the partners have laid out three key initiatives to work on this year.

"We are initiating opportunities for (quit-smoking) support groups."

"They are hoping to create mobile quit-smoking clinic supports to work sites."

With this, employers could invite a team to their work site to speak to staff about quitting

employer is St. Joseph's General Hospital (SJGH). It has initiated a smoking cessation program for its employees at the hospital, St. Joseph's Manor and the Oaka Centre. The program offers free nicotine replacement therapy to participants, as well as counselling with trained staff, said Chris Irving, a registered nurse for the Team."

The FHT staff gets the patient into the program so they can get the nicotine replacement.

Family Health Team

Kaela Hilderley, a respiratory therapist at the FHT, said they are able to provide free nicotine replacement through the STOP study research pro-


Dennie Pownall, Sandy Meyers, Deborah Blahey, Chris Irving, Connie Free, Cindy Mathison, Kaela Hilderley, Melanie and Jay Reaume were at the launch of APH's smoking cessation program 'Five In 5' at St. Joseph's General Hospital on Jan. 20.

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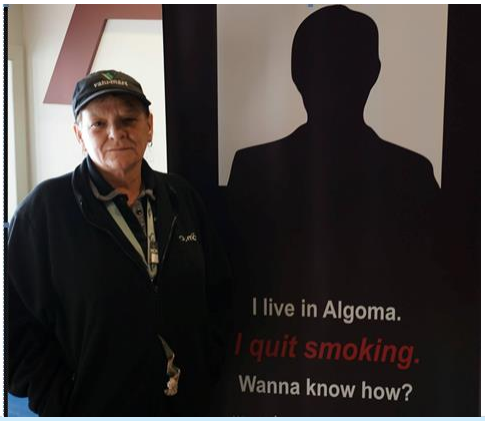
Strategy Initiative's Progress to Date

Social media/communications campaign



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Strategy Initiative Progress to Date

Social Media/Communications Campaign

The QUIT CAFE

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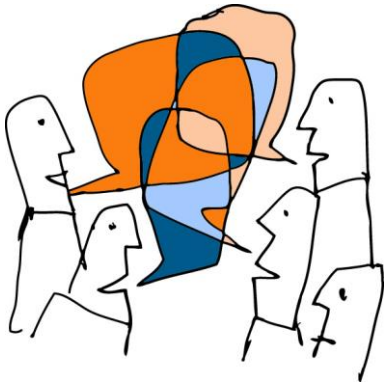
Strategy Initiative Progress to Date

Quit Smoking Facilitated Groups



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Strategy Initiative Progress to Date

First Week Challenge Contest

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Strategy Initiative Progress to Date

Mobile Smoking Cessation Clinic Services for Worksites

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Individual Partner Initiatives

DO YOU WANT TO QUIT SMOKING?

Smoking Cessation Treatment

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Tracking the Goal

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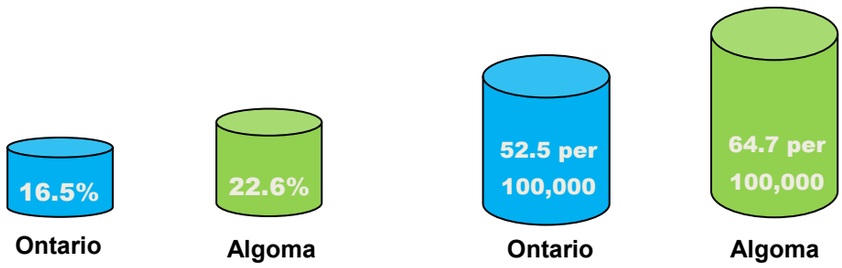
5 IN FIVE

A Tobacco Cessation Community Partnership Campaign to Reduce Smoking Rates in Algoma by 5% in Five Years

WHY?

Because Algoma's Smoking Rates and Lung Cancer Rates are statistically higher than the Ontario average



Ontario — Algoma

Current smokers as the percent of the population 12 years and older[1]

Ontario — Algoma

Newly diagnosed cases of lung cancer per 100,000 people from 2000-2009[2]

WHERE?

WHO?

Over **30** PARTNER ORGANIZATIONS

19

COMMUNITIES HAVE PASSED RESOLUTIONS TO SUPPORT **5 IN FIVE**

HOW?

4

2016 KEY INITIATIVES

- INITIATE OPPORTUNITIES FOR QUIT SMOKING SUPPORT GROUPS
- CREATE MOBILE CESSATION CLINICS FOR WORKSITES
- SUPPORT A SOCIAL MEDIA PLATFORM THAT HIGHLIGHTS QUIT SMOKING STORIES
- PROMOTE CANADIAN CANCER SOCIETY'S *FIRST WEEK CHALLENGE* QUIT CONTEST

WHAT WILL IT TAKE?

100,000 QUIT ATTEMPTS by 22,000 SMOKERS in Algoma

=

A FIVE PERCENT REDUCTION in smoking rates

For more information please contact Janet Allen at (705) 942-4646 Ext. 3042 Email: *jallen@algomapublichealth.com*

[1]Canadian Community Health Survey (Master File), 2013/2014. [2]Algoma Public Health (2015). Report on Cancer in Algoma, Release 2015. Sault Ste. Marie, ON: Author

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MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER
BOARD REPORT
OCTOBER 2016

Prepared by Tony Hanlon Ph.D., CEO and Dr. Alex Hukowich, Associate MOH

During the week of August 22nd, 2016, APH ran the *You're the Chef* program with 12 children in grades 5-8. The goal of the program is to help children develop the skills and confidence to prepare healthy and tasty recipes emphasizing vegetables and fruit. On graduation day the kids prepared lunch for their families and earned their chef hat.

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APH AT-A-GLANCE

We are pleased to announce that the successful candidate for the manager of Vaccine Preventable Diseases and Sexual Health is Roylene Bowden and the successful candidates for the position of Supervisor of Community Alcohol/Drug Assessment Program and Community Mental Health Program are Alana Anderson Brassard and Shawna Thomas. All three will be starting their new roles on October 24, 2016.

The Board held a full day orientation on Saturday October 15, 2016 with all board members in attendance. Topics covered included what is public health, determinants of health, overview of HPPA and related legislation, Program and Organizational Standards, Accountability Agreements, Governance Roles and Responsibilities, Governance Best Practices, APH Financial , Budget and Risk Management, Algoma Demographics and an update on the Strategic Plan. Feedback regarding the organization and content of the orientation from board members was very positive.

The 2016/2017 Flu Campaign officially began with the opening of the phone line on October 3, 2016. Flu clinics in Sault Ste. Marie started on October 11, 2016 and will start on October 20, 2016 throughout the district. This year there are 23 Pharmacies participating in the Flu Campaign; 3 in Elliot Lake, 1 in Richards Landing and 19 in Sault Ste. Marie. Last year pharmacies across the district administered 10, 686 doses of flu vaccine. In the first week of flu clinics in Sault Ste. Marie 979 doses were administered.

October 24-28, 2016 is Employee Wellness Week at APH. APH's Employee Wellness Committee will be running a variety of activities throughout the week, including a washer toss tournament in Sault Ste. Marie and an agency wide pedometer challenge. District offices are also planning healthy potlucks, walking and hiking in their individual offices.

We are pleased to welcome Dr. Jennifer Loo, a fifth year public health resident from University of Toronto. Dr. Loo is completing a four-week management rotation in public health medicine at APH. She will be interacting with many of our public health staff, the leadership team and executive team as well as the Board of Health.

PROGRAM HIGHLIGHTS

COMMUNITY MENTAL HEALTH PROGRAM
Director: Sherri Cleaves
Manager: Jan Metheany

Program: Community Mental Health

Topic: Targets – Deliverables Update

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables:

This report addresses the following Strategic Directions: Improve Health Equity

Kingsford Place Supportive Housing Program

The APH-Community Mental Health Support Services' goal of establishing a second 'recovery-focused', semi-supported, congregate living home for six individuals living with serious mental illness, called Kingsford Place was realized on October 1st of this year. Three individuals have moved into the home and are receiving support from CMH staff and peer support staff (people with the lived experience of mental illness) through a formal partnership and service agreement with People for Equal Partnership in Mental Health (PEP) - a 100% peer- led organization in North Bay. The remaining three resident spots have been filled but will be staggered in terms of move-in dates, allowing residents and staff adequate transition time (one on November 1st, one on December 1st, and finally, the 6th resident on January 1st 2017). All 6 of the residents are individuals for whom stable housing has been a chronic issue. Although it is too early for formal evaluation of the program, the current residents report feeling safe, supported, and as if they have a real home for the first time; for some in a very long time.

Chronic Disease Prevention for Individuals Living with Serious Mental Illness.

People with serious mental illnesses face a greater risk of developing a range of chronic physical conditions compared to the general population, impacting almost every biological system in the body. The life expectancy of persons with serious mental illness is an alarming 25–30 years less than that of the general population. The main cause of this early mortality is cardiovascular disease associated with modifiable risk factors such as obesity, sedentary lifestyle, poor diet and smoking. CMHP staff along with APH-Chronic Disease Prevention Program continue to plan activity around creating group opportunities for clients to engage in physical activity, health and wellness teaching,

and whole health assessment and recovery planning which can help to improve CMH client overall health outcomes.

Fish to Quit Group

Eight CMH clients participated in a five-week "Fish to Quit" group for smoking cessation this fall. Participants agree not to smoke during the two hour group time frame. In addition clients receive information on supports and education regarding tobacco cessation. Clients have pre and post assessment of where they are at in the stages of change regarding smoking. All participants started out as pre-contemplative. Post evaluation of this last group, showed two participants moving to "contemplation" of quitting smoking.

CMH Walking Group

Twenty CMH clients participated in the CMH walking group. Health education is provided and regular exercise is promoted. The number of participants in this six-week group has continued to increase over the past four years.

All of these groups increase socialization and utilize the motivating benefits of mutual engagement (group intervention).

CHRONICE DISEASE PREVENTIION/INJURY PREVENTION

Director: Sherri Cleaves
Manager: Chris Spooney

Topic: 10, 000 Steps Towards Healthy Living

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables: Chronic Diseases and Injuries Program Standards, Requirement 11: The BOH shall increase public awareness in the following areas: *Physical Activity*

This report addresses the following Strategic Directions:

- Collaborate Effectively
- Be Accountable

The 10 000 Steps Towards Healthy Living is a 4 week structured program for individuals who would like to increase their level of physical activity while learning about healthy eating. In partnership with Thessalon, Bruce Mines and Desbarats, each Municipal office worked with the PHN in the Central Algoma to organize and deliver the program within each community. Each town's recreation coordinator helped promote and put on each event and got permission from their municipal staff. The classes were advertised in the municipal newsletters.

This program demonstrates the benefits of physical activity, stretching and resistance exercises. This program is open to people of all ages and promotes a social environment. People can choose to walk, jog, or run. There are lots of laughs but most of all lots of fun had by all.

Over the course of the summer and into the fall, the program was offered throughout the district. It was very well attended and considered a success.

30 people attended the 10 000 steps class in Bruce Mines in May.
26 people attended the 10 000 steps class in Desbarats in June.
24 people attended the 10 000 steps class in Thessalon in October.

PARTNERSHIPS

Group Health Centre
For the past 15 years APH and GHC, in partnership, have provided flu clinics to area residents in Sault Ste. Marie. This partnership began in 2001/2002 with clinics held at the Pine St. Armoury, local high schools and drop-in centres throughout the city.

Municipalities - Healthy Kids Challenge
The goal of the Healthy Kids Community Challenge (HKCC) is to support the well-being of our children. This strategy is a cross-government initiative to promote children's health. HKCC focuses on: a healthy start in life, healthy food, and healthy active communities.

The North Channel and the Sault Ste. Marie Healthy Kids Community Challenges have moved into the second provincial health promotion theme - "Water Does Wonders". This theme promotes the consumption of water as the healthy drink choice for children and youth. Personal and environmental supports for water consumption are planned for this theme, such as water bottles and water fountain/fountain refill stations. The promotion of this theme is occurring at a number of community events in the respective communities. The APH dieticians and public health nurses are providing support to both projects by providing resources and education.

Joint First Nation and Public Health Unit Planning
On October 17 and 18, staff from the Sudbury and District Health Unit, Algoma Public Health and the First Nations and Inuit Health Branch of Health Canada met with representatives from the Maamwesying North Shore Health Services and the First Nations communities along the Hwy 17 corridor between the 2 health units. The agenda for the 2 days provided an opportunity for all in attendance to network and share the collaborations that currently are occurring between public health and the communities. There was consensus that the 2 days created an opportunity to raise awareness and understanding of public health, health equity and the Indigenous Determinants of health. Round table discussions, focused on specific practice areas of public health, enabled participants to share common issues, discuss experiences and begin a dialogue on how to further enhance and build upon current collaborations.

SSM/NOSM Joint Relations Committee

On October 4, 2016 Laurie Zeppa, Jordan Robson and Tony Hanlon attended a SSM/NOSM Joint Relations Committee meeting on behalf of APH. This committee consists of NOSM, SAH, APH, GHC, Algoma U and Sault College and is chaired by Dr. Janice Willett, Associate Dean, Faculty Affairs NOSM. It was agreed that the terms of reference needs updating to be more inclusive of all members of the committee. Dr Willet will lead this initiative. There was a sharing of health research currently being conducted by the members and discussion about opportunities for further collaboration in the future.

NE LHIN NE PHU meeting

There will be a face to face meeting in Sudbury on October 25 at the Sudbury and District Health Unit with senior staff from the NELHIN, MOH/CEOs and senior staff from the health units across northeast Ontario. The purpose **is** to strengthen the engagement between the NE LHIN and NE Boards of Health to improve health and health equity in northeastern Ontario. To this end, the meeting will serve to:

- Further mutual understanding of respective mandates
- Explore the current context of change including Patients First proposals
- Identify current and future opportunities for collaboration
- Prepare for November 29, 2016 meeting of senior leadership and board chairs

Sault Area Hospital

Over the past year, Algoma Public Health has participated in the Sault Area Hospital's Leadership Development Institute (LDI). The purpose of LDI is to provide leadership teams at both organizations with opportunities to develop skills and to incorporate leadership best practices into their work.

The most recent LDI was held September 28th and 29th. The theme of the LDI was "Planning Your Way to Paradise." The key learning objectives were to ensure clarity and focus for each level of leadership to fulfill their accountability for the execution of operational/program plans and strategic planning. The learning outcome centered upon ensuring annual operating plans are aligned with the organization's strategic plan. The creation of a 90 day plan to help facilitate the execution of annual operating/program plans will help to set priorities.

APH would like to formally recognize and thank the Sault Area Hospital for their continued support in providing leadership learning opportunities to APH.

Respectfully submitted,
Tony Hanon, Ph.D., CEO and Dr. Alex Hukowich, Associate MOH

Algoma Public Health
Financial Statements August 31, 2016

Algoma Public Health
Statement of Operations
August 2016

Public Health Programs

	Actual YTD 2016	Budget YTD 2016	Variance Act. to Bgt. 2016	Annual Budget 2016	Variance % Act. to Bgt. 2016	YTD Actual/ YTD Budget 2016
Revenue						
Municipal Levy - Public Health	$ 2,556,269	$ 2,549,843	$ 6,426	$ 3,399,791	0%	100%
Provincial Grants - Public Health 75% Prov. Funded	5,093,457	5,140,067	(46,610)	7,710,100	-1%	99%
Provincial Grants - Public Health 100% Prov. Funded	1,413,090	1,366,467	46,623	2,049,700	3%	103%
Fees, other grants and recovery of expenditures	479,633	549,469	(69,836)	824,204	-13%	87%
Provincial Grants - Fiscal	0		-			
Provincial Grants - Funding for Prior Yr Expenses	139,000		139,000			
Total Public Health Revenue	$ 9,681,449	$ 9,605,846	$ 75,603	$ 13,983,795	1%	101%
Expenditures						
Public Health 75% Prov. Funded Programs	$ 7,781,584	$ 7,968,100	$ (186,515)	$ 11,934,098	-2%	98%
Public Health 100% Prov. Funded Programs	1,178,425	1,352,765	(174,340)	2,049,700	-13%	87%
Public Health Fiscal						
Total Public Health Programs Expenditures	$ 8,960,009	$ 9,320,865	$ (360,856)	$ 13,983,797	-4%	96%
Excess of Rev. over Exp. 75% Prov. Funded	$ 347,774	$ 271,280	$ 76,495	$ (3)		
Excess of Rev. over Exp. 100% Prov. Funded	234,665	13,702	220,964	0		
Excess of Rev. over Fiscal Funded	-	-	-	-		
Provincial Grants for Prior Yr Expenses	139,000		139,000			
Total Rev. over Exp. Public Health	$ 721,440	$ 284,981	$ 436,459	$ (2)		

Community Health Programs

Calendar Programs

Revenue						
Provincial Grants - Community Health	$ 712,011	$ 712,007	$ 4	$ 1,068,011	0%	100%
Municipal, Federal, and Other Funding	162,645	157,637	5,009	236,455	3%	103%
Dental Benefits Ontario Works Recoveries	195,054		195,054			
Total Community Health Revenue	$ 1,069,710	$ 869,644	$ 200,066	$ 1,304,466	23%	123%
Expenditures						
Healthy Babies and Children	$ 689,808	$ 712,007	$ (22,200)	$ 1,068,011	-3%	97%
Child Benefits Ontario Works	13,174	16,093	(2,919)	24,135	-18%	82%
Dental Benefits Ontario Works	178,440		178,440			
Algoma CADAP programs	127,421	141,547	(14,125)	212,320	-10%	90%
Total Calendar Community Health Programs	$ 1,008,843	$ 869,647	$ 139,195	$ 1,304,466	16%	116%
Total Rev. over Exp. Calendar Community Health	$ 60,868	$ (3)	$ 60,871	$ 0		

Fiscal Programs

Revenue						
Provincial Grants - Community Health	$ 2,281,659	$ 2,354,652	$ (72,993)	$ 5,712,299	-3%	97%
Municipal, Federal, and Other Funding	310,657	311,543	(885)	800,253	0%	100%
Other Bill for Service Programs	9,596		9,596			
Total Community Health Revenue	$ 2,601,912	$ 2,666,195	$ (64,283)	$ 6,512,552	-2%	98%
Expenditures						
Northern Ontario Fruit & Vegetable Program	53,903	52,983	$ 921	117,400	2%	102%
Brighter Futures for Children	41,129	48,775	(7,646)	114,447	-16%	84%
Infant Development	261,899	263,306	(1,408)	631,935	-1%	99%
Preschool Speech and Languages	221,993	255,940	(33,947)	614,256	-13%	87%
Nurse Practitioner	50,576	51,189	(613)	122,853	-1%	99%
Genetics Counseling	144,631	157,836	(13,205)	378,806	-8%	92%
Community Mental Health	1,349,503	1,414,458	(64,955)	3,394,698	-5%	95%
Community Alcohol and Drug Assessment	291,744	284,232	7,512	682,157	3%	103%
Diabetes	0	29,111	(29,111)	131,000	-100%	0%
Healthy Kids Community Challenge	68,631	80,636	(11,805)	225,000	-15%	85%
Stay on Your Feet	32,710	41,667	(8,956)	100,000	-21%	79%
Bill for Service Programs	20,654	-	20,654	-		
Misc Fiscal	0	-	-	-		
Total Fiscal Community Health Programs	$ 2,537,573	$ 2,680,132	$ (142,559)	$ 6,512,553	-5%	95%
Total Rev. over Exp. Fiscal Community Health	$ 64,340	$ (13,937)	$ 78,276	$ (0)		

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months
and variances of 10% and $10,000 occurring in the final 6 months

Algoma Public Health
Revenue Statement
For the Eight Months Ending August 31, 2016

	Actual YTD 2016	Budget YTD 2016	Variance Act. to Bgt. 2016	Annual Budget 2016	Variance % Act. to Bgt. 2016	YTD Actual/ YTD Budget 2016	*Comparison Prior Year:* YTD Actual 2015	YTD BGT 2015	Variance 2015
Levies Sault Ste Marie	1,772,134	1,772,134	0	2,362,846	0%	75%	1,489,148	1,312,972	176,176
Levies Sault Ste Marie Capital	0	0	0	0		0%	192,990	195,747	(2,757)
Levies Vector Bourne Disease and Safe Water	44,575	44,575	0	59,433	0%	75%	43,969	43,970	(1)
Levies District	739,560	733,134	6,426	977,512	1%	76%	658,369	536,284	122,085
Levies District Capital	0	0	0	0		0%	82,710	79,953	2,757
Total Levies	**2,556,269**	**2,549,843**	**6,426**	**3,399,791**	**0%**	**75%**	**2,467,186**	**2,168,926**	**298,260**
MOH Public Health Funding	4,946,623	4,998,533	(51,910)	7,497,800	-1%	66%	4,996,611	5,012,733	(16,122)
MOH Funding Vector Bourne Disease	72,465	72,467	(2)	108,700	0%	67%	72,403	72,467	(64)
MOH One Time Funding Dental Health	27,967	22,667	5,300	34,000	23%	82%	17,738	22,667	(4,929)
MOH Funding Safe Water	46,400	46,400	0	69,600	0%	67%	46,371	46,400	(29)
Total Public Health 75% Prov. Funded	**5,093,455**	**5,140,067**	**(46,612)**	**7,710,100**	**-1%**	**66%**	**5,133,123**	**5,154,267**	**(21,144)**
MOH One Needle Exchange	33,805	33,800	5	50,700	0%	67%	29,860	33,800	(3,940)
MOH Funding Haines Food Safety	16,400	16,400	0	24,600	0%	67%	16,353	16,400	(47)
MOH Funding CINOT/Healthy Smiles	320,340	273,733	46,607	410,600	17%	78%	285,026	273,733	11,293
MOH Funding - Social Determinants of Health	120,335	120,333	2	180,500	0%	67%	120,292	120,333	(41)
MOH Funding Chief Nursing Officer	81,005	81,000	5	121,500	0%	67%	80,934	81,000	(66)
MOH Enhanced Funding Safe Water	10,333	10,333	(0)	15,500	0%	67%	10,325	10,333	(8)
MOH Funding Unorganized	333,535	333,533	2	500,300	0%	67%	290,593	333,533	(42,940)
MOH Funding Infection Control	208,270	208,267	3	312,400	0%	67%	208,185	208,267	(82)
Funding Ontario Tobacco Strategy	289,067	289,067	0	433,600	0%	67%	286,380	304,733	(18,353)
Total Public Health 100% Prov. Funded	**1,413,090**	**1,366,467**	**46,623**	**2,049,700**	**3%**	**69%**	**1,327,948**	**1,382,133**	**(54,185)**
Funding for Prior Yr Expenses	**139,000**	**0**	**139,000**						
Recoveries from Programs	23,952	6,707	17,245	10,061	257%	238%	5,030	6,707	(1,677)
Program Fees	149,948	164,762	(14,814)	247,143	-9%	61%	142,994	164,762	(21,768)
Land Control Fees	75,530	106,667	(31,137)	160,000	-29%	47%	96,935	106,667	(9,732)
Program Fees Immunization	128,812	106,667	22,146	160,000	21%	81%	132,455	106,667	25,788
HPV Vaccine Program	3,018	6,667	(3,649)	10,000	-55%	30%	867	6,667	(5,800)
Influenza Program	1,405	40,000	(38,595)	60,000	-96%	2%	760	40,000	(39,240)
Meningococcal C Program	2,849	6,667	(3,818)	10,000	-57%	28%	255	6,667	(6,412)
Interest Revenue	7,583	1,333	6,250	2,000	469%	379%	7,109	1,333	5,776
Other Revenues	86,533	110,000	(23,467)	165,000	-21%	52%	19,982	110,000	(90,018)
Funding Holding		0	0	0		0%	(0)	0	(0)
Total Fees, Other Grants and Recoveries	**479,630**	**549,469**	**(69,839)**	**824,204**	**-13%**	**58%**	**406,387**	**549,469**	**(143,082)**
Panorama	0	0	0	0		0%	0	0	0
First Nations Inititative -One Time	0	0	0	0		0%	112,214	0	112,214
Total Provincial Grants Fiscal	0	0	0	0		0%	112,214	0	112,214
Total Public Health Revenue	**$ 9,681,444**	**$ 9,605,846**	**$ 75,598**	**$ 13,983,795**	**1%**	**69%**	**$ 9,446,858**	**$ 9,254,795**	**$ 192,063**

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months
and variances of 10% and $10,000 occurring in the final 6 months

Algoma Public Health

Expense Statement- Public Health

For the Eight Months Ending August 31, 2016

	Actual YTD 2016	Budget YTD 2016	Variance Act. to Bgt. 2016	Annual Budget 2016	Variance % Act. to Bgt. 2016	YTD Actual/ YTD Budget 2016	*Comparison Prior Year:* *YTD Actual 2015*	*YTD BGT 2015*	*Variance 2015*
Salaries & Wages	$ 5,217,446	$ 5,541,515	324,069	$ 8,314,147	-6%	63%	$ 5,159,370	$ 5,419,975	$ 260,605
Benefits	1,285,851	1,385,379	99,528	2,078,537	-7%	62%	1,278,476	1,353,330	74,854
Travel - Car Allowances	0	0	-			0%	39,322	41,307	1,985
Travel - Mileage	74,222	97,669	23,447	146,784	-24%	51%	85,773	83,631	(2,141)
Travel - Other	38,720	63,284	24,564	95,301	-39%	41%	44,963	84,205	39,242
Program	468,866	373,204	(95,662)	557,306	26%	84%	646,124	482,833	(163,292)
Office	79,274	61,333	(17,940)	92,000	29%	86%	37,115	87,967	50,852
Computer Services	521,228	597,272	76,043	895,908	-13%	58%	474,583	513,153	38,569
Telephone Charges	8,563	26,000	17,437	39,000	-67%	22%	15,467	32,175	16,708
Telecommunications	156,057	118,989	(37,068)	180,483	31%	86%	97,204	113,974	16,770
Program Promotion	58,600	142,723	84,123	214,085	-59%	27%	69,366	141,055	71,689
Facilities Expenses	527,400	542,616	15,216	813,924	-3%	65%	473,953	506,068	32,115
Fees & Insurance	281,023	160,803	(120,220)	241,205	75%	117%	252,551	186,327	(66,224)
Debt Management	311,391	304,000	(7,391)	456,000	2%	68%	(60,889)	(95,205)	(34,316)
Recoveries	(62,391)	(93,922)	(31,531)	(140,883)	-34%	44%	0	0	0
	$ 8,966,249	$ 9,320,865	$ 354,616	$ 13,983,797	-4%	64%	$ 8,917,379	$ 9,254,795	$ 337,416

	Current YTD	*2015*	*Total*	Total Budget	*Total % Spent*
Elliot Lake Renovations	426,894	277,890	704,784	724,960	97%

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months and variances of 10% and $10,000 occurring in the final 6 months

Notes to Financial Statements – August 2016

Reporting Period

The August 2016 financial reports include eight months of financial results for Public Health and the following calendar programs; Healthy Babies & Children, Child & Dental Benefits Ontario Works, and Algoma CADAP programs. All other programs are reporting five month results from operations year ended March 2017.

NOTE: Algoma Public Health received the 2016 Program-Based Grants approval letter from the Ministry of Health and Long-Term Care on September 23rd, 2016. APH will be receiving up to $237,112 in additional base funding and up to $368,000 in one-time funding for the 2016-2017 funding year to support the provision of mandatory and related public health programs and services within the District of Algoma.

One-time funding requests and approvals are summarized below:

One Time Funding Request	Provincially Funded	Amount Requested ($)	2016 Approved Allocation ($)
Immunization of School Pupils Act - Regulatory Amendments Implementation	100%	13,800	13,800
Outbreaks of Diseases: Rabies Module Software Change	100%	28,875	28,900
Outbreaks of Diseases: IPAC Lapse	100%	55,716	55,800
Panorama	100%	96,250	74,600
Pharmacists Integration into the UIIP Program	100%	4,780	4,800
Public Health Inspector Practicum Program	100%	20,000	10,000
Sexual Health: Legal Costs	100%	150,068	150,100
Smoke-Free Ontario Strategy: Expanded Smoking Cessation Programming for Priority Populations	100%	30,000	30,000
Electronic Land Control File Transition	100%	58,000	-
Interim CEO Position	75%	31,036	-
Total One-Time Funding		488,525	**368,000**

The budget has NOT been adjusted to reflect the noted funding changes for the following reasons:

- *Teleconference scheduled with the Ministry and APH for October 18/16 to address questions pertaining to the 2016 Program-Based Grants specifically related to dental integration*
- *The attached statements are as of August 31/16, and APH received funding letters on September 23/16*

The budget will be adjusted in the reporting of the September 2016 financial statements.

Notes Continued...

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

As of August 31st 2016, Public Health programs are reporting a $436k positive variance.

Revenues are indicating a positive $75k variance. Fees, Other Grants & Recoveries are indicating a negative $70k variance. In an effort to balance the budget, recognition of deferred revenue was planned for 2016. Management will determine if this is required as the year progresses. This is being offset with HST recoveries APH has received. Provincial Grants – Funding from prior years is showing a positive variance of $139k. This is associated with 2015 approved and settled one-time funding requests related to the Interim CEO Position and New Purpose-Built Vaccine Refrigerators.

There is a positive variance of $360k related to Public Health Expenses being less than budgeted. 100% Provincially Funded programs are indicating a positive $174k variance. 100% Provincially Funded Programs typically relate to specific Public Health initiatives and are prescriptive in what an eligible expense is. Driving this variance is an $84k positive variance related to Unorganized Territories Program, a $25k positive variance related to Food Safety Program and a $28k positive variance related to Infectious Disease Control Program. It is managements plan to re-allocate eligible dollars to these respective 100% Provincially funded programs.

Community Health Calendar programs are reporting a $61k positive variance.

On the revenue side, $195k positive variance is associated with Dental Benefits Ontario Works as these funds are not budgeted. This is being offset by the corresponding expenses related to this program that are also not budgeted.

On the expense side, a $14k positive variance is associated with the Algoma CADAP program. This is a result of timing of expenditures not yet incurred.

Community Health Fiscal programs are reporting a $78k positive variance.

Timing of receipt of Provincial Grants – Community Health is generating a $72k negative variance.

On the Expense side, Preschool Speech and Language is showing a positive $34k variance. This is a result of the timing of payment to the Children's Rehab Center for purchased services. The Diabetes Program is showing a negative $29k variance. This is a result of timing of expenditures not yet incurred. The Healthy Kids Community Challenge is indicating a positive $11k variance. This is a result of timing of expenditures not yet incurred. It is anticipated that this positive variance will decrease as the year progresses.

Public Health Revenue (see page 2 for details)

Public Health funding revenues are showing a positive $75k variance.

Notes Continued...

The municipal levies are operating within budget.

Funding Grants are operating relatively within budget. The positive $46k variance related to CINOT/Healthy Smiles is a result of the Ministry mandate to consolidate dental programs. The negative variance associated with MOH Public Funding offsets the noted positive variance.

There is a negative variance of $69k associated with Fees, Other Grants & Recoveries. In an effort to balance the budget, recognition of deferred revenue was planned for 2016. Management will determine if this is required as the year progresses. This is impacting the negative $23k variance related to Other Revenues. The negative $31k variance associated with Land Control Fees and the negative $38k variance related to the Influenza Program should be reduced as the year progresses. APH typically captures the bulk of its fees between the spring and fall months. Somewhat offsetting these negative variances are positive variance associated with Recoveries from Programs and Program Fees Immunization.

Public Health Expenses (see page 3)

Travel (Mileage, Other)
Travel (Mileage) is showing a positive $23k variance due to timing of employee claim submissions. Travel (Other) is showing a positive $24k variance. Staff travel typically occurs between the spring and fall months.

Program
Program expense is indicating a negative $95k variance. The purchased services for the Acting MOH and Associate MOH roles are driving the noted variance.

Office
Office expense is indicating a negative $18k variance. This is a result of timing of expenditures not yet incurred.

Computer Services
Computer Services is showing a positive variance of $76k. APH's 2016 Operating Budget was approved by the Board of Health in November of 2015 and included the buy-back of IT equipment. In December of 2015, the decision was made to buy-back leased IT equipment prior to 2016. This is driving the noted positive variance.

Telephone Charges/Telecommunications
Telephone Charges are indicating a positive variance of $17k. Telecommunications is indicating a negative variance of $37k. When netted together Telephone/Telecommunications are operating relatively within budget.

Notes Continued...

Program Promotion
Program Promotion is showing a positive variance of $84k. Revisions to the budgeted Program Promotion figure will be implemented in the 2017 APH Budget.

Fees & Insurance
Fees & Insurance is indicating a negative variance of $120k. This is due to the $83k payment of the annual insurance premium paid in full during the month of February. In addition, APH has incurred legal expenses regarding a Public Health policy matter. APH has submitted a one-time funding request to the MOHLTC, with the intention of recouping these costs. (As noted above in the summary of one-time funding requests, APH has been approved for these one-time funding charges which will be reflected in the September 2016 financial statements.)

Recoveries
Recoveries are indicating a negative variance of $31k. This is a result of recoveries being less than budgeted. Revisions to the budgeted Recoveries figure will be implemented in the 2017 APH Budget.

Non Public Health Programs Revenue and Expenses (see page 1)

All Non Public Health Programs are operating without budget issues.

Financial Position - Balance Sheet (see page 7)

Our cash flow position continues to be stable and the bank has been reconciled as of August 31st, 2016. Cash includes $.324 million in short-term investments.

Long term debt of $5.950 million is held by the Royal Bank @ 2.76% for a 60 month term (amortization period of 240 months) matures on September 1, 2016. For the next 60 month term (amortization period of 180 months), long-term debt will be held at TD Bank. $350,000 loan relates to financing of the Elliot Lake office renovations with the balance related to the financing of the 294 Willow Avenue facility located in Sault Ste. Marie.

There are no material collection concerns for accounts receivable. Letters were issued by APH to three participating municipalities regarding late levy payments. All three participating municipalities have since paid all outstanding levy payments.

Algoma Public Health
Statement of Financial Position

Date: As of August 2016	August 2016	December 2015
Assets		
Current		
Cash & Investments	$ **1,920,010**	$ 2,368,709
Accounts Receivable	**806,113**	658,510
Receivable from Municipalities	**40,950**	5,134
Receivable from Province of Ontario		
Subtotal Current Assets	**2,767,073**	3,032,353
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,395,507**	1,490,132
Payable to Gov't of Ont/Municipalities	**256,237**	641,766
Deferred Revenue	**760,795**	664,615
Employee Future Benefit Obligations	**2,453,960**	2,453,960
Capital Lease Obligation	**0**	107,264
Term Loan	**6,173,490**	6,173,490
Subtotal Current Liabilities	**11,039,989**	11,531,227
Net Debt	**-8,272,916**	-8,498,874
Non-Financial Assets:		
Building	**22,732,421**	22,732,421
Furniture & Fixtures	**1,914,772**	1,914,772
Leasehold Improvements	**1,169,635**	1,169,635
IT	**3,029,040**	3,029,040
Automobile	**40,113**	40,113
Accumulated Depreciation	**-6,880,999**	-6,880,999
Subtotal Non-Financial Assets	**22,004,981**	22,004,981
Accumulated Surplus	**13,732,064**	13,506,107

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Briefing Note

To: The Board of Health

From: Dr. Alex Hukowich, Associate Medical Officer of Health

Date: October 26, 2016

Re: Legalization of Cannabis – Provincial Collaboration

☒ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Canada has one of the highest rates of cannabis use in the world. In Algoma, 49.12 % of individuals indicated that they have used cannabis in their lifetime compared to 40.22% in Ontario (2011-2012 CCHS Share Files). Cannabis also ranks 3rd on the list of top drugs presented at intake in both North and East Algoma according to Algoma Public Health's Community Alcohol/Drug Assessment Program.

RECOMMENDED ACTION:

It is recommended that the Board of Health for the District of Algoma Health Unit consider a Board Resolution regarding the legalization of cannabis. And further, that the Board of Health for the District of Algoma Health Unit continue to support staff in their continued alignment with the "Provincial Marijuana Collaborative" of public health units on cannabis.

BACKGROUND:

The Government of Canada has announced that it has committed to the legalization, regulation and restriction of access to marijuana in the spring of 2017. A call for a provincial collaboration on cannabis was issued in order to discuss areas of concern with the recent announcement. A total of 27 health unit managers and staff participated in the initial meeting in June and discussed areas of:

- Adolescent brain development/mental health
- Cannabis impaired driving
- Medical marijuana
- Dependence

- Cannabis use during pregnancy/lactation
- Environmental issues – second hand smoke
- E-cigarettes/vaporizers

Unanimously, all health units agreed to continue to meet in order to build capacity, share resources, develop common messaging and discuss provincial/local policy work. A follow-up meeting took place on September 23, 2016.

Recently, an announcement was made indicating that a Task Force on cannabis legalization and regulation was developed. A discussion paper was produced noting that legalization will focus on:

1. Minimizing harms of use
2. Establishing a safe and responsible production system
3. Designing an appropriate distribution system
4. Enforcing public safety and protection
5. Accessing marijuana for medical purposes

In the announcement, the Task Force stated multiple times that this legislation will have a public health focus. Algoma Public Health supported a provincial health unit public response providing a public health perspective on the legislation, regulation and restriction regarding access to marijuana.

While noting that this will be a complex task, the Task Force has promised that they will take all viewpoints into consideration, but that the protection of youth, concern for social and health harms and the production, distribution and consumption of marijuana will take precedent.

ASSESSMENT OF RISKS AND MITIGATION:

Not applicable.

FINANCIAL IMPLICATIONS:

Supporting APH staff costs are estimated at 50 hours which would include meeting times, organization and preparation for upcoming meetings.

OPHS STANDARD:

Prevention of Injury and Substance Misuse Requirement #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

Prevention of Injury and Substance Misuse Requirement #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

STRATEGIC DIRECTION:

Collaborate Effectively
Be Accountable

CONTACT:

Jennifer Flood, Acting Program Manager
Chronic Disease Prevention, Injury Prevention, Genetics, Smoke Free Ontario, and Youth Engagement

References:

Provincial Marijuana Collaborative – Draft (attached)

Canadian Community Health Survey (2011-2012). Statistics Canada, Share File, Ontario MOHLTC

Cannabis: A Public Health Approach (2016). Middlesex-London Health Unit. Report No. 003-16.

Cannabis Policy Framework (2014). Centre for Addiction and Mental Health. Retrieved August 3, 2016 from https://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf

Toward the Legalization, Regulation and Restriction of Access to Marijuana: Submission to Federal Task Force

Ontario Public Health Unit Collaboration on Cannabis

The Ontario Public Health Unit Collaboration on Cannabis is a group of substance misuse professionals from 27 public health units who have joined together to promote a comprehensive public health approach to marijuana legalization.

This feedback was developed by a working group of the Collaborative:

Algoma Public Health, Durham Public Health, Elgin St. Thomas Public Health, Grey Bruce Health Unit, Haliburton, Kawartha, Pine Ridge District Health Unit, Huron County Health Unit, KFL&A Public Health, Middlesex-London Health Unit, Niagara Region Public Health, Northwestern Health Unit, Ottawa Public Health, Perth District Health Unit, Peterborough Public Health, Peel Public Health, Sudbury & District Health Unit, Thunder Bay District Health Unit, Timiskaming Health Unit, Wellington-Dufferin-Guelph Public Health Unit, York Region Public Health

Discussion Issues: Elements of a New System
Section One: Minimizing harms of use

1(a). Do you believe that these measures are appropriate to achieve the overarching objectives to minimize harms, and in particular to protect children and youth?

(1) Minimum age for legal purchase.

Recommendation:

- **The minimum age for purchasing and possessing marijuana should be 21.**
- **The minimum age for purchasing and possessing marijuana should be consistent across Canada in order to provide clear policy direction and eliminate cross-border variations which limit the effectiveness of minimum legal age regulations to protect young people.**
- **Regulations must be coupled with rigorous enforcement and penalties for violations in order to be effective.**

See responses to question 2 (a) and (b) for further detail.

(2) Advertising and marketing restrictions.

Recommendation:

- **Prohibit all forms of marijuana advertising, marketing, and sponsorship through federal legislation, similar to that of the Tobacco Act and include language that addresses volume and content restrictions**
- **Adopt plain packaging regulations that restrict or prohibit the use of logos, colors, brand images, or other promotional information on packaging other than brand and product names displayed in a standard color and font style. Also require that packaging include health warnings.**
- **In the case that marketing, advertising and promotion of marijuana is made allowable within strict limitations, it is crucial that an effective advertising regulatory system be put in place. This system must apply to all forms of marketing and have the flexibility to adjust restrictions as needed.**

- **Given that there is strong evidence from tobacco research that promotion at the point of sale, increases the likelihood that children and adolescents will start to smoke, it is recommended that federal legislation is enacted to prohibit youth under the minimum age for purchase of marijuana from entering marijuana retail outlets.**
- **Develop a supporting infrastructure to ensure accountability for these restrictions.**

Rationale:

There is strong evidence from tobacco research that advertising and promotion, including promotion at the point of sale, increases the likelihood that children and adolescents will start to smoke. (1) Furthermore a growing body of research identifies that exposure to alcohol advertising and marketing increases the likelihood of underage drinking. (2)

Given that lessons learned from tobacco and alcohol show partial restrictions on marketing, advertising and promotion are ineffective, and difficult to enforce, it is strongly recommended that a comprehensive ban on all forms of marijuana marketing be put in place. A substantial opportunity exists currently as a ban would likely appear very restrictive if put in place retrospectively but would be lessened for a new product, such as marijuana, because of its first chance to be legally traded. (3) A comprehensive ban should address all forms of advertising (e.g., print, television, radio, transit, billboards, point-of-sale including retail displays, Internet, and social media outlets), promotion (e.g., price discounting, coupons, free sample distribution), sponsorships, and other indirect forms of marketing (e.g., brand stretching, branded merchandise). (4) Such a ban would be in keeping with the Government of Canada's intention to legalize marijuana for the purposes of reducing its social and health harms, and not for the purpose of promoting its use.

In light of the fact that Health Canada recognizes that tobacco packages have become powerful promotional vehicles for the tobacco industry and has stated that it is committed to introducing plain packaging as part of its continued efforts to protect Canadians against the dangers of tobacco use, it is prudent the same regulations be put in place for marijuana products. (5)

Plain packaging of marijuana will be a useful tool for minimizing harms from use for this new product in an emerging industry, as there are no standards set as yet, and the government has the advantage in setting these standards. The 2013 Guidelines for

Implementation of the WHO Framework Convention on Tobacco Control recommends plain packaging measures that restrict or prohibit the use of logos, colors, brand images, or other promotional information on packaging other than brand and product names displayed in a standard color and font style. [4] Plain packaging of tobacco products has been adopted in Australia and has been shown to reduce the appeal of tobacco products among youth, increase the effectiveness of health warnings, and reduces the ability of the packaging to mislead the consumer. [6, 7]

If, as proposed by the discussion paper, marketing, advertising and promotion of marijuana was to be allowed within strict limitations, it would be crucial that an effective advertising regulatory system be put in place. Best practice evidence from Canadian alcohol advertising research identifies that an effective advertising regulatory system must include content restrictions, volume restrictions and an overall supporting infrastructure. This requires a supporting legal context, a commitment of all stakeholders, transparency of the decision-making process, a mandatory pre-screening system, an effective complaint system, an independent advertising committee, effective sanctions, and a monitoring system. This infrastructure should apply to all forms of marketing and have the flexibility to adjust restrictions as needed. [8]

The State of Washington has adopted some specific advertising content and volume restrictions in order to reduce expose to young people. For example, Washington State Legislature prohibits advertising through any medium within 1,000 feet (300 metres) of the perimeter of a school, playground, recreation center or facility; child care center, public park or library; or any game arcade, admission to which is not restricted to people over 21. State law also prohibits marijuana advertising from including any depiction designed in any manner to be especially appealing to children or other persons under legal age to consume marijuana. [9]

Colorado has placed strict requirements on advertising, including outright bans on Internet pop-up advertisements and any type of advertisement that targets minors. Advertising is only allowed via television, radio, print, Internet, or event sponsorship when it can be documented that less than 30% of the audience is younger than 21 years. Outdoor advertising is prohibited other than signs that identify the location of a licensed retail marijuana store. Additionally, Colorado's Marijuana Enforcement Division rules ban the presence of anyone younger than 21 years in marijuana retail stores. [10]

(3) Taxation and pricing

Recommendations:

- **Index marijuana prices to inflation to ensure prices do not decrease relative to other goods over time.**
- **Further regulate marijuana prices through tax increases, while giving consideration to the level at which minimum prices should be set to curb demand and reduce consumption (especially among youth) , while minimizing the opportunity for continuation of lucrative illicit markets.**
- **Base prices (including minimum prices) on THC content so that higher strength products are more expensive than lower strength products in order to create incentives for the production and consumption of safer, lower strength products.**

Rationale:

As identified in the Centre for Addiction and Mental Health's 2014 Cannabis Policy Framework document, it is important that marijuana pricing policy be designed to curb demand while minimizing the opportunity for continuation of lucrative illicit markets. In addition, it is strongly recommended that pricing encourage use of lower-harm products over higher-harm products. (11)

Alcohol research has shown that it is important to index prices to inflation to ensure prices do not decrease relative to other goods over time. The same research identifies that young people are particularly price-sensitive because of lower average disposable incomes as well as the fact that regular heavy drinking is most common among this age group. In order to reduce harm associated with the use of products with higher alcohol content, research recommends that prices (including minimum prices) need to be based on alcohol content as this creates price incentives for lower strength, less hazardous products and price disincentives for higher strength products. (12)

With regards to tobacco, there is strong and unequivocal evidence that increases in the price of cigarettes result in decreased demand and consumption as well as increased intentions to quit smoking. (13) Research also shows that higher taxes are an effective way to prevent young people from progressing from experimentation with tobacco to regular use. (14)

There is also some evidence that pricing strategies can reduce health-related inequities from tobacco use as well as having a greater impact on reducing tobacco use rates among individuals with lower incomes. The evidence highlights that while low income smokers are more likely to quit smoking in response to tax rate increases those who do not quit pay higher prices and bear a greater cost burden associated with price

increases. It is recommended that these distributional concerns be addressed by coupling tax increases with publically financed smoking cessation initiatives that are structured to particularly target low-income populations. [13]

(4) Limits of allowable THC potency in marijuana

Recommendation:

- **Determine maximum THC limit, which balances the risk for harm against the need to minimize the attractiveness of illegal production and trafficking of higher potency products.**
- **Set regulations that mandate clear and visible labelling of THC content in products, accompanied by evidence-based health warnings.**
- **Establish government right to impose regulations related to marijuana from the beginning, since lessons from tobacco demonstrate how challenging it can be to expand regulatory scope after the fact. As research reveals better evidence about the harms and therapeutic uses related to marijuana, regulations should be adjusted.**
- **Conduct further research into the short and long term health effects associated with the use of higher potency marijuana products.**

Rationale:

Young people are at a higher level of risk for experiencing negative impacts from marijuana use and evidence from Washington and Colorado shows that there are indications that youth are more likely to use products in concentrated format with higher levels of THC. [15] While further research is needed to confirm these issues, consumption of higher THC levels may be associated with a greater chance of a harmful reaction and explain the rise in emergency room visits involving marijuana use. Additionally, regular exposure to higher THC levels may be associated with an increased risk for addiction. [16]

(5) Restrictions on marijuana products:

Recommendation:

- **Set a maximum THC limit for all marijuana products, including specifying what constitutes a single serving size of edible product (e.g. 10 milligrams of THC) regulating the maximum number of serving to be allowed in a single packaged food item.**

- **Require that edible products have clearly marked serving sizes that are appropriate to the food being consumed. (For example a cookie should be one or two servings not ten)**
- **Prohibit production and sale of products that are attractive to youth (e.g., products which mimic popular brand-name snacks and candies (such as gummy bears), additives, flavorings and combinations with other substances (e.g., nicotine, caffeine, alcohol).**
- **Require that marijuana products be sold a child-resistant container that conform to federal consumer product safety regulations and include specific warning statements (e.g., Keep all marijuana products away from children.)**
- **Require that products be sold in plain packaging and be marked with a universal symbol indicating the container holds marijuana.**
- **Require that edible products be labeled with all ingredients, if refrigeration is required, standard serving limit and expiration date (for edibles).**
- **Offer producers of edible products access to its food safety training to help reduce the risk of foodborne illness.**
- **Ensure that a reliable system is put in place for product monitoring and testing to ensure production consistency and consumer safety.**

Rationale:

With regards to marijuana derivative products, such as edibles, salves and creams, it is agreed that regulations be put in place in order to limit the appeal to children and youth as well as to reduce the risk of unintended consumption. Edibles pose a particular risk of accidental expose and overdose, especially to children. Colorado experienced an increase incidence of childhood exposure to marijuana infused edibles following the legalization of medical marijuana in the state in 2000. Following legalization, Colorado also made national news related to residents' and tourists' overconsumption of edible marijuana products. Although initial regulations for edible marijuana sold on the recreational market specified a single serving size of 10 milligrams of THC and a maximum of 100 milligrams of THC per single packaged food item, it was sometimes difficult for consumers to identify serving size portions in a single edible or drinkable product. For example, early regulations allowed up to 10 servings in a single cookie. The resulting fact that 1 serving could only be one tenth of a product that would normally be consumed in one sitting, combined with the delayed onset of the effects of THC after eating, contributed to overconsumption. [(10)]

(6) Limitations on quantities for personal possession.

Recommendation:

- **Set limitations on quantities for personal possession that align with current practice in other jurisdictions, and with current definitions of quantities for personal possession under the criminal law in Canada.**
- **Limitations should include all types of marijuana products, including edibles.**
- **Consideration should be given to having lower limits for products containing higher levels of THC.**

Rationale:

Given that setting limits on quantities of marijuana may serve to minimize opportunities for resale on the illicit market, particularly to youth, it makes good sense that restrictions be put in place. Given that there is currently a lack of evidence to support specific best-practice limitations, restrictions for dried product should minimally align what is currently considered possession for personal use under Canada's current criminal law (30 grams), as possession of more than 30 grams is considered possession for the purpose of trafficking. However, at the outset it would be wise to have tighter limits and to study its impact over time prior to increasing allowable amounts.

Since products such as edibles and concentrates have a much higher level of THC in relation to marijuana in flower form, consideration should be given to having lower limits for these products. For example, in August 2015 the Marijuana Enforcement Division (MED) in Colorado conducted a study to determine the THC equivalent of concentrates and edibles as compared to marijuana in flower form. [(17)] As a result of this study, the MED has issued 'Marijuana Equivalency' guidelines and have updated their recreational marijuana purchasing laws accordingly. These new regulations will take effect as of October 1, 2016. [(18)]

(7) Limitation on where marijuana can be sold.

See comments on "Designing an Appropriate Distribution System."

1(b): Are there other actions which the Government should consider enacting alongside these measures?

We urge the task force to consider the following recommendations:

1) Develop a comprehensive strategy to clearly communicate the risks and harms associated with marijuana use, particularly for youth as well as conveying details of the regulations prior to implementation, so that the public and other stakeholders understand what is permitted, and so that individuals can make informed choices. [15]

2) Invest in evidence-based health promotion, prevention, awareness and education, targeted at both youth and parents, [15] with a secondary focus on other vulnerable groups (pregnant and lactating women, people with personal or family history of mental illness, and individuals experiencing issues with substance abuse) as well as harm-reduction messaging for those who choose to use marijuana.

3) Invest proactively in a collaborative public health approach that prioritizes investment in a continuum of evidence-informed prevention and treatment services to prevent and respond to problematic use. [15]

4) Invest in research to address gaps in knowledge in order to better understand short and longer-term health impacts of both non-therapeutic and medical marijuana use and to guide best-practice policy development. [15] The criminal status of marijuana has limited research opportunities up until now, leaving many gaps in knowledge, such as the full range of risks and therapeutic uses. Many recommendations for a regulatory framework have been made based on evidence borrowed from alcohol and tobacco research, and these should be substantiated by ongoing research specific to marijuana.

5) Conduct ongoing surveillance and monitoring on the patterns and trends associated with use, including the collection of baseline data prior to legalization. Stakeholders from Colorado and Washington expressed that they encountered challenges in monitoring impacts because no baseline data existed, particularly because marijuana was not reported separately from other illegal substances in many data systems. [15] Canada is in a position whereby we can put systems in place beforehand to confidently measure impact moving forward. This data will be extremely valuable in making evidence based decisions, regarding the impact of this new legislation and in making adjustments of this new system in years to come.

6) Restrict the sale of drug paraphernalia (e.g., pipes, bongs) in places where children and youth frequent and prohibit the sale of these products to minors. As experience with tobacco shows that the presence and availability of these products can

undermine other regulations by serving to normalize or increase the social acceptability of marijuana use among youth.

2(a): What are your views on the minimum age for purchasing and possessing marijuana?

Recommendation:

- **The minimum age for purchasing and possessing marijuana should be 21.**
- **Regulations must be coupled with penalties for violations and be strictly and consistently enforced in all situations in order to be effective.**

Rationale:

A wealth of evidence exists to support the importance of delaying onset of drug use, including marijuana use, among youth. Current evidence confirms brain development is not complete until approximately age 25. [(19)] And further evidence demonstrates that both early and frequent marijuana use can alter the structure of the developing brain, and that some of these adverse effects may be irreversible, with the potential to seriously limit a young person's educational, occupational and social development. [(20)]

With regards to setting a minimum age for purchasing and possessing marijuana, a precedent has been set given that the legal age for tobacco consumption is 18 and varies between 18 and 19 across the provinces for alcohol. Given that both alcohol and tobacco are dependence–inducing substances that are legal for adults but subject to legal and social constraints on underage use, lessons can be learned for marijuana policy from the Canadian and U.S. experience with regards to the public health impact associated with enacting and raising the minimum age of legal access to tobacco products as well as the minimum legal drinking age.

The U.S. Institute of Medicine recently conducted a comprehensive review of the public health impact of raising the minimum age for purchasing tobacco products. A committee of public health, medical and other experts reviewed the, U.S. and international experience with enacting and raising the minimum age of legal access to tobacco products as well as the minimum legal drinking age. Results of the review were released in the 2015 report, Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products. [(21)]

With regards to alcohol, the review found that that raising the minimum legal drinking age to 21, together with strict enforcement and penalties for violations, has been associated with lowered rates of alcohol consumption among adolescents and adults as

well as with reduced rates of alcohol-related adverse events (e.g., traffic crashes and hospitalizations). [21]

In terms of tobacco, the review concluded that increasing the minimum age of legal access to tobacco products will likely prevent or delay initiation of tobacco use by adolescents and young adults. The review also noted that while these legislative changes would directly pertain to individuals who are age 18 and older, the greatest impact would be on adolescents 15-17 years old. Furthermore, the report states that "The impact on initiation of tobacco use of raising the minimum age of legal access to tobacco products to 21 will likely be substantially higher than raising it to 19, but the added effect of raising the MLA beyond age 21 to age 25 will likely be considerably smaller" (p. 202). [21]

In Canada, an expert panel of scientists and researchers recently compared the effectiveness of provincial strategies to reduce alcohol related harms and costs in Canada. The resulting report, Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Comparison of Provincial Policies (2013), also highlights that a higher minimum legal drinking age is more effective in decreasing alcohol consumption and related harms among youth with a minimum legal drinking age of 21 years representing the best practice. [22]

The Canadian report also recommended that the legal drinking age be supported by legislation that prohibits not only the purchase of alcohol by those below the minimum legal drinking age but also prohibits the sale of alcohol to these individuals. In doing so, the drinker and alcohol retailers share the responsibility of upholding the legal drinking age. Finally, it is important to consider policies that permit individuals under the legal drinking age to drink under specific circumstances (i.e. social hosting policies) due to the permissive attitude towards alcohol they may promote. [22]

2(b): Should the minimum age be consistent across Canada, or is it acceptable that there be variation amongst provinces and territories?

Recommendation:

- **The minimum age for purchasing and possessing marijuana should be consistent across Canada in order to provide clear policy direction and eliminate cross-border variations which limit the effectiveness of minimum legal age regulations to protect young people.**

Rationale:

Both experience from Ontario communities located near inter-provincial borders with Quebec and evidence from Canadian alcohol research demonstrate that cross-border variations in legal drinking age limit the effectiveness of a minimum age to protect young people.

The 2007 National Alcohol-Related Harm in Canada: Toward a Culture of Moderation report proposed that harmonizing minimum purchase ages across jurisdictions would help to reduce certain risky drinking behaviours. An example of this is where youth cross provincial/ territorial borders to take advantage of less restrictive regulations in neighbouring jurisdictions. [23]

Given alcohol, tobacco and marijuana are all clearly linked with varying levels of youth related harm, our recommendation ideally would be that tobacco, alcohol and marijuana all have a legal access age of 21. Given however the complexities involved in altering the legal access age for alcohol and tobacco in order to attain consistency, we are addressing our recommendation from the context of marijuana access only. Consistent age restrictions will provide clear policy direction and eliminate cross-border variations which limit the effectiveness of a legal drinking age to protect young people.

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Section Two: Establishing a safe and responsible Production system

1. ***What are your views on the most appropriate production model? Which production model would best meet consumer demand while ensuring that***

public health and safety objectives are achievable? What level and type of regulation is needed for producers?

Recommendation:

- **A government controlled monopoly on marijuana production.**
- **Marijuana should not be regulated or treated as a food product in the context of the agricultural industry**. This is especially important because it will likely be included as an ingredient in various types of food products (edibles), however marijuana is a psychoactive drug and not an ordinary commodity. This concern stems from the current representation of beer and wine as 'local food' and a 'farming crop' in Ontario's agricultural industry. This representation has been very detrimental to societal perceptions about alcohol and has contributed to its normalization. As lessons learned from alcohol show that normalization results in increased use and associated harms, (3) it is important that this recommendation be followed from the outset of legalization of recreational marijuana.

Rationale:

A government controlled monopoly has been used in different parts of the world on the production of various regulated substances to limit the influence of for-profit businesses. [(1)] Considerable evidence from alcohol literature indicates that government monopolies are better for public health than less regulated options. [(1, 2)] A government controlled monopoly on marijuana production controls diversion, eludes advertising, slows product innovation, maximizes tax revenue, decreases market competition and increases retail price. [(1)] Product innovation is projected to be slower within a government controlled monopoly. This is important from a public health perspective as product innovation will likely decrease production costs, which leads to decreased retail pricing in a competitive market. [(1)] While decreased pricing may appear to benefit consumers, strong evidence from alcohol literature suggests that a decrease in price is associated with an increase in consumption and harm. [(3, 4)] Higher pricing strategies are particularly effective in reducing consumption, especially among high-risk populations, such as youth. [(3)]

A government controlled monopoly also has the benefit of reversibility. [(1)] The health, social and economic implications of legalization are largely unknown. Following legalization, if a government monopoly on marijuana production proves to be the most effective model for reducing consumption and harms, this model will be easiest to retain from the outset. If governments initially choose a commercialized market, change to a more restrictive model will be difficult.

Having said this, a commercialized model (similar to that of alcohol regulation) is **not** recommended. Commercialization aims to "maximize the efficiency of production, the appeal of products to consumers, and the size, scale and scope of the market" (Caulkins et al., 2015, p. 53). While the trajectory of a commercialized model is far from certain, some potential outcomes include:

- decreased production costs resulting from increased production scales, a shift in cultivation from indoor to greenhouse or outdoor spaces, and an increase in production of extract-based products. [1] This has negative health implications as evidence from alcohol literature suggests that a decrease in price is associated with an increase in consumption and harm; [3, 4]
- increased product innovation toward concentrates, edibles and high potency products, and alarmingly, new and unknown products from extraction and blending of psychoactive chemicals in the marijuana plant;
- increased marketing; and
- increased competition and therefore decreased costs. [1]

The following chart was adapted from Caulkins et al. (2015) and highlights the attributes of government monopoly and commercial models.

Attributes	**Strategy**	
	Government monopoly	**Commercial model**
Production costs (without fees, taxes, regulation)	Low or medium	Very low
Product quality assurance and labelling	Very good	Good
Incentive for producers to promote use that is harmful to public health	Low	Very high
Government's ability to restrain suppliers promotion of harmful use	Very good	Low
Likelihood of promoting harmful use	Low or medium	Very high
Cost or effort for government control efforts	High	Low
Ability to generate government revenue	Very high	Fair

It is clear that a government monopoly on production is the best model for public health and safety.

2. *To what extent, if any, should home cultivation be allowed in a legalized system? What if any government oversight should be put in place?*

Recommendation:

- **Home cultivation is not recommended.**

Rationale:

From a public health perspective, home cultivation presents the following challenges:

- potential for increased access among children and youth;
- significant challenges in regulating potency, quality and labelling; [1]
- high cost and effort for governments to control and regulate marijuana production; [1]
- increased challenges in regulating commercial production and preventing diversion; [5]
- inability to generate government revenue to support health promotion initiatives.
- lack of authority to inspect homes to ensure safe production; and
- potential health impacts in the surrounding environment and risks to property from home growth, including fire and mould.

3. *Should a system of licensing or other fees be introduced?*

Recommendation:

- **Licensing should be required and a licensing fee enacted to increase revenue to enhance public health and safety through increased producer compliance with regulatory standards, and to** offset t**he health and social costs associated with legalization.**

Rationale:

Licensing will ensure all producers meet standards of regulations for ongoing safe production and storage to protect public health and safety. Licensing also enables governments to geographically track the number of producers to determine community trends and density.

If a commercialized model is considered, incentives are required to ensure production companies comply with regulations rather than opting to violate regulations and take the

chance of being caught. Restricting the number and size of licensed producers and establishing strict penalties to discourage violations creates a sense of value to the license and is a possible strategy to increase compliance. Producers would have a strong incentive to follow regulations. Without restrictions, the value of a license decreases, as does the fear of losing a license for a violation.

In addition, monitoring regulatory compliance is more efficient and less costly within a limited number of firms. [(1)]

4. *The MMPR* (ACMPR as of Aug. 24, 2016) *sets out rigorous requirements over the production, packaging, storage and distribution of marijuana. Are these types of requirements appropriate for the new system? Are there features that you would add or remove?*

Production

Recommendation:

- **Strengthen requirements set out in the ACMPR to develop a more comprehensive regulatory system, including: Development of national standards for production, packaging, storage, distribution and testing of marijuana products. This is an important strategy for public health and safety.**
- **Expansion to include regulation of a wider variety of marijuana products (e.g., edibles, concentrates, and tinctures).**
- **Provision of government resources for inspection and other accountability functions.**
- **Mandating food safety training for producers of edible marijuana products.**
- **Aligning marijuana production with public policy goals related to climate change.**

Rationale:

- The ACMPR sets out strict conditions for the production of medical marijuana in Canada, including batch testing for contaminants. These requirements form a good basis for the new regulatory system for non-medical marijuana.

- Other jurisdictions have measures in place that can inform Canada's system. In Colorado, one department provides key monitoring and accountability functions, including:
    - inspecting all growers, infused product manufacturers and retail outlets; and
    - inspecting and certifying marijuana testing facilities that perform potency and contamination testing on plants, concentrates and edibles. [6]

- In other jurisdictions, governments offer producers of edible marijuana products access to its food safety training to reduce the risk of food-borne illness (e.g., risk of contamination with certain viruses and bacteria). [6]

- There is an opportunity to align marijuana production with public policy goals related to climate change. The indoor production of marijuana has been shown to have a significant carbon footprint. Indoor cultivation uses significant energy resources, including intensive lighting and climate control. For example, one marijuana 'cigarette' represents 1.5 kg of CO2 emissions. This is equal to driving a hybrid car 35 kilometres. [7] Regulation and licensing options worth considering include mandating carbon-free electricity generation. Boulder, Colorado requires marijuana businesses to offset 100% of their electricity consumption with renewable energy. [8]

Product Packaging

Recommendations:

- **Develop and enforce product design requirements, including plain and standardized packaging regulations that prohibit branding and promotion of all marijuana products.**
- **Develop and enforce labelling requirements, including marijuana strain, dosage, and THC levels. Lessons can be learned from regulating product packaging of tobacco and alcohol and from other jurisdictions that have legalized marijuana.**
- **Commission research on the effectiveness of health warning labels on marijuana products and update labelling requirements as necessary.**

Rationale:

- Colorado has rules on packaging, labelling and product safety equal to or exceeding those for tobacco that should be considered in the development of Canadian standards. These include:
    - prohibiting appeal to children or youth under age 21;

- restricting use of cartoon characters in the design;
- mandating child-resistant packaging. [6]

- Strategies that prevent the promotion and marketing of marijuana will help reduce consumption and related harms. Health experts recommend the use of plain packaging as a means of reducing promotion and marketing of marijuana. [9, 10] The World Health Organization also recommends plain packaging as one measure to decrease tobacco smoking initiation and cessation. [11]

- There is limited research on the effectiveness of health warning labels on marijuana products to reduce marijuana-related harm. While further research is currently underway to evaluate the effectiveness of warning labels on alcohol products, there is evidence to suggest that consumers support the inclusion of more health/nutrition information on alcohol products. [12] Where evidence supports, health warning labels on marijuana products should advise against frequent use, use prior to age 25, use in combination with alcohol or other drugs, use prior to driving or operating heavy machinery, use during pregnancy, use with a family history of psychosis or with cardiovascular problems, use above recommended dosage, and about the risk for respiratory issues and of second hand smoke.

Distribution

Recommendations for regulations related to the distribution of marijuana are provided in section 3.

5. What role, if any, should existing licensed producers under the MMPR (ACMPR) have in the new system (either in the interim or the long-term)?

- *Out of public health scope. No response.*

Section Two References:

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Section 3: Designing an appropriate distribution system

1. Which distribution model makes the most sense and why?

Recommendation:

A government owned and controlled store front system is the best model to emphasize health and safety over customer and profit generation and to prevent youth access, through:

- **controlling availability and accessibility of marijuana;**
- **providing adequate staff training;**
- **providing evidence-based information on the potential health effects of using cannabis to consumers;**
- **restricting and enforcing limitations on marketing and advertising;**
- **establishing and maintaining a minimum price; and**
- **ensuring marijuana is not sold alongside other products that can have synergistic effects when combined with marijuana (e.g., alcohol and tobacco).**

Rationale:

Experience from alcohol demonstrates that government ownership of alcohol outlets can regulate alcohol availability in a comprehensive way. There is strong evidence that off-premise monopoly systems limit alcohol consumption and alcohol-related problems if alcohol control is a central goal, and that elimination of those monopolies can increase total alcohol consumption, especially when privatization leads to increased outlets, expanded hours of sale and reductions in the enforcement of policies such as not selling to underage customers. (1)

We can infer that government ownership is the most effective way to achieve the overall government goals of reducing harm related to marijuana consumption. Research on state run alcohol monopolies have shown that monopolies help keep the price of a product higher through reduced competition and help reduce access to alcohol by youth and overall levels of use. (2)

It is difficult to change a policy to make it more restrictive once the use of a substance and its regulations have been socially embedded and accepted. Policies and regulations regarding recreational marijuana should be more restrictive rather than less restrictive in the beginning. The policies and regulations could be loosened if the evidence and experience collected over time is evaluated and supports changes.

Retail outlets

There are several safeguards that protect the health and safety of the public. Some of these regulations include:

- Limiting the number and type of retail outlets
- Restricting hours and days of operation
- Restricting locations of retail outlets
- Restricting density of retail outlets (geographic density or population density)
- Allowing for broad Zoning powers at the municipal level
- Restricting the type of products that can be sold through outlets along with cannabis
- Restricting marketing, promotion and displays
- Training of staff/education of consumers at point of sale
- Training of staff/promotion of health risks through educational material at point of sale

This is supported by evidence:

- The widespread availability of tobacco and alcohol products for purchase helps to normalize their use and to undermine health risk messaging. Contextual cues play a significant role in shaping understanding of the magnitude of a hazard. There is a discord between the risk information provided by health authorities and the contextual cues that tobacco (and alcohol are) commonplace. (3)
- Easy access to tobacco reduces the total cost (price plus time, distance and transportation) to use. Frequent cues (i.e. seeing products in many outlets) prompts impulse buys among experimental and occasional smokers and smokers trying to quit. For former smokers receiving cues to smoke in places where they regularly shop also contributes to high levels of recidivism. (3)
- More than one third of smokers and a higher proportion of young smokers said they would smoke less if they had to travel further to buy cigarettes. (3)

Free Enterprise (Business) Market

There are several public health and safety concerns regarding a free enterprise market for cannabis distribution, including**:**

- Commercial interest and profits take priority over public health interests.
- Lack of control over staff training to prevent youth access to marijuana.
- Decreased accountability to provide health education regarding potential risks of using cannabis for consumers.
- Economic burden on the government to prevent or delay use by youth. More costly and less efficient enforcement of regulations.

These concerns are supported by evidence:

- Research strongly indicates that as alcohol becomes more available through commercial or social sources, consumption and alcohol-related problems rise. Conversely, when availability is restricted, alcohol use and associated problems

decrease. The best evidence comes from studies of changes in retail availability, including reductions in the hours and days of sale, limits on the number of alcohol outlets and restrictions on retail access to alcohol. (1)

- Evidence from privatization experiments in the USA and abroad has shown that privatization leads to more outlets, longer hours of operation, increased promotions and increased sales and use. (4)
- Research suggests that roughly 80% of marijuana purchases in the USA are made by 20% of the users (heavy users who use daily or near daily). (5) To maximize profits, companies would benefit from creating and maintaining heavy users.

2. To what extent is variation across provinces in terms of distribution models acceptable?

Recommendation:

- **A uniform distribution model consistent across Canada is important for public health.**

Rationale:

Cross border variations can present many complexities and challenges, as is seen now between Ontario bordering Quebec and Manitoba, where the legal age to drink alcohol is different.

When it is left to each province to add additional policies and regulations, local health units and our partners are burdened with the challenging task of demonstrating the need for additional safeguards at the local level.

Even within a strict health-focused federal regulatory system, provinces and municipalities will require the jurisdiction to strengthen the regulations and policies in order to further safeguard the health and safety of their residents. For example, municipalities should be able to use zoning bylaws when determining locations of outlets.

3. Are there other models worthy of consideration?

Recommendation:

- **A government monopoly with cross-border consistency is the preferred model for Ontario health units.**

Section Three References

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Section 4: Enforcing public safety and protection

1. *How should governments approach designing laws that will reduce, eliminate and punish those who operate outside the boundaries of the new legal system for marijuana?*

Recommendation:

- **A federal legislative framework that sets out clear minimum standards that all provinces and territories must follow, including a minimum age for sale or provision, restrictions on labelling and promotion, and clear enforcement infrastructure**, will result in a strong foundation upon which more restrictive provincial and municipal laws can be built, if required.

- **Youth possession of marijuana should not be considered a criminal offense.** The onus of compliance with the laws should be placed on the commercial supplier with increasing penalty with each infraction, and include prohibition of any sale or storage of product. This recommendation, however, should not preclude criminal charges of youth related to impaired-driving. Offences regarding youth access should be aligned with those in alcohol and tobacco control.

- **Develop an enforcement infrastructure that prevents the diversion of marijuana products from the legal supply chain**. This will require collaboration at all levels of government and enforcement bodies.

- **Provide mandatory labelling or markings that easily identify permitted products thereby facilitating the removal of prohibited products from the supply chain. Ensure penalties are aligned with alcohol and tobacco contraband offences.**

- **Creating a new role of 'marijuana control officer' (similar to tobacco control officers) to help enforce regulations.**

Rationale:

It is important that the federal government take a public health approach that focuses on preventing youth access to marijuana through the legal and illegal supply chains. Existing alcohol and tobacco control policies provide structures that could support marijuana legislation.

The commercial model of marijuana legalization adopted in Washington, Colorado, Alaska and Oregon State performs well in terms of consumer access and reducing street level illicit marijuana trade. However, like alcohol, tobacco, and gambling, the goal of the commercial for-profit model is to attract new customers, keep existing customers and convert moderate users into consistent users. The preferred approach from a public health standpoint is a regulatory approach similar to alcohol that makes the sale of marijuana a provincially controlled state monopoly similar to the LCBO. This approach, provides an effective means of controlling the quality, cost and availability of the product, promotes responsible use amongst adults while restricting access to minors. [(1)]

Evidence suggests that a regulatory approach can reduce the burden on the criminal justice system and provide a platform for government or health care professionals to effectively address and help prevent problematic use. [(1)] If a regulatory controlled system for the legal purchase and use of marijuana is adopted, criminal sanctions should be strengthened for those who sell to minors or act outside the boundaries of the new regulatory system and civil violations punishable by a small fine to enforce regulatory non-compliance.

For example, a federal regulated legal system for marijuana should set out clear minimum standards that all provinces and territories should follow. At a minimum all provinces and territories should be required to ensure:

- That all sales of marijuana are done through provincially controlled outlets/dispensaries.
- No criminal sanctions for anyone who is the minimum age for purchasing and possessing marijuana or over and in possession of what is deemed to be within the limit for persona possession.
- Provincially appointed enforcement staff (non-criminal) should be given the option to issue Provincial Offences Act (POA) tickets plus tax assessment penalties similar to the taxation powers given to enforcement staff under the Ontario Tobacco Tax Act for all marijuana possession that exceeds the limit for personal possession and/or that was not purchased from a state or provincially controlled outlet/dispensary.
- Criminal charges under the Control Drug and Substances Act should be laid for all sales to persons less than the minimum age for purchasing and possessing marijuana and for distribution or sales without federal or provincial marijuana sales permit.

2. What specific tools, training and guidelines will be most effective in supporting enforcement measures to protect public health and safety, particularly for impaired driving?

Recommendation:

- **Develop a comprehensive framework which includes prevention, education, and enforcement to address and prevent marijuana-impaired driving with a focus on groups at higher risk of harm, such as youth.**
- **Continue with public health support for local law enforcement activities through education and awareness raising efforts on the dangers of marijuana-impaired driving.**
- **Direct provincial education ministries to work with public health to update and provide supports for health and physical education curriculums, embedding key evidence-based messages about risky use.**
- **Additional provincial funding to allow for the expansion of the role of public health inspectors by creating 'marijuana control officer positions (similar to tobacco control officers) to help enforce regulations.**

Rationale:

As highlighted in the discussion paper, it will be important to develop a comprehensive framework to address and prevent marijuana-impaired driving. Such a framework should include prevention, education, and enforcement. [(1)] This strategy should focus on groups at higher risk of harm, such as youth, and should emphasize the risk associated with marijuana use and drug-impaired driving. Targeted campaigns via the use of radio ads, news outlets, TV commercials, or movie stills could be an effective method used to inform the public of the new legislative requirements.

There is a recognized need for research on and the development of reliable technologies that can be used at road-side check points to detect impairment due to marijuana use. The use of these technologies, including training and guidelines, would fall to local, provincial and federal law enforcement agencies, depending upon the jurisdiction. Additional training opportunities could assist enforcement staff to further enhance their ability to combat difficult situations such as dealing with drug-impaired driver or managing conflict with individuals who may be impaired due to the use of marijuana.

Public health can play a role in supporting local police agencies through education and awareness raising efforts. Traditional public health communication channels could be used to help make the public aware of the dangers of marijuana-impaired driving, similar to efforts currently being done around drinking and driving.

Public health staff currently partner with school boards as well as school staff, school councils and students of elementary, secondary and post-secondary educational settings

to raise awareness of the health and safety risks to youth posed by alcohol, tobacco and marijuana use. [2] These efforts can be expanded to include greater emphasis on marijuana and youth-related health effects as well as marijuana-impaired driving. The communication of risk to the wider population can be undertaken using existing social media channels and providing support to relevant local partners, as needed.

3. Should consumption of marijuana be allowed in any publicly-accessible spaces outside the home? Under what conditions and circumstances?

Recommendation:

- **A comprehensive ban of the consumption of marijuana in workplaces and in shared indoor and outdoor spaces at the federal level would prevent a patchwork approach similar to what is observed in tobacco control across Canada. A federal level ban positions marijuana use as having risk, and provides a minimum standard upon which provinces and municipalities can build. Enforcement of these regulations must be jointly shared at the federal, provincial and local levels.**

Rationale:

The prohibition of alcohol consumption in public spaces has its roots in federal and provincial temperance laws and the prohibition movement with the misdirected aim to maintain social order. Currently, alcohol consumption is limited for the most part to private residences or licensed premises. On the other hand, the prohibition of smoking in workplaces, public indoor and outdoor spaces have been implemented to varying degrees across Canada over the last 30 years. The implementation of these policies was in response to the body of evidence that identified the link between tobacco use and chronic diseases. [3]

According to the World Health Organization, 100% smoke-free environments are the only effective way to protect the population from the harmful effects of second hand smoke (SHS). SHS can disperse quickly through a building traveling between adjacent units through cracks in walls and ceiling, windows, heating and ventilations systems. According to the American Society of Heating, Refrigerating & Air-Conditioning Engineers (ASHRAE) there is currently no available or reasonably anticipated ventilation or air cleaning system that can adequately control or significantly reduce the health risks of SHS. ASHRAE also says the only effective means of eliminating the health risk associated with indoor exposure to SHS is to ban smoking altogether. [4]

Studies have shown that smoke-free policies can reduce smoking rates, youth initiation rates and increase quit attempts. Smoking bans have also been associated with improved health outcomes, such as reductions in heart disease and respiratory illness. [4] Tobacco and other combustible smoking products should be the highest priority for no-smoking provisions. Exposure to all smoke, including tobacco, marijuana and herbal products such as shisha water pipe smoke, can trigger cardiovascular events, severe asthma attacks and can aggravate existing chronic obstructive pulmonary disease and other respiratory conditions. [5, 6, 7]

In March 2016, the Ontario government announced plans to further strengthen the smoking and vaping laws by proposing six additional changes to the regulations made under the Smoke-Free Ontario Act (SFOA) and ECA. The Province tabled Bill 178 that would amend the SFOA to prohibit the smoking of any substance or product prescribed by regulation. Bill 178 was carried on third reading in June. The Government would next promulgate the regulations that would stipulate what products/substances (other than tobacco) are not to be smoked in the same places where smoking of tobacco is prohibited. The Province to date has only formally proposed that medical marijuana be prescribed under the regulations but it is recommended that they extend this to recreational use of marijuana as well.

It is evident that the Task Force on Marijuana Legalization and Regulations seeks to protect young Canadians and protect the health of all. In the case of smoking or vaping of marijuana, a prohibition of its consumption in workplaces and public spaces, both indoor and outdoor, ensures the same reasonable and precautionary safeguards to employees, customers and bystanders from exposure to second-hand smoke. Further still, lessons from tobacco control suggest that a prohibition of consumption in public spaces, in conjunction with sufficient taxation and banning advertising, promotion and sponsorship, would prevent the normalization of consumption among youth. [1]

Section Four References:

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Section Five: Accessing marijuana for medical purposes

1. ***What factors should the government consider in determining if appropriate access to medically authorized persons is provided once a system for legal access to marijuana is in place?***

   Recommendation:

   - **Utilizing a health equity lens, the government needs to provide regulations including price and accessibility to suit the needs of all Canadians who require medical marijuana while maintaining effective controls to reduce potential harm.**

   Rationale:

   Ontario public health units focus on the issue of health equity.

   The legalization of marijuana will impact the current system of medical marijuana. If it is anticipated that there will be a continuation of access to marijuana for medical reasons, the proper measures need to be put in place to allow for enforcement.

   Affordability and accessibility have been identified as reasons for the commercial medical marijuana system not meeting the needs of all. Utilizing a health equity lens, the government needs to provide regulations including price and accessibility to suit the needs of all Canadians who require medical marijuana while maintaining effective controls to reduce potential harm. Regardless if the marijuana is medical or recreational, there is a need for strong regulation and control the methods by which people are accessing it.

Algoma PUBLIC HEALTH
Santé publique Algoma

Board of Health

Date: October 26, 2016	**RESOLUTION NO.: 2016 -**
MOVED:	**SECONDED:**
SUBJECT: A PUBLIC HEALTH APPROACH TO THE LEGALIZATION OF CANNABIS	

Resolution:

WHEREAS Algoma Public Health is committed to prevent disease and promote the health of individuals and communities in the Algoma District; and

WHEREAS the Government of Canada has indicated the intention to legalize, regulate, and restrict access to marijuana; and

WHEREAS within the current criminalization context, 49.12 % of individuals in Algoma indicated that they have used cannabis in their lifetime compared to 40.22% in Ontario; and

WHEREAS cannabis also ranks 3rd on the list of top drugs presented at intake in both North and East Algoma according to Algoma Public Health's Community Alcohol/Drug Assessment Program; and

THEREFORE BE IT RESOLVED THAT the Board of Health for the District of Algoma Health Unit continue to support staff in their alignment with the "Provincial Marijuana Collaborative" on cannabis, with the purpose of forwarding public health recommendations to the Federal Task Force reviewing the legalization, enforcement and regulation of cannabis; and

FURTHER THAT this resolution be shared with the Honourable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-Term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

CARRIED: Chair's Signature _____

☐ **Lee Mason - Chair**	☐ **Ian Frazier – Vice Chair**	☐ **Patricia Avery**
☐ **Lucas Castellani**	☐ **Deborah Graystone**	☐ **Sue Jensen**
☐ **Candace Martin**	☐ **Heather O'Brien**	☐ **Dennis Thompson**

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September 30, 2016

Hon. Mitzie Hunter, MPP
Minister of Education
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Hon. Helena Jaczek, MPP
Minister of Community and Social Services
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Hon. Michael Coteau, MPP
Minister of Children and Youth Services
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Dear Honourable Ministers:

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

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

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

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

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

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

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

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

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

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September 30, 2016

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

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

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

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

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Maryam Monsef, MP, Peterborough-Kawartha
Kim Rudd, MP, Northumberland-Peterborough South
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

Municipality of Chatham-Kent
Public Health Unit
PO Box 1136, 435 Grand Avenue West, Chatham, ON N7M 5L8
Tel: 519.352.7270 Fax: 519.352.2166
Email ckhealth@chatham-kent.ca

September 27, 2016

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Rm. 281
Queen's Park
Toronto ON M7A 1A1

The Honourable Chris Ballard
Minister Responsible for the Poverty Reduction Strategy
6th Floor, Mowat Block
900 Bay Street
Toronto ON M7A 1L2

Dear Premier Wynne and Minister Ballard:

RE: FOOD SECURITY IN THE DISTRICT OF THUNDER BAY

At its September 21, 2016 meeting, the Board of Health for the Chatham-Kent Public Health Unit considered a motion and a report from the Thunder Bay District Health Unit (attached) concerning Food Security in the District of Thunder Bay. This report specifically addresses the need for the implementation of a universal hot meal program in Ontario elementary and secondary schools.

This report has raised concerns among our Board of Health members about poverty and food insecurity issues. These pose serious risks for the health of our community and for the Province as a whole.

The Board felt there was significant evidence presented to support the recommendation for changes to current government policy in addressing food insecurity.

Sincerely,

Joe Faas, Chair
Chatham-Kent Board of Health

Attach.

…/2

cc: Rick Nicholls, M.P.P., Chatham-Kent – Essex
Monte McNaughton, M.P.P., Lambton – Kent - Middlesex
Association of Local Public Health Agencies
Ontario Boards of Health

Thunder Bay District
Health Unit

MAIN OFFICE
999 Balmoral Street
Thunder Bay, ON P7B 6E7
Tel: (807) 625-5900
Toll Free in 807 area code
1-888-294-6630
Fax: (807) 623-2369

GREENSTONE
P.O. Box 1360
510 Hogarth Avenue, W.
Geraldton, ON P0T 1M0
Tel: (807) 854-0454
Fax: (807) 854-1871

MANITOUWADGE
1-888-294-6630

MARATHON
P.O. Box 384
Marathon Library Building
Lower Level,
24 Peninsula Road
Marathon, ON P0T 2E0
Tel: (807) 229-1820
Fax: (807) 229-3356

NIPIGON
P.O. Box 15
Nipigon District
Memorial Hospital
125 Hogan Road
Nipigon, ON P0T 2J0
Tel: (807) 887-3031
Fax: (807) 887-3489

TERRACE BAY
P.O. Box 1030
McCausland Hospital
20B Cartier Road
Terrace Bay, ON P0T 2W0
Tel. (807) 825-7770
Fax: (807) 825-7774

TBDHU.COM

May 19, 2016

VIA ELECTRONIC MAIL

Thunder Bay DSSAB
231 May Street South
Thunder Bay, ON P7E 1B5

Attn: Mr. William Bradica
Chief Administrative Officer

Re: Food Security in the District of Thunder Bay

At the regular meeting of May 18, 2016, the Board of Health for the Thunder Bay District Health Unit considered the attached "Report Number 29-2016 (Healthy Living) TBDSSAB Position Paper: Food Security in the District of Thunder Bay" providing information on the TBDSSAB's position that a universal hot meal program should be implemented in Ontario elementary and secondary schools. The following motion was passed:

> "THAT with respect to Report No. 29-2016 (Healthy Living), we recommend endorsement of the TBDSSAB Position Paper: Food Security in the District of Thunder Bay; as presented,
>
> AND THAT we circulate this endorsement to the Association of Local Public Health Agencies (alPHa) for distribution to all Ontario Public Health Units."

It is the Board's hope that this endorsement will add support to the calls for changes to current government policy in addressing food insecurity.

Sincerely,

Original signed by

Joe Virdiramo, Chair
Board of Health for the Thunder Bay District Health Unit

Encl. 2

cc. Association of Local Public Health Agencies
Ontario Boards of Health

Thunder Bay District Health Unit

Issue Report

PROGRAM/ DIVISION	Healthy Living Health Promotion	**REPORT NO.**	29 - 2016
MEETING DATE	May 18, 2016	**MEETING TYPE**	Regular
SUBJECT	TBDSSAB Position Paper: Food Security in the District of Thunder Bay		

RECOMMENDATION

FOR INFORMATION ONLY

REPORT SUMMARY

To provide the Board of Health with information relative to the request to endorse the TBDSSAB Position Paper: Food Security in the District of Thunder Bay.

BACKGROUND

The Thunder Bay District Health Unit is mandated to reduce the burden of preventable chronic diseases of public health importance. The health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions.

Addressing these determinants of health and reducing health inequities are fundamental to the work of public health in Ontario. A key determinant of health is income and related household food security (Public Health Agency of Canada).

Addressing Food Insecurity

It is important that everyone has consistent access to safe, affordable, and nutritious food to promote health and prevent chronic disease. Addressing food insecurity at the individual, household and community levels requires a multifaceted approach; one that calls upon changes to current government public policy and that targets the barriers faced by our most vulnerable populations, as well as addressing the food system as a whole.

Emergency Food in the District of Thunder Bay

Charitable food programs such as food banks, soup kitchens and meal programs provide short-term relief and are only part of a comprehensive strategy needed to fully address food insecurity. They have many limitations related to the quantity and quality of the food provided and do not address the root causes of food insecurity. The Regional Food Distribution Association (RFDA) serves approximately 3,447 people per month through its 38 member food banks and

meal programs in Northwestern Ontario, with an average of 9000 meals being served at 7 emergency daily meal programs every month.

As outlined in the TBDSSAB Position Paper, it is very difficult to ascertain the specific number of unique individuals served by the emergency food system. It should be noted, however, that research shows only 25% of the food insecure population are accessing food banks, making this statistic a serious underestimate of food insecurity in our community.

School Nutrition Programs in the District of Thunder Bay

Student Nutrition Programs have been recommended as an important part of a comprehensive food and nutrition strategy and a key component of health-promoting schools. They help to provide healthy food to children and have shown effective outcomes for short-term relief of food insecurity.

Research has established that proper nutrition, particularly during the morning hours, plays an important role in supporting learning. However, studies have shown that 31% of elementary students and 62% of secondary students in Canada do not eat a healthy breakfast before school. There are a number of reasons why children may start their day without breakfast including lengthy commutes, busy family routines, lack of hunger when first waking and lack of availability of food due to poverty.

Participation in student nutrition programs is associated with positive educational outcomes including improved academic performance, reduced tardiness and improved student behaviour. Recent studies from northern Ontario and British Columbia found that students who participated in a school food program reported higher intakes of fruits and vegetables and lower intakes of non-nutritious foods. Student Nutrition Programs are an opportunity to establish life-long healthy eating habits beyond participation in the program.

Canada remains one of the few industrialized countries without a federally-funded, universal school meal program. The Healthy Kids Panel Report, released in 2012, also includes a recommendation for a universal school nutrition program for all publicly-funded schools, as part of an overall strategy for promoting the health and well-being of children and youth in Ontario.

In Thunder Bay there are 81 school meal and snack programs offered throughout the District, with funding from the Ministry of Children and Youth Services, administered locally through the Red Cross. This funding only covers up to 15% of total costs for the programs. It is up to individual programs to make up the remainder through other fund-raising, in-kind and volunteer contributions. Health Unit staff support these programs by assisting in providing menu suggestions and safe food handling information.

FINANCIAL IMPLICATIONS

None.

STAFFING IMPLICATIONS

None.

CONCLUSION

A universal hot meal program in elementary and secondary schools across the province would make a significant contribution to household and community food security, complementing other policies and programs to comprehensively address the issue.

LIST OF ATTACHMENTS

None.

PREPARED BY: Catherine Schwartz Mendez, Public Health Nutritionist

THIS REPORT RESPECTFULLY SUBMITTED BY: ***DATE:***

Lynda Roberts, Director – Health Promotion May 11, 2016

Chief Executive Officer Medical Officer of Health

THE DISTRICT OF THUNDER BAY
SOCIAL SERVICES ADMINISTRATION BOARD

THE DISTRICT OF THUNDER BAY SOCIAL SERVICES ADMINISTRATION BOARD

BOARD REPORT

	REPORT NO.: **2016-19**
MEETING DATE: **MARCH 24, 2016**	***DATE PREPARED:*** FEBRUARY 16, 2016
SUBJECT: **FOOD SECURITY IN THE DISTRICT OF THUNDER BAY**	

RECOMMENDATION

THAT with respect to Report No. 2016-19, we, The District of Thunder Bay Social Services Administration Board (the Board), approve the Position Paper: Food Security in the District of Thunder Bay, as presented;

AND THAT with respect to Report No. 2016-19, we, the Board, encourage the Ontario Government through their respective responsible Ministers, including the Ministry of Education and The Ministry of Community and Social Services, to develop and implement a universal, hot meal program in elementary and secondary schools;

AND THAT the Regional Food Distribution Association (RFDA) develop and implement a data collection plan that will, minimally, monitor food bank usage in terms of numbers of unique individuals served, client demographics, and amount of food distributed on a monthly basis;

AND THAT we direct Administration to circulate this Position Paper and resolution to Hon. Liz Sandals, Minister of Education, Hon. Helena Jaczek, Minister of Community and Social Services, Hon. Deborah Matthews, Minister responsible for the Poverty Reduction Strategy, Hon. Michael Gravelle, MPP, Hon. Bill Mauro, MPP, Thunder Bay District Health Unit, all Thunder District School Boards and the Regional Food Distribution Association.

REPORT SUMMARY

To provide The District of Thunder Bay Social Services Administration Board (TBDSSAB or the Board) with information on Food Security in the District of Thunder Bay, and the need for a universal, hot meal program in elementary and secondary schools.

BACKGROUND

In the fall of 2014, the TBDSSAB Board Chair attended a meeting in Kakabeka regarding the local food bank. The Chair brought back information to the Board regarding the Rural Cupboard Food Bank's request for funds to build a new building.

This was discussed at the September 24, 2014 Board meeting and a request was made of Administration to review the food resources within the District and complete a report.

COMMENTS: FOOD SECURITY, FOOD BANKS AND SCHOOL NUTRITION PROGRAMS

There are many ways in which to obtain food in the District of Thunder Bay. Most often food is purchased at a retail location including a Grocery Store. Other sources include community cooperatives, pop up markets, good food box, community gardens and gleaning. As drug stores are often situated in many neighborhoods, and rural communities, they are fast becoming a normal source for purchasing food as well.

In addition to the types of food sources listed above, there are sources that have a specifically targeted user group. An example of this is the School Nutrition Program (SNP) run through the Canadian Red Cross and is available in some but not all schools across the District. Where the program is offered it has universal access to safe and nutritious food, and is locally designed. Red Cross has partnered with Ministry of Child and Youth Services as its main funder for the SNP.

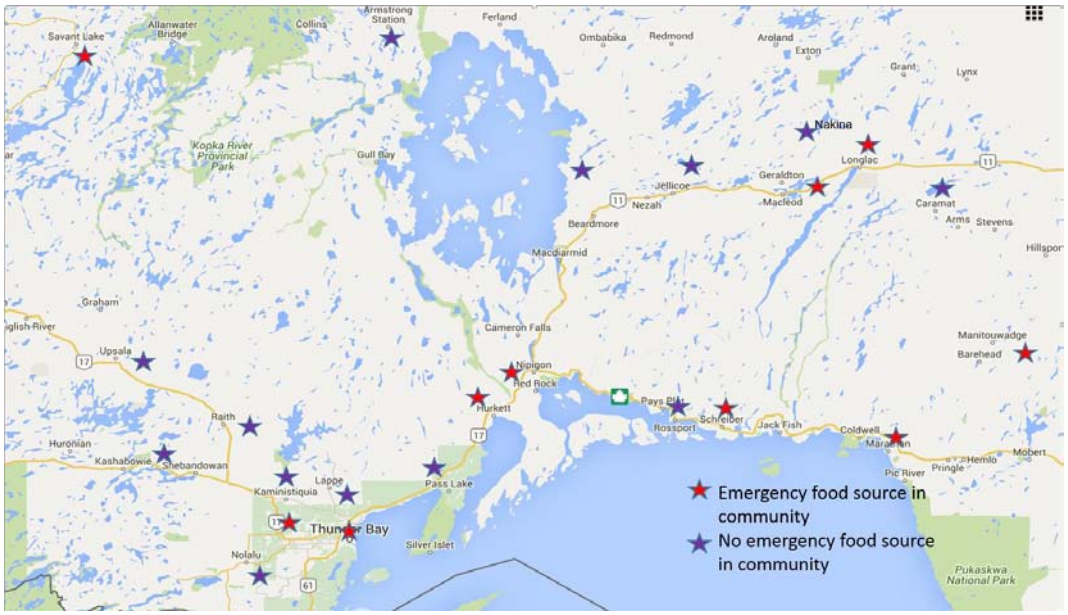
Universal access means that all children enrolled in the school have access to the program regardless of the family's ability to pay. The program is designed to be non-stigmatizing. The foods and beverages are purchased by the school or are donated and are compliant with the Ministry of Educations Nutrition Guidelines. The program encourages community volunteering and local fundraising.

Although there is the SNP at some schools in the District, children often go hungry on the weekend without the support provided. A national program called Blessings in a Backpack has begun services in a few Thunder Bay schools. The backpacks are filled with nutritious food that children take home on the weekend to ensure they are fed. The backpack is brought back to the school on Monday to be refilled for the following weekend. This service is available at Ogden Community, McKellar and Sherbrook Public Schools. See attachment #4 for a list of the schools receiving funding from Red Cross for student nutrition programs within the Thunder Bay District.

The TBDSSAB supports this Canadian Red Cross initiative through the Community Social Reinvestment Program (CSRP). In 2016 the Board approved a recommended amount of $18,000.

Another source of food that is "targeted" are Food Banks, however, most food banks are open to the public at large. A **food bank** is a non-profit, charitable organization that distributes food to those who have difficulty purchasing enough food to avoid hunger.[1] Warehouse models are most often used in North America. They are storage and distribution "depots" used to supply smaller front line agencies. Outside of North America, a front line model is used in which all operations deal directly with the front end user of the service. In the Thunder Bay District there is a hybrid of both models employed. The warehouse is the Regional Food Distribution Association (RFDA). There are also many front line models such as local food banks and soup kitchens.[2]

Food Banks in the District of Thunder Bay



Food Banks and Emergency Food Sources in the District of Thunder Bay are available in Oliver Paipoonge, the City of Thunder Bay, Dorion, Red Rock and Nipigon, Geraldton, Longlac, Schreiber and Terrace Bay, Marathon and Manitouwadge.

The Regional Food Distribution Association of Northwestern Ontario has a mandate to create a reliable and accountable emergency food delivery system

[1] https://en.wikipedia.org/wiki/Food_bank
[2] https://en.wikipedia.org/wiki/Food_bank

throughout the region and coordinate collective efforts of stakeholders to meet needs and provide information on programs to better serve the community.

The RFDA receives shipments of food from the National Food Share System through their membership in the Ontario Association of Food Banks (OAFB). Since their first shipment in January of 2005, the RFDA has received approximately 110,000 lbs. of food valued at approximately $220,000. The OAFB membership also gives RFDA access to producer donated foods such as milk, bacon, canned/ processed foods, etc. Local gardeners and other food producers also donate food products in season.
http://www.readperiodicals.com/201403/3330434591.html#ixzz40Mh6rMQR

The TBDSSAB supports the RFDA through the CSRP. In 2016 the Board approved a recommended amount of $70,000.00. See attachment #5 for a list of the 39 partners in the District of Thunder Bay to whom food supplies are provided by the RFDA.

The CSRP offers eligible program applicants financial support for initiatives within the District of Thunder Bay that reduce the depth and breadth of child poverty. Many of these involve core food security issues, and the funding of school food programs.

The Regional Food Distribution Association and The Canadian Red Cross have been identified as two major partners in the District food availability chain. For programs associated with these agencies, it has been identified that the funding from RFDA and Red Cross is not enough to cover the expense of running a food security program. The CSRP often is called upon to support the purchase of perishable vegetable and fruit items and infant necessities of life. Many of these items need to be purchased within the local community due to the perishable nature and immediate child need.

RECOMMENDATIONS AND RATIONALE

As a result of this review of food security and the work of the Thunder Bay District Health Unit (TBDHU-as referenced), Administration recommends the following two recommendations that are put forth in the attached position paper.

1) Given the immediate and long-term impacts of food security on children, it is recommended that the Ontario Ministry of Education implement a universal, hot meal program in elementary and secondary schools. Based on available information, it appears that children in Thunder Bay and surrounding areas are increasingly vulnerable in the domains studied through the Early Developmental Instrument (EDI). Aside from the nutritional benefits, a universally applied hot meal program would limit stigma associated with means testing or self-identification as low income,

and such a program would also help to increase the disposable incomes of families that are on a fixed budget.

2) While broader social trends indicate the strong likelihood of an increase in food insecurity in the District of Thunder Bay, at present time there is insufficient data with which to adequately determine the needs, monitor the trends, or track progress in the area of addressing food security issues. Given that reliable data is necessary for making good, evidence-based decisions and policies, it is recommended that the Regional Food Distribution Association of Northwestern Ontario – as the central hub for charitable food distribution in the District of Thunder Bay – develop and implement a data collection plan that will, minimally, monitor food bank usage in terms of numbers of unique individuals served, client demographics, and amount of food distributed on a monthly basis. The use of free software for this purpose, such as the Homeless Individuals and Families Information System (HIFIS) – as utilized by a growing number of food banks across Ontario – could be employed to help get a better sense of the needs of those using the food bank system.

FINANCIAL IMPLICATIONS

There are no financial implications related to this report.

REFERENCE MATERIALS ATTACHED

Attachment #1: Pamphlet - Where to get Food in Thunder Bay
Attachment #2: List - Food Banks in the District of Thunder Bay
Attachment #3: Food Security Information Report TBDHU
Attachment #4: List - Red Cross Funded Student Nutrition Programs
Attachment #5: List - RFDA Food Partners
Attachment #6: Position Paper – Food Security in the District of Thunder Bay

PREPARED BY:	Jennifer Lible, Manager, Client Services, Client Services Division Saku Pinta, Senior Social Policy Analyst, CAO's Office The District of Thunder Bay Social Services Administration Board
APPROVED / SIGNATURE:	
	Lori Roulston, Director – Client Services Division The District of Thunder Bay Social Services Administration Board
SUBMITTED / SIGNATURE:	
	William (Bill) Bradica, Chief Administrative Officer The District of Thunder Bay Social Services Administration Board

Grocery Delivery

George's Market - 14 Balsam Street, 345 - 7021

- Call in grocery order any time for pick up or same day delivery
- Call for current delivery pricing
- Every Wednesday is Seniors' Day
- Personal service
- Pay by cash, Visa, Mastercard and Amex

Westfort Foods Inc. - 111 Frederica Street, 623-4220

- Delivery to residents South of the Harbourview Expressway: Mondays, Wednesdays and Friday's
- Delivery to residents North of the Harbourview: Tuesday's and Thursday's
- Minimum $30 purchase
- Delivery charges apply
- Deliveries made after 3:00pm
- Phone in orders by 1:30 p.m
- Method of payment: Cash, Mastercard, Visa, Debit
- No deliveries on weekends

Food for Seniors

Senior Lunch A Month
NorWest Community Health Centres
Thunder Bay Site - 525 Simpson Street
622-8235

- Soup & sandwich lunch on last Monday of each month
- Call to register, transportation is available

Thunder Bay 55+ Centre - 700 River Street, 684-2795

- For people 55 and over
- Hot lunches served Monday - Friday, 11:30 a.m. - 1:30 p.m.
- Soup and Sandwiches 8:30am—3:30pm
- Price: $6.75 for main dish
- Takeout available; pick-up only

Our Kids Count Older Adult Kitchen Program
704 McKenzie Street, 623-0292

- Cook and take home healthy meals
- Runs Monday mornings, call to register

Meal Delivery

Meals on Wheels
Southward - 625-3667 Northward 684-2862

- Meals include soup, main plate and dessert
- Cost: $7.25 per meal for eligible customers
- **Delivery between 10:30 a.m. and 12:30 p.m. by qualified volunteers**
- Call to apply, not available on weekends

George's Market - 14 Balsam Street, 345 - 7021

- Daily lunch specials, choice of dinners
- Call for pick up, same day delivery or more information

Blue Door Bistro - 116 S. Syndicate 623-5001

- Frozen meal delivery
- Call for more information

Stretching Your Food Dollars

Community Gardens

- Garden plots for people to grow their own vegetables and lower their food costs.
- Call TBDHU for more details, 625-5956

Community Kitchens

- Small groups of people who get together to cook healthy, economical meals to take home to their families.
- Call TBDHU for more details, 625-5956

Gleaning

- Provides transportation to local farms to pick crops for free after the main harvest.
- Call TBDHU for more details, 625-5956

Good Food Box

- A program for people who want to buy quality, fresh, local produce at a lower price than shopping at the grocery store, delivered to their neighborhood.
- Call 345-7819 for more details

For more information on programs and services, call the Community Information and Referral Centre: 211

Produced by the
Thunder Bay Food Action Network
with support from the
Thunder Bay District Health Unit.

To download a copy go to:
http://www.nwofood.com

Where to get Food in Thunder Bay

A List of Food Programs and Food Banks

food action network

Attachment #1
Report No. 2016-19

N-137 Nov. 2015

Emergency Food Programs

Southward

Thunder Bay Food Bank
129 Miles Street E., 626-9231

- **Open Tuesday and Friday 9:00 - 11:00 a.m.** (except the first Tuesday and Friday of every month)
- Limit once a month, must bring ID for self and children, with current address.

Family Giving Centre c/o St. Thomas Anglican Church
1400 S. Edward Street, 623-3608
Email: stthomasfgc@gmail.com

- Open to Westfort residents and individuals and families living in close proximity of Westfort
- Must show ID
- Please phone ahead before coming
- **Open two Fridays per month 10:30 - 11:30 a.m. with a free community lunch 11:00—12:30 on those days**

Redwood Park Opportunities Centre
532 N. Edward Street, 577-3463

- **Open every Thursday 12:30 - 2:30 p.m.**
- Closed the week of New Year's
- Only Northwood and County Park residents
- I.D. required
- Limit once per month, pick-up only
- Call for more details

St. Vincent de Paul Society South Ward Branch
1019 Brown Street, St. Agnes Church, 577-3464

- Must live in the South Ward
- Limit once every 2 months
- **Hampers distributed from 9:00am—10:30 am Fridays**
- Proper ID with current address must be shown

The Losier Centre
920 Sprague St. Thunder Bay Methodist Church
622-7686

- Food available on an emergency basis only
- **Open Wednesday 9:00 - 11:00 a.m.**
- Closed during July and August and on holidays

The Gathering Place
239 W. Amelia St., 623-8184

- **Hampers available on Tuesdays between 12:30—2:30 p.m.**
- Limit once a month
- Must show ID

Northward

Elevate NWO
574 Memorial Avenue, 345-1516

- For clients only
- **Phone for details.**
- Available on Wednesday's

St. Vincent de Paul Society North Ward Branch
664 Red River Road Corpus Christi Church, 344-4898

- **Wednesday by walk-in from 1:00 p.m. - 3:00 p.m.**
- Available to North Ward families with children only, does not include Current River residents
- Must show ID for entire family with current address
- Limit 6 visits / year

Current River Churches Food Cupboard
360 Blackbay Rd. (Elim Community Church), 344-3391

- **Open every Tuesday from 9:30 a.m. to 11:30 a.m.**
- For residents from Current River Ward, Lakeshore Drive, Pass Lake, and Shuniah Township
- Requires proof of current residence
- Can be used once every two weeks

Salvation Army Community & Family Services
545 N. Cumberland Street, 344-7300

- **Hampers by appointment only**
- Appointments must be made a week in advance
- Limit once a month, must show ID, income and expense information

Students

Lakehead University Food Bank 343-8850 or 343-8259

- **Open Monday - Friday 10:30 a.m. - 4:00 p.m.**
- Reduced hours May-September 2:30-3:30
- For Lakehead University students only; must show ID
- Limit once a month
- If no one at food bank, go to Student Union office
- Contact foodbank@lusu.ca

Confederation College Food Bank, 475-6110 or 475-6226

- **Open Monday - Friday 8:30 a.m.- 4:00 p.m.**
- For Confederation College students only
- Visit SUCCI office or call for further details

Rural

Rural Cupboard Food Bank
Highway 11/17 Kakabeka Falls at Redeemer Lutheran Church, 285-0836
Email: ruralcupboardfoodbank@gmail.com

- For east and south rural residents only; must show ID, SIN card and verification of address.
- **Open every third Wednesday from 11:00 a.m. to 1:30 p.m. (except December is the second Wednesday)**
- Please bring your own bags.

Daily Meals (no charge)

St. Andrew's Dew Drop Inn - 286 Red River Road, 345-0481

- Daily meals from 2:00 - 3:30 p.m., open to the public

Shelter House Soup Kitchen - 420 George Street, 623-8182

- Lunch 1:00 - 2:30 p.m., and Dinner 7:00 - 8:00 p.m., open daily to the public
- Sandwiches available at the door

Salvation Army Soup Van, 344-7300

- 6:00 p.m for Southward residents
- 7:00 p.m for Northward residents
- Call for information and locations

Grace Place - 235 Simpson Street, 473-3538 or 627-9848

- Meals 2x week:
  Tues, Wed. 1:00 p.m. - 4:00 p.m.
- Sunday service; coffee and baking at 2:00 p.m.

Wiisinyog Food Van (ONWA), 623-3442

- Thursdays only
- 12:00-12:30 p.m. in Port Arthur (Cumberland St. by the Hydro building)
- 1:00-1:30 p.m. in Fort William (Corner of Donald & Simpson St.)

Elim Community Church Soup Kitchen
360 Black Bay Rd.

- Tuesdays and Thursdays, 10:00-12:30 p.m.
- Open to the public

Community Food Programs

Our Kids Count

- Kitchens, food cupboards and food vouchers available for participants.
- 704 McKenzie street location call 623-0292

Thunder Bay Indian Friendship Centre
345-5840

- Pre/postnatal program, community kitchen and garden.

NorWest Community Health Centres - Thunder Bay
525 Simpson Street, 622-8235

- Pre/postnatal programs including cooking and food packages for program participants. Call for further details.

Beendigen Inc. - 541 Luci Court, 628-0624

- Pre/postnatal programs for Aboriginal mothers, including community kitchens, hot meals, food packages and food coupons for program participants only.

June Steeve Lendrum Family Resource Centre
283 Pearl Street, 345-0311

- Call for details.

SAM-MISOL 475-6502

- Pre/postnatal programs for teen mothers aged 13-21 looking to complete their high school education. Daycare and breakfast program available for program participants. Call for further details.

Anishnawbe Mushkiki Aboriginal Health Access Centre 343-4843

- Pre/postnatal support. Healthy Kindred Kitchen Program, Healthy choices, Community Kitchens, Fetal Alcohol Syndrome/Fetal Alcohol Effects Project.

Ontario Women's Native Association (ONWA)
380 Ray Boulevard, 623-3442

- Community kitchen last Tuesday of each month-from 12-2pm

Food Banks in the District of Thunder Bay (other than the City of Thunder Bay)

Rural Food Cupboard

115 Clergue Street, Kakabeka Falls, ON; 807-475-4276

Oliver Paipoonge Municipal Office; 4569 Oliver Road, Murillo, ON; 807-935-2613

Oliver Paipoonge Library in Rosslyn Village, 3405 Rosslyn Road; 807-939-2312

Neebing Municipal office, 4766 Highway 61, Neebing, ON; 807-474-5331

Churches in rural areas

Food Bank Third Wed of the month Jan-Nov 11 am-1:30 pm
Second Wed of the month Dec 11 am-1:30 pm

Nipigon

Church of the Annunciation, 26 Second St 807-887-2348

Open 3rd Saturday of the month from 1 – 3. Clients can call anytime.

Schreiber

North Shore Harvest Cupboard, 501 Winnipeg St, 807-824-2018. Open 3rd Wednesday of the month from 2 – 4, clients can call anytime

Terrace Bay

North Shore Harvest Cupboard, 58 Laurier Ave 807-824-2018, Open 3rd Wednesday of the month from 2 – 4, clients can call anytime

Marathon

Marathon Food Bank, 84 Evergreen Drive, 807-229-0514, can be accessed 1/month. Only open Fridays

Manitouwadge

Neighbour to Neighbour Program, 51 Oshweken rd. 807-826-4326

Geraldton

Greenstone Harvest Centre. 401 Main St, 807-854-1100, 2nd and 4th Thursday of each month 6 – 8

Longlac

Longlac Town Office, 105 Hamel Rd, 807-854-3663, 2nd Thursday of each month

Thunder Bay District Health Unit

Issue Report

PROGRAM/ DIVISION	Healthy Living Health Promotion	***REPORT NO.***	60 - 2015
MEETING DATE	November 18, 2015	***MEETING TYPE***	Regular
SUBJECT	Food Security: An Important Public Health Issue		

RECOMMENDATION

FOR INFORMATION ONLY

REPORT SUMMARY

To provide the Board of Health with information relative to food security, its implications for population health and effective interventions to address it at the community level.

BACKGROUND

The Thunder Bay District Health Unit is mandated to reduce the burden of preventable chronic diseases of public health importance. The health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions.

Addressing these determinants of health and reducing health inequities are fundamental to the work of public health in Ontario. A key determinant of health is income and related household food security (Public Health Agency of Canada).

Defining Food Security

Food security exists in a household when all people, at all times, have access to sufficient, safe and nutritious food for an active and healthy life. Food insecurity occurs when food quality and/or quantity are compromised, typically associated with limited financial resources.

To achieve food security, all of these four components must be present:

1. availability of food - the quantity of food available for a population;

2. stability of supply - a reliable food source over time;

3. accessibility of food - the ease with which a population may obtain available food; and

4. utilization of food – the cultural and culinary acceptability of the food, as well as the extent to which people have the skills to properly utilize the food.

Food Insecurity and Health

Food insecurity is recognized as an important determinant of health and an urgent public health problem in Canada, that affected 4 million Canadians in 2012, including 1.15 million children, and is associated with significant health concerns. It affects at least 10.2% of households (95% CI: 7.9-13.0) in the Thunder Bay District Health Unit (Canadian Community Health Survey – CCHS, 2013-2014).

When individuals and families are unable to access safe, nutritious food, their overall health can be negatively impacted. They may skip meals, eat fewer vegetables and fruit, drink less milk, and fill up on non-nutritious foods because they are inexpensive. The result of this unhealthy diet is an increased risk of chronic illness, and poor growth and development in children. Household food insecurity has been associated with a range of poor physical and mental health outcomes, for example, self-assessed poor/fair health, multiple chronic conditions, distress, chronic stress, depression, and overweight and obesity.

As food security is an emerging field and much of the activity has, of necessity, occurred at the local level through involvement of community stakeholders, there is limited scientifically rigorous research available on the clinical significance and causal pathways of food security initiatives with respect to human health. However, there are a number of program evaluations and case studies available, as well as a growing body of theoretical analysis, planning documents and guides prepared by experts in the field which help to inform understanding of the field.

Relationship Between Income and Food Security

Since the mid-1990s, several national population health surveys have demonstrated a clear linkage between income and food security. Consistently these surveys show that the adequacy of household income deteriorates, the likelihood that a household will report some experience of food insecurity increases dramatically to almost 50% in the lowest income group.

The risks for food insecurity vary according to household characteristics. Food insecurity is most prevalent among households with children under the age of 18. The most recent analysis of food security in Canada, using the 2012 CCHS, was carried out by PROOF, an international, interdisciplinary team of researchers. They found that one in six (16%) children in Canada are affected by household food insecurity. Most vulnerable are lone parent families headed by women, those renting rather than owning a home, households whose major source of income is social assistance and those reliant on Employment Insurance or Workers' Compensation. The majority of food insecure households (62.2%) are reliant on wages or salaries from employment. Being Aboriginal (28%) also increases the risk for food insecurity with a rate over two and one-half times that of all Canadian households.

Costs of Poverty and Food Insecurity

The extreme levels of material deprivation associated with household food insecurity have been associated with extensive dietary compromise, higher levels of stress and compromises across a broad spectrum of basic needs, decrease an individuals' abilities to manage health problems and increase the need for health care.

A PROOF study looking at the Canadian Community Health Survey in 2005, 2007/08 or 2009/10 found that total health care costs and mean costs for inpatient hospital care, emergency department visits, physician services, same-day surgeries, home care services and prescription drugs covered by the Ontario Drug Benefit Program rose systematically with increasing severity of household food insecurity. Costs were 23% higher in households with marginal food insecurity, 49% higher in those with moderate food insecurity and as much as 121% higher in those with severe food insecurity compared to those who were food secure.

Achieving Household and Community Food Security

To achieve food security, it is widely understood that communities must address matters that impact both the general population and vulnerable groups. Food security at the individual and household level are imbedded within a larger context of the global food system and the broader community in which individuals live. Community Food Security is both an important process and an outcome for achieving food security for individuals. It exists when all community residents obtain food security through a sustainable food system that maximizes healthy choices, community self-reliance and equal access for everyone.

To identify effective measures for improving access to, and availability of, healthy, culturally appropriate food within communities, the British Columbia Ministry of Health, Population and Public Health Division completed a comprehensive review of evidence and best practice in 2011 and updated it in 2013. This is being used as a basis for program planning in the Healthy Living Team at TBDHU and additional literature from 2013-present is being reviewed to ensure it is current.

SOLUTIONS

It is important that everyone has consistent access to safe, affordable, and nutritious food to promote health and prevent chronic disease. Addressing food insecurity at the individual, household and community levels requires a multifaceted approach; one that calls upon changes to current government public policy and that targets the barriers faced by our most vulnerable populations, as well as addressing the food system as a whole.

The solutions recommended by a high level United Nations task force highlight the need for a unified response to the challenge of global food security requiring a twin-track approach to address immediate needs as well as longer term

structural needs through participation of government, civil society, businesses and researchers. They include land use and agricultural policies that support environmental sustainability, as well as support for “closer-to-home” food production that improves access to healthy foods and builds partnerships and networks to strengthen the social fabric of communities.

Networking and community capacity are key to the successful development of food security initiatives. Public health is uniquely positioned and mandated to engage stakeholders in cross-sectoral partnerships, networks and strategies to share information and best practices, align programs and priorities, and build a broader understanding of food system issues.

Barriers to Accessing Food: The Local Picture

The barriers to consuming nutritious food can be both economic and physical. Studies conducted over the past decade have shown that access to nutritious, affordable food is often better in neighbourhoods with a large proportion of high-income earners and highly educated people. Lower income neighbourhoods have fewer food outlets offering nutritious food compared to higher-income ones; and have a higher proportion of both people who are obese and people with poor health. Community design and planning can significantly affect food access.

Transportation can also impact access to nutritious and affordable food; in both rural and low-income urban neighbourhoods under-served by public transport. This problem is more acute in rural areas, in northern communities and among Aboriginal peoples living on reserves.

Key findings from local research:

Access to healthy food

A Food Access Mapping Project and Surveys implemented in 2014-15 by the Food Strategy Food Access Working Group, identified a number of issues and solutions for increasing food access in Thunder Bay that are consistent with the evidence. Results suggested that:

- People obtain their food from a variety of sources around Thunder Bay; the most common being grocery stores and “other” food sources (such as pharmacies and large discount department stores).

- Accessibility in terms of price and location are major factors that impact where people obtain their food, with transportation being a key issue.

- A considerable percentage of respondents reported accessing alternative food sources on a monthly basis: 48% reported accessing local Food Banks every month; 38% reported using the Good Food Box program monthly; 27% reported accessing various Church food hamper programs throughout the month.

Local food system development

The Strengthening Connections Project led by the City of Thunder Bay with two rounds of Greenbelt funding (2013-15) identified a number of challenges and opportunities that the Food Strategy will be working on over the next few years. The supply of local food in our area is limited by a short growing season and capacity to meet the growing demand. More infrastructure is also required to support increased purchasing i.e. distribution, storage, processing. The seven institutions that were the focus of the project serve nearly 3000 meals and snacks daily with a combined annual food procurement budget of $1.5 million, so the potential for business development are being met enthusiastically by all stakeholders.

Community Response to Food Insecurity

There is considerable, consistent evidence that better access to healthy food corresponds to the likelihood of healthier eating, healthier weights and reduced rates of diabetes. In addition, there is strong evidence that reducing the cost of healthier foods, through subsidies or other mechanisms, increases their purchase.

Regional and municipal governments can incorporate food security initiatives into a variety of community strategies, development plans/permits, land use policies, and community development processes, as well as a range of incentives or restrictions that encourage access to, availability of, healthy food. Although public health does not manage these initiatives directly, we play an important role in advising and supporting regional and local governments in these efforts. Strategies that have been adopted by the District and viewed generally as being helpful in increasing food security in communities include:

- Food policy coalitions/councils to provide advice, leadership, advocacy, coordination, networking, education, and research i.e. the Food Action Network, led by TBDHU has been networking, advising and developing initiatives since 1995, and more recently, have spearheaded the more formal Food Strategy Steering Committee.

- Community assessment and mapping of healthy food sources and food access resources in the community as a basis for identifying and assessing community strengths and weaknesses i.e. annual “Where to Get Food in Thunder Bay” inventory, Community Food Assessment Report (2004), the Healthy School Food Zones Report (2013), Food Access Mapping Focus Group Report (March 2014), Food Access Solutions Report (March 2015)

- Increasing availability of, and access to, healthy foods by facilitating establishment of grocery stores in low-income neighbourhoods, stocking healthy foods in a range of local food outlets, and the use of development permits, zoning by-laws, regulations, subsidized permits and other incentives i.e. advised on Official Plan review 2014, exploring feasibility of

mobile markets, conducted Healthy Food Zones Around Schools research project in 2012-13.

- Policies and guidelines on the provision of healthy foods in public institutions i.e. support City of Thunder Bay's Local Food Procurement project.

- Mechanisms to support farmers markets, farm-to-cafeteria programs and other means of direct food purchase from farms i.e. support Thunder Bay and Area Food Strategy implementation plan.

- Transportation policies to enable people to easily access healthy food outlets i.e. Thunder Bay and Area Food Strategy working with City of Thunder Bay Transit to increase access through the Transportation Master Plan.

Programs and initiatives that have been adopted by the District and viewed generally as being helpful in increasing food security in communities include:

Programs that support immediate/short-term food relief:

- Charitable food programs such as food banks, soup kitchens and meal programs provide short-term relief (although they have many limitations and do not address the root causes of food insecurity) i.e. RFDA serves 38 member food banks and meal programs in Northwestern Ontario.

- Food recovery programs such as gleaning and encouraging donations of perishable food to charitable food programs can increase the availability of healthy food i.e. the TBDHU Gleaning Program organized 8 gleaning trips to 3 area farms in 2015. The 7600 pounds of berries and vegetables gleaned on these trips benefitted at least 1148 people including the 218 participants.

- Nutrition support programs for low-income pregnant women have shown positive health outcomes i.e. cooking with good food box with young mothers and HBHC food skills programming (includes cooking in homes with families and providing food vouchers)

- School meal programs also help to provide healthy food to children and have shown effective outcomes. In Thunder Bay there are 80 school meal and snack programs throughout the District. We support these programs by assisting in providing menu suggestions and safe food handling information with funding administered through the Red Cross.

Programs that support longer term food security:

- Programs to develop food skills, including planning and preparing food and the use of community kitchens, indicate positive outcomes and are generally considered promising practices i.e. TBDHU has a number of food skills programs such as Cooking with the Good Food Box and

Adventures in Cooking, and provide training and support to social service agencies to help them run community kitchens and cooking programs.

- Urban agriculture has demonstrated promise in improving nutrition and strengthening neighbourhoods i.e. TBDHU supports the Community Garden Collective (21 community gardens), Roots to Harvest, and Backyard Chicken By-law development, and provides advice to community groups wishing to establish community gardens across the District.

- Farmers' markets can improve access to healthy foods in the community while also supporting local farmers and the sustainability of local supplies. Subsidies for low income people in the form of coupons and vouchers for use at farmers' markets in combination with knowledge and skill building programs have had a positive impact on participants' food knowledge and healthy eating.

- Farm-to-school programs have, in combination with teacher knowledge, attitudes and behaviours, positively contributed to healthier dietary choices i.e. support 16 School Gardens, Roots to Harvest Farm to Caf program. In 2013, 1123 local food meals were served through a partnership with the Lakehead Public Schools secondary schools Westgate, Superior, Churchill, and Hammarskjold.

- Food boxes of fresh fruits and vegetables and community-supported agriculture (membership fees to a farm for a share of the harvest) are considered to be helpful mechanisms for facilitating access to nutritious foods i.e. support the Thunder Bay Good Food Box program, that provides over 400 boxes of fresh produce a month at a discounted price through 33 hosts sites with over 100 active volunteers, and provided advice to community groups to establish programs in Nipigon and Marathon.

Public Health Role in Food Security

The overall goal of the Thunder Bay District Health Unit's food security program is to increase food security for the population in the Thunder Bay District. To achieve this we are working at various levels in the community to achieve the following objectives:

- To create policies that support food security initiatives on all levels, thereby enhancing access to affordable, high quality foods (using environmentally sustainable production and distribution methods).

- To strengthen community action by increasing community capacity to address local food security.

- To create supportive environments that will increase accessibility to, and the availability of, healthy foods in a sustainable and dignified manner.

- To increase food knowledge and skills by providing information and education resources.

- To facilitate services and resources that communities and individuals require for increasing the accessibility, availability and affordability of healthy foods.

- To partner with other sectors and levels of government in addressing barriers to food security for all communities and citizens in the District.

These objectives provide the context for considering the evidence and a foundation for developing programs and strategies.

FINANCIAL IMPLICATIONS

None

STAFFING IMPLICATIONS

None

CONCLUSION

Food security is an important public health issue. Public health has a role to play in what has become a significant population health issue, and the evidence exists to guide TBDHU's efforts.

LIST OF ATTACHMENTS

Attachment 1 - Cost of Eating in the District of Thunder Bay Report, 2015
(Distributed Separately)

PREPARED BY: Catherine Schwartz Mendez, Public Health Nutritionist

THIS REPORT RESPECTFULLY SUBMITTED BY: ***DATE:***
Lynda Roberts, Director – Health Promotion October 30, 2015

Chief Executive Officer Medical Officer of Health (A)

The Red Cross reports the following schools are currently funded for student nutrition programs in the Thunder Bay District

Agnew H Johnston Public School	Hammarskjold High School	Sam/Misol Program
Armstrong Public School	Holy Angels School	Schreiber Public School
B.A Parker Public School	Holy Cross School	Sir Winston Churchill Collegiate and Vocational Institute
Beardmore Public School	Holy Family School	St. Bernard School
Bernier Stokes Public School	Holy Saviour School	St. Bridgid Catholic School
Bishop E.Q Jennings	Hyde Park Public School	St. Edward Catholic School
Bishop Gallagher Elementary School	Johnny Terriault School	St. Francis Catholic School
Boys and Girls Club (after school programs)	Kakabeka Falls Public School	St. Hilary Catholic School
C.D Howe Public School	Kingsway Park Public School	St. Ignatius High School
College Jump Start Alternate Education	Lake Superior High School	St. James Public School
College Link	Manitouwadge Breakfast Club	St. Joseph School
Connections Alternative Education	Manitouwadge High School	St. Martin School
Crestview Public School	Marathon High School	St. Patrick High School
Dennis Franklin Cromarty High School	Margaret Twomey Public School	St. Paul School
Dorion Public School	Marjorie Mills Public School	St. Thomas Aquinas School
Ecole Catholique Val des Bois	McKellar Park Central School	St. Vincent School
Ecole Gron Morgan Public School	McKenzie Public School	Superior Collegiate and Vocational Institute
Ecole Sec. Cite Superisure	Nakina Public School	Terrace Bay Public School
Ecole Secondaire Chateau Jeunesse	Nipigon Red Rock District High School	Upsala Public School
Ecole St. Joseph	Ogden Community Public School	Valley Central Public School
Edgewater Park Public School	Our Lady of Charity	Westgate Collegiate and Vocational School
Five Mile Public School	Our Lady of Fatima	Westmount Public School
Gateway Alternative Education	Pope John Paul II Sr. Elementary	Whitefish Valley Public School
George O'Neil Public School	Sherbrook Public School	Woodcrest Public School
Gorham and Ware Public School	Red Rock Public School	

The 39 partners in the District of Thunder Bay to whom food supplies are provided by the Regional Food Distribution Association

Elevate NWO	PACE/Efry
Anishnawbe Mushkiki	Redwood Oppunities Food Bank
Beendigan	Rural Cupboard Food Bank
Brain Injury Services of Northern Ontario	Salvation Army-Thunder Bay
Confederation College Food Bank	Shelter House
Current River Churches Food Cupboard	St Andrew's Kitchen Inc - Dew Drop Inn
Faye Peterson House	St. Thomas Anglican Church Food Cupboard
Grace Ministries	St. Vincent De Paul- Corpus Christi Church
Greestone Harvest Centre	St. Vincent De Paul- St. Agnes Church
John Howard Society of Thunder Bay	Teen Challenge
June Steeve-Lendrum Family Resource Centre	Thrift R Us- Marathon Food Bank
Kateri	Gathering Place
Mary Berglund Health Centre	Thunder Bay Counselling Centre
Metis Nation of Ontario	Thunder Bay Food Bank
Neighbourhood Capacity Building Project	Thunder Bay Indian Friendship Centre
New Life Christian Fellowship	The River
Nipigon Food Bank	New Life Ministries Hope House
North Shore Harvest Food Cupboard	Youth Centres Thunder Bay
Our Kids Count	Gaa Mino Bimaadiziwaad Counselling

THE DISTRICT OF THUNDER BAY
SOCIAL SERVICES ADMINISTRATION BOARD

POSITION PAPER:

FOOD SECURITY IN THE DISTRICT OF THUNDER BAY

Jennifer Lible, Manager – Client Services

Saku Pinta, Senior Social Policy Analyst

March 1, 2016

Introduction

That food is one of the paramount necessities of life is an obvious truism. Food is identified, for example, as one of the basic physiological requirements in Maslow's hierarchy of needs, and food security is naturally considered to be one of the cornerstones of individual well-being and social stability. Health Canada, in adopting the United Nations Food and Agricultural Organization definition, defines food security as a condition "when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life." Similarly, food insecurity is defined as "the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so."[1]

Recognizing the well-documented social consequences of food insecurity – ranging from negative health outcomes to diminished educational attainment – there is cause for heightened concern with regards to food security issues in Canada in general, and more specifically, in the District of Thunder Bay. As will be shown, the price of food has been steadily climbing over the past decade and food inflation in Canada is again projected to exceed the general inflation rate in 2016. Rising food prices will have a disproportionate impact on low income individuals and families, as is already evident in the increasing number of people relying on food banks in Ontario.

With these factors in mind, it is of critical importance to ensure not only that food security issues in the District of Thunder Bay are being addressed but also that data on food insecurity is accurately tracked as an evidence-based foundation to monitor progress and to assist in further planning or interventions.

The objectives of this position paper are twofold. First, to provide a broad overview of food security issues on the national and regional level as well as summarizing some of the social consequences of food insecurity, with a special focus on children as the most vulnerable group. Second, to offer recommendations that will help to better prepare for, and alleviate, some of the anticipated impacts of food insecurity. Specifically, two recommendations will be proposed. Firstly, that the Board advocate that the Ontario Ministry of Education implement a universal hot meal program in elementary and secondary schools. Secondly, that the Regional Food Distribution Association of Northwestern Ontario (RFDA) – as the central hub for charitable food distribution in the District of Thunder Bay – develop and implement a data collection plan that will, minimally, monitor food bank usage identifying the number of unique individuals served, client demographics, and the amount of food distributed on a monthly basis.

Food Security and the Cost of Food in Canada

The Food Price Report published by the Food Institute of the University of Guelph forecasts that the rate of food inflation across Canada will be anywhere between 2.0%

[1] "Household Food Insecurity in Canada: An Overview" 2012, available at http://www.hc-sc.gc.ca/fn-an/surveill/nutrition/commun/insecurit/index-eng.php#fnb2

to 4.0% in 2016 and will again exceed the general inflation rate. Notably, two of the factors identified in the report that are predicted to affect retail food prices in Canada are climate change and the value of the Canadian dollar.

Climate will be a significant, yet unpredictable, factor influencing food prices. As the report states, "El Nino could be a significant factor in 2016, in fact meteorologists predict next year's El Nino to be one of the strongest on record. This may cause more precipitation in southern and western regions in the United States." While the impacts of El Nino are uncertain at this stage, the primary area of concern is in the production of vegetables and fruits that are grown in these regions "as 81% of all vegetables and fruits consumed in Canada are imported." This intersects with another major driver impacting food prices in Canada, namely, the value of the Canadian dollar. The report predicts "the Canadian dollar to devalue further against the American dollar" perhaps dropping as low as $0.70 or lower. As a consequence, "every cent drop in the dollar over a short period of time, currency-exposed food categories like vegetables, fruits, and nuts are likely to increase by more than 1%."[2]

These forecasted price increases should be placed in the context of a much greater, longitudinal trend towards higher food prices (refer to Figure 1). The price of fresh or frozen beef, for example, increased by more than 117% between the years 2000 to 2015.

These factors have contributed significantly to food insecurity in Canada. Increased food prices, as well as other economic trends since 2008, have a significant and disproportionate impact on low income individuals and families who typically have less discretionary income or a financial buffer to mitigate against rising prices. This is reflected in available food bank usage statistics. The 2015 HungerCount Report, produced by the Food Banks Canada, reported that 825,137 Canadians turned to a food bank in 2015 – a 1.3% increase in food bank use since 2014, but an alarming overall 26% increase since 2008.[3] Low-income is, unsurprisingly, consistently found to be the most reliable predictor of food insecurity, with Aboriginal Canadians, recipients of social assistance, single mothers, and those housed in rental accommodations amongst the groups with the highest rates of food insecurity.[4]

Social Consequences

The social consequences of food insecurity are well-documented through a vast and ever increasing academic literature. The impacts of hunger are well-known.

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[2] Sylvain Charlebois et. al, "Food Price Report 2016," available at https://www.uoguelph.ca/foodinstitute/system/files/Food%20Price%20Report%202016%20English.pdf

[3] HungerCount 2015, available at https://www.foodbankscanada.ca/getmedia/01e662ba-f1d7-419d-b40c-bcc71a9f943c/HungerCount2015_singles.pdf.aspx

[4] For a collection of recent, Canadian academic studies on social determinants of food insecurity, refer to the Proof Food Insecurity Policy website, available at http://proof.utoronto.ca/resources/research-publications/social-determinants-of-food-insecurity/

Figure 1

Source: Statistics Canada information, compiled by Global News

Some of the most damaging immediate and long-term effects of hunger are experienced by children. These include reduced learning and productivity, higher rates of mental health disorders and chronic diseases, and increased rates of child obesity. In the context of pregnancy and infancy, iron deficiency has been linked to "poor performance on language comprehension tests and an inability to follow directions over the first five years of a child's life" as well as "delays in socioemotional, cognitive, motor and neurophysiological development." Studies on food insecure school-aged children have found that nutritional deficiencies double the likelihood "persistent symptoms of hyperactivity/inattention," with evidence of improvement "after the introduction of a healthy diet." The adverse impact of food insecurity on the mental health of children is wide-ranging, with evidence of "depression and suicidal ideation" and increased rates of "adolescent mood, behaviour and substance abuse disorders" linked to child hunger. Overall health is also negatively impacted, with a "higher likelihood of chronic conditions and of asthma." Some Canadian and American studies have also found a correlation between food insecurity and childhood obesity, thought to be a result of "more restrictive

and pressuring maternal feeding styles" which "decrease the ability of children to self-regulate eating behaviours."[5]

Given the strong linkages between hunger and reduced cognitive ability in children, on the one hand, and the correlation between educational attainment and socio-economic status, on the other, the likelihood of impoverished children remaining in low income in adulthood is increased.

Local Context

As was demonstrated in the preceding sections, there are several strong indicators that point to a continued increase in food insecurity on the national level, and that the well-researched impact of food insecurity is experienced particularly intensely by children. Turning now to the local context, this section will provide an overview of food insecurity in the District of Thunder Bay.

There are multiple food banks and feeding programs in the District of Thunder Bay (please refer to the Food Bank Information document). Beyond extrapolating from the macro-economic data and larger-scale social indicators, it is somewhat difficult to get an accurate picture of food security in the District of Thunder Bay.

It is known that the RFDA has had a recent, staggering drop in food donations and that rising food prices are having an impact on donations.[6] According to the 2015 Hunger Report, produced by the Ontario Association of Food Banks, the RFDA serves approximately 14,000 individuals per month, however, no statistical breakdown of food bank usage per community or other similar data appears to be publicly available.[7] The Thunder Bay and Area Food Strategy 2015 'Community Food Security Report Card' states that the average number of food bank users per month is 3,447 with 9,000 meals served by emergency programs each month, however, it is unclear if this refers to unique individuals and/or if this information pertains only to the City of Thunder Bay or if it includes other communities.[8]

Another approximate conception of those who are at risk of food insecurity can be extrapolated from the Thunder Bay District Health Unit's 'The Cost of Eating Well in the District of Thunder Bay.' This report provides an income-based analysis combined with

[5] Janice Ke and Elizabeth Lee Ford-Jones, "Food insecurity and hunger: A review of the effects on children's health and behaviour" in *Paediatrics & Child Health* 20:2 March 2015 pp.89-91, available at http://foodsecurecanada.org/sites/default/files/effects.food_.insecurity.hunger.march_.2015_2.pdf

[6] "Food donations to RFDA down a staggering $400,000 in 2015," available at http://www.tbnewswatch.com/News/382796/Food_donations_to_RFDA_down_a_staggering_$400,000_in_2015

[7] See pg.18-19 in the 2015 Hunger Report, available at http://www.oafb.ca/tiny_mce/plugins/filemanager/pics_cms/3/303/FINAL_-_2015_OAFB_Hunger_Report_updated.pdf

[8] Community Food Security Report Card 2015, available at http://tbfoodstrategy.ca/files/7014/5504/9817/FoodStrategy_FoodSecurityReportCard.pdf

an annual survey to determine the average cost of a healthy diet.[9] Singles on Ontario Works are shown to be the most vulnerable with the highest proportion of income devoted to rent and the lowest amount remaining to cover basic expenses.

In terms of school-aged children, a valuable study and social indicator is the Early Development Instrument (EDI) report produced by Communities Together for Children. The EDI is an early child development questionnaire that measures a child's readiness to learn upon entry in Grade 1. The EDI measures 5 domains, including "Physical Health and Well-Being" which features hunger as a risk factor. Although the study only covers the region of Thunder Bay-Atikokan – rather than the District of Thunder Bay – the numbers are revealing. The region "had a vulnerability rate (Vulnerable on One or More Domains) of 31.5% in 2006, which increased to 33.1% in 2012. The Ontario Vulnerability rate was 28.0% in 2012."[10]

Recommendations and Rationale

Given the immediate and long-term impacts of food security on children, it is recommended that the Ontario Ministry of Education implement a universal, hot meal program in elementary and secondary schools. Based on available information, it appears that children in Thunder Bay and surrounding areas are increasingly vulnerable in the domains studied through the EDI. Aside from the nutritional benefits, a universally applied hot meal program would limit stigma associated with means testing or self-identification as low income, and such a program would also help to increase the disposable incomes of families that are on a fixed budget.

While broader social trends indicate the strong likelihood of an increase in food insecurity in the District of Thunder Bay, at present time there is insufficient data with which to adequately determine the needs, monitor the trends, or track progress in the area of addressing food security issues. Given that reliable data is necessary for making good, evidence-based decisions and policies, it is recommended that the Regional Food Distribution Association of Northwestern Ontario (RFDA) – as the central hub for charitable food distribution in the District of Thunder Bay – develop and implement a data collection plan that will, minimally, monitor food bank usage in terms of numbers of unique individuals served, client demographics, and amount of food distributed on a monthly basis. The use of free software for this purpose, such as the Homeless Individuals and Families Information System (HIFIS) – as utilized by a growing number of food banks across Ontario – could be employed to help get a better sense of the needs of those using the food bank system.

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[9] The Cost of Eating Well in the District of Thunder Bay 2015, available at http://www.tbdhu.com/NR/rdonlyres/60D58A19-E9EB-464F-86CE-16320D2CA6AF/0/TheCostofEatingWellintheDistrictofThunderBay_website.pdf

[10] Executive Summary, "Thunder Bay-Atikokan Region Early Development Instrument Report (2005-2012)," available at: http://www.ctctbay.org/data_analysis_coordination/documents/Executive_Summary_EDI_Report_Electronic.pdf

Peterborough Public Health

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October 6, 2016

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

Dear Minister Hoskins:

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

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

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

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/ag
Encl.

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

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PUBLIC HEALTH
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May 31, 2016

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

Dear Minister Hoskins:

RE: Changes to the HPV Immunization Progra.

At its meeting on May 25, 2016, The Board of Health for the District of Algoma Health Unit carried the following resolution #2016-50.

WHEREAS Ontario is expanding the publicly funded human papillomavirus (HPV) vaccination program to include boys in Grade 7; and

WHEREAS Algoma Public Health supports the immunization of boys to help prevent the spread of HPV and prevent cancer; and

WHEREAS the HPV vaccine will continue to be provided to girls in Grade 8 for the transition year until all grade 7 students receive the vaccination; and

WHEREAS the Ministry estimates about 154,000 students will be eligible to receive the vaccine each year; and

WHEREAS APH, similar to other PHUs, plans to deliver the vaccination program over the course of three school visits in order to avoid giving more than two doses of vaccine per student per visit, which will increase the number of school clinics by approximately 33% (previously two visits per year); and

WHEREAS the Ministry of Health and Long-Term Care's (MOHLTC) Immunization 2020 Strategy strives to "reduce health risks related to vaccine-preventable diseases in the province"; and

WHEREAS the MOHLTC has not increased funding to the Vaccine Preventable Disease (VPD) program despite adding responsibilities and new vaccines to the program.

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9B Lawton Street
Blind River, ON P0R 1B0
Tel: 705-356-2551
TF: 1 (888) 356-2551
Fax: 705-356-2494

Elliot Lake
ELNOS Building
302-31 Nova Scotia Walk
Elliot Lake, ON P5A 1Y9
Tel: 705-848-2314
TF: 1 (877) 748-2314
Fax: 705-848-1911

Sault Ste. Marie
294 Willow Avenue
Sault Ste. Marie, ON P6B 0A9
Tel: 705-942-4646
TF: 1 (866) 892-0172
Fax: 705-759-1534

Wawa
18 Ganley Street
Wawa, ON P0S 1K0
Tel: 705-856-7208
TF: 1 (888) 211-8074
Fax: 705-856-1752

THEREFORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health commends the Ministry of Health and Long- Term Care for its commitment to expand its HPV vaccination program to young males who are starting grade 7 this September; and

FURTHERMORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health urges the MOHLTC to consider increasing the annual funding for the VPD program in order to provide the staff resources to meet the above mandate.

FURTHERMORE BE IT RESOLVED that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Executive Director, Ministry of Health and Long-Term Care, Dr. David Williams, Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Medical Officers of Health, and Ontario Boards of Health, and member municipalities.

Sincerely,

Lee Mason
Board of Health Chair

cc: The Honourable Dr. Bob Bell, Deputy Minister of Health and Long-Term Care
Roselle Martino, Executive Director, Ministry of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
The Association of Local Public Health Agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member municipalities.

2016 FALL SYMPOSIUM

Cultural Competencies to Support Indigenous Truth and Reconciliation

November 17 & 18

Radisson Admiral Hotel – Toronto Harbourfront

249 Queen's Quay West

Downtown Toronto

A conference for:

- Board of Health (BOH) Members
- Medical & Associate Medical Officers of Health
- Health Unit Directors & Senior Managers

Program:

- Day 1 (full day): **Plenary presentation and workshop on Indigenous Cultural Competencies**
- Day 2 (half day): **BOH Section Meeting** *(will include updates on Patients First and OPHS Review)* **and COMOH Meeting**

Guestroom Accommodations:

- A limited block of rooms have been reserved at the Radisson Admiral at a special conference rate. Please call the hotel directly at **416-203-3333** or **1-800-333-3333** by **OCTOBER 26, 2016** and quote "Association of Local Public Health Agencies". Or **click here** to reserve a room online (enter stay dates, click on More Search Options, and enter ALPHA under Promotional Code field).

REGISTER ONLINE HERE

2016 FALL SYMPOSIUM

Cultural Competencies to Support Indigenous Truth and Reconciliation

November 17 & 18, Radisson Admiral Toronto Harbourfront
249 Queens Quay West, Downtown Toronto

REGISTRATION INFORMATION

Session Registration Fee

Plenary Presentation & Workshop (full day) – November 17, 2016 **$325 + HST per person**
Includes continental breakfast, 2 breaks, lunch, all speaker sessions

Boards of Health Section Meeting (half day) – November 18, 2016 **$325 + HST per person**
Includes continental breakfast, break, lunch, all speaker sessions

COMOH Meeting (half day) – November 18, 2016 **$325 + HST per person**
Includes continental breakfast, break, lunch, all speaker sessions

**NOTE: If you plan to attend both days, please register and pay separately for each event.*

Registration & Payment

Online Registration / Credit Card Payment:
Register and pay online using Visa or Master Card by accessing our secure system.

Click here to register for November 17 and/or November 18 sessions.

If you wish to be billed an invoice, please indicate so when registering online.

Cancellation Policy:

Cancellations must be received at alPHa by **November 10, 2016** for a full refund of your registration fee. Cancellations received between November 11 and 15 are partially refunded but subject to a 20% administrative fee. There are no refunds for cancellations received *after* November 15; however, substitutions are allowed.

Important! Hotel room cancellations must be confirmed directly with the Radisson hotel and *not* through alPHa. Click here for more information on room cancellation requirements.

Contact: For questions about registration and payment contact Karen Reece, at 416-595-0006 ext 24, by email at karen@alphaweb.org

ABOUT THE RADISSON ADMIRAL TORONTO HARBOURFRONT

alPHa encourages attendees to think about their impact on the environment and consider carpooling, VIA Rail or GO Train where possible.

HOTEL WEBSITE
www.radissonadmiral.com

DIRECTIONS (see map next page)

From the East:

- Exit Gardiner Expressway at Bay Street South
- Continue to Queen's Quay
- Turn right onto Queen's Quay and follow to Rees/Robertson Crescent
- Turn left onto Robertson Crescent and follow around to self-parking and the front entrance of the hotel

From the West:

- Exit Gardiner Expressway at Bay/York Street exit toward Yonge Street
- Keep left at the fork and follow signs marked Yonge/Queen's Quay
- Turn right onto Bay Street Turn right onto Queen's Quay
- Follow Queen's Quay to Rees Street and turn left
- Rees will become Robertson Crescent—follow around to the east side of the complex for self-parking and the front entrance of the hotel

or

- Travelling east of Spadina Avenue, continue eastbound on Lakeshore Blvd
- Turn right at Rees Street
- Travelling south, cross over Queen's Quay and drive around Robertson Crescent to hotel self-parking and entrance (located on east side of complex).

From Billy Bishop Toronto City Airport: Taxis available outside ferry terminal of this airport. Or walk 1 km from the airport to the hotel: Exit ferry terminal, walk northeast toward Bathurst St, turn right onto Queens Quay W, turn left onto Lower Spadina Rd, and turn right onto Queens Quay W. Hotel is on the right at 249 Queens Quay W.

Please note the hotel does not provide shuttle service to/from Toronto Pearson International Airport.

Rail station: Union Station

Subway station: From Union Station, exit station and board 509 Harbourfront streetcar. Get off at Rees St stop and cross street to other side to reach the hotel.

PARKING
Access to hotel's underground parking is on Robertson Crescent off Queens Quay W. For overnight guests, self-parking in the underground garage is available at a minimum of $21 (+taxes) per car per day with in and out privileges; this service is available at the Front Desk. For self-parking non-hotel guest parking, parking meters are located on each parking level.

Continued on next page

HOTEL RESERVATIONS

A limited block of guestroom accommodations have been reserved at the Radisson Admiral Hotel - Toronto Harbourfront located at 249 Queen's Quay West in downtown Toronto. Please book with the hotel directly by **October 26, 2016** to reserve a room; call **416-203-3333** or **1-800-333-3333**. Please quote "Association of Local Public Health Agencies" when reserving your room. Or **click here to book a guestroom online (enter stay dates, click on More Search Options, and enter ALPHA under the Promotional Code field).** Check-in time is after 3:00 PM; check-out is 12:00 PM. Click here for more information on room cancellation requirements.

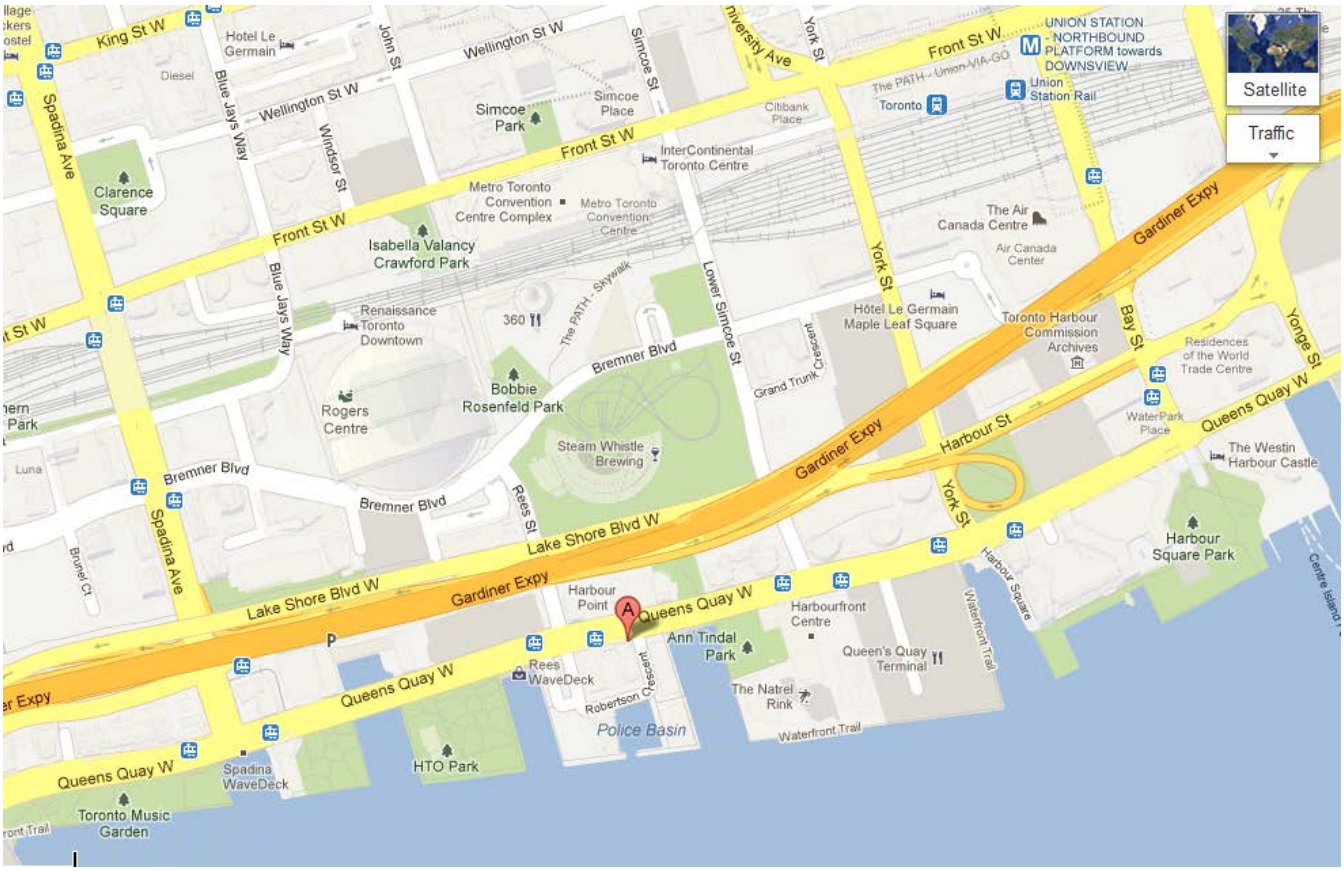
NEARBY AMENITIES/ATTRACTIONS

- Hotel 24 hour fitness centre (note: pool operates only in summer) and on-site restaurant/lounge
- Sony Centre for the Performing Arts
- Air Canada Centre
- Rogers Centre
- Hockey Hall of Fame
- Toronto Harbourfront Centre
- Theatre District (Mirvish Theatres)

NEARBY RESTAURANTS

Click here for a list.

A = Hotel's location on map below (i.e. Radisson Admiral Hotel - 249 Queens Quay West)



For questions on registration, contact:
Karen Reece, tel. (416) 595-0006 x 24, e-mail: karen@alphaweb.org

Information Break

October 13, 2016

This semi-monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

Registration Now Open for 2016 Fall Symposium

alPHa has planned an exciting 2016 Fall Symposium that will take place on November 17 and 18 at the Radisson Admiral Hotel, 249 Queens Quay W., downtown Toronto. Entitled "Cultural Competencies to Support Indigenous Truth and Reconciliation", the event will feature a day-long facilitated workshop on Indigenous cultural competency training on November 17. It will be followed by separate half-day business meetings for board of health members and COMOH members on November 18. The Symposium is open to all board of health members and health unit staff. Please register online at the link below. We hope you can attend.
Learn more about the 2016 alPHa Fall Symposium
Register to attend the 2016 alPHa Fall Symposium

NOTE: In the August edition of the Information Break, incorrect dates were given for the 2016 Fall Symposium. The correct dates are November 17 & 18, 2016. Apologies for the error.

Patients First Update

After proroguing the Ontario legislature in early September, the Liberal government re-introduced the *Patients First Act* on October 6, 2016 as Bill 41. alPHa has analyzed the new bill and compared it to the Bill 210 version from a public health perspective. The only substantial change does not concern the public health sector. The sections relevant to the LHINs-MOH engagement remain unchanged.
View alPHa's summary of Patients First Act sections relevant to public health

Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation, MOHLTC, recently presented to the alPHa Board and COMOH Section on separate occasions to introduce the provincial Capacity Planning Framework. The framework aims to bring consistency to health system planning and support health transformation goals of improved health outcomes and fiscal sustainability. A population health measurement tool is being developed with a particular focus on the population aged 50 and over to assist with system planning at the ministry level.

To facilitate the implementation of the Patients First Act, fifteen work streams have been created to focus on areas such as Clinical Leadership, Indigenous Health, Public Health, etc. Each work stream is co-chaired by a LHIN and Ministry lead person. Co-chaired by Michael Barrett, CEO for South West LHIN, and Roselle Martino, Associate

Deputy Minister, Population and Public Health Division, the Public Health Work Stream consists of representatives from senior ministry staff and the following alPHa participants: Linda Stewart, alPHa Executive Director; Dr. Liana Nolan, MOH, Region of Waterloo Public Health; and Dr. Penny Sutcliffe, MOH, Sudbury & District Health Unit.

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alPHa Online Risk Management Resources

Online resources for health unit risk management are now available on alPHa's website. Created by the alPHa Risk Management Working Group, the resource area allows viewers to access information about the risk management implementation approach, among other items. Health unit staff also have the opportunity to share their own resources by posting these to the alPHa website. For information on how to post, please click the second link below.
Visit the alPHa Risk Management Resources page here
Instructions for sharing risk management resources

As a governance best practice, the alPHa Board itself is presently looking at risk management from an association viewpoint. The Board of Directors has undergone a risk management exercise and developed a risk matrix for further discussion and review.

Recent Government Items of Interest

Provincial Opioid Strategy
Towards a Canadian Poverty Reduction Strategy
Senate Private Bill S-228 on Food & Beverage Marketing to Children
Ontario Ministers' Mandate Letters
Shingles Vaccine for Ontario Seniors
Ontario Fall 2016 Speech from the Throne

Upcoming Events - Mark your calendars!

November 17 & 18, 2016 - alPHa Fall Symposium, Radisson Admiral Hotel Toronto Harbourfront, Toronto, Ontario.
Click here to register and learn more!

June 11, 12 & 13, 2017 - 2017 alPHa Annual General Meeting and Conference, Chatham-Kent John D. Bradley Convention Centre, Chatham, Ontario.

February 23 & 24, 2017 - alPHa Winter Symposium, Doubletree Hilton, Toronto, Ontario.

alPHa is the provincial association for Ontario's public health units. You are receiving this update because you are a member of a board of health or an employee of a health unit.