Our Vision:
Healthy People in Vibrant Communities

Board of Health Meeting

St. Thomas Location: 1230 Talbot St. St. Thomas, ON
Talbot Boardroom
MS Teams Participation
Thursday, March 28, 2024
1:00 p.m.

AGENDA			
ITEM	**AGENDA ITEM**	**LEAD**	**EXPECTED OUTCOME**
1.0 CONVENING THE MEETING			
1.1	Call to Order, Recognition of Quorum • Introduction of Guests, Board of Health Members and Staff	Bernia Martin	
1.2	Approval of Agenda	Bernia Martin	Decision
1.3	Reminder to disclose Pecuniary Interest and the General Nature Thereof when Item Arises including any related to a previous meeting that the member was not in attendance for.	Bernia Martin	
1.4	Reminder that meetings are recorded for minute-taking purposes.	Bernia Martin	
2.0 APPROVAL OF MINUTES			
2.1	Approval of Minutes • February 22, 2024	Bernia Martin	Decision
3.0 APPROVAL OF CONSENT AGENDA ITEMS			
3.1	**Letter: Minister of Finance Peter Bethlenfalvy Alcohol Policy Reply to SWPH** February 26, 2024: *Minister Peter Bethlenfalvy replied to SWPH's letter requesting stricter controls on the sale and consumption of alcohol. His reply is related to the recommendation included in the Actions to Reduce Alcohol-Related Harms Report (RESOLUTION # 2023-BOH-1026-3.1) that was presented to the Board of Health at the October 26, 2023, Board of Health meeting.*	Bernia Martin	Decision
4.0 CORRESPONDENCE RECEIVED REQUIRING ACTION			
5.0 AGENDA ITEMS FOR INFORMATION.DISCUSSION.ACCEPTANCE.DECISION			
5.1	SWPH Engagement with Local First Nations Report for March 28, 2024	Cynthia St. John	Decision
5.2	Medical Officer of Health's Report for March 28, 2024	Dr. Tran	Decision
5.3	Chief Executive Officer's Report for March 28, 2024	Cynthia St. John	Decision
6.0 NEW BUSINESS/OTHER			
7.0 CLOSED SESSION			
8.0 RISING AND REPORTING OF THE CLOSED SESSION			
9.0 FUTURE MEETINGS & EVENTS			

AGENDA			
ITEM	**AGENDA ITEM**	**LEAD**	**EXPECTED OUTCOME**

9.1	• Board of Health Orientation: Thursday, April 25, 2024 at Noon
	• Board of Health Orientation: Thursday, April 25, 2024 at 1:00 p.m.
	  ○ Oxford County Administration Building
	  21 Reeve Street, Woodstock, ON
	  ○ Virtual Participation: MS Teams
		Bernia Martin	

10.0 ADJOURNMENT			

February 22, 2024

Board of Health Meeting

Open Session Minutes

A meeting of the Board of Health for Oxford Elgin St. Thomas Health Unit was held on Thursday, February 22, 2024 commencing at 1:00 p.m.

PRESENT:

Ms. C. Agar	Board Member
Mr. J. Couckuyt *	Board Member
Mr. J. Herbert	Board Member
Mr. G. Jones	Board Member (Vice-Chair)
Ms. B. Martin	Board Member (Chair)
Mr. S. Molnar	Board Member
Mr. M. Peterson	Board Member
Mr. L. Rowden	Board Member
Mr. M. Ryan	Board Member
Ms. C. St. John	Chief Executive Officer
Dr. N. Tran	Medical Officer of Health
Ms. W. Lee	Executive Assistant

GUESTS:

Ms. M. Cornwell*	Manager, Communications
Ms. K. Chambers	Registered Dietitian, Healthy Communities
Ms. J. Gordon	Administrative Assistant
Mr. P. Heywood	Program Director
Ms. R. Gregoire	Public Health Nurse, Healthy Communities
Mr. D. McDonald	Director, Corporate Services and Human Resources
Ms. M. Nusink*	Director, Finance
Mr. I. Santos	Manager, Information Technology
Mr. D. Smith	Program Director
Ms. M. Van Wylie	Program Manager, Healthy Communities
Ms. R. Wallace	Public Health Nurse, Healthy Communities

MEDIA:

Mr. R. Perry*	Aylmer Express

**represents virtual participation*

REGRETS:

Mr. D. Mayberry	Board Member

Mr. J. Preston	Board Member
Mr. D. Shinedling	Board Member
Mr. D. Warden	Board Member
Ms. S. MacIsaac	Program Director

REMINDER OF DISCLOSURE OF PECUNIARY INTEREST AND THE GENERAL NATURE THEREOF WHEN ITEM ARISES

1.1 CALL TO ORDER, RECOGNITION OF QUORUM

The meeting was called to order at 1:00 p.m.

AGENDA

Resolution # (2024-BOH-0222-1.2)
Moved by Mark Peterson
Seconded by Marcus Ryan

That the agenda for the Southwestern Public Health Board of Health meeting for February 22, 2024 be approved.

Carried.

1.3 Reminder to disclose Pecuniary Interest and the General Nature Thereof when Item Arises.

1.4 Reminder that meetings are recorded for minute-taking purposes.

2.0 APPROVAL OF MINUTES

Resolution # (2024-BOH-0222-2.1)
Moved by J. Herbert
Seconded by M. Peterson

That the minutes for the Southwestern Public Health Board of Health meeting for January 25, 2024 be approved.

Carried.

3.0 CONSENT AGENDA

No Items.

4.0 CORRESPONDENCE RECEIVED REQUIRING ACTION

C. St. John and D. Smith reviewed the briefing note from the Ontario Association for Public Health Dentistry (OAPHD), *The Roles of Public Health in the Future State of Oral Health*.

J. Herbert asked how patients can access the Canadian Dental Care Plan (CDCP). D. Smith noted that those that qualify are currently receiving letters which explain how you apply and outline the next steps to access the federal program. Currently, the provincial senior's dental program is via public health units where staff provide system navigation.

J. Herbert asked if there was any support for emergency oral services. D. Smith noted that this is one of the gaps in the system which need to be addressed. Dr. Tran noted that the provincial program and those who are eligible for the service should get registered early before emergencies occur. M. Peterson notes that seniors who have no family or friends to support them would not know about these services easily. C. St. John agreed that people who face most barriers are those who are most vulnerable.

The group noted that more could be done regarding access to programs and removing barriers to service such as applying for another service card. M. Ryan recommended the Board support simpler healthcare access and advocate for ease of access to navigate the oral healthcare system.

Resolution # (2024-BOH-0222-4.1)
Moved by Stephen Molnar
Seconded by Mark Peterson

> That the Board of Health for Southwestern Public Health support correspondence 4.1 Briefing Note: Enhancing Public Health Functions for Optimal Oral Health in Ontario, additionally advocating for ease of access to navigate the oral healthcare system.

Carried.

5.0 AGENDA ITEMS FOR INFORMATION.DISCUSSION.DECISION

5.1 Municipal Collaboration and the Social Determinants of Health Report for February 22, 2024

Ashlyn Brown presented the report to the Board of Health.

M. Ryan and S. Molnar noted the excellence of a report. S. Molnar suggested further action to engage municipalities such as a symposium of municipal partners.

J. Herbert inquired about logistics and implementation timelines for the report's suggestions. M. Van Wylie emphasized the importance of planning and stakeholder engagement. B. Martin mentioned current actions such as Planet Youth and Living Wage initiatives that are in place already.

G. Jones highlighted the need for engagement and delegation for implementation that will likely require delegation or training amongst lower-tier municipalities, noting the team should factor in the added time for municipalities to assess cost considerations. C. St. John and the team expressed readiness to engage with municipalities. C. St. John noted that part of the consideration today is for each Board member to further promote that work as leaders in the communities and public health champions.

L. Rowden noted that work should be done in the HUs with community centres in terms of getting the public to understand public health work and initiatives. A. Brown agreed that each of the actions requires a public communications rollout plan.

A. Brown noted there is currently a review of evidence to examine governance structures for sustainable food systems, drawing insights from successful models in other communities, particularly in large rural and small urban settings. Progress is already underway in this regard. Following the completion of this review, the team will consider more direct outreach to groups such as the Oxford County and Elgin County Federations of Agriculture.

M. Ryan proposed amendments to involve individual councillors and community safety and wellbeing plans, which received support from S. Molnar.

C. Agar raised questions when the climate change study results will be available. Dr. Tran noted this will likely be ready this spring. C. Agar suggested including physiological and psychosocial assessments regarding the climate change portion, which A. Brown noted in agreement.

Resolution # (2024-BOH-0222-5.1)
Moved by Marcus Ryan
Seconded by Jim Herbert

That the Board of Health for Southwestern Public Health approve the report titled, "Municipal Collaboration and the Social Determinants of Health," for February 22, 2024, and that the report to be circulated to all local Municipal Community Safety & Wellbeing Plan Committees asking for a recommendation to their Councils that a resolution of support be passed by the respective Council directing municipal staff to work with SWPH staff to implement the recommendations in the report.

Carried.

M. Ryan emphasized the amendment will ensure municipal staff actively engage with public health outreach. Without clear direction, municipal staff may prioritize other tasks even in face of how public health work aligns with municipal strategic goals. Engaging councils through community plans is constructive as it respects resources and council structures, ensuring effective collaboration.

The motion was carried as amended.

A. Brown and M. Van Wylie left the meeting at 1:51pm

5.2 Chief Executive Officer's Report

C. St. John reviewed her report.

C. St. John noted that a limited number of solar eclipse viewing glasses would be available to the public at both SWPH sites with the hope that vulnerable populations will be able to access them if needed. D. Smith noted the messaging will be to protect your eyes from 3:00pm – 4:30pm on April 8, 2024 if you are in the geographical path of totality.

Resolution # (2024-BOH-0222-5.2)
Moved by Grant Jones
Seconded by Lee Rowden

> That Board of Health for Southwestern Public Health accept the Chief Executive Officer's report for January 25, 2024.
>
> Carried.

6.0 NEW BUSINESS

J. Herbert asked if SWPH practices mock emergency preparedness exercises.

D. Smith responded that SWPH does engage in emergency preparedness exercises, noting that under the new Ontario Public Health Standards (OPHS), annual exercises are now mandated and the results of the exercise will now be publicly available on SWPH's website.

7.0 TO CLOSED SESSION

Resolution # (2024-BOH-0222-C7)
Moved by Mark Peterson
Seconded by Grant Jones

> That the Board of Health move to closed session in order to consider one or more the following as outlined in the Ontario Municipal Act:
> (a) the security of the property of the municipality or local board;
> (b) personal matters about an identifiable individual, including municipal or local board employees;
> (c) a proposed or pending acquisition or disposition of land by the municipality or local board;
> (d) labour relations or employee negotiations;
> (e) litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;
> (f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
> (g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act;
> (h) information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;
> (i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the municipality or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;

(j) a trade secret or scientific, technical, commercial or financial information that belongs to the municipality or local board and has monetary value or potential monetary value; or

(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board. 2001, c. 25, s. 239 (2); 2017, c. 10, Sched. 1, s. 26.

Other Criteria:

(a) a request under the *Municipal Freedom of Information and Protection of Privacy Act*, if the council, board, commission or other body is the head of an institution for the purposes of that Act; or

(b) an ongoing investigation respecting the municipality, a local board or a municipally-controlled corporation by the Ombudsman appointed under the *Ombudsman Act*, an Ombudsman referred to in subsection 223.13 (1) of this Act, or the investigator referred to in subsection 239.2 (1). 2014, c. 13, Sched. 9, s. 22.

Carried.

8.0 RISING AND REPORTING OF CLOSED SESSION

Resolution # (2024-BOH-0222-C8)

Moved by Mark Peterson
Seconded by Stephen Molnar

That the Board of Health rise with a report.

Carried.

Resolution # (2024-BOH-0222-C3.1)

Moved by Mark Peterson
Seconded by Grant Jones

That the Board of Health for Southwestern Public Health accept the Special Ad Building Committee Report for February 22, 2024.

Carried.

Resolution # (2024-BOH-0222-C3.2)

Moved by Stephen Molnar
Seconded by Marcus Ryan

That the Board of Health for Southwestern Public Health accept the Special Ad Hoc Strengthening Public Health Committee Report for February 22, 2024.

Carried.

Resolution # (2024-BOH-0222-C3.3)

Moved by Grant Jones
Seconded by Jim Herbert

That the Board of Health for Southwestern Public Health approve the Chief Executive Officer's Report for February 22, 2024.

Carried.

9.0 FUTURE MEETING & EVENTS

10.0 ADJOURNMENT

That the meeting adjourned at 3:46 p.m.

Resolution # (2024-BOH-0222-10)
Moved by Marcus Ryan
Seconded by Lee Rowden

That the meeting adjourns to meet again on Thursday, March 28, 2024, at 1:00 p.m.

Carried.

Confirmed: _____

Ministry of Finance
Office of the Minister
Frost Building S, 7th Floor
7 Queen's Park Crescent
Toronto ON M7A 1Y7
Tel.: 416-325-0400

Ministère des Finances
Bureau du ministre
Édifice Frost Sud 7e étage
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Minister of Finance | Ministre des Finances
PETER BETHLENFALVY

880-2024-34

Mr. Peter Heywood
Program Director
Southwestern Public Health
1230 Talbot Street, St. Thomas Site
St. Thomas, ON N5P 1G9
c/o Abdul Makanjuola: amakanjuola@swpublichealth.ca

Dear Mr. Heywood:

Thank you for your email about social responsibility in Ontario's alcohol marketplace. I appreciate you taking the time to write.

Since 2018, the government has remained committed to increasing choice and convenience for consumers in the safe and responsible sale of beverage alcohol. The government intends to uphold its high standard of social responsibility through a safe and responsible implementation of an expanded and modernized alcohol marketplace.

The government is providing an additional $10 million in funding over five years to the Ministry of Health to support social responsibility and public health efforts to ensure alcohol continues to be sold and consumed safely in the expanded marketplace.

Ontario maintains rigorous standards for the safe and responsible sale and consumption of alcohol in the province. A modernized alcohol marketplace will maintain these rigorous standards:

- Standard hours of sale (7 a.m. – 11 p.m., 7 days per week).
- Minimum drinking age (19 years).
- Minimum retail pricing requirements.
- Requirements for warning signs (retailers display signs warning of the risk of drinking alcohol in pregnancy).
- Mandatory staff training (currently run by Smart Serve) would be required for all new retailers.
- Rigorous standards for licensing and enforcement through the Alcohol and Gaming Commission of Ontario.

…/cont'd

In the months ahead, the government will continue to consult with industry partners and others on upholding Ontario's high standards of social responsibility.

As we move towards implementing this expansion, the government will be taking a responsible, measured approach so we can ensure the transition to a new marketplace is smooth, safe, and stable.

We take your concerns very seriously around the social responsibility of expanded sales of alcohol, and we appreciate you writing in on this matter.

Thank you again for writing.

Sincerely,

Peter Bethlenfalvy
Minister of Finance

c: The Honourable Sylvia Jones, Minister of Health
Ernie Hardeman, MPP, Oxford County
Rob Flack, MPP, Elgin-Middlesex-London

BOARD REPORT

Southwestern Public Health Engagement with Local First Nations Report

MEETING DATE:	March 28, 2024
SUBMITTED BY:	Cynthia St. John (written as of March 20, 2024)
SUBMITTED TO:	Board of Health
PURPOSE:	☐ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.1
RESOLUTION #	2024-BOH-0328-5.1
REPORT TITLE:	Southwestern Public Health Engagement with Local First Nations Report

Introduction

Southwestern Public Health (SWPH) recognizes the significance of engaging with local First Nations communities to promote public health and well-being. Our interactions with these communities are essential for understanding their unique health needs, addressing health disparities, and fostering partnerships to improve overall health outcomes. This report reviews SWPH's current engagement with local First Nations communities and offers recommendations for a more meaningful and mindful approach.

Background

The Chippewas of the Thames First Nation (COTTFN), culturally affiliated with the Anishinaabe (Ojibwe), is located near Muncey, Ontario, situated to the west of Elgin County and shares a border with it. The Oneida Nation of the Thames (ONOTT), part of the Haudenosaunee (Iroquois) Confederacy, is situated near Southwold, Ontario, and is located to the northwest of Elgin County and is also in close proximity to Oxford County. While not directly adjacent to Elgin County, the Munsee-Delaware Nation (MDN), culturally affiliated with the Lenape (Delaware), is situated northeast of Elgin County and shares a border with Middlesex County.

Although it is essential to acknowledge the broader historical and ancestral presence of Indigenous peoples in the region who have inhabited and traversed the area, contributing to its rich cultural heritage, it is appropriate to note that there are no First Nations communities situated within the geographical area served by Southwestern Public Health. More direct and extensive interaction with Indigenous individuals on First Nations reserves generally occurs with neighbouring health units such as Middlesex London Health Unit (MLHU). As such, SWPH engagement predominantly occurs with individuals who self-identify as First Nations and live off-reserve (noted in this report as urban Indigenous) within our region.

Current SWPH Engagement with Local First Nations Communities

Chronic Disease and Injury Prevention Program

Indigenous engagement is central to SWPH's commitment to engage in inclusive public health initiatives. With the recent Harm Reduction Consumption Treatment and Services (CTS) Feasibility Study Project, the Chronic Disease and Injury Prevention (CDIP) team collaborated with the Chippewa of the Thames First Nation (COTTFN) Health Centre, offering an Indigenous-specific partner focus group option. Staff invited a Cultural Harm Reduction Outreach Supervisor to participate in the External Advisory Committee who emphasized that a co-design and reciprocal dialogue process with Indigenous partners would be essential to the success of the research. SWPH staff also worked with the COTTFN Outreach Supervisor to develop and review the research methods (including the focus group guide and associated research questions) with careful consideration of Indigenous cultural values and processes in mind. Additionally, input was sought from respected cultural leaders and knowledge keepers who reviewed and approved the plan for the Indigenous-specific research proposal. The Outreach Supervisor assisted with recruitment of Indigenous partners for the focus group, as well as provided a culturally appropriate introduction at the beginning of the focus group (including guiding principles and a Land Acknowledgement). There was also an Indigenous-specific data event to ensure that the qualitative data received in the focus group was captured and analyzed appropriately by the research team; this is imperative to ensuring that cultural narratives and Indigenous worldviews are accurately depicted in research.

In substance prevention, a meeting was convened with the Elgin Ontario Health Team (OHT) Indigenous lead to strategize consultation approaches with local elders and youth concerning the Planet Youth model and the potential for Indigenous engagement and partnership. For reference, Planet Youth Calgary serves as an exemplar of the initiative's goals and objectives.

Environmental Health Program

The Environmental Health (EH) Team oversees a range of programs, such as food safety, safe water, animal bite investigations, and health hazard issues. However, it is important to note that these programs do not extend to First Nations communities, which fall under the federal jurisdiction of Health Canada. For individuals and businesses identifying as Indigenous and not covered by Health Canada legislation, our EH programs offer services on an information/resource/inspection basis. The EH programs prioritize equitable service provision but do not collect data about cultural identification.

With SWPH's Climate Change initiatives, the External Advisory Committee for the Climate Change and Health Vulnerability Assessment includes representation from the Indigenous Solidarity & Awareness Network (ISAN-Oxford). This EH program notes the value of Indigenous representation in land use discussions and climate change initiatives in fostering considerate program delivery.

Healthy Growth and Development Program

The Healthy Growth and Development (HGD) program engages with First Nations clients who reside in our community individually. Such clients would be involved with our program through the Healthy Babies Healthy Children (HBHC) screening process (in the prenatal or postpartum period). The program is voluntary, and if Indigenous clients wish for sustained support, the HGD team will work with the client and often involve band support (depending on the situation). The HGD program does not directly reach the Indigenous population; instead, it is through its liaison process and/or self or community partner referral.

Healthy Schools Program

While SWPH has no specific Healthy Schools programs or connections with Indigenous groups, offering the same programming to all students within our schools, we do note that the Thames Valley District School Board (TVDSB) has an Indigenous Student Trustee and a First Nations, Inuit, Métis (FNIM) Student Leadership Council. As new programs or initiatives are planned, the team has identified a process to engage these groups as appropriate and applicable.

Infectious Diseases Program

If SWPH receives a notification of a disease of public health significance (DOPHS) for an Indigenous individual, the Infectious Diseases (ID) team will provide the desired service if the individual requests support from public health, either via referral to the relevant health unit or directly if the individual is urban Indigenous. If the ID team identifies trends such as elevated disease risk in relevant areas or populations, more direct strategies and communications are developed to mitigate the risk.

Oral Health Program

FNIM individuals in Canada have access to dental benefits through the federal Non-Insured Health Benefits (NIHB) program. SWPH does not directly reach out to the Indigenous community regarding public health oral health programs (seniors and children). Generally, those seeking oral health care would contact the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) offices in Muncey or London. If urban indigenous individuals do reach out to SWPH for oral health supports of system navigation, staff will support individuals in finding a suitable dental home.

Sexual Health Program:

SWPH connects with urban Indigenous individuals via case and contact management, clinical services, and the Needle Exchange Program (NEP), providing services as needed.

Vaccine Preventable Disease Program

The Covid-19 Program recently contacted the Métis Nation of Ontario (MNO) and the Director of Client Care for the SOAHAC to inform them of the Covid Spring/Fall campaigns occurring in the SWPH region. Program planning has identified the FNIM community as a priority population for the Covid vaccine program and SWPH continues to share information regarding local access and eligibility.

Generally, however, the Vaccine Preventable Disease (VPD) program does not reach out directly to individuals in a formalized manner, although it does connect with residents who may identify as urban Indigenous via our general VPD clinics (open to all) if they face access barriers to vaccination. The team may also work with the urban Indigenous population through the Immunization of School Pupils Act (ISPA) and Childcare and Early Years Act (CCEYA) immunization record review process but these contacts would be in a routine fashion and not specific to their Indigenous identity.

SWPH Staff Training and Engagement

Cultural Sensitivity and Safety training for all staff is currently being developed. Program plans developed by the CDIP and Human Resources (HR) team have identified the importance of cultural training and awareness for all SWPH staff, and a mandatory online Indigenous Cultural Humility and Safety training program will begin in late March 2024.

Additionally, the planning group will provide more intensive supplementary training for staff on SWPH's Health Equity Priority Populations (HEPP) Committee (the San'yas Anti-Racism Indigenous Cultural Safety Training Program). Acknowledging that cultural humility is a continual process, this training represents an additional move toward fostering a greater awareness of potential service biases and practices. The CDIP and HR teams will continue investigating additional avenues for staff to enhance their understanding of cultural humility and sensitivity.

Assessment

When we consider the act of collecting data to inform our programs and services, it is crucial to be mindful of the First Nations principles of ownership, control, access, and possession, more commonly known as OCAP®:

- **Ownership** asserts that First Nations communities collectively own their cultural knowledge, data, and information, akin to how individuals own their personal information.
- **Control** affirms that First Nations communities have the right to control all aspects of research and information management that affect them. This control encompasses the entire research process, including resource allocation, planning, management, and review processes.
- **Access** emphasizes that First Nations communities should have access to information and data concerning themselves and their communities, regardless of location. Furthermore, it establishes their right to manage and decide who can access their collective information, often through standardized protocols.
- **Possession** delineates the concrete control of data, distinct from ownership. It highlights the physical stewardship of information as the mechanism through which ownership rights are upheld and safeguarded.

Reference: The First Nations Principles of OCAP®. First Nations Information Governance Centre. https://fnigc.ca/ocap-training/

These principles assert that First Nations must have control over data collection processes and own and control how this information can be used. Essentially, these principles were created because data can, and has, been used to increase discrimination or hurt populations and groups like First Nations communities. As such, challenges persist in effectively engaging with First Nations communities, as these may include historical mistrust, cultural differences, communication barriers, and resource limitations, wherein colonial legacy and systemic inequities continue to impact health outcomes among Indigenous populations.

The implication for SWPH is that we should not collect information about someone's background, race, or status as part of a First Nations community without consideration of the OCAP principles. Data collection is not as simple as including it as a survey question and having informed individual consent to answer these questions. Rather, a data collection plan needs to be developed collaboratively with the leadership of First Nations communities in our surrounding region. In partnership, we would explore what data would benefit both us and them; if we collected it, and what is a culturally safe and appropriate way of analyzing and reporting the data collected; and together we would agree on data access and ownership of the data.

A recent example of when we recognized and respected the OCAP tenets was during the data collection for the CTS feasibility assessment. Members of the First Nations communities reached out and identified that they would like a culturally safe and specific way to participate in the CTS study. SWPH worked directly with the representatives of the community in developing the research protocol, including the details about data collection and reporting.

Combined with the First Nations OCAP principles, our Community Engagement Framework (CEF) will support our ongoing engagement with First Nations. The CEF outlines our guiding principles via the International Association for Public Participation (IAP2) Spectrum of Participation (Inform, Consult, Involve, Collaborate, and Empower), and eight steps for an effective community engagement continuum. It provides a recommended approach for ongoing consultation and dialogue with our communities and partner agencies to ensure active participation in the planning, implementation, and evaluation of our programs and services, as mandated by the Ontario Public Health Standards.

As we assess how we currently engage with the First Nations communities, we cannot assume the privilege of engaging in data collection, and we cannot lose sight of the fact that Indigenous communities possess data sovereignty. While public health values evidence-based data, we must acknowledge the path to a more meaningful and respectful relationship with First Nations communities and urban indigenous populations

begins from a place of curiosity and mindfulness, and a willingness to engage and build relationships at the leadership level, asking them for input on how public health can best serve their communities and their urban indigenous populations.

Future Engagement with Local First Nations Communities

SWPH acknowledges the importance of recognizing its historical and organizational assumptions, including its traditional reliance on evidence-based data and resources. To understand how it can deepen its engagement with local First Nations communities, SWPH commits to approaching Indigenous leaders in the spirit of curiosity, openness, and collaborative respect, valuing the guidance they provide. This commitment entails aligning our outreach, communications, and engagement efforts with their direction to address health disparities, promote health equity, and improve the health and well-being of the urban Indigenous residents in the SWPH region.

1. **Initiate Outreach to First Nations Leaders:** SWPH will reach out to Indigenous leaders and elders in the community to establish trust and seek guidance on how best to engage with their communities. This involves conducting respectful consultations to understand their priorities, needs, and preferences regarding public health initiatives.
2. **Collaborate with Indigenous Organizations:** Consult with Indigenous organizations such as the COTTFN and SOAHAC to ensure that public health programs are delivered in a culturally sensitive manner. This collaboration may involve co-designing programs, sharing resources, and leveraging existing community networks to reach First Nations communities effectively.
3. **Coordinate with Local Partners:** Work closely with local partners, including Community Health Centres (CHCs) and, Ontario Health Teams (OHTs) and other relevant stakeholders, to avoid duplication of efforts and ensure a coordinated, respectful approach to engaging with First Nations communities. This collaboration can help maximize resources and leverage existing relationships within the community.
4. **Provide Staff with Ongoing Cultural Competency Training:** Offer regular cultural competency training for all staff to deepen their understanding of Indigenous cultures, histories, and perspectives. This training should focus on building respectful and collaborative relationships with Indigenous communities, enhancing communication skills, and addressing implicit biases.

MOTION: 2024-BOH-0328-5.1
That the Board of Health for Southwestern Public Health accept the Southwestern Public Health Engagement with Local First Nations Report for March 28, 2024.

MOH REPORT

Open Session

MEETING DATE:	March 28, 2024
SUBMITTED BY:	Dr. Ninh Tran, Medical Officer of Health (written as of March 18, 2024)
SUBMITTED TO:	Board of Health
PURPOSE:	☐ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.2
RESOLUTION #	2024-BOH-0328-5.2

1.0. Respiratory Season

Covid-19-19, Influenza, RSV

The 2023-2024 respiratory season is winding down marking a turning point in the management of respiratory illnesses. As of March 9th, 2024, both Covid-19 and Influenza activity are stabilizing and improving. There have been no confirmed cases of Respiratory Syncytial Virus (RSV) in the Southwestern Public Health (SWPH) region since the week ending February 3, 2024.

Measles

There has been a rise in measles cases globally, including Ontario. As of March 13th, 2024, there were 8 cases of measles in Ontario and 19 cases in Quebec. The majority of current cases in Canada are linked to international travel; however, some regions have reported cases that are not linked to travel, which is concerning. As of March 18th, 2024, no cases have been reported in the SWPH region.

As a disease of public health significance (DOPHS), Measles, also known as Rubeola or Red Measles, is a very serious infection caused by a virus. It spreads easily from person-to-person through the air when a sick person coughs, sneezes, or breathes. The virus stays in the air and on surfaces for up to 2 hours after the infected person leaves. A person with measles can spread the virus from 4 days before the rash starts (and one day before the first symptoms appear) until 4 days after the rash appears.

Measles often starts with a fever, cough, runny nose, and red eyes. Small bluish white spots (Koplik's spots) may appear inside the mouth and a red, blotchy rash may appear on the face and then the rest of

the body 3 to 5 days after the start of symptoms. Common complications include diarrhea, ear infections, and pneumonia, and in rare cases, cause brain infections and even death.

In light of this rise in cases and its highly infectious nature, SWPH has been active in measles preparedness. Our Infectious Diseases (ID) and Vaccine Preventable Diseases (VPD) teams, as well as our Emergency Management manager, have participated in provincial and regional discussions with the Office of the Chief Medical Officer of Health (OCMOH), as well as meeting with local health sector partners (including hospitals and primary care) to discuss preparedness issues such as: immunization, testing and assessment, case and contact management, and communications.

Parallel internal discussions have taken place to ensure we are able to respond to cases of measles in our community. Currently, our immunization team has been focused on school-aged children, including hosting clinics to provide catch-up immunizations. We issued a media release as well as a memo to parents through school boards prior to March break travel to remind residents of measures to prevent measles. As the best protection against measles is being up to date on immunizations, that will be our focus and we ask that everyone reviews their own records to determine their immunization status and whether or not they need any vaccine dose(s).

2.0 Solar Eclipse Event

In the spring of 2024, a solar eclipse is expected to travel across North America with prime viewing in several southern Ontario locations, notably Niagara Falls. The event is expected to occur on April 8, 2024. The last total eclipse experienced in the province was February 26, 1979, in Northern Ontario.

A solar eclipse occurs when the moon passes between the sun and the earth. The sun's disk is partially or fully (path of totality) obscured from sight by the moon, rendering the day into momentary darkness. In Ontario, daylight will be affected from approximately 2pm to 4:30pm. Several communities, including Port Stanley will experience the path of totality.

It is a rare cosmic event and has become a moment of awe and wonder.

Safety precautions are necessary to participate in the event safely. Previous experiences during the August 2017 solar eclipse in Kentucky and Oregon reported some potential public health impacts, including gastrointestinal illness, heat-related illness, respiratory illness, drug overdose, bites, and/or stings, as well as eye-related injuries.

Regarding eye safety, it is critical not to watch the solar eclipse with the naked eye. Health impacts include retinal burs, blurred vision, and loss of eyesight. To view the solar eclipse safely, use international standard (ISO) certified eye protection glasses with special filters to watch all the phases of a solar eclipse. Currently, SWPH has a limited number of eye protection glasses available free of charge to the public and available at reception.

The other potential health concerns such as other injuries and illnesses is due to the nature of such a significant event. The 2024 solar eclipse will be both a planned and spontaneous mass gathering event. SWPH has been involved in the 2024 solar eclipse preparedness, including collaborating with local partners as well as participating in provincial discussions.

Conclusion

SWPH continues to take an active and proactive approach to identifying and mobilizing community responses to both existing and emerging threats and challenges. Through our connections with

provincial, regional, and local health and social systems, we ensure a coordinated approach to safeguarding public health.

Although Covid-19, Influenza, and RSV activity has stabilized and we are approaching the end of the respiratory season, we must not be complacent. Just as we witnessed a local resurgence in pertussis last season, we are now observing a broader global resurgence in measles, largely attributed to declines in immunization rates.

This serves as a reminder of the importance of ensuring everyone is up-to-date with vaccinations and protected against preventable diseases, as increasing immunization uptake is key to safeguarding the health of our various communities.

MOTION: 2024-BOH-0328-5.2
That the Board of Health for Southwestern Public Health accept the Medical Officer of Health's Report for March 28, 2024.

CEO REPORT

Open Session

MEETING DATE:	March 28, 2024
SUBMITTED BY:	Cynthia St. John, Chief Executive Officer (written as of March 20, 2024)
SUBMITTED TO:	Board of Health
PURPOSE:	☐ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.3
RESOLUTION #	**2024-BOH-0328-5.3**

1.0 PROGRAM UPDATES (RECEIVE AND FILE):

1.1 PETROLEUM EMERGENCY AWARENESS WORKSHOP

Southwestern Public Health (SWPH) participated in a Petroleum Emergencies Awareness Workshop on February 22, 2024, hosted by Elgin County. Over two hundred participants gathered to discuss the risk of abandoned natural gas and oil wells to communities. Risks to the public include exposure to the "knock down gas," Hydrogen Sulfide (H_2S), and the explosive risk of Methane (CH_4). Local municipalities, with funding from the province, have launched awareness campaigns and begun to monitor and/or remediate sites identified as elevated risk. SWPH continues to collaborate with local partners on messaging from a public health lens.

1.2 UNIVERSAL ACCESS TO CONTRACEPTION

On February 29, 2024, the Government of Canada announced the next step toward a national universal pharmacare program and the intention to provide universal, single-payer coverage for a range of contraception medications and devices in collaboration with provinces and territories.

Currently, in Ontario, women aged 24 and under who do not have private insurance can access some kinds of birth control free from the pharmacy. But this program leaves out many women who may still have difficulty regularly affording contraceptives. Universal access to contraception will help achieve the population health objective of reducing unintended pregnancies for all women in our region.

1.3 HEALTH SCHOOLS TEAM: SUMMARY OF RESULTS: PILOTING HEALTHY RELATIONSHIPS PLUS IN SWPH PRIORITY SCHOOLS

Healthy Relationships Plus (HRPP) is a fourteen-week evidence-informed intervention that uses open dialogue and role-play to teach students key mental health and relationship concepts (Fournie et al., 2023). Students learn to apply critical thinking, problem-solving, and communication skills to relevant concepts such as suicide prevention, substance use, and healthy relationships, among others (Fournie et al., 2023).

In the fall of 2022, SWPH, Middlesex London Health Unit (MLHU), Thames Valley District School Board (TVDSB), London District Catholic School Board (LDCSB), and Western's Centre for School Mental Health (CSMH) piloted HRPP to grade seven and eight classrooms across Oxford County, Elgin County, the City of St. Thomas, Middlesex County, and the City of London.

Despite the challenges of piloting a new method of delivery, HRPP proved successful in improving student knowledge, self-efficacy, and behavioural intentions (Fournie et al., 2023). The CSMH evaluated the HRPP pilot using a retrospective pre-post survey and hypothetical scenario-based questions. The evaluation demonstrated that 78.1% of students were able to identify an abusive relationship accurately, and 85.2% were able to identify a bullying situation (Fournie et al., 2023). Furthermore, when asked how they would address the hypothetical scenario, students accurately identified two courses of action from the program material, demonstrating an ability to apply HRPP concepts (Fournie et al., 2023). When evaluated, HRPP demonstrated a uniquely beneficial impact on reducing bullying, improving social behaviours, and improving help-seeking behaviours (Exner-Cortens et al., 2019).

In April 2023, the Government of Ontario invested $24 million to help reduce the risk of violence in schools, demonstrating that bullying is not without economic costs (Ontario Newsroom, 2023). Preventative and evidence-based programs, such as HRPP, have been proven to reduce the cost of negative health outcomes to the individual and the taxpayer (Aos et al., 2007). The Fourth R program, which HRPP is based on, underwent a cost-benefit analysis in 2017 (Crooks et al., 2017). That review demonstrated that the program costs approximately 0.8% of the annual allotted educational funds per student (approximately $3-5 per student) while saving an estimated $2,000 in related health expenses per student (Crooks et al., 2017). These savings are likely to be higher in the present time due to inflation and other factors. When appropriately modified to address the unique challenges of a classroom, HRPP improves student mental health outcomes and represents an exceptional return on investment. SWPH looks forward to continuing this program in our grade seven and eight classrooms across the region.

1.4 VACCINE PREVENTABLE DISEASES

The Immunization of School Pupils Act (ISPA), RSO 1990, requires students attending school in Ontario to have up-to-date immunization records on file with local public health agencies (LPHAs), or have completed (and notarized) Statements of Conscience or Religious Beliefs (Exemptions).

As mentioned in a previous report, SWPH began a complete elementary student immunization record review beginning in January 2024 after finishing a full secondary student immunization record review in the Fall of 2023. During this process, each student attending a school in our area is

reviewed and parents/guardians are notified via formal notices if their child is overdue for immunizations or, most often, missing immunization records in the provincial immunization data repository known as Panorama. Failure to act or respond to these notices may result in the student being suspended from attending school. In early January, 3093 students received first notices that flagged overdue or missing up-to-date records as part of this review. In late February, 1699 students (a 45% reduction from those receiving first notices) were still flagged, whereby they have now received a notice and suspension order that will take effect March 20th if no action is taken.

SWPH's Vaccine Preventable Disease (VPD) team has worked with school staff and administrators to send notifications to families impacted by this review to encourage action and response to notices sent out. Our Communications team has leveraged social media to also encourage reporting of immunizations and to share clinic appointment availability. Our team has also opened daily clinics throughout March Break and the weeks leading up to the suspension day (including evening appointments) to assist families who may find access to vaccination challenging with their primary health care providers. As part of our outreach, vaccination clinics are also provided in Aylmer, Norwich, Ingersoll, and Tillsonburg.

Our goal at SWPH is to work with the families, wherever possible, to avoid suspensions under ISPA and we support consultations by phone and in person during this review period. In the face of a growing global measles concern, this record review process is of critical importance in assessing the childhood vaccination coverage in our area and in having accurate and current immunization records should they be required during an infectious disease exposure incident, where case and contact management by public health is key to identifying and containing the spread of the virus.

1.8 COVID-19 RESPONSE

Generally, Covid cases, outbreaks, and hospitalizations are decreasing. Local Covid Vaccination Clinics were offered weekly in January and February, and in March, half-day clinics will be available exclusively for infants beginning or completing their primary series. Guidance concerning the Spring campaign is expected soon, with further decisions regarding clinics to be made accordingly. Pharmacies, like SWPH, are observing similar decreases in vaccinations within the community. Our vaccination team has been actively engaging with long-term care homes (LTCHs) in the region, providing short in-services to offer support and guidance for early preparation and independent administration of Covid-19 vaccines to residents for the Spring campaign. Additionally, email outreach for retirement homes (RHs) is planned to distribute an algorithm aimed at fostering early planning and facilitating access to supports for administering Covid-19 clinics to residents.

1.5 INFECTIOUS DISEASES

World Tuberculosis (TB) Day is March 24th. Our buildings will be illuminated with red lights to bring awareness to the campaign to end TB in the world. Social media posts and communication to health care providers will be taking place to bring awareness to symptoms, treatment, and the sobering incidence of TB cases in the world. To learn more, watch a short informative video from the World Health Organization (WHO): Tuberculosis (TB) Explained.

1.6 HEALTHY ENVIRONMENTS

The Environmental Health (EH) Team's Public Health Inspectors (PHIs) are currently focusing on maintaining inspection completion rates as warmer weather signals an increase in special events, farmers' markets, and seasonal food safety inspection demands.

Ticks continue to be submitted to SWPH for identification, and though the rate of submission slowed greatly over the winter months, it never actually stopped. This is due to a mild winter season resulting in temperatures and environments that allowed the ticks to remain active during winter. The EH team is working on messaging for the public aimed at providing education around protection, risks, and Lyme disease awareness, as well as promoting an online platform, www.etick.ca, that can identify ticks and risks for Lyme disease.

Members of the EH team will be attending the Lessons Learned from the 2023 Wildfire Season: Challenges and Opportunities for Local Public Health Units workshop at the Ontario Public Health Conference on March 26th. Learning objectives include understanding health outcomes, methodologies, and technologies for measuring and describing air quality events, gathering experiences of health units during 2023 wildfire season, risk communication, and more.

1.7 CLIMATE EQUITY STUDY REPORT

Further to the *Building Healthier Communities Together Report* shared at the February Board of Health Meeting, the attached report, *2023 Health Equity and Climate Change Report* was written for SWPH and informed by municipal planners across the region. It highlights the opportunities and desire for ongoing municipal planning partnership and collaborations to realise synergies and enrich the built environment, fostering healthy, equitable, and climate-resilient communities.

Community planning, design, services, and maintenance significantly affect health. Per the Ontario Public Health Standards (OPHS), Boards of Health aim to decrease health hazards and promote healthy built and natural environments. These environments should support health and address existing and emerging risks, including those from climate change. Municipal planners facilitate planning, design, and development processes to respond to, mitigate, and adapt to climate change.

This report outlines the progress made in 2023, building upon the 2019 report (available via the provided link). Conducted by SWPH, it evaluates the level of policy support and impact reflected in municipal plans concerning climate change and health equity. Specifically, it updates newly implemented and adopted official plans since 2019 and suggests actions for SWPH to enhance collaboration with local municipalities effectively. There is a strong sense of commitment from all partners to find meaningful opportunities to enhance the processes and practices between organizations. Future work will place emphasis on education, raising awareness, and fostering a clear understanding of public health outcomes and planning principles.

2.0 GOVERNANCE MATTERS (RECEIVE AND FILE):

2.1 SPECIAL AD HOC STRENGTHENING PUBLIC HEALTH COMMITTEE REVISED TERMS OF REFERENCE (DECISION):

At a recent Special Ad Hoc Strengthening Public Health Committee (SASPHC) orientation meeting between the new Chair and new Vice-Chair, it was identified that adding the previous chair to the committee brings valuable experience, continuity, leadership, and representation to the table.

As such, the Terms of Reference for the committee have been modified to include the past chair as a voting member.

MOTION: 2024-BOH-0328-5.3-2.1
That the Board of Health approve the revised Terms of Reference for the Special Ad Hoc Strengthening Public Health Committee, effective March 28, 2024.

3.0 FINANCIAL MATTERS (DECISION):

3.1 2024 ANNUAL SERVICE PLAN AND BUDGET SUBMISSION (RECEIVE AND FILE):

The Annual Service Plan (ASP) is a consolidated Ministry document that includes all of our program planning activities and our 2024 Board approved budget. I am pleased to report that the requirement to complete this has been met and the report was submitted to the Ministry of Health at the end of February by the deadline date. The report was approved by me and signed by the Board Chair. As the report is about 120 pages long, it is available only on the Board portal for any Board member who wishes to review it.

MOTION: 2024-BOH-0328-5.3-3.1
That the Board of Health ratify the signing of the Annual Service Plan for 2024.

3.2 2024/2025 IPAC HUB FUNDING (RECEIVE AND FILE):

On March 11th SWPH received notification via email that a decision has been made to continue funding the Infection Prevention and Control (IPAC) Hubs in the 2024-25 fiscal year and in the years following. The Ministry of Health is currently working to prepare funding letters to extend the current agreements that expire on March 31, 2024; however, they are urging all LPHAs to continue to provide IPAC expertise and support to congregate living settings in our respective regions/communities.

When a formal funding letter is received, it will be shared with the Board.

MOTION: 2024-BOH-0328-5.3
That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's Report for March 28, 2024.

2023 Municipal Planning

Exploration & Engagement

SWPH Health Equity & Climate Change

Prepared by CIMA+ for Southwestern Public Health
February 2024

SOUTHWESTERN Public Health
Oxford · Elgin · St.Thomas

Team Acknowledgements

We would like to thank the following individuals who were supportive in the development of the Health Equity & Climate Change Policy Initiative and the development of this report.

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FOOD

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Introduction

The way communities are planned, designed, serviced, and maintained has considerable impact on health. Both Public Health and Municipal Planning Practitioners have a significant role to play in designing healthy, climate resilient, and equitable communities.

According to the Ontario Public Health Standards[i], Boards of Health will work to reduce exposure to health hazards and promote the development of healthy built and natural environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate. Municipal planners are responsible for facilitating the processes and practices of planning, design, and development of communities to respond, mitigate, and adapt to climate change.

This report documents the work completed in 2023. It is an update to the 2018 initiative undertaken by Southwestern Public Health (SWPH) to determine the degree of policy support and impact demonstrated through municipal plans for climate change and health equity. This report provides an update on new official plans that have been implemented and adopted since 2019 and highlights the recommended actions SWPH can take moving forward to work more effectively and collaboratively with their local municipalities.

1.1 Project Purpose & Process

In 2018, SWPH wanted to gain a better understanding of the degree that climate change resiliency and health equity is supported through existing municipal policies, with a specific focus on Municipal Official Plans[ii]. To do so, the project team undertook a comprehensive review to determine the prevalence of health indicators within the current Municipal Official Plans.

In 2018, municipal engagement was undertaken with a select number of municipalities to discuss current practices and potential areas for improvement regarding the inclusion / integration of health indicator terminology as part of Official Plan review processes. A summary report was developed in 2019 which has been and continues to be referenced for municipal and public health planning and policy work related to health equity and climate change.

The 2018 project and the report aimed to:

- Establish a common definition and key terms associated with health equity and climate change for Southwestern Public Health.
- Provide SWPH with the policy background, best practices, principles, and considerations to inform future Official Plan reviews undertaken by local municipalities.
- Provide the foundation for public and decision-maker education to establish a greater understanding of and buy-in to health equity and climate change within the region.

In late 2022, SWPH initiated a project to revisit and update the findings from 2019. The new scope was to review the newly developed and adopted Official Plans. The intent was to determine if changes had been made to municipal planning policy in support of health equity and climate change and the degree of variation between municipalities relative to public health priorities. In addition, it also was used to re-engage and broaden the engagement with local municipalities to find mechanisms, tools, and strategies to help foster more effective and efficient coordination and collaboration as part of the process of policy development.

The 2023 project goals include:

- *Find opportunities and identify future actions that support enhanced collaboration between public health practitioners and municipal planners.*
- *Determine how to best promote health equity and climate change-responsive policies and processes.*
- *Educate partners such as decision makers, community members, developers, etc. about the strong connection and interplay between public health and community planning.*

1

1.2 Context & Considerations

SWPH has a vision for healthy people in vibrant communities. The agency is regulated by the Ontario Health Promotion and Protection Act[iii] with a mandate to complete work under the Ontario Public Health Standards[iv].

How communities are designed is vitally important to our health and well-being. Planning decisions such as zoning, transportation systems, and community design significantly influence health. SWPH works with its partners to build communities where optimal health is possible. Social determinants of Health and Health Equity[v] considerations need to be embedded in planning policy to protect and support our most vulnerable residents.

At a local level, it is an upper-or-lower-tier municipality's Official Plan that acts as the primary guiding document for community growth and development. While staff play a key role in the Official Plan's development, other stakeholders, agencies, indigenous partners, and the public have the opportunity to provide comments and help shape the policy direction that is approved by the Council. Other plans and tools are then developed with input from the public and other partners through a public process. These tools are also approved by Council and provide helpful direction to municipal staff.

The Ontario Public Health Standards stipulate that Boards of Health shall collaborate with municipalities under the Ontario Planning Act to address local impacts of climate change and reduce exposure to environmental health hazards in the community. Opportunities for coordination and consultation vary depending on the project, the municipal approach, and the relationship of partners.

What are social determinants of health?

Many factors have an influence on health. In addition to our individual genetics and lifestyle choices, where we are born, grow, live, work and age also have an important influence on our health.

Determinants of health are the broad range of personal, social, economic, and environmental factors that determine individual and population health.

1. Income and social status
2. Employment and working conditions
3. Education and literacy
4. Childhood experiences
5. Physical environments
6. Social supports and coping skills
7. Healthy behaviours
8. Access to health services
9. Biology and genetic endowment
10. Gender
11. Culture
12. Race / Racism

Source. Public Health Canada
https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

1

Although public health practitioners and planners have established strong working relationships, there continues to be opportunities for improved collaboration. This section is a documentation and record of the work completed as part of the 2023 climate change and health equity project.

1.2.1 Local Context

Context is typically shaped by political, socio-demographic, and geographic conditions. For this project, context was necessary to define as it helped to clarify the scale of impact, and the municipalities that were to be engaged throughout the project process. Figure 1 illustrates the geographic context of Southwestern Public Health.

This is the geographic area of Southwestern Public Health, which includes the two upper-tier municipalities of Elgin County and Oxford County, and their respective lower-tier municipalities. The City of St. Thomas, a single tier municipality, is also located in this area.

In total, the population of the Southwestern Public Health catchment area is approximately **260,000** with a geographic area of just under **4,000** square kilometres.[vi]

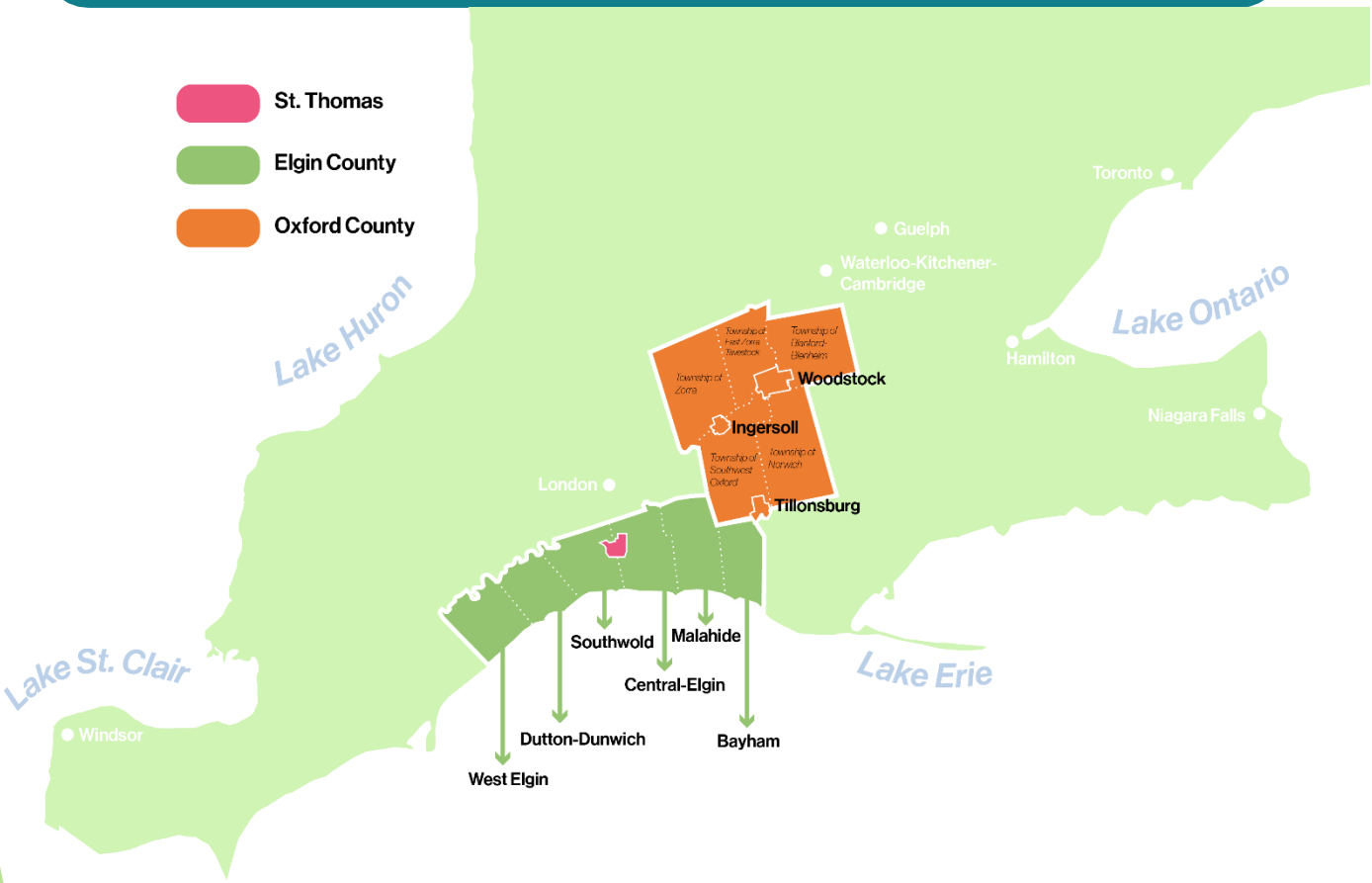


Figure 1: Map of SWPH geographic area, conceptually adapted from Google Maps

In the 2019 report, a series of community profiles were developed. These profiles illustrate the current trends and context, translated into five (5) built environment categories developed by SWPH. The categories are an adaptation of a widely accepted Healthy Built Environment Toolkit, created by the BC Centre for Disease control[vii]. The five (5) categories are summarized below.

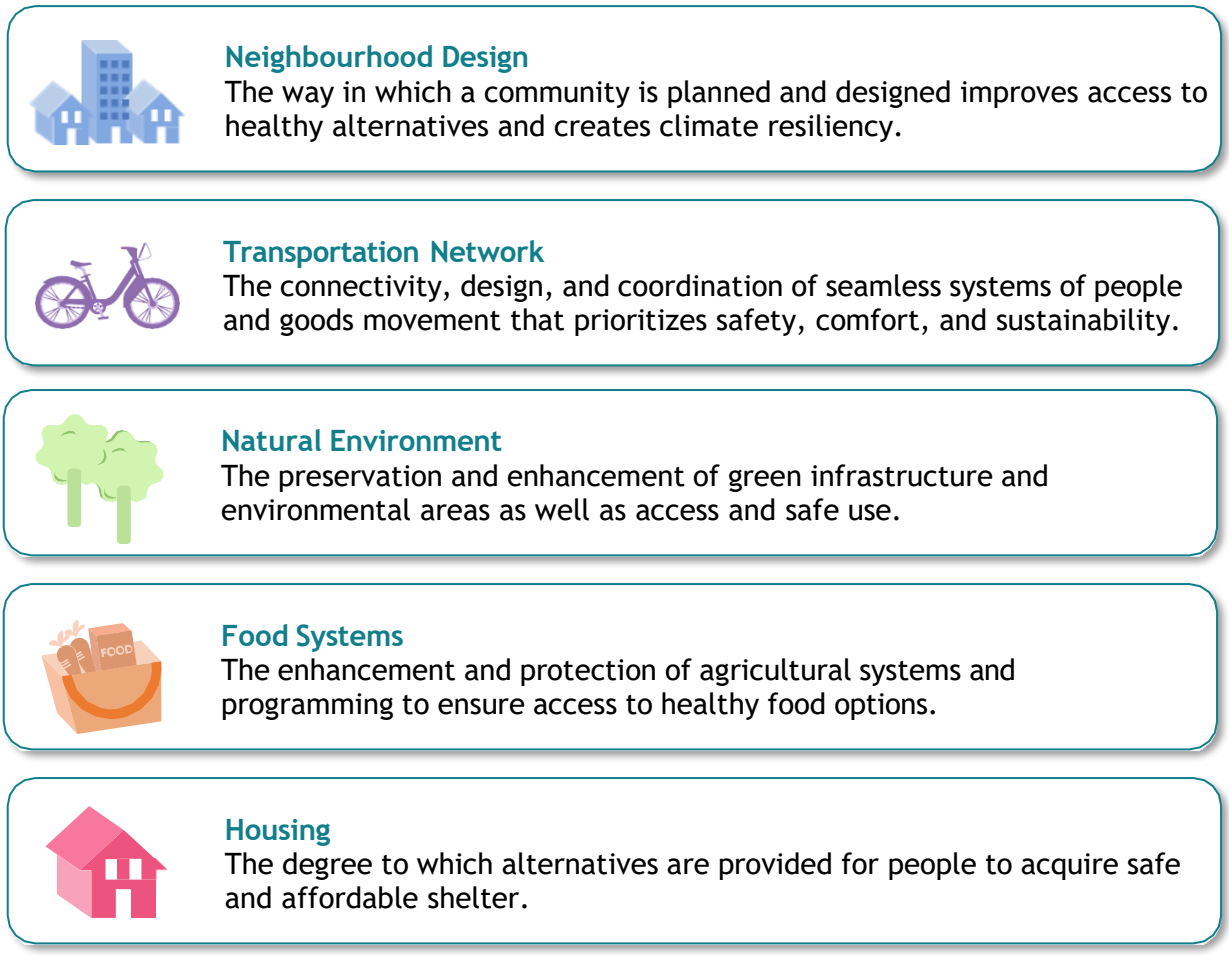


Figure 2: Overview of Built Environment Indicators

As part of the 2023 project, the community profiles were updated to reflect changes to publicly available data. Profiles were generated for the upper and single tier municipalities within the SWPH area that include Oxford County, Elgin County, and the City of St. Thomas.

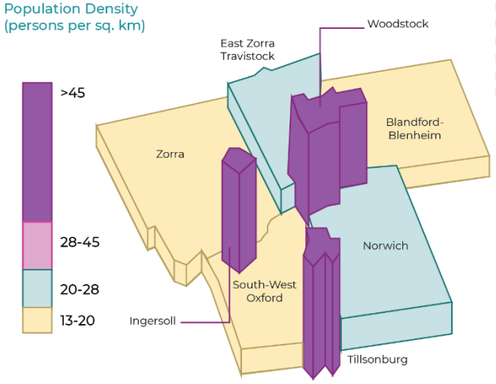
The updated community profiles outlined in Figure 3, Figure 4 and Figure 5 on the following pages will be used as the basis for the monitoring and evaluation of changes to the development, adoption, implementation and investment of climate change and health equity related initiatives and policies over the long-term.

1

COUNTY OF OXFORD CONTEXT

Basic Statistics — 121, 781 pop. — 49, 445 total dwellings — 2,038.18 sq.km — 41.6 median age

Population Density (persons per sq. km)



9.9% ↑
Population growth 2016-2021

NEIGHBOURHOOD DESIGN

Land Use Breakdowns

Large Urban Centres
4% Land Cover
- Residential
- Central Business District
- Open space
- Environmental protection
- Industrial
- Community Space
- Commercial
- Entrepreneurial District

Townships
96% Land Cover
- Agricultural reserve
- Settlement
- Open space
- Environmental protection
- Future urban growth
- Quarry area

HOUSING

Residential Typologies

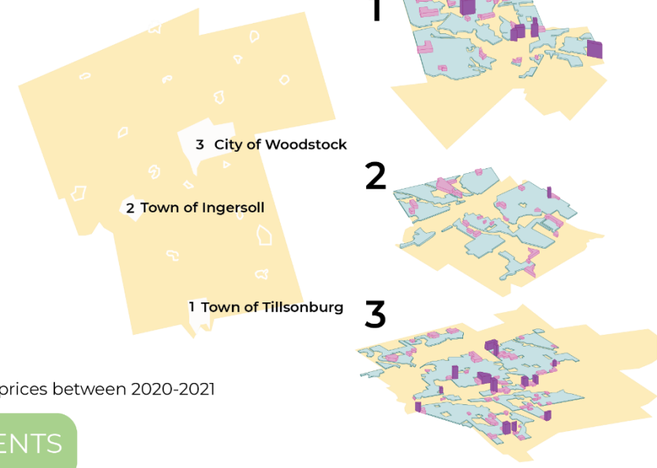
71% Single detached homes

5% Apartment <5 storeys

24% Other attached dwellings

45% increase in average home prices between 2020-2021

Residential Density of Urban Cores (high, mid and low)



NATURAL ENVIRONMENTS

Parks and Open Spaces

73 Parks — **160km** of trails

1.6°C Expected temperature increase by 2100

Natural Areas

543 Significant Woodlands
395 Significant Wetlands
>1000 acres (20% land cover)

AFFORDABILITY

$160,000
Household income needed to qualify for a standard mortgage in 2021

$36,400
Median market income for individuals in 2020

TRANSPORTATION

86% drive
- Car, as a driver
- Car, as a passenger
- Public Transit
- Walk
- Bicycle

48 EV charging stations

HEALTH

87% good physical health

64% good mental health

4 Hospitals

ISOLATION

73%
Reported feeling a strong sense of community belonging

FOOD SYSTEMS

6.2%
Experienced food insecurity

90%
Never purchase locally produced foods

16%
Ate less due to financial limitations

Figure 3: Community profile of Oxford County

Statistic	Source
Context	
Population, total dwellings, sq.km, median age, and population growth	Statistics Canada. Oxford County Census Profile. Statistics Canada. 2021. Available from: 2021 Census: Oxford County
Population density visualization	Southwestern Public Health. Community Profile: Elgin-Oxford. Southwestern Public Health. 2011.
Neighbourhood Design	
Land use types	Oxford County. Oxford County Official Plan. 1995. Available from: Oxford County Official Plan.
Belonging statistic	County of Oxford Committee. Oxford County Community Wellbeing Survey: A Profile of the Wellbeing of Oxford County Residents. In Partnership with the University of Waterloo. 2016
Number of hospitals	Oxford County. Geographic Land Information and Mapping Resource (GLIMR). No year. Available from: Oxford County maps
Health statistics	County of Oxford Committee. Oxford County Community Wellbeing Survey: A Profile of the Wellbeing of Oxford County Residents. In Partnership with the University of Waterloo. 2016
Housing & Affordability	
Residential Typologies	Statistics Canada. Oxford County Census Profile. Statistics Canada. 2021. Available from: 2021 Census: Oxford County
Residential densities of the urban core	Oxford County. Geographic Land Information and Mapping Resource (GLIMR). No year. Available from: Oxford County maps
Housing affordability statistics	Oxford County. Affordable Housing Update. November 10, 2021. Available from: Affordable Housing Update.
Transportation	
Mode split	Statistics Canada. Oxford County Census Profile. Statistics Canada. 2021. Available from: 2021 Census: Oxford County
Number of EV charging stations	Oxford County. EVSE Data Mapping and Analysis in Support of Oxford County's Electric Vehicle Accessibility Plan. 2018.
Natural Environment	
Parks and Open Spaces Map	Oxford County. Geographic Land Information and Mapping Resource (GLIMR). No year. Available from: Oxford County maps
Natural Areas Map	Oxford County. Geographic Land Information and Mapping Resource (GLIMR). No year. Available from: Oxford County maps
Number of significant woodlands and wetlands	Oxford County. Geographic Land Information and Mapping Resource (GLIMR). No year. Available from: Oxford County maps
Number of Trails Kms	Tourism Oxford. Trails and Hiking. Oxford County. Available from: Tourism Oxford: Trails and Hiking
Climate change statistic	Southwestern Public Health. Healthy Environments: Health Status by Program Area. June 2019. Available from: Heathy Environments: Health Status by Program Area
Percent of natural land cover	Oxford County. Forest Conservation and Management. No date. Available from: https://www.oxfordcounty.ca/en/services-for-you/forestry-conservation-and-management.aspx
Food Systems	
Locally purchased foods	County of Oxford Committee. Oxford County Community Wellbeing Survey: A Profile of the Wellbeing of Oxford County Residents. In Partnership with the University of Waterloo. 2016
Financial security and food consumption	County of Oxford Committee. Oxford County Community Wellbeing Survey: A Profile of the Wellbeing of Oxford County Residents. In Partnership with the University of Waterloo. 2016
% Experiencing food insecurity	County of Oxford Committee. Oxford County Community Wellbeing Survey: A Profile of the Wellbeing of Oxford County Residents. In Partnership with the University of Waterloo. 2016

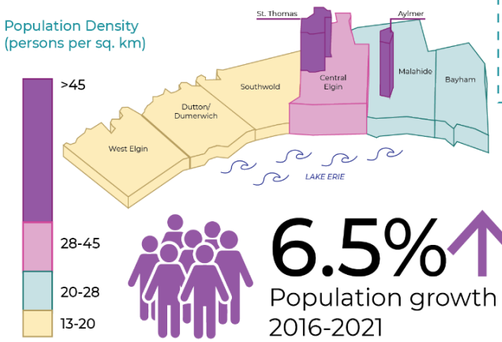
COUNTY OF ELGIN CONTEXT

Basic Statistics

94,752 pop. --- 38,889 total dwellings --- 1,878. 57 sq.km --- 43.2 median age

51, 912 pop.
Excluding St. Thomas

Population Density (persons per sq. km)



6.5% Population growth 2016-2021

45% Reside in the City of St. Thomas

St. Thomas is 1.8% of the County's land cover

NEIGHBOURHOOD DESIGN

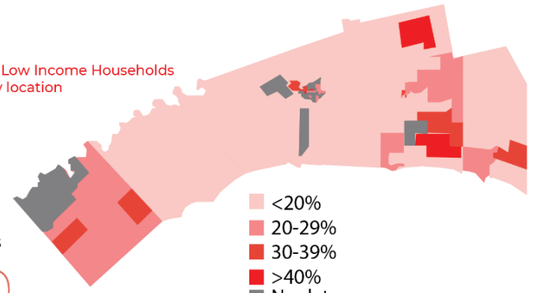
47 Settlement areas (including villages and hamlets), will 11 tier 1 settlement areas

45% Of all new housing constructed in Elgin since 2016 has been in Central Elgin

Currently, there are **9** developments in the municipality of Central Elgin, in Norman/Lyndale, Port Stanley and Belmont

HOUSING

% Low Income Households by location



42% of renters have challenges with housing affordability

Residential Typologies

77% Single detached homes

2%* Apartments <5 storeys

21% Other attached dwellings

*93% Apartment <5 storeys are in St. Thomas

TRANSPORTATION

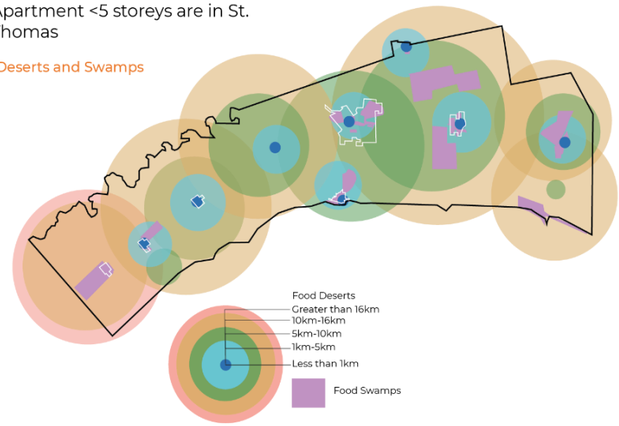
86% drive
- Car, as a driver
- Car, as a passenger
- Public Transit
- Walk
- Bicycle

4% cycle in St. Thomas compared to 0.4% in the overall county

63% of urban and 52% of rural drivers feel that conflicts with pedestrians and cyclists are a major concern

FOOD SYSTEMS

Food Deserts and Swamps



60% Do not consume enough fruits and vegetables

9.5% Experienced food insecurity from 2011-2014

Urban areas are often food swamps

BELONGING

88% Find it easy to get around

66% Participated in social clubs, events, or activities

Health conditions are the largest barrier to older adult mobility

SAFETY

98% Feel safe in Elgin County

HEALTH

18-34 year olds Are more likely to use walk-in or telephone health services

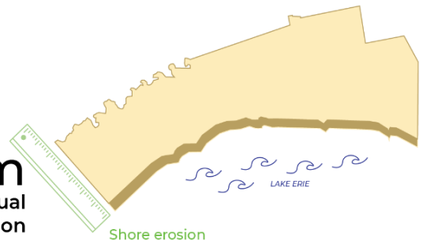
68% Visited a physician in the last year

NATURAL ENVIRONMENTS

>77 Rare species of flora

371.5km of trails (as of 2018)

4.5m Annual shoreline erosion



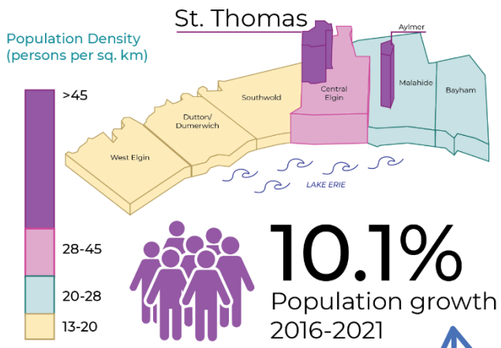
Shore erosion

Figure 4: Community profile of Elgin County

Statistic	Source
Context	
Population, total dwellings, sq.km, median age, and population growth, % population in St. Thomas	Statistics Canada. Elgin County Census Profile. Statistics Canada. 2021. Available from: 2021 Census Elgin County
Population density visualization	Southwestern Public Health. Community Profile: Elgin-Oxford. Southwestern Public Health. 2011.
Neighbourhood Design	
Number of settlement areas	Elgin County. Discussion Paper #5 County of Elgin Official Plan 5 Year Review Population, Housing and Employment Forecasts and Associated Land Needs Analysis. Elgin County. 2023. Available from: Discussion Paper #5 County of Elgin Official Plan 5 Year Review Population, Housing and Employment Forecasts and Associated Land Needs Analysis
Housing construction trends	Elgin County. Discussion Paper #5 County of Elgin Official Plan 5 Year Review Population, Housing and Employment Forecasts and Associated Land Needs Analysis. Elgin County. 2023. Available from: Discussion Paper #5 County of Elgin Official Plan 5 Year Review Population, Housing and Employment Forecasts and Associated Land Needs Analysis
Number of current developments	Municipality of Central Elgin. Current Planning Applications. No Date. Available from: https://www.centralelgin.org/en/building-and-development/current-planning-applications.aspx#Minor-Variance
Belonging statistics	Report on the City of St. Thomas and Elgin County Community Survey. 2017.
Safety statistics	Report on the City of St. Thomas and Elgin County Community Survey. 2017.
Health statistics	Report on the City of St. Thomas and Elgin County Community Survey. 2017.
Housing & Affordability	
Residential Typologies	Statistics Canada. Elgin County Census Profile. Statistics Canada. 2021. Available from: 2021 Census Elgin County
Percent of low-income households by location	Addressing Food Insecurity and Food Access Issues in St. Thomas and Elgin County. 2017.
Housing affordability statistics	Aylmer-Elgin-St Thomas Coordinating Committee. 2021-2024 Community Safety and Well-Being Plan. Elgin County. 2021. Available from 2021-2024 Community Safety and Well-Being Plan
Transportation	
Mode split, percent difference of cyclists in St. Thomas	Statistics Canada. Elgin County Census Profile. Statistics Canada. 2021. Available from: 2021 Census Elgin County
Transportation safety statistics	Elgin County. Phase I: Needs and Opportunities County of Elgin Transportation Master Plan. March 2022. Available from: Phase 1 Needs and Opportunities County of Elgin Transportation Master Plan.
Natural Environment	
Rare flora species	Carolinian Forest Coalition. Participate in the Elgin Natural Heritage Inventory. No date. Available from: https://caroliniancanada.ca/grow-wild/participate-elgin-natural-heritage-inventory-0
Number of Trails Kms	Elgin County. Elgin County Trails Study. 2018. Available from: Elgin County Trails Study.
Annual shoreline erosion	Bunnell, Erin. Lake Erie shoreline management plan says erosion of bluffs is a fact of life in Elgin County. St. Thomas Times Journal. Oct 22, 2015. Available from: https://www.stthomastimesjournal.com/2015/10/22/lake-erie-shoreline-management-plan-says-erosion-of-bluffs-is-a-fact-of-life-in-elgin-county
Food Systems	
Food consumption	Report on the City of St. Thomas and Elgin County Community Survey. 2017.
Food desert and swamp map	Addressing Food Insecurity and Food Access Issues in St. Thomas and Elgin County. 2017.
% Experiencing food insecurity	Report on the City of St. Thomas and Elgin County Community Survey. 2017.

CITY OF ST. THOMAS CONTEXT

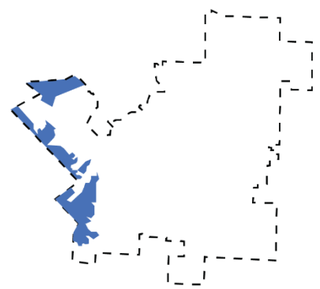
Basic Statistics — 42, 840 pop. — 18,596 total dwellings — 35 sq.km — 43.6 median age



10.1% Population growth 2016-2021

DEVELOPMENT

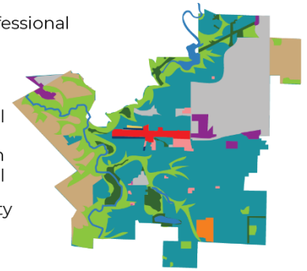
76 hectares
Of land needed to support population growth as of 2018



Settlement growth areas in St. Thomas

NEIGHBOURHOOD DESIGN

- Central Business District
- Natural Heritage
- Open Space
- Office Professional
- Rural
- Residential
- Downtown Residential
- Community Use
- Power Centres
- Seconday/ Minor Commercial
- Industrial



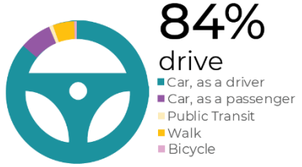
AMENITIES

- **3** Community Centres
- **8** Health facilities
- **15** Schools
- **1** Settlement Agency
- **2** Employment Services
- **6** Childcare Services

TRANSPORTATION

5 transit routes

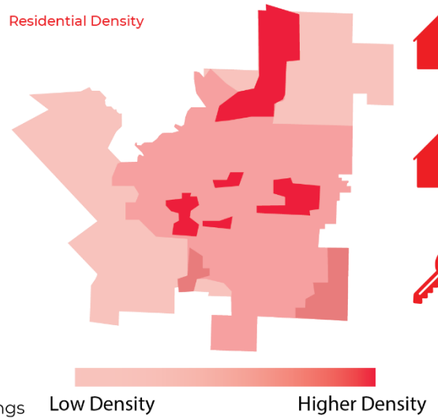
Community interest in longer transit availability and more frequent transit trips



HOUSING

Residential Typologies

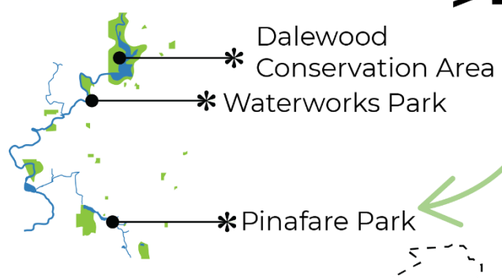
- **65%** Single detached homes
- **4%** Apartment <5 storeys
- **31%** Other attached dwellings



- **$665,000** Q3-2023 cost of a single detached home
- **$213,993** 2016 cost of a single detached home
- **0%** Vacancy for bachelor apartments

NATURAL ENVIRONMENTS

Parks and Waterbodies



>40 Parks

43.3km of trails (as of 2018)

FOOD SYSTEMS

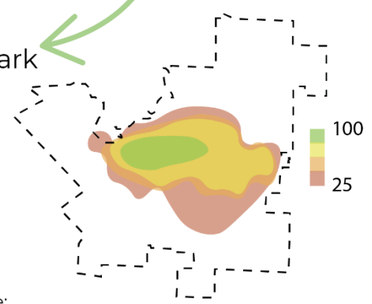
Food Swamps in St Thomas

~20 Food stores

WALKING AND CYCLING

28% Goals of the 2014 Cycling Master Plan have been met as of 2017

33 Walkscore: Most errands require a car



Walkability map

Figure 5: Community profile of St. Thomas

Statistic	Source
Context	
Population, total dwellings, sq.km, median age, and population growth	Statistics Canada. St. Thomas Census Profile. Statistics Canada. 2021. Available from: 2021 St. Thomas (City) Census Profile
Population density visualization	Southwestern Public Health. Community Profile: Elgin-Oxford. Southwestern Public Health. 2011.
Neighbourhood Design	
Land use types	City of St. Thomas. Retail Market Study. City of St. Thomas. 2016. Available from: Retail Market Study.
Amenities	Welcome to St. Thomas-Elgin. Explore the Area. No date. Available from: https://www.welcometoste.ca/explore/
Development	City of St. Thomas. St. Thomas Positioned for Growth. 2018. Available from: https://www.stthomas.ca/positionedforgrowth
Housing & Affordability	
Residential Typologies	Statistics Canada. St. Thomas Census Profile. Statistics Canada. 2021. Available from: 2021 St. Thomas (City) Census Profile
Residential density	City of St. Thomas. Transit Strategic Plan. 2020. Available from: Strategic Transit Plan.
Cost of a single detached home 2021	Canadian Real Estate Association. London and St. Thomas Area Realtors Residential Activity. 2023. Available from: https://creastats.crea.ca/mls/lond-residential-activity
Cost of a single detached home 2016	Southwestern Public Health. St. Thomas-Elgin Selfie. Updated November 2022. Available from: https://public.tableau.com/app/profile/foundational.standards/viz/ElginSt_ThomasSelfie/ElginSt_ThomasSelfie
Vacancy rates for bachelor apartments	Aylmer-Elgin-St Thomas Coordinating Committee. 2021-2024 Community Safety and Well-Being Plan. Elgin County. 2021. Available from 2021-2024 Community Safety and Well-Being Plan
Transportation	
Mode split	Statistics Canada. St. Thomas Census Profile. Statistics Canada. 2021. Available from: 2021 St. Thomas (City) Census Profile
Transit routes	City of St. Thomas. Transit System: Our services. No date. Available from: https://www.stthomas.ca/living_here/transit_system/our_services
Walk score	Walk Score. St. Thomas Walk Score. No date. Available from: https://www.walkscore.com/CA-ON/St._Thomas
Community interest in transit	City of St. Thomas. Transit Strategic Plan. 2020. Available from: Strategic Transit Plan.
Percent of Cycling Master Plan complete	Southwestern Public Health. St. Thomas-Elgin Selfie. Updated November 2022. Available from: https://public.tableau.com/app/profile/foundational.standards/viz/ElginSt_ThomasSelfie/ElginSt_ThomasSelfie
Natural Environment	
Parks and waterbodies map	Railway City Tourism. Trails Map. No Date. Available from: https://www.railwaycitytourism.com/uploads/2/1/4/9/21492992/2020_st._thomas_trail_map.pdf
Number of Trails Kms	Elgin County. Elgin County Trails Study. 2018. Available from: Elgin County Trails Study.
Number of parks	City of St. Thomas. Living here: Parks. 2023. Available from: St. Thomas Parks.
Food Systems	
Food swamps map	Addressing Food Insecurity and Food Access Issues in St. Thomas and Elgin County. 2017.
Number of grocery stores	Google. Google maps review. 2023.

1.2.2 Provincial Trends

Since the 2019 project was completed, there have been significant changes related to public health and planning.

As denoted by Figure 6, the 2023 project aimed to quantify these changes where possible, notably the shifting public health conditions amid a global pandemic, new census data (2016 to 2021), and a changing Ontario policy landscape.

Identifying and considering these changes helps understand the context within which municipalities and public health practitioners are now making decisions. It also helps understand the capacity of municipal and public health practitioners to focus on climate change and health equity-related work.

WHY UPDATE? TRACKING CHANGE

Since 2019, we have seen many critical changes in Elgin County, Oxford County and St. Thomas which can impact how to best shape supportive practices for health equity and climate change. Some of these key context considerations are summarized below, including updated census information from the 2021 census, the COVID-19 pandemic, and shifts to provincial policy directives.

CENSUS DATA UPDATE 2016 to 2021

The previous report, **published in 2019** relied on census data from 2016. Now in 2023, the 2021 census data was used to track ongoing changes in population, transportation, and housing across Oxford County, Elgin County, and St. Thomas.

	pop.	dwellings	age	income	mode split
Oxford County 2016	110,862	45,350	42.3	$36,025	86% drive
Oxford County 2021	121, 781	49,445	41.6	$36,400	86% drive
Elgin County 2016	88,978	36,613	42.5	$32,886	86% drive
Elgin County 2021	94,752	38,889	43.2	$39,200	86% drive
St. Thomas 2016	38,909	16,586	42.9	$32,402	84% drive
St. Thomas 2021	42,840	18,596	43.6	$40,000	84% drive

Other trends...

Larger increase in population between 2016-2021 when compared to 2011-2016 in all communities

Increase in apartments that are over 5 storeys in all communities

KEY TAKEAWAYS

Population has increased from 2016 across all communities

Median income has risen marginally in all communities

Mode-shift has not changed between 2016-2021 in all communities

There has been an increase in housing density, and in Elgin County, more density is located outside of St. Thomas with the percent of apartments over 5 storeys going from 99% in St. Thomas in 2016, to 93% in 2021

COVID-19 PANDEMIC

Since 2020, the COVID-19 pandemic has uprooted much of everyday life globally. The impacts of the pandemic were felt in physical and mental population health, transportation trends, and housing trends. In Oxford County, Elgin County and St. Thomas, understanding how COVID-19 has impacted each of these is crucial to understand resiliency and equity in future planning initiatives.

Long term COVID-19 impacts...

In Elgin County, there was a steady reduction in workplace commuting with the count of commuters reducing 20-60% between March 2020- Jan 2021 and 40% of commuters intending to continue to work from home post pandemic.

Increase in mental health crises and needs for support with calls to the police for mental health concerns doubling in 2020 within St. Thomas.

Fluctuation in home prices, especially in rural areas and small towns. Across Canada, 2021 represented the largest national increase in home price since 1989.

KEY TAKEAWAYS

Transportation in all communities may be impacted by COVID-19 travel trends in years to come.

Home prices have increased exponentially, and income has not equally increased, causing potential concerns for housing affordability in all communities.

SHIFTING PROVINCIAL POLICY

Since 2019, there have been multiple changes to provincial policy, including updates to the Planning Act, Provincial Policy Statement, and the introduction of new acts which impact planning priorities for municipalities.

Notable Changes...

In 2020, The Provincial Policy Statement was updated. The new update prioritized increasing the mix and supply of housing, protecting the environment and public safety, and reducing the costs and barriers to new development. All Ontarian municipalities must be consistent with the PPS.

In November of 2022, The More Homes Built Faster Act (MHBA) became law. This new act imposed many changes to planning processes and responsibilities in Ontario, some of which are pertinent to the development of official plans within Oxford County, Elgin County, and St. Thomas.

Within the More Homes Built Faster Act changes to the Conservation Authorities Act with less responsibility given to Conservation Authorities.

KEY TAKEAWAYS

Local official plans in Elgin County, Oxford County, and St. Thomas must be in alignment with the provincial planning directives outlined in the PPS update. This could impact future Official Plan updates, and types of policies contained within.

Changes to the roles and responsibilities of Conservation Authorities could impact current climate planning initiatives, especially surrounding conservation areas.

Sources: 2021 Census data https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E
COVID-19 Commuting patterns: Elgin County. Phase I: Needs and Opportunities County of Elgin Transportation Master Plan. March 2022. Available from: Phase 1 Needs and Opportunities County of Elgin Transportation Master Plan.
Health during COVID-19: Southwestern Public Health. Indirect Health Impacts of COVID-19. 2022. Available from: Indirect health impacts of COVID-19
Housing price increases: Statistics Canada. https://www150.statcan.gc.ca/n1/daily-quotidien/220121/dq220121b-eng.htm
Provincial Policy: Provincial Policy Statement, MOMAH. 2020. Available from: https://www.ontario.ca/page/provincial- policy-statement-2020
Provincial Policy: More Homes Built Faster Act, MOMAH. 2022. Available from: https://www.ola.org/en/legislative-business/bills/parliament-43/session-1/bill-23

Figure 6: Notable Changes in the Planning Landscape

1.2.3 Frameworks

Frameworks refers to the policy and programming structure that dictates how work is done by both public health and planning practitioners. The 2019 report included content that presented the specific mandates of the two professions. The following provides more detail on their roles and responsibilities relative to the context and scope of this project.

Public Health Frameworks & Considerations

Public Health is legislated by the Health Promotion and Protection Act and the work is prescribed in the Ontario Public Health Standards: Requirements for Programs, Services and Accountability (gov.on.ca). Built Environment and planning considerations fall specifically within the Environmental Health, Chronic Disease, and Health Equity Standards.

Additional frameworks and practice guidelines that inform public health practice include but are not limited to:

Health Hazard Response Protocol – Health Hazard Response Protocol, 2019 (gov.on.ca)

Healthy Environments and Climate Change Guideline - Healthy Environments and Climate Change Guideline, 2018 (gov.on.ca)

Chronic Disease Prevention Guideline- Chronic Disease Prevention Guideline, 2018 (gov.on.ca)

Ontario Climate Change Toolkit – The Ontario Climate Change and Health Toolkit

Health Equity Impact Assessment – The Ontario Health Equity Impact Assessment | ontario.ca

Source: Ontario Public Health Standards
Figure 2: Policy Framework for Public Health Programs and Services https://files.ontario.ca/moh-ontario-public-health-standards-en-2021.pdf

Planning Frameworks & Considerations

Planning starts with Provincial policies and plans which provide the context and support from which climate change and health equity policies are developed and adopted at the local level. The Planning Act[viii] and the Provincial Policy Statement (PPS)[ix] are the two primary documents that impact local policies within the SWPH region. The PPS is currently under review with potential adoption as the Provincial Planning Statement[x].

While both the Planning Act and the PPS do not currently make specific reference to health equity, there are terms that are used throughout the PPS that have an influence on health equity, such as supporting human heath, building healthy communities, and protecting public health. Building healthy communities is one of the core directives of the PPS, and as such it includes guidance for supporting healthy neighbourhood design, transportation, and housing throughout Ontario.

In terms of climate change, the PPS supports building climate resilient communities and recognizes the potential health impacts and maximized vegetation in settlement areas as interventions that prepare for the impacts of climate change.

> Depending on how the Provincial Planning Statement is finalized and confirmed, there may be significant changes to the degree to which the Province of Ontario provides planning direction specifically on climate change and in-directly on health equity. No matter the outcome, provincial policies, such as the Planning Act or the PPS address health equity and climate change is important as they are the precursor for the planning guidance at the municipal scale across Ontario.

Beyond Provincial policies and plans, official plans are the policy documents that guide all municipal decisions related to community growth and development.

The Planning Act provides direction on the creation of official plans. While the official plans are the most impactful planning document and the one with the regulatory support for planning decisions, there are other tools developed and adopted by municipalities that support the decision-making framework.

Planning policies are designed and implemented with different intents and purposes. The structure that is in place within the Province of Ontario has been designed to provide multiple levels of support and direction for various land use planning jurisdictions and issues.

Figure 7 shows the planning policies and tools typically adopted/used by a municipality. Not every planning policy or tool is applicable to the geographic area of SWPH. Those applicable have been highlighted. It is important to note that the municipal planning structures vary between Oxford County, Elgin County, and the City of St. Thomas.

Within the context of the SWPH region, there are three ways planning policy is adopted / utilized:

1. A single-tier municipality with its own Official Plan i.e., City of St. Thomas.
2. A two-tier municipality with multiple official plans developed within both upper and lower tier municipalities. i.e., Elgin County and its area municipalities.
3. A two-tier municipality with a single Official Plan developed by the upper-tier municipality and used by the lower-tier municipalities i.e., Oxford County

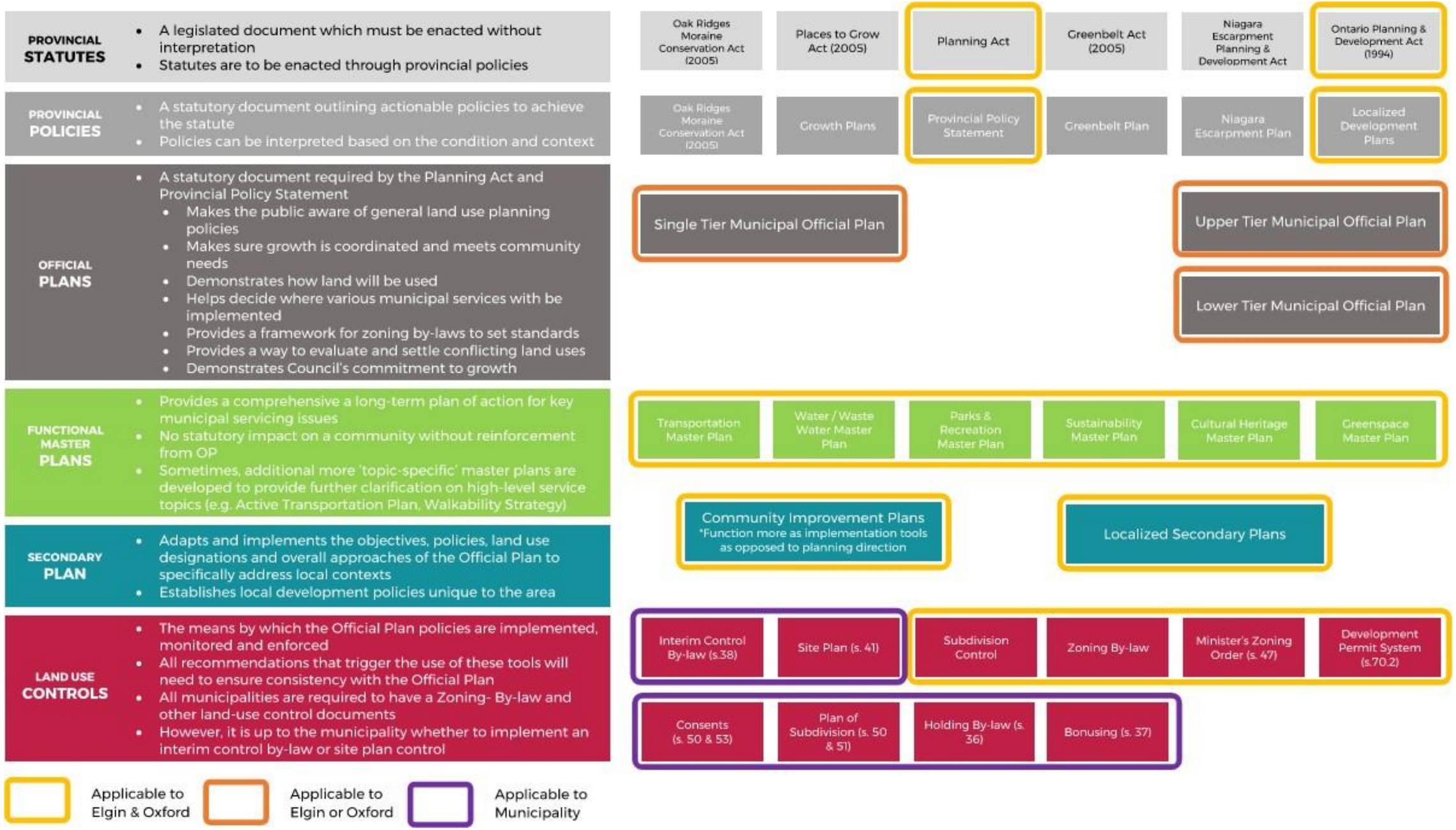


Figure 7: Provincial Policy Structure

1.2.4 Current Policy Support

One of the project's main goals was to identify and assess where and how local Official Plans supported climate change and health equity initiatives. In 2019, SWPH indicated that it was their understanding that Official Plan documents were the most direct and effective means of influencing public health change in planning. To assess impact, a key term assessment was used to analyze each of the SWPH region's Official Plan documents. One hundred (100) key terms relating to the five (5) built environment categories were identified and confirmed based on discussions with the public health team and relevant research. While some of the terms specifically addressed climate change and others health equity, the ones that had impacts on both topics were deemed to be high impact and of the greatest interest to the team. For a more detailed overview of the terms and their application, please refer to the 2019 project report.

In 2023, several municipalities had either recently adopted or were reviewing/revising their Official Plans. The newly available Official Plans were assessed using the same key term approach and a comparison of findings was developed. To more effectively assess and document change, additional considerations were assessed and highlighted including:

The **type of support** within the policy i.e., the type of planning tool / reference that is being made and the degree of impact of those statements. There were five (5) different types of support which the various references were categorized by:

- V – vision statement
- M – motherhood statement
- G – guideline
- R – recommendation
- P – policy

The aim is to have a range of several types of support throughout the Official Plan which lends itself to a greater degree of influence and impact.

The **change** is a comparison of the number of climate change and health equity terms referenced throughout the document between 2019 and 2023. Four (4) categories of change were identified including:

- Significant increase (20+ references)
- Some increase (1-20 references)
- No change (0 references)
- Some decrease (less than the 2019 number of references)

The **strength** of support i.e., how influential the references are in their potential to create change. Four (4) categories of strength were identified based on the number of times the term was referenced:

- High (<50 references across all types of policy)
- Moderate (<10 and >50 with representation in most types)
- Low (>10 references and all vision or motherhood statements)
- None (there are no references)

Updated infographic summaries of the Official Plan reviews were developed for the 2023 report. Copies of the infographic summaries are provided in Appendix A and are intended to be used as a resource by public health practitioners and municipalities where appropriate. A summary of key findings is presented to the right.

The 2019 the Official Plan review was shared with our local municipal planners but due to the timing of the COVID-19 pandemic, there was no opportunity to implement the learnings. As part of the 2023 project, every effort was made to engage with municipal staff on both the 2019 and 2023 findings. All but one of the municipal representatives were engaged.

A more detailed summary of the engagement process and input is presented in Chapter 2.0.

2023 Policy Findings

Some municipalities experienced no change as they had not updated their Official Plan since 2019. For those that did, there were general increases across the key terms with a unanimous significant increase seen in neighbourhood design key terms, which aligns to updates from provincial directives.

Terms related to neighbourhood design significantly increased across all municipalities.

Transportation-related terms saw significant increases in some municipalities with others showing some increase or even decrease.

Food systems terms saw some increase in one municipality with otherwise no change in the other updated OPs.

Natural systems terms saw significant increase in some municipalities with others showing some increase or no change.

Housing terms saw a significant increase in some municipalities, with others showing some increase or no change.

1

1.2.5 Coordination & Collaboration

The review of Official Plans led to a conversation about how other planning policies and tools, i.e., Master plans, are utilized in municipalities. Collaboration and coordination should be leveraged between municipal planning and public health which can promote responsive health equity and climate change supportive practices.

Each level of planning policy or planning implementation tool adopted by a municipal agency has statutory requirement or direction as to how agencies and the public are to be engaged in the development process. Aside from Official Plan documents, municipalities are not required to engage with agencies such as public health unless the plans are being developed utilizing another regulatory process e.g., the Municipal Class Environmental Assessment or the municipality prioritizes agency involvement.

This dynamic has resulted in a disconnect between municipal planning process and public health practitioners in developing and implementing planning policy. Furthermore, while there is an acknowledgement, appreciation and respect for the work being done, there are also some unique challenges in facilitating coordination/collaboration.

In the current state, coordination and collaboration primarily occurs in three different formats: written submissions, working groups, and attendance at events. The summary was informed by discussions with municipal planners and best practices and lessons learned from past public health projects.

Written Submissions

Traditionally, public health practitioners submit comments or questions to municipal planning processes and planning applications. This includes comments on proposed policy amendments or new policy directions when developing Official Plans and / or functional master plans. In this case, the municipal staff contact public health practitioners notifying them of a specific request.
Requests are typically submitted using a general public health email which can generate some confusion as to the appropriate public health contact or the certainty of response.

Public health practitioners at times feel challenged with the degree of detail that is to be provided relative to the type of planning request. In addition, there are concerns regarding the applicability and consideration of the comments by municipal planning staff. Though the most traditional approach, public health practitioners sometimes feel that they may not have the experience or understanding to provide comments and are not guided as to how comments could be adapted or improved to create greater impact or influence.

Working Groups

In 2015, Elgin-St. Thomas Public Health struck a healthy community's partnership which included representatives from all area municipalities and other affected agencies. The group was to work collaboratively to identify and implement mutually beneficial initiatives. It provided municipal and public health staff with a place to discuss projects and initiatives and to identify opportunities for additional coordination.

Working groups are common for large scale planning projects as an effective way to bring a range of perspectives together to influence the full planning process. They encourage dialogue, education, and a greater degree of understanding of varying priorities and perspectives. For a large topic such as climate change and health equity, in-person coordination and communication may be the most effective and efficient.

Attendance at Events

On occasion, public health staff have been invited to participate with municipal planning staff in public or council-facing events and outreach to support major planning applications. While this can be effective for a project specific outcome, it may not solve two-way communication issues on ongoing matters related to health equity and climate change. Positioning public health as a support to municipal planning staff should continue to be the focus, not the specific tactic.

2

Action Plan

SWPH will continue the important work related to climate change and health equity with more focus on enhanced coordination and collaboration with municipalities. Emphasis will also be put on education with key stakeholders and

partners. To help inform next steps, actions are being recommended for consideration and implementation by SWPH.

The details of these recommended actions are presented in Chapter 2.0 along with a more detailed summary of the engagement process and input received through discussions with municipal planners and public health practitioners.

The action plan is intended to guide SWPH as they move forward with a continued commitment to climate change resiliency and healthy and equitable communities. The information is further supplemented by additional resources and materials provided to SWPH as part of the project process.

2.1 Insights on Future Actions

As noted in Chapter 1, the 2023 project prioritized the engagement of municipal planning staff to inform the project outputs and identify potential next steps. A series of meetings were held between SWPH and each municipality responsible for implementing an Official Plan. Eight of the municipalities participated. The intent of each meeting was three-fold:

- To provide an overview of the 2019 project and its findings and updated scope of work for the 2023 assignment.
- To present the Official Plan review findings and suggested policy considerations.
- To solicit input from municipal planning staff on opportunities for future policy development in support of climate change and health equity.

Through these engagements, the following key take-aways emerged:

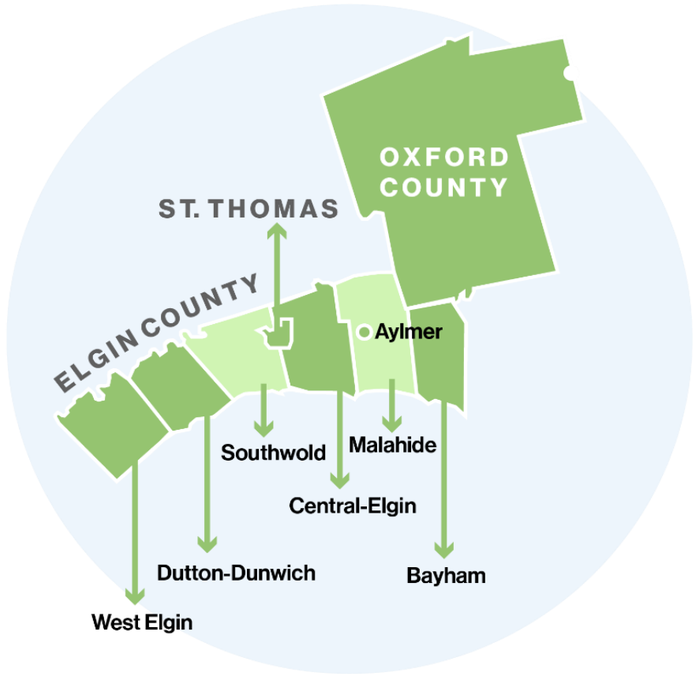
- Both SWPH and the municipal planning departments have similar aspirations when it comes to planning and designing healthy and resilient communities.
- Planning departments and public health have different tools, structures, and processes available to them to achieve these goals.
- There is a strong desire for collaboration but lack of clarity on when and how SWPH should be engaged.
- Municipalities have unique needs dependent on geography and capacity.
- There is a lack of clarity on how to leverage/access SWPH data effectively.
- Detailed information is needed about how planning interventions support health outcomes for the population.
- There is a disconnect between what municipal planning staff and public health practitioners can comment on in comparison to public health or municipal staff's comfort and capacity for commenting.
- There is a need for strategies and recommendations for internal turnover management and general change management.

In summary, there is a varying degree of engagement and coordination between municipal planners and public health practitioners. There are also considerable differences between the tools, tactics and strategies used by public health and municipalities resulting in varying policy approaches and strengths. Both can be attributed to challenges of capacity, education, political will, and communication. A more detailed summary of the findings is presented on the following page.

2

MUNICIPAL ENGAGEMENT **SUMMARY**

In Spring 2023, the project team engaged with municipal staff members from the planning departments of multiple municipalities within Southwestern Public Health's geographic area. These meetings built upon the select engagement that was completed in 2019 to form a comprehensive understanding of how climate change and health equity are considered within municipal planning efforts and the challenges and opportunities for collaboration between municipal planning staff and public health staff. The below graphic is a summary of these municipal meetings.



Engaged municipalities

St. Thomas
Central Elgin
Bayham
Oxford County
Aylmer
Dutton Dunwich
West Elgin
Aylmer

8
total meetings

MEETING **STRUCTURE**

1.5 hour meeting, split into two parts

PART 1
2023 Policy Review and Reflections

The **2023 updated review** of the Official Plan was shared and discussed with municipal staff.

Discussion after centered around following questions:

To what degree was climate change/ equity considered when your OP was reviewed?

What is the level of support for these topics provided by your Council?

Where do you see these topics being most applicable?

PART 2
Coordination Discussion

Following the policy discussion, **existing coordination practices** between municipal staff and public health were reviewed.

Discussion after centered around following questions:

Have you seen policy tools that you think could be adapted for SWPH?

What would be the most effective way for SWPH to engage?

KEY **FINDINGS**

- Both SWPH and the municipal planning departments have similar aspirations when it comes to planning and designing healthy and resilient communities.
- Planning departments and public health have different tools, structures, and processes available to them to achieve these goals.
- There is a strong desire for collaboration but lack of clarity on when and how SWPH should be engaged.
- Municipalities have unique needs dependent on geography and capacity.
- There is a lack of clarity on how to leverage/access SWPH data effectively.
- Detailed information is needed about how planning interventions support health outcomes for the population.
- There is a disconnect between what municipal planning staff and public health practitioners can comment on in comparison to public health or municipal staff's comfort and capacity for commenting.
- There is a need for strategies and recommendations for internal turnover management and general change management.

Recommended Actions

Through the engagement, it became evident that to best integrate public health considerations, such as health equity and climate change, focus needed to be given to the processes of coordination, collaboration and knowledge exchange between municipalities and public health.

The project team identified potential future actions that could be undertaken by SWPH, in partnership with municipal staff and other stakeholders, to find opportunities to shape healthy and climate resilient community planning and design.

The environment of municipal planning and public health is continually changing which can lead to outdated policies, programs, and practices. Prioritizing effective and efficient processes that withstand changes to staff, roles and responsibilities, budget etc. should be considered.

A table summarizing each of the proposed actions is provided on the following page and includes details on potential implementation considerations. The proposed actions consider degree of influence, resources, partners, and key considerations.

Degree of Influence

How much responsibility public health has over the outputs and the outcomes of the recommended action. Alternatives available include:

- High (green) - the responsibility is solely that of SWPH.
- Moderate (yellow) - SWPH has partial responsibility with input from municipalities.
- Low (red) - SWPH has minimal responsibility; significant stakeholder input needed.

Resources

The type and number of staff and budget needed to facilitate the work. Alternatives available include:

- Existing - efforts accommodated by current SWPH staff.
- New Partial - out of the current staff mandate but could be accommodated.
- New Full - out of current staff mandate and would require new staff to complete.

Partners

Partnerships would need to be established to support the preparation and completion of the work recommended.
Alternatives available include a range of options including internal partners specific to public health, municipalities, decision makers, developers, stakeholders, and local interest groups - among others.

Key Considerations

Aspects of the recommendation that would need to be factored into future work based on previous work completed, input received, or information gathered.

#	Recommendation	Degree of Influence	Resources	Partners	Key Considerations
1	Develop and adopt a Municipal Collaboration Strategy specific to SWPH identifying policies, guidelines, standards, processes, and tools that can be used by public health, municipal practitioners, and other partners. This will ensure climate resiliency and health equity initiatives are integrated into planning projects within Elgin, Oxford, and The City of St. Thomas.		Funding would be required to support a consultant to work with SWPH and municipal stakeholders to develop the strategy and guidance on new practices, policies, and processes.	Decision Makers Municipal Single Tier Municipal Two-tier Municipal Upper Tier Developers	SWPH will work with a consulting firm and municipalities to develop a public facing document that shows our current population health data, related built environment features of the SWPH region and the connection of health outcomes with planning principles. Following this report, SWPH will develop processes and tools that are aligned with the established land use planning process for staff to use to organize input on various planning projects from official plans to site plan applications.
2	SWPH should evaluate the effectiveness of its efforts/next steps to determine the effectiveness of new programs and processes and determine opportunities for improvement as needed.		SWPH staff would undertake reviews (potentially annually) in consultation with municipal stakeholders.	Internal Municipal Single Tier Municipal Two-tier Municipal Upper Tier	SWPH would have to determine the conditions that are considered a success and establish a series of criteria and framework for evaluation. Input from both internal staff as well as external collaborators would be required for fulsome evaluation which would be facilitated through either the working group (see below) or other individual outreach methods. Information should be documented clearly and communicated to SWPH staff and the board.
3	Dedicate SWPH staff to liaise with municipalities on planning projects that address healthy community design to ensure effective coordination and communication.		SWPH front line staff and management allocate the time necessary to facilitate this work.	Internal	Dedicated staff would oversee the implementation of the strategy and the implementation of recommended actions. They would coordinate internal planning projects that extend to areas beyond climate change and health equity.
4	Establish a working group made up of SWPH staff and municipal representatives to meet bi-annually with the intent of monitoring and facilitating the implementation of the collaboration strategy.		SWPH front line staff and management allocate the time necessary to facilitate this work.	Internal Municipal Single Tier Municipal Two-tier Municipal Upper Tier Developers	The working group should work collaboratively to identify and implement mutually beneficial initiatives and should include representatives from groups/agencies that have a role to play in the planning process. At a minimum, there should be representation from each of the area municipalities with the potential to expand to other stakeholders including but not limited to members of Council and developers.
5	Update internal SWPH policies and procedures to address timely and efficient coordination of municipal planning requests.		SWPH staff will work together to develop clear processes to ensure efficient review and comment of planning documents across teams.	Internal Municipal Single Tier Municipal Two-tier Municipal Upper Tier	Consider a designated email address such as landuseplanning@swpublichealth.ca that can be directed to appointed staff as well as a tagging system to streamline the request and response process.
6	Develop a mechanism for SWPH to communicate their role effectively and continually with municipal planning practitioners on planning matters i.e. timing, input type, meeting requests, data, etc.		Staff time will need to be designated to the design of an efficient mechanism to respond to planning matters.	Internal Municipal Single Tier Municipal Two-tier Municipal Upper Tier Developer	A table summarizing the various types of planning requests and various approaches for public health involvement and commentary was developed in 2019. See Figure 7.
7	Share research, data, and evidence with municipal partners to support climate change and health equity initiatives		Ensure there is epi support designated to this work and that there are mechanisms in place to share data and follow up on data requests.	Internal Municipal Single Tier Municipal Two-tier Municipal Upper Tier	SWPH epidemiologists should work with Municipalities to understand what data would be useful to planners to connect health outcomes with community planning and design options as they relate to climate change and health equity.

#	Recommendation	Degree of Influence	Resources	Partners	Key Considerations
8	Provide opportunities for enhanced education related to climate change and health equity for municipal decision makers and other partners.		Allocate budget and time for professional development in program plans to support ongoing learning with external stakeholders.	Decision Makers Municipal Single Tier Municipal Two-tier Municipal Upper Tier Developers Local Interest Groups	SWPH to actively seek knowledge exchange opportunities for and with external stakeholders to increase capacity and understanding of best practices to address climate change and health equity through community planning and design.
9	SWPH staff will participate in training on planning matters, policy changes, and emerging trends related to SWPH priorities.		Allocate budget and time for professional development in program plans to support ongoing learning.	Internal Municipal Single Tier Municipal Two-tier Municipal Upper Tier	SWPH to actively seek opportunities for knowledge transfer internally to increase capacity and understanding of best practices to address climate change and health equity through community planning and design.
10	Explore external and internal funding to support projects related to climate change and health equity based on municipal interests and needs		Ensure program plans consider the staff time to seek and apply for funding opportunities to support projects relating to community planning	Internal	Public health staff are encouraged to continually monitor external funding opportunities which could facilitate the implementation of climate change and health equity-related work.

2.2 Next Steps

The recommended actions for SWPH and the supporting resources have been identified within this report. There is a strong degree of support and desire to see these actions move forward in a way that encourages and enhances collaboration and coordination between SWPH and municipal partners to create equitable, healthy and climate resilient communities. There is a strong sense of commitment from all partners to find meaningful opportunities to enhance the processes and practices between organizations. Future work requires education, awareness, and a clear understanding between public health outcomes and planning principles.

SWPH is committed to exploring the recommendations outlined in this report to ensure ongoing efforts are as effective as possible. SWPH aims to strengthen the relationships it has with community members, decision makers, municipal planners, developers, and other agency representatives to ensure a deeper understanding of the health impacts of planning processes and policies that shape the built environment.

2.3 References and Supplementary Resources

[i] Ontario Public Health Standards, MOHLTC. 2018. Available from:

Ontario Public Health Standards - Programs and Services - Health Care Professionals - MOHLTC (gov.on.ca)

[ii] Walker, C, Arnett, E, Lang, J, Basinski, C, Leger, S, Stone, E. Southwestern Public Health: Health Equity and Climate Change: Shaping Supportive Policy. 2019

[iii] Ontario Health Protection and Promotion Act, MOHLTC. 1990. Available from: https://www.ontario.ca/laws/statute/90h07

[iv] Ontario Public Health Standards: Requirements for Programs, Services and Accountability. 2021. Available from: https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Ontario_Public_Health_Standards_2021.pdf

[v] Social Determinants of Health, Health Canada. 2023. Available from: Social determinants of health and health inequalities - Canada.ca

[vi] Statistics retrieved from 2021 Census information for County of Elgin, County of Oxford, and St. Thomas: https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E

[vii] BC Centre for Disease Control. Healthy Built Environment Linkages Toolkit: making the links between design, planning and health, Version 2.0. Vancouver, B.C. Provincial Health Services Authority, 2018.

[viii] Planning Act, MOMAH. 1990. Available from: https://www.ontario.ca/laws/statute/90p13

[ix] Provincial Policy Statement, MOMAH. 2020. Available from: https://www.ontario.ca/page/provincial- policy-statement-2020

[x] Proposal for Provincial Planning Statement, MOMAH. 2023. Available from https://ero.ontario.ca/notice/019-6813

Southwestern Public Health

APPENDIX A: Official Plan Policy Review

Summary

November 2023

Key Term Overview

Neighbourhood Design

35 terms; 12 high impact

Transportation Network

20 terms; 10 high impact

Natural Environment

28 terms; 7 high impact

Food Systems

9 terms; 4 high impact

Housing

8 terms; 2 high impact

2023 Policy Review Overview

Municipalities	2019 Review Completed	2023 Review Completed
Elgin County	Yes	Yes
City of St. Thomas	Yes	Yes
Municipality of Bayham	Yes	No
Oxford County	Yes	Yes
Municipality of Aylmer	Yes	Yes
Municipality of Dutton Dunwich	Yes	Yes
Municipality of West Elgin	Yes	No
Elgin County	Yes	No

2023 Policy Review Summary

Type of Policy Support

What type of reference is being made in the context of the OP

V – Vision statement

M – Motherhood statement

G – Guideline

R – Recommendation

P – Policy

Change Indicator

How the # of term references has changed within the new OP document

- Significant Increase (20+ references)
- Some Increase (1-20 references)
- No change (0)
- Some Decrease (less than original #)

Strength

How influential the references are in their potential to create change

High – <50 references across all types of policy

Moderate – <10 and >50 with representation in most types

Low – >10 references and all V or M

None – there are no references

2023 Municipal Policy Findings

- Significant Increase (20+ references)
- Some Increase (1-20 references)
- No change (0)
- Some Decrease (less than original #)

City of St. Thomas

2019 key term references **34**

2022 key term references **34**

	Neighbourhood Design		Transportation Systems		Natural Environment		Food Systems		Housing	
	2019	2022	2019	2022	2019	2022	2019	2022	2019	2022
#	20	20	4	4	4	4	1	1	5	5
%	59	59	12	12	12	12	3	3	15	15

In 2019

15%

of high impact terms referenced

In 2022

15%

of high impact terms referenced

Analysis Outcomes

- No change demonstrated based on review of updated Official Plan
- Greatest emphasis on neighbourhood design, transportation and environment
- References not reflective of changes to municipal or provincial planning practices

Policy Review Findings

- Significant Increase (20+ references)
- Some Increase (1-20 references)
- No change (0)
- Some Decrease (less than original #)

Municipality of Central Elgin

2012 key term references **211**

2022 key term references **433**

	Neighbourhood Design		Transportation Systems		Natural Environment		Food Systems		Housing	
	2012	2022	2012	2022	2012	2022	2012	2022	2012	2022
#	112	320	19	43	50	50	16	16	14	14
%	53	72	9	10	24	11	8	4	7	3

In 2012

21%

of high impact terms referenced

In 2022

36%

of high impact terms referenced

Analysis Outcomes

- General increase in the number of key terms referenced with a focus on high impact terms
- Greatest change demonstrated in neighbourhood design and transportation systems
- No change in number of references in other categories but overall representation less

2023 Policy Review Findings

- Significant Increase (20+ references)
- Some Increase (1-20 references)
- No change (0)
- Some Decrease (less than original #)

Oxford County

2017 key term references **1481**

2022 key term references **1805**

	Neighbourhood Design		Transportation Systems		Natural Environment		Food Systems		Housing	
	2017	2022	2017	2022	2017	2022	2017	2022	2017	2022
#	1147	1388	94	74	126	177	2	2	112	164
%	77	77	6	4	9	10	0	0	8	9

In 2017

36%

of high impact terms referenced

In 2022

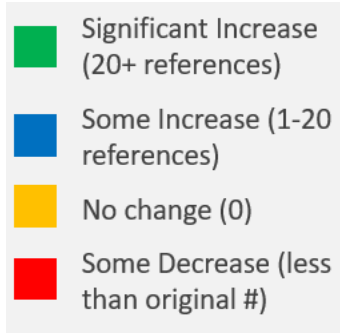
48%

of high impact terms referenced

Preliminary Outcomes

- Overall increase in references in indicators consistent with provincial priorities
- Concerning decrease in key terms relative to transportation systems
- High reference terms also consistent with provincial priorities
- Room for improvement in more equity reflective terms

Policy Review Findings



Municipality of Aylmer

2000 key term references **222**

2021 key term references **294**

	Neighbourhood Design		Transportation Systems		Natural Environment		Food Systems		Housing	
	2000	2021	2000	2021	2000	2021	2000	2021	2000	2021
#	143	172	7	23	30	41	0	0	42	58
%	64	59	3	8	14	14	0	0	19	20

In 2000

24%

of high impact terms referenced

In 2021

30%

of high impact terms referenced

Analysis Outcomes

- Some increase in references to key terms
- Focus on high impact terms demonstrated
- Greatest focus placed on increased reference to neighbourhood design followed by transportation
- Updates in the area of housing – unique to Aylmer

Policy Review Findings

- Significant Increase (20+ references)
- Some Increase (1-20 references)
- No change (0)
- Some Decrease (less than original #)

Municipality of Dutton Dunwich

2013 key term references **84**

2021 key term references **260**

	Neighbourhood Design		Transportation Systems		Natural Environment		Food Systems		Housing	
	2013	2021	2013	2021	2013	2021	2013	2021	2013	2021
#	34	109	6	35	42	99	0	1	2	16
%	40	42	7	13	50	38	0	0	2	6

In 2013

24%

of high impact terms referenced

In 2021

58%

of high impact terms referenced

Analysis Outcomes

- Overall increase in the number of high impact terms
- Overall increase in reference to key terms (generally)
- Focus placed on enhancing reference to neighbourhood design, transportation and environment
- Greatest focus on transportation systems

SPECIAL AD HOC COMMITTEE:
STRENGTHENING PUBLIC HEALTH PROVINCIAL STRATEGY

TERMS OF REFERENCE

Membership:

Chair, Board of Health	- - - -
Vice Chair, Board of Health	- - - -
Board Member: Previous Term Chair	- - - -
Chief Executive Officer, non-voting ex officio	Cynthia St. John
Medical Officer of Health, non-voting ex officio	Dr. Ninh Tran

Invited individuals (employees or consultants), as deemed necessary, non-voting

Purpose:
To provide advice and recommendations to the Board of Health for decision.
To provide advice, guidance, and direction to the Chief Executive Officer, related to the Strengthening of Public Health strategy involving merger discussions with other health units.

This Special Ad Hoc Committee is established further to the resolution passed at the October 26, 2023, Board of Health meeting, noted below:

- As per Board of Health (BOH) meeting, October 26, 2023, MOTION: 2023-BOH-1026-C3.1A That the Board of Health for Southwestern Public Health approve striking a Special Ad Hoc Committee related to the Strengthening Public Health initiative issued by the Ministry of the Health and that the membership of the committee be comprised of Chair, Vice-Chair, CEO, MOH, and relevant administrative support.

Duties and Responsibilities:

1. To review merger proposals and provide recommendations to the Board of Health for the best course of action.

2. To receive updates from SWPH's Executive Leadership related to merger discussions with other health units and related to updates from provincial authorities.

3. To provide updates to the Board of Health on the Committee's discussions and directions.

Meetings:
Meetings will initially be held on an ad hoc basis with the intention of more regular meetings (potentially monthly or biweekly in some cases) and as the Committee Chair deems necessary. Additional meetings will be at the call of the Chair.

Specific Roles and Responsibilities:

1. Chair:
   a. Chair meeting in accordance with current procedural Bylaw No. 1 Conduct of the Affairs,
   b. Guide the meeting according to the agenda and time available,
   c. Provide an opportunity for all members of the Committee to participate in the discussion,
   d. Ensure adherence to the Terms of Reference, and
   e. Review and approve the draft minutes and notes.

2. All Committee members:
   a. Prepare for each meeting by thoroughly reading all pre-circulated reports in advance of the meetings,
   b. Attend and actively participate in the discussion and business of the Committee,
   c. Speak as a collective (with one voice) following Committee decisions on matters, and
   d. Maintain confidentiality concerning any closed session discussions.

3. Chief Executive Officer:
   a. Update the Committee of any relevant concerns or issues as they arise,
   b. Provide written reports regarding the provincial strategy and as directed by the Committee, and
   c. Draft written Committee updates as directed.

4. Recorder of the Meeting:
   a. Schedule meetings as needed,
   b. Book room for meetings,
   c. Request agenda items in advance of the meeting,
   d. Post agenda and committee packages to the portal at least 3 days prior to the meeting (where possible), and
   e. Record minutes.

Terms of Office:
This committee will exist until such time as initiatives related to the Strengthening of Public Health strategy are resolved.

Minutes & Notes:
Minutes and notes of the Committee shall be taken by the Executive Assistant, approved by the Chair, signed by the Chair, and minutes will be posted to the portal, once approved and within two weeks following the meeting.

Quorum:
A quorum of members must be present either in person or via electronic means before a meeting can proceed. Quorum shall be a majority (50% plus 1) of the voting members of the Committee.

A scheduled meeting will be cancelled if the Chair is unable to confirm that a quorum of members can attend. This decision will be based on the members' replies to the meeting invitation.

Decision Making:
The Committee will endeavour to reach consensus. The committee has the authority to make decisions concerning its purpose up to the point of approving legal merger-related decisions.

Accountability:
This Committee reports to and makes recommendations to the Board of Health.

Confidentiality:
Each member of the Committee has a duty to keep confidential any information which the Committee has identified as such and/or at the request of the Board of Health.

Date adopted:
Approved: November 22, 2023 by the Board of Health
(MOTION: 2023-BOH-1123-5.2-3.1)

Amended: March 28, 2024 by the Board of Health

Ministry of Health

2024 Annual Service Plan and Budget Submission

Board of Health for:

the Oxford Elgin St. Thomas Health Unit

Version 1.0

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

Introduction and Instructions

Introduction

The Annual Service Plan and Budget Submission (the “Annual Service Plan”) is prepared by boards of health to communicate their program plans and budgeted expenditures for a given year. Information provided in the Annual Service Plan will describe the programs and services boards of health are planning to deliver in accordance with the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (the "Standards"), based on local needs and budgets at the program level.

As part of the Annual Service Plan, boards of health will describe the needs of the population they serve using the most recent available data. There is an opportunity for boards of health to provide high-level indices of the population they serve along with more specific data for unique sub-populations with common indicators of risk. This information is critical to prioritizing programs and services for the community as a whole and ensuring identified populations receive tailored support as required. The knowledge gained from implementation of the Foundational Standards will inform the preparation, implementation, and monitoring of the Annual Service Plan.

The Standards allow for greater flexibility in program delivery in several Program Standards including, but not limited to, Chronic Disease Prevention and Well-Being, Healthy Growth and Development, School Health, and Substance Use and Injury Prevention. In the Annual Service Plan, boards of health will identify local priorities within each individual program area, and provide a summary of the data used to support their assessment of community need and their program delivery decisions, while also meeting all requirements under the Standards.

Please note that boards of health are required to include budget information on Ministry of Health (ministry) funded public health programs only (both cost-shared and 100% funded programs) and must include 100% of budgeted costs (municipal and provincial portions) for these programs, including any municipal contributions over the ministry approved allocation, intended for the delivery of public health programs and services.

The deadline to submit the 2024 Annual Service Plan is Tuesday, April 2, 2024.

In order to further assist boards of health in completing the Annual Service Plan, a section outlining technical instructions on how to navigate through the Annual Service Plan worksheets is included as part of the Cover Page section of the template.

Instructions

The Annual Service Plan is organized according to the order of the Standards. Boards of health are required to provide budgeted financial data for each Foundational Standard, and for all programs and services planned under each Program Standard. For a list of admissible expenditures that can be included in the Annual Service Plan, refer to the current versions of the Accountability Agreement, instructions included as part of the Annual Service Plan, and Appendix B of the 2017 Program-Based Grants User Guide (as reference only). Provincial funding must only be utilized on admissible costs. Boards of health shall also ensure that all funding and accountability requirements are adhered to and budgeted forecasts are as accurate as possible. All information reported by boards of health in the Annual Service Plan will be reviewed for reasonability and eligibility of costs by the ministry, and may be subject to further review or audit.

The Annual Service Plan includes multiple worksheets that are accessible from a menu on the left-hand side of the Annual Service Plan workbook. In each worksheet, cells that require input have been colour-coded blue. Cells that are pre-populated with data previously inputted are colour-coded white.

The Annual Service Plan worksheets are organized as follows:

Annual Service Plan Structure

This worksheet sets the structure of the Annual Service Plan and requires each board of health to specify the number of programs to be delivered under each Program Standard, program titles, number of board of health members, and number of obligated municipalities to complete the apportionment worksheet. Space to enter titles for programs will be visible once the board of health specifies the number required for each. These titles will automatically populate all appropriate sections in the Annual Service Plan (this worksheet must be completed/updated by boards of health prior to completing the Annual Service Plan).

Boards of health can input a number value of up to 20 programs under each Program Standard. Information pertaining to the Foundational Standards is not required on this worksheet.

The ministry acknowledges that boards of health continue to use different program names for similar services, and there is a variation in the way boards of health group activities into programs. In order to address these challenges, the ministry is continuing the standardization of categories as part of the 2024 Annual Service Plan.

The ministry is requesting that boards of health provide budgeted financial data based on the following standardized categories:

Program Standard	Standardized Program Name	Applicable Requirements	Examples of Activities
Chronic Disease Prevention and Well-Being or Healthy Growth and Development	Non-Mandatory Oral Health Programs		Oral health services and activities provided outside of the requirements related to Healthy Smiles Ontario, the Ontario Seniors Dental Care Program, and School-based screening.
Chronic Disease Prevention and Well-Being	Ontario Seniors Dental Care Program	See Schedule B of the most recent Accountability Agreement.	See Schedule B of the most recent Accountability Agreement.
Chronic Disease Prevention and Well-Being	Menu Labelling	See the Menu Labelling Protocol, 2020 (or as current).	See the Menu Labelling Protocol, 2020 (or as current).
Chronic Disease Prevention and Well-Being	Tanning Beds	See the Tanning Beds Protocol, 2019 (or as current).	See the Tanning Beds Protocol, 2019 (or as current).
Food Safety	Food Safety Program	See the Food Safety Protocol, 2019 (or as current) and the Operational Approaches for Food Safety Guideline, 2019 (or as current)	See the Food Safety Protocol, 2019 (or as current) and the Operational Approaches for Food Safety Guideline, 2019 (or as current)
Healthy Environments	Health Hazards Program	See the Health Hazard Response Protocol, 2019 (or as current)	See the Health Hazard Response Protocol, 2019 (or as current)
Healthy Environments	Healthy Environments and Climate Change Program	See the Healthy Environments and Climate Change Guideline, 2018 (or as current)	See the Healthy Environments and Climate Change Guideline, 2018 (or as current)
Immunization	Community Based Immunization Outreach (excluding vaccine administration)	Applicable requirements include: working with community partners to improve public knowledge and confidence in immunization programs and services; providing consultation to community partners on immunization and immunization practices; working with school boards and schools to identify opportunities to improve public knowledge and confidence in immunization for school-aged children; and, assessing, maintaining records, and reporting on immunizations administered at board of health-based clinics.	Examples of activities include: community outreach, consultations and partnerships on immunization and immunization practices; activities to improve public knowledge and confidence in immunization programs and services; and, activities to improve health professional knowledge and understanding of immunization and the Ontario immunization schedule.
Immunization	Immunization Monitoring and Surveillance	Applicable requirements include: conducting epidemiological analysis of surveillance data for vaccine preventable diseases, vaccine coverage, and adverse events following immunization, including monitoring of trends over time, emerging trends, and priority populations; having a contingency plan to deploy board of health staff capable of providing vaccine preventable diseases outbreak management and control; promoting the reporting of adverse events following immunization by health care providers to the local board of health; and, monitoring, investigating, and documenting all suspected cases of adverse events following immunization that meet the provincial reporting criteria and promptly report all cases	Examples of activities include: data entry and management of clinics, including Universal Influenza Immunization Program (UIIP); monitoring, investigating, and documenting, as appropriate, adverse events following immunization (AEFI); promotion of reporting of AEFIs by health care providers to the local board of health; epidemiological analysis of surveillance data for vaccine preventable diseases, vaccine coverage, and AEFI, including monitoring of trends over time, emerging trends, and priority populations; and, outbreak management (excluding immunization clinical services). Excludes activities related to the Immunization of School Pupils Act (ISPA)/ Child Care and Early Years Act

			and promptly report all cases.	(CCEYA) data collection, entry, monitoring and reporting.

Immunization	Vaccine Administration	Applicable requirements include: promoting and providing provincially funded immunization programs and services to eligible persons, including priority populations, in the board of health (Immunization Standard); and, providing provincially funded immunization programs to eligible students in the board of health through school-based clinics (School Health Standard).	Vaccine administration for provincially funded immunization programs for eligible persons in the board of health, including: School-based clinics for Hepatitis B, Human Papillomavirus and Meningococcal ACYW; community-based clinics and other catch-up immunization services (not school-based); UIIP clinics; and, RSV.
Immunization	Vaccine Management	Applicable requirements include: providing comprehensive information and education to promote effective inventory management for provincially funded vaccines; promoting appropriate vaccine inventory management ((a) prevention, management, and reporting of cold chain incidences, (b) prevention, management, and reporting of vaccine wastage); and, ensuring that the storage and distribution of provincially funded vaccines is in accordance with the Vaccine Storage and Handling Protocol, 2018 (or as current).	Examples of activities include: provision of information and education to promote effective inventory management for provincially funded vaccines; and, activities related to the storage, handling and distribution of vaccines.
Immunization	COVID-19 Vaccine Program	Applicable requirements include: Coordinating, overseeing, and direct service delivery for COVID-19 vaccinations, including activities as specified for Immunization in other requirements - Community based Immunization Outreach, Monitoring and Surveillance, Administration and Vaccine Management.	Vaccine administration for the COVID-19 Vaccine Program with focused programming for vulnerable and priority populations. Vaccine inventory management and AEFI investigation. COVaxON data entry and support for local vaccine administrators.
Infectious and Communicable Diseases Prevention and Control	Vector-Borne Diseases Program	See the Infectious Diseases Protocol, 2018 (or as current).	See the Infectious Diseases Protocol, 2018 (or as current).
Safe Water	Drinking Water Program (including Small Drinking Water Systems Program & Other Drinking Water Programs)	See the Safe Drinking Water and Fluoride Monitoring Protocol, 2019 (or as current) and Small Drinking Water Systems Risk Assessment Guideline, 2018 (or as current).	See the Safe Drinking Water and Fluoride Monitoring Protocol, 2019 (or as current) and Small Drinking Water Systems Risk Assessment Guideline, 2018 (or as current).
Safe Water	Recreational Water Program	See the Recreational Water Protocol, 2019 (or as current) and the Operational Approaches for Recreational Water Guideline, 2018 (or as current)	See the Recreational Water Protocol, 2019 (or as current) and the Operational Approaches for Recreational Water Guideline, 2018 (or as current)

School Health (Oral Health)	Healthy Smiles Ontario Program	See the Oral Health Protocol, 2021 (or as current) (sections 5 - 10).	Examples of activities include: program eligibility assessment and client-level oral health navigation (e.g., clinical and financial eligibility determination, client enrollment support into the various streams of Healthy Smiles Ontario, assistance with finding a dental home); post-screen notification and follow-up; oral health service delivery (e.g., clinics/mobile buses providing oral health services to Healthy Smiles Ontario clients); promotion and education (i.e., Oral Health and Healthy Smiles Ontario); and, other, if applicable.
School Health (Oral Health)	Oral Health Assessment and Surveillance	See the Oral Health Protocol, 2021 (or as current) (sections 1 - 4).	Examples of activities include: pre-screen notification (e.g., liaising with school boards, issuing pre-screen notification letters); school risk level determination; screening and surveillance; and other, if applicable.
School Health (Immunization)	Immunizations for Children in Schools and Licensed Child Care Settings	Applicable requirements include: enforcing the ISPA; and, assessing, maintaining records, and reporting on the immunization status of children enrolled in licensed childcare settings and the immunization status of children attending schools in accordance with the ISPA.	Examples of activities include: maintenance of records, assessment and reporting on the immunization status of children in schools and licensed childcare centres; ISPA suspension process; and, ISPA education sessions. Excludes all activities related to vaccine administration such as school clinics and catch-up clinics for ISPA vaccines. Those activities should be included under "Immunization/ Vaccine Administration."
School Health (Vision)	Child Visual Health and Vision Screening	See the Child Visual Health and Vision Screening	Parent Notification Form-A (PNF-A): Notifies the parents/guardians of children who have been screened and identified in need of visual health services and/or treatment within two business days of completing the screening. This form shall include a referral to an optometrist for a comprehensive eye exam. Parent Notification Form-B (PNF-B): Notifies the parents/guardians of all other children who have been screened. This notification shall encourage parents/guardians to book an appointment with an optometrist for a comprehensive eye exam.

		Protocol, 2018 (or as current) (sections 3a and 3b).	Child Vision Screening Reminder Letter: Sent 20 business days after the PNF-A to remind parents to book an optometrist appointment. Vision Screening Assessment Form: Used by boards of health for each child screened, to record the results of each of the three vision screening tests and indicate whether the overall result is pass, refer or automatic referral. This form is kept for board of health records and not issued to the student.

School Health (Other)	Comprehensive School Health	See the School Health Guideline, 2018 (or as current). Applicable requirements include a) developing and implementing a program of public health interventions using a comprehensive health promotion approach to improve the health of school-aged children and youth; and, b) offering support to school boards and schools to assist with the implementation of health-related curricula and health needs in schools.	Activities that promote the health of school-aged children and youth per the School Health Program Standard and related guidelines and protocols under the Ontario Public Health Standards. Examples could include: conducting assessments to identify priority health issues in the school community, engaging in program planning or developing action plans, collaborating with or consulting school boards and schools, supporting implementation of health-related curricula, developing or reviewing school policies and practices, developing or implementing interventions to address specific topics in schools (e.g., substance use, healthy eating, mental health promotion, etc.), promoting a safe school environment, etc.
Substance Use and Injury Prevention	Alcohol	See the Substance Use Prevention and Harm Reduction Guideline, 2018 (or as current). The board of health shall collaborate with local partners in health and other sectors to develop programs and services that address varying substance use patterns in order to reduce the burdens associated with substance use, including: a) Preventing or delaying substance use; b) Preventing problematic substance use; c) Reducing harms associated with substance use; d) Re-orienting health services to meet population needs; and/or, e) Contributing to the planning of, and referrals to, treatment and other services to meet population needs.	Activities may include: **Public Education**: Public education and awareness campaigns to promote responsible alcohol use and educate the public about health harms associated alcohol use. **Monitoring and Surveillance**: Data collection and analysis of local trends related to alcohol use (e.g., prevalence, problematic use, etc.) **Prevention and Harm Reduction**: Initiatives to prevent or delay alcohol use, prevent problematic alcohol use and reduce harms associated with alcohol use.
Substance Use and Injury Prevention	Cannabis	See the Substance Use Prevention and Harm Reduction Guideline, 2018 (or as current). The board of health shall collaborate with local partners in health and other sectors to develop programs and services that address varying substance use patterns in order to reduce the burdens associated with substance use, including: a) Preventing or delaying substance use; b) Preventing problematic substance use; c) Reducing harms associated with substance use; d) Re-orienting health services to meet population needs; and/or,	Activities may include: **Public Education**: Public education and awareness campaigns to promote responsible alcohol use and educate the public about health harms associated cannabis use. **Monitoring and Surveillance**: Data collection and analysis of local trends related to cannabis use (e.g., prevalence, problematic use, etc.) **Prevention and Harm Reduction**: Initiatives to prevent or delay alcohol use, prevent problematic cannabis use and

			e) Contributing to the planning of, and referrals to, treatment and other services to meet population needs.	delay alcohol use, prevent problematic cannabis use and reduce harms associated with cannabis use.

Substance Use and Injury Prevention	Harm Reduction Program Enhancement	See the Substance Use Prevention and Harm Reduction Guideline, 2018 (or as current) and Schedule B of the most recent Accountability Agreement. The board of health shall support the implementation of the Ontario Harm Reduction Program Enhancement which includes: a) designing and implementing local opioid response initiatives based on an assessment of local data; b) implementing or support the implementation of opioid overdose early warning systems; and, c) serving as naloxone distribution leads, and providing training and other supports, to eligible community organizations	Activities may include: conducting population health/situational assessment, leading/ supporting the development, implementation, and evaluation of a local overdose response plan (or drug strategy), engaging stakeholders, adopting and ensuring timely data entry of the Ontario Harm Reduction Database.
Substance Use and Injury Prevention	Needle Syringe Program	See the Substance Use Prevention and Harm Reduction Guideline, 2018 (or as current). The board of health shall: a) provide or ensure the availability of sterile needles and syringes, as well as safer drug use supplies currently funded and provided through the Ontario Harm Reduction Distribution Program to individuals who use drugs in the public health unit's region; b) provide or ensure the availability of initiatives related to the disposal of used harm reduction supplies; c) provide education to clients of the Ontario Needle Exchange/Syringe Program (including fixed satellites and outreach locations) and individuals who use drugs on how to reduce harms associated with drug use; and, d) provide referrals to addiction treatment, other harm reduction services, health and social services (including HIV, HCV, and STI testing, community support and treatment)	Activities may include: distribution of needles/syringes; needles/syringes pickup and disposal; distribution of sharps containers within communities; and, distributing safer drug-use information.
		See the Substance Use Prevention and Harm Reduction Guideline, 2018 (or as current). The board of health shall collaborate with local partners in health and other sectors to develop programs and	Activities may include: **Public Education**: Public education and awareness campaigns to educate the public about health harms

Substance Use and Injury Prevention	Other Drugs (not including opioids)	services that address varying substance use patterns in order to reduce the burdens associated with substance use, including: a) Preventing or delaying substance use; b) Preventing problematic substance use; c) Reducing harms associated with substance use; d) Re-orienting health services to meet population needs; and/or, e) Contributing to the planning of and referrals to treatment and other services to meet population needs.	campaigns to educate the public about health harms associated with use of other drugs. **Monitoring and Surveillance**: Data collection and analysis of local trends related to other drug use (e.g., prevalence, problematic use, polysubstance use etc.) **Prevention and Harm Reduction**: Initiatives to prevent or delay other drug use and reduce harms.

Substance Use and Injury Prevention	Smoke-Free Ontario	Implement **Comprehensive Tobacco Control** (See Tobacco, Vapour and Smoke Guideline, 2021 (or as current) under the pillars of "**prevention**", "**protection**" and "**cessation**", including enhanced knowledge translation, coordination/collaboration among boards of health, and with a focus on priority populations. **Prevention:** Initiatives to prevent individuals from becoming daily (and nicotine dependent) users of tobacco and vapour products, including primary (initiation) and secondary (escalation) prevention of the use of tobacco and vapour products. **Protection:** Enforcement of the *Smoke-Free Ontario Act, 2017* (SFOA, 2017) and its regulation. Initiatives to protect individuals from second-hand exposure to tobacco, vapour products, the smoking and vaping of cannabis (medical and recreational) and other emerging products. **Cessation:** Initiatives to motivate, encourage and support efforts to quit the use of tobacco and vapour products. Initiatives to educate that focus on the harms of tobacco and vapour product use. Referrals to Health 811 and regional health partners (e.g., primary health care; community agencies) to increase access to cessation services.	**Prevention:** Broad-based public education and awareness initiatives on youth vaping. Peer-to-peer youth engagement activities to address tobacco use and vaping. **Protection:** Activities related to the enforcement of the SFOA, 2017. Local policy development that is beyond the SFOA, 2017 (e.g., smoke-free housing, smoke and vape-free workplace policies; smoke and vape-free campuses). **Cessation:** Maintaining an integrated network of community partners in smoking cessation. Broad-based public education and awareness initiatives on the harms of tobacco and vapour product use. The ministry does not support advocacy activities targeting provincial and federal governments.

The standardized programs listed above have been added to the Annual Service Plan Structure worksheet under the relevant Program Standard. Boards of health that deliver other programs under the above mentioned Program Standards may still include these programs as long as there is no duplication or overlap in the activities and services provided. In order to add additional programs under a Program Standard, boards of health must update the total number of programs under a Program Standard in the Structure worksheet.

It is also important to note the following:
● Some public health programs may be delivered under multiple Standards (boards of health are required to allocate these programs across all applicable Standards);
● For 2024, the COVID-19 Vaccine Program will continue to be reflected as a standardized program under the Immunization Standard. Similar to other standardized programs in the Annual Service Plan, boards of health are required to provide the 100% budgeted costs for the COVID-19 Vaccine Program as part of their budget submission; and,
● A review of the Standards is currently underway as part of the Strengthening Public Health strategy announced in August 2023. For the purposes of completing the 2024 Annual Service Plan, boards of health are to assume no change to current requirements in the Standards, pending confirmation from the ministry of future changes to the Standards.

Community Assessment

Boards of health are required to provide a high-level description/overview of the communities within their public health unit on this worksheet.

Program Plans

Boards of health are required to provide a narrative on all programs and services they plan to deliver under each Standard as follows:

Foundational Standards: Boards of health are required to describe how they plan to implement each of the four (4) Foundational Standards, and for the Emergency Management Foundational Standard describe the objectives and key partners/stakeholders.

Program Standards: Within each Program Plan worksheet, boards of health are required to provide summary narrative details on community needs/priorities, key partners/stakeholders, and programs/services that boards of health plan to deliver in a given year, including objectives that include timelines, and a description of all public health interventions within each program.

Budget Allocation and Summaries

Includes a set of worksheets to allocate staffing and other costs at 100% (both provincial and municipal portions) for each Foundational Standard, and for all programs under each Program Standard as identified in the Annual Service Plan. Note that budgeted costs in the Annual Service Plan are for the period of January 1st to December 31st.

Boards of health are required to identify sources of funding in the allocation of expenditures worksheet as per the board of health's most recent version of the Accountability Agreement (please note that sources of funding must be identified for programs to which they are applicable and allocated based on the 100% budgeted cost - not just the provincial portion). For 2024, the sources of funding include:

Mandatory Programs (Cost-Shared): Refer to the cost-shared public health programs and services boards of health are required to deliver in accordance with the *Health Protection and Promotion Act* (HPPA) and the Standards.

Ontario Seniors Dental Care Program (100%): Provides comprehensive dental care to eligible low-income seniors to help reduce unnecessary trips to the hospital, prevent chronic disease and increase quality of life for seniors.

Unorganized Territories / Indigenous Public Health Programs (100%): Refers to the public health programs and services boards of health are required to deliver in unorganized territories (areas without municipal organization) in accordance with the HPPA and the Standards and/or to Indigenous Communities and organizations to build relationships and enhance engagement. Only boards of health that received base funding from the ministry for the delivery of this program in 2023 will have the option to identify this as a funding source.

Funding received at 100% for the MOH/AMOH Compensation Initiative should not be included in the Annual Service Plan.

New for 2024, boards of health are no longer required to complete separate budget worksheets for the COVID-19 General Program and the COVID-19 Vaccine Program. Boards of health are required to input their 100% budget for the COVID-19 Vaccine Program in the same manner as other programs under the Standards.

The Budget worksheets are organized as follows:

Staff Allocation to Programs: Boards of health are required to input the total number of full-time equivalents (FTEs) and total budget for each position title under each Standard in the light blue cells. The total FTEs and total budget are inputted in the same row as the title for that Standard. For Program Standards, boards of health are then required to allocate the total FTEs and budget to each program listed under that Program Standard. Cells will be yellow until all FTEs and budgets have been allocated. Data inputted in this worksheet will pre-populate salaries and wages in the Allocation of Expenditures worksheet. Boards of health are also required to allocate a budget for each Foundational Standard.

Similar to 2023, boards of health are asked to input the percentage of bi-lingual FTEs that make up the total FTEs for each Foundational Standard and each program under the Program Standards.

Medical Officer of Health & Administrative Staff: Boards of health are required to input the total FTEs and total budget for the Medical Officer of Health position and each administrative position in this separate worksheet. Data inputted in this worksheet will pre-populate salaries and wages in the Allocation of Expenditures worksheet, in the indirect costs section.

Similar to the Staff Allocation to Programs worksheet, boards of health are asked to input the percentage of bi-lingual FTEs that make up the total FTEs for each position category.

Allocation of Expenditures: Salaries and wages will pre-populate from the staffing worksheets. Benefits are calculated based on the average percentage (%) of benefits entered for the entire organization at the top of this worksheet. Benefits can also be entered directly in each cell as benefits cells have been left unlocked for this purpose. All other expenditure categories should be manually allocated in each Foundational Standard and each program under the Program Standards. Costs associated with the Office of the Medical Officer of Health, administration and other overhead/organizational costs are to be inputted in the section at the end of this worksheet as an indirect cost and are not to be allocated across the Standards. Sources of funding must be identified for each Foundational Standard and each program under the Program Standards. Sources of funding are populated by selecting from a drop-down menu. Please refer to the "How to Use the ASP Template" section from the Cover Page for any troubleshooting help with the budget worksheets.

Budget Summaries: This worksheet includes three (3) budget summaries that reflect budget data at 100% (municipal and provincial portions): 1) Budget Summary by Funding Source that summarizes budget data and the provincial share; 2) Summary of Expenditures by Standard; and, 3) Staff Allocation by Standard.

Please note that for the 2024 Annual Service Plan, the Ministry Approved Allocation amounts are based on 2023 ministry approvals (annualized base funding).

For the purposes of the Annual Service Plan, the cost-share is based on the Board of Health approved budget (at 100%) and the current Ministry Approved Allocation, and may change based on future funding approvals. Note that the cost-share is no longer being calculating based on a 70% provincial share while change processes are underway related to Strengthening Public Health.

One-Time Funding Requests

At this time, one-time requests are limited to requests submitted through the Voluntary Merger Proposal Business Case, to support the Strengthening Public Health strategy. Requests for one-time funding will not be considered through the 2024 Annual Service Plan.

Board of Health Membership

Boards of health are required to provide details on board of health membership on this worksheet. Boards of health must enter the total number of board of health members in the Annual Service Plan Structure worksheet, which will provide sufficient space to complete details for each member.

Apportionment of Board of Health Costs

Boards of health are required to provide information on how their costs are apportioned to obligated municipalities, totalling 100%.

Certification by the Board of Health

This worksheet requires that the Board of Health Chairperson, Medical Officer of Health/Chief Executive Officer, and Chief Financial Officer/Business Administrator certify that all costs and information submitted in the Annual Service Plan are accurate and conform with categories specified as eligible.

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

Annual Service Plan Structure

NOTE:
The *Annual Service Plan Structure* worksheet must be completed prior to completing the rest of worksheets.

Chronic Disease Prevention and Well-Being		# Programs	8
P 1)	**Menu Labelling**	# Interventions	
P 2)	**Non-Mandatory Oral Health Programs**	# Interventions	
P 3)	**Ontario Seniors Dental Care Program**	# Interventions	2
i 1)	Ontario Senior's Dental Care Program (OSDCP)		
i 2)	Oral Health Mobile Services		
P 4)	**Tanning Beds**	# Interventions	
P 5)	Healthy Eating Behaviours	# Interventions	2
i 1)	Fostering Positive Relationships with Food in Children		
i 2)	Sustainable Food Systems		
P 6)	Physical Activity	# Interventions	
P 7)	Built Environment	# Interventions	
P 8)	Mental Health Promotion	# Interventions	2
i 1)	Mental Health Protection and Promotion in Schools		
i 2)	Mental Health Promotion		
Food Safety		# Programs	1
P 1)	**Food Safety Program**	# Interventions	1
i 1)	Food Safety		
Healthy Environments		# Programs	2
P 1)	**Health Hazards Program**	# Interventions	3
i 1)	Health Hazard Response		
i 2)	Migrant Farm Housing Inspection Program		
i 3)	Recreational Camp Inspection Program		
P 2)	**Healthy Environments and Climate Change Program**	# Interventions	2

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

Annual Service Plan Structure

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i 1)	Climate Change		
i 2)	Extreme Heat and Cold Response		
Healthy Growth and Development		# Programs	3
P 1)	Reproductive Health	# Interventions	1
i 1)	Reproductive Health (Preconception, Healthy Pregnancies & Preparation for Parenthood)		
P 2)	Breastfeeding	# Interventions	1
i 1)	Breastfeeding (Promotion, Information & Surveillance)		
P 3)	Parenting	# Interventions	1
i 1)	Healthy Growth and Development		
Immunization		# Programs	5
P 1)	**Community Based Immunization Outreach (excluding vaccine administration)**	# Interventions	
P 2)	**COVID-19 Vaccine Program**	# Interventions	1
i 1)	COVID-19 Response		
P 3)	**Immunization Monitoring and Surveillance**	# Interventions	1
i 1)	Immunization Administration and Surveillance (incl. AEFIs)		
P 4)	**Vaccine Administration**	# Interventions	1
i 1)	Universal Influenza Immunization Program		
P 5)	**Vaccine Management**	# Interventions	1
i 1)	Vaccine Inventory, Storage, and Handling (incl. Adverse Storage Conditions)		
Infectious and Communicable Diseases Prevention and Control		# Programs	5
P 1)	**Vector-Borne Diseases Program**	# Interventions	1
i 1)	Vectorborne Diseases Surveillance, Testing, and Education		
P 2)	Sexual Health	# Interventions	2
i 1)	Sexually Transmitted and Blood Borne Infections		

Annual Service Plan Structure

NOTE:
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i 2)	Unplanned Pregnancy		
P 3)	Infection Prevention & Control	# Interventions	4
i 1)	Community Case and Contact Management of Diseases of Public Health Significance		
i 2)	Infection Prevention and Control		
i 3)	Institutional Outbreak Management for Infectious Diseases		
i 4)	Personal Services Settings Program		
P 4)	Tuberculosis Prevention & Control	# Interventions	1
i 1)	TB Prevention and Control		
P 5)	Rabies & Zoonotics	# Interventions	1
i 1)	Rabies Investigation Program and Education		
Safe Water		# Programs	2
P 1)	**Drinking Water Program**	# Interventions	1
i 1)	Safe Drinking Water Program		
P 2)	**Recreational Water Program**	# Interventions	1
i 1)	Recreational Water Program		
School Health - Oral Health		# Programs	2
P 1)	**Healthy Smiles Ontario Program**	# Interventions	1
i 1)	Healthy Smiles Ontario (HS)		
P 2)	**Oral Health Assessment and Surveillance**	# Interventions	1
i 1)	Oral Health Screening & Surveillance		
School Health - Vision		# Programs	1
P 1)	**Child Visual Health and Vision Screening**	# Interventions	1
i 1)	Vision		
School Health - Immunization		# Programs	1

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

Annual Service Plan Structure

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P 1)	**Immunizations for Children in Schools and Licensed Child Care Settings**	# Interventions	1
i 1)	Immunization for Children in Schools and Licensed Child Care Settings		
School Health - Other		# Programs	1
P 1)	**Comprehensive School Health**	# Interventions	1
i 1)	Comprehensive School Health		
Substance Use and Injury Prevention		# Programs	8
P 1)	**Alcohol**	# Interventions	1
i 1)	Alcohol		
P 2)	**Cannabis**	# Interventions	
P 3)	**Other Drugs**	# Interventions	
P 4)	**Harm Reduction Program Enhancement**	# Interventions	2
i 1)	Comprehensive Harm Reduction Plan		
i 2)	Consumption and Treatment Services (Phase 2)		
P 5)	**Needle Syringe Program**	# Interventions	1
i 1)	Needle Syringe Program		
P 6)	**Smoke-Free Ontario**	# Interventions	2
i 1)	Nicotine Cessation and Smoke/Vape-Free Housing Policy		
i 2)	Smoke-Free Ontario Act Enforcement		
P 7)	Substance Use	# Interventions	1
i 1)	Primary Prevention of Substance Use		
P 8)	Injury Prevention	# Interventions	1
i 1)	Older Adult Fall Prevention		
Board of Health Membership		# Members	13
Apportionment of Board of Health Costs		# Municipalities	3

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

Annual Service Plan Structure

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Community Assessment

A. Community Needs and Priorities

Describe the process your board of health uses to understand your community's population health needs and priorities. Include information on how you assess whether your community's population health needs are changing and whether your board of health's programs and interventions have been or will be adapted to address changes in the community's population health needs.

Our annual program planning process at SWPH is driven by our community's population health needs and priorities. As each intervention is planned, the staff document the community need, driven by the data provided by the epidemiologists, they identify factors that are contributing to the need and the readiness of the community and stakeholders to implement any proposed changes. The plans are created new each spring, or previous plans are reviewed and updated to include the new data and address any changes.

In support of the annual program planning process, teams continue to do in-depth situational assessments to review the evidence that drives their programs and interventions. Additionally, the epidemiologists are updating the community health status data this year to use in planning and priority-setting.

B. Priority Populations

Provide a high-level description of the priority populations (including Indigenous and Francophone populations, as appropriate) within your community.

The following are some of our organization-wide priority populations. These are groups of people who are at higher risk for negative health outcomes and who can be better served by a proportionate universalism approach to the delivery of our program and services.

- Low German Speaking Mennonites - there are approximately 5,000 members of this community living primarily in East Elgin and who access services across Elgin and Oxford Counties. They often have risk factors for negative health outcomes including low income, dental decay, smoking, lower rates of immunization and higher rates of chronic diseases.
- Amish – there are just over 1,000 members of the Amish community currently living in our health unit region. There are approximately 550 in Oxford County and about 450 living in Elgin County.
- Indigenous Populations - 2.0% of our population identify as Indigenous; this largely represents people living off-reserve.

C. Unique Challenges and Risks

Describe any unique challenges, issues, and/or risks that are being faced by your community including those that have been exacerbated because of the pandemic and impacts on programming and service delivery decisions.

We face challenges with our low immunizing populations partly because of relationships that were strained during the pandemic. Many of our low-immunizing populations are faith-based communities that did not respond well to public health measures throughout covid. We continue to experience challenges engaging this population in our regular programs and services.

Foundational Standards

Population Health Assessment

Description

Please describe how the board of health plans to implement this Standard, including:

a) A description of how the board of health is planning for the integration of social determinants of health into population health assessment (PHA) work as well as how PHA work is being used in the planning/prioritizing processes.

The social determinants of health are being highlighted in the analysis and reporting of our many topics as we continue to update our Community Health Status reports this year. Indicators like income, for example, are included in the analysis and highlighted in the final report (when the data show a significant impact of that variable).

Program planning happens in our Program Planning database. The database includes a section on “what is the local need” where the planning leads directly incorporate the data from our health status reports into their intervention planning. Our planning is driven by need.

b) How the board of health plans to engage and provide population health information to the public, Ontario Health, Ontario Health Teams, other health system partners and primary care.

Our updated health status data will be shared with partner agencies via presentations. The completed health status reports will be shared with the public via our website.

The Foundational Standards team produces both internal and community-facing dashboards covering the following topics that are updated on an ongoing basis throughout the year -Respiratory Viruses, Opioids and Infectious Diseases.

c) The data sources the board of health will be purchasing to support assessment and surveillance activities and provide the total estimated budgeted costs for the data sources.

We will not be purchasing any additional data sources this year.

Health Equity

Description

Please describe how the board of health plans to implement this Standard, including:

a) How a health equity approach will be incorporated throughout all programs and services.

A Health Equity Framework has been developed along with associated tools and learning sessions. These learning sessions will begin in Q1, progressing to all program teams throughout the LPHA in Q2. This activity will equip staff with the knowledge and skill to recognize and act on health inequities within their program areas, and ultimately apply this learning to program planning. This capacity building strategy will feature ongoing developmental

b) How effective local strategies to reduce health inequities will be identified.

SWPH collaborates with partners and/or committees to address the SDoH and health inequities in our region. For example, SWPH staff are engaged in local tables addressing poverty, income and food insecurity, and housing and homelessness. In addition to collaboration with community partners and people with lived/living experience, SWPH will also use a health equity framework to help identify the systems contributing to health inequities and create

c) The role of the social determinants of health nurses in this work, if applicable.

There are a variety of staff and disciplines involved in this work and the Health Equity and Priority Populations committee. A public health nurse and health promoter have been leading the internal capacity building activities outlined above.

Effective Public Health Practice

Description

Please describe how the board of health plans to implement this Standard related to the following under Effective Public Health Practice:
a) Program Planning, Evaluation, and Evidence-Informed Decision-Making.

Our annual program planning initiative engages all staff and management in planning their interventions and associated activities. This initiative builds on knowledge established in previous years and aims to populate our program budgets and the Annual Service Plan and it helps us to plan in a more evidence-informed manner.

If a population health need exists and there is a gap in programming in the community, then teams complete a situational assessment to prioritize evidence-based interventions to determine which activities best suit our local context. This year, the Foundational Standards team will support staff from various teams across the health unit to complete situational assessments on relevant topics in their program areas so that they can make programming decisions (i.e. begin new activities, stop existing activities or continue as-is) based on population health need(s), evidence in the literature that addresses risk and protective factors and whether programming already exists in our community.

The Foundational Standards Team will provide support to program staff in evaluation activities. The team will support the Healthy Growth and Development Team, the Sexual Health Team and the Chronic Disease and Injury Prevention Team to develop, administer, analyze and/or report on a prenatal and syphilis education evaluation and a Health Equity Framework evaluation, respectively.

b) Research, Knowledge Exchange, and Communication.

The completed situational assessments from our work during program planning will be shared on our website and in the National Collaborating Centre for Methods and Tools (NCCMT) Repository to ensure that the knowledge we've gained as a health unit is shared widely across the field of public health.

The Foundational Standards Team also contributes to knowledge exchange with colleagues across the province by participating in committees and networks such as the Association of Public Health Epidemiologists in Ontario (APHEO) and the Ontario Public Health Evaluation Network (OPHEN).

Southwestern Public Health's Board of Health is committed to sharing transparent, timely, relevant public health information with its stakeholders through a variety of channels including traditional media, social media, website, community publications and paid advertising. The goal is to use plain language and a clear call to action to ensure the community understands the steps that need to be taken to protect or promote their health. The health unit also shares regional, provincial and federal public health resources relevant to the local community as well as the data that may influence or direct local decision-making about health-related matters. Increasingly the health unit is using dashboards, infographics, video, and other visuals to communicate public health information. This is in keeping with current trends in communication and addresses the need for more visual information by people with lower literacy skills.

c) Describe the role of the board of health in research activities (e.g., contributor/participant, member of working groups/committees, principal researcher).

The Foundational Standards team provides research and evaluation support to front-line staff, the Leadership and Senior Leadership Teams. The team also provides support for projects that will require an ethics review. Additionally, a member of the Foundational Standards Team contributes to maintaining ethical practices in research and other evidence-gathering initiatives across Ontario by sitting on Public Health Ontario's Research Ethics Board.

Teams across the health unit participate or contribute to research with external agency partners. For example, the Chronic Disease and Injury Prevention Team is working with community health agencies and school boards to implement the Planet Youth Model. This program would require data to be collected from area schools.

The Foundational Standards team is providing research and evaluation support to the Chronic Disease and Injury Prevention Team to conduct a large-scale evaluation of the Pharmacy-Led Smoking Cessation Program in conjunction with The Public Health Agency of Canada. This includes helping create the study, identifying the purpose and objectives, creating data collection tools and completing ethics applications.

d) Quality and Transparency.

We will be adding a new reporting dashboard to our program planning database. The program planning database already has a feature for staff to update progress on their quarterly indicators. However, this new dashboard will display how teams are performing on their program indicators. We will monitor outputs, outcomes and process-level indicators so that we can improve efficiencies and effectiveness of our programs.

The Foundational Standards Team will work with the Infectious Diseases Team to standardize data entry practices so that information entered into provincial reporting systems is more consistent and data can be exported and used to monitor and report on internally facing performance indicators.

The Foundational Standards Team elicits responses from all teams that participate in our program planning initiative. These responses are assessed and then used to modify the initiative so that staff can complete their program plans more efficiently and effectively. For example, in 2024 we will add a function to our program planning database that will notify managers when staff complete their quarterly reviews. This function will save time for staff because an email notification will automatically be sent from the program planning database when they click a button to confirm their updates are complete. In the past, staff had to manually send emails to their managers when they completed their updates.

The Board of Health ensures all inspection information is disclosed publicly.

Emergency Management

A. Description

Please describe how the board of health plans to implement this Standard related to emergency management. The following details should be included in the description:

a) The emergency management planning activities you will conduct, including how you will engage key stakeholders in the development and implementation of these activities.

The situational assessment of SWPH's emergency management program utilized the Public Health Emergency Preparedness Framework and Indicators Workbook (PHO, 2020). Following the assessment findings, three key policies (Emergency Preparedness, Emergency Response, and Continuity of Operations) will be formulated and implemented. These policies aim to outline employee and team roles and responsibilities, articulate SWPH's emergency management approach, and delineate crucial procedures within the program. Additionally, the all-hazards Emergency Response Plan and Continuity of Operations Plan will be updated, incorporating insights from the COVID-19 pandemic response and pertinent recommendations from our 2022 COVID-19 After-Action Review.

Input from the internal Emergency Preparedness and Response Committee will be sought to ensure alignment with program and service needs and available resources. The Manager of Emergency Response Planning will actively seek feedback from municipal and health system partners regarding the harmonization of these documents with their own emergency plans and potential involvement in SWPH plans. Collaboration extends to engagement with emergency management personnel in local public health units through the Ontario Public Health Emergency Managers Network and the broader emergency management community via membership in the Ontario Association of Emergency Managers. These avenues provide opportunities for advice and feedback on emergency plans through professional development and networking activities.

In the upcoming year, the Emergency Preparedness and Response Committee will determine the hazard-specific plans to be developed in 2024-25 based on the Hazard Identification and Risk Assessment conducted in 2022. Additionally, a training plan for SWPH staff will be devised and executed in late 2024/early 2025.

b) The processes you plan to put in place (and/or update) for recovering health services identified as time critical.

The challenges encountered in developing and implementing a continuity of operations plan (COOP) amid the dynamic circumstances of the COVID-19 pandemic have highlighted the inadequacy of a static COOP in addressing evolving threats and interventions. Specifically, the initial COOP did not sufficiently meet organizational and community needs throughout the prolonged emergency phases, transitioning from spread prevention to containment and immunization. Consequently, SWPH is reassessing its approach to continuity planning, intending to formulate a new COOP by the end of 2024.

The forthcoming plan will involve the Senior Leadership Team in identifying time-critical health services and administrative processes essential for swift recovery and maintenance during any emergency situation. Strategies addressing continuity threats, such as insufficient human resources, restricted access to critical information or vital records, technological/equipment loss, and inadequate safe space, will be outlined for each time-critical service and process, documented in the official COOP. The Emergency Preparedness and Response Committee will contribute to establishing guiding principles. These principles will guide the Emergency Control Group and/or Incident Commanders in decision-making regarding the continuity and recovery of other programs, services, and administrative processes during emergency responses.

An evaluation of this refined continuity planning process is slated for 2025, likely to be conducted through an emergency exercise.

c) The communication modes that will be used to disseminate information during responses (i.e., 24/7 processes).

Rave Alert serves as the platform for disseminating emergency response information to employees, volunteers, Board of Health members, and partner agencies, including municipalities. This tool facilitates simultaneous communication through both phone and email channels as necessary. In the context of emergency responses, our primary communication channels with the public are the website, social media platforms, and media releases.

During non-traditional office hours, on-call public health inspectors and managers can utilize Rave Alert to send messages and update critical sections of the website, such as outbreak status reports. In the event of an emergency outside regular office hours, Rave Alert will play a crucial role in activating the Emergency Control Group. This activation allows for additional communication with the public through various channels like social media and media releases.

d) How you will communicate hazard information to your staff and your community.

Information regarding hazards is primarily communicated to the public through the SWPH website, SWPH social media channels, and media releases. Additional communication channels are selected based on the specific hazard and the populations most vulnerable, which may involve person-to-person conversations between SWPH staff and clients, placement of posters in public spaces, or distribution of an e-newsletter to health system partners.

For instance, in the case of identifying a Hepatitis A case in a food service worker at a highway rest stop, we reached out to trucking and transport agencies, as well as publications targeting truck drivers, to disseminate information about the potential exposure risk and provide guidance on seeking testing and treatment if symptoms developed.

Internally, communication of hazard-related information to our staff primarily occurs through our intranet, all-staff emails, team meetings, and Rave Alert. As an example, we used an intranet announcement to share details about an anticipated ice storm and outlined the notification process for staff in the event of power outages in our offices.

e) Emergency management learning/practice/training opportunities you plan on delivering in order to build capacity (include the planned audience for these opportunities).

In 2024, operational plans include the execution of a tabletop exercise aimed at evaluating the effectiveness of our newly established IT Disaster Recovery Plan. This exercise will involve the active participation of both the Senior Leadership Team and Leadership Team members, guiding them in utilizing the plan to shape an emergency response to a potential cybersecurity incident. As a proactive measure, all SWPH staff have completed ongoing cybersecurity training, with the goal of minimizing the risk of cybersecurity incidents.

Looking ahead to 2025, the Emergency Preparedness and Response Committee will formulate a training plan to address the specific training needs of employees. Simultaneously, the Manager of Emergency Response Planning will craft a multi-year exercise plan designed to enhance staff proficiency in essential emergency response competencies. This plan will also contribute to refining the content of both all-hazards and hazard-specific emergency response plans.

f) How you plan on incorporating lessons learned from previous or future exercises/events into your program for the upcoming year.

Our analysis of the COVID-19 response has identified a need to enhance awareness of the IMS decision-making model among our entire staff and to improve the skills of those likely to take on IMS roles during emergency situations. To address the first area of improvement, we intend to incorporate information on how IMS will guide SWPH activities into an Emergency Response Policy, which will be implemented soon. This implementation will

B. Objectives

Please describe the objectives and what the board of health expects to achieve through the delivery of this Standard. Only describe those objectives that will not also be reflected in other program plans in this template.

By 2025, increase SWPH's score on the Public Health Emergency Preparedness Framework Indicator self-assessment to 80% of indicators with full or partial coverage in each of the following elements of the Framework: Workforce Capacity; Practice & Experience, By 2025, increase SWPH's score on the Public Health Emergency Preparedness Framework Indicator self-assessment to 80% of indicators with full or partial coverage in each of the following elements of the Framework: Governance and Leadership, by 2025, increase SWPH's score on the Public Health Emergency Preparedness Framework Indicator self-assessment to 80% full or partial coverage of indicators in each of the following domains of the Framework: Surveillance & Monitoring; Resources; Planning Process; Risk Analysis and By 2025, increase SWPH's score on the Public Health Emergency Preparedness Framework Indicator self-assessment to 80% of indicators with full or partial coverage in each of the following elements of the Framework: Collaborative Networks, Community Engagement.

C. Key Partners/Stakeholders

Provide information on the internal (e.g., board of health program areas) and external partners (e.g., health care and other providers) the board of health will collaborate with to carry out programs/services under this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanism for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), planned frequency of engagement, and any collaboration in the development and implementation of emergency management planning activities.

SWPH's Emergency Preparedness and Response Committee encompasses various staff members including the Executive Leadership Team (CEO & MOH), Senior Leadership Team, Environmental Health, Infectious Diseases Prevention and Control, Facilities (Office Manager), IT, and Communications. The Committee convenes quarterly with the overarching goal of providing leadership and formulating strategies to support Southwestern Public Health in all facets of emergency management. This includes planning, preparedness, response, and recovery from both internal and external public health emergencies.

The Committee not only solicits input and feedback during the development of emergency management program policies and activities but also engages program and administrative teams affected by these initiatives during the developmental phase. Our future plan involves transitioning the responsibility for creating hazard-specific emergency response plans to the respective program or administrative teams with content expertise relevant to that hazard (e.g., the Office Manager would be responsible for the Fire Safety Plans and the Environmental Health team would be responsible for an Extreme Weather Response Plan); the Manager, Emergency Response Planning and the Emergency Preparedness and Response Committee would support these teams by providing templates, content standards, resources, and feedback on draft plans.

The Manager of Emergency Response Planning actively engages in networking and information sharing opportunities with the Community Emergency Management Coordinators (CEMCs) representing each local municipality served by SWPH. Additionally, the manager participates in local municipal Emergency Management Program Committees, convening as required for program activities, with email being the primary mode of communication with these partners. Currently, we are exploring the feasibility of organizing one or two in-person meetings involving all regional CEMCs.

To gather input and insights, our municipal partners, along with relevant health system partners such as primary care providers and hospitals, will be invited to provide feedback on pertinent sections of our all-hazards Emergency Response Plan. This collaborative effort extends to sections of the Continuity of Operations Plan (COOP) that may involve them, for instance, by offering space or services to aid in the recovery of time-critical services. Anticipating a collaborative emergency exercise with municipal and health system partners in 2024 or 2025, we aim to strengthen our joint preparedness efforts.

Health system partners receive a monthly e-newsletter from the Medical Officer of Health, with the inclusion of relevant and timely emergency management content as needed.

Chronic Disease Prevention and Well-Being

A. Community Needs and Priorities

Please identify which topics of consideration listed in requirement 2 of the Chronic Disease Prevention and Well-Being Standard **are being prioritized** by your board of health over the reporting period. Please briefly describe your rationale (i.e., key data and information including but not limited to, local conditions, comparison with provincial rates, acute elevations) to demonstrate why these topics are being prioritized.

The topics from requirement 2 of the Chronic Disease Prevention and Well-being standard that are being prioritized for this reporting period include: oral health, healthy eating behaviours, built environment, mental health promotion, physical activity and substance use (captured in SUIP tab).
Here is some additional information and data that has led to the Board of Health's decisions to prioritize these areas:
-Healthy eating and food systems are a priority for our region because the frequency of fruit and vegetable consumption is low; slightly over one-quarter of the population (aged 12 years and older) reported that they consumed fruits and vegetables five or more times a day (25.9%) (CCHS, 2016). Additionally, in 2021-2022, 19.2% of households in the Southwestern Public Health (SWPH) region were food insecure. We also understand that Individuals who are food insecure may also need help managing their chronic health conditions. They are more likely to experience adverse disease outcomes, be hospitalized, and have a shorter life expectancy. This significantly burdens our healthcare system and results in increased healthcare costs.
-The built environment has been prioritized because of the potential to impact behaviour change across many health topics and demographics. Topics being addressed through the built environment portfolio include: food systems, transportation and physical activity, climate change, and social connectedness. A well-designed built environment can give opportunity to all to participate in their community and achieve health.
-According to Statscan 2019/2022, 12.2% of the SWPH population aged 12+ reported having fair or poor mental health (while Ontario had 9.8%). Additionally, in 2022, Southwestern Public Health released a report on the indirect health impacts of Covid 19. The report highlighted a decline in mental health in our local community. It should also be noted that mental health is connected to many other topics of consideration for our region, such as substance use.
-Physical activity data for our region shows that our rates are similar to the province. Physical activity has been prioritized this year, however, because it has been identified as a protective factor for substance use prevention in youth and mental health.
-Substance use has been prioritized because of the connection between substance use and chronic diseases such as cardiovascular disease and cancer. What's more, most of our local substance-related indicators are significantly worse than the Ontario average. This work will be outlined in the SUIP section of this ASP.

Please briefly describe how the topics for consideration listed in requirement 2 of the Chronic Disease Prevention and Well-Being Standard **that are not addressed** in the Annual Service Plan were assessed or considered.

The topics for consideration listed in requirement 2 of the Chronic Disease Prevention and Well-being Standard that are not being addressed here are healthy sexuality, sleep and UV exposure. If it is determined that there is a local need through surveillance and review of local data, situational assessments will be conducted to inform evidence-informed decision making. It should also be noted that these topics were assessed and considered for School Health and not deemed to be priority areas.

B. Key Partners/Stakeholders

Please provide a high level summary of the specific key internal and external partners (e.g., community organizations, people with living/lived experience, research institutions) you will collaborate with to deliver on this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanism for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include: the Foundational Standards Team, the Dental Team, the IPAC Hub, the Environmental Health Team, Corporate Services and Human Resources Team

External partners include: School boards, Ontario Dietitians in Public Health, Neighbouring Health Units, Ontario Student Nutrition Program - Southwest Region, Eating Disorders Ontario - Prevention (EDO-P), Community Registered Dietitians, School Mental Health Ontario, Long-Term Care Homes, Retirement Homes, Primary Care Providers, Local Hospitals, Dental Laboratories, Dental Providers, Transportation Providers (VON, Can companies), Elgin St. Thomas Age-Friendly Committee, Ontario Falls Prevention Collaborative, Ontario Age-Friendly Outreach Program, Oxford Social Planning Council, Ontario Dietitians in Public Health Food Systems Working Group, West Elgin Community Health Centre, CMHA Thames-Valley, Wellkin, Local Integration Partnership, Southwest Mental Health Working Group, Mental Health in Public Health CoP Steering Committee, PHU Internal Mental Health Subgroup, Mental Health Promotion in Public Health Community of Practice, the Chambers of Commerce and Business Improvement Associations, Downtown Development Board (St. Thomas) and the Ministry of Labour, and the Ontario Public Health Association Health Equity- Mental Health and substance use working group.

Working with the Elgin St Thomas age-friendly committee and hoping to bring in an academic partner from a local university. This will likely be at least quarterly meetings. We will support work with the Ontario Falls Prevention Collaborative to stay up to date with provincial policy advocacy and the availability of up-to-date resources through Zoom meetings a few times a year. Working with the Ontario Public Health Association Built environment health supportive tools workgroup quarterly to align municipal policy work across health units. Connected to the Ontario Age-Friendly Outreach Program for support with our strategy as often as needed. We are hoping to connect to the Oxford Safe and Well Plan or the Social Planning Council, where options for an Oxford strategy or prioritizing older adults could happen. We are also planning to increase collaboration with agencies such as VON and the Oxford community paramedicine program run by Oxford Paramedics.

Work is done in collaboration with the Ontario Dietitians in Public Health Food Systems Workgroup (ODPH FSWG), which is comprised of Registered Dietitians working in public health units across Ontario. The group meets monthly to collaborate on various topics about food systems, including indicators, climate change, food security, and evidence reviews. The SWPH RD is a co-chair of the Evidence Review subgroup, which was started in February 2023. Members of this group meet at least once a week. This subgroup has received support from librarians and NCCMT to carry out this research and critically appraise the literature. Members of the subgroup are responsible for developing research questions as well as inclusion and exclusion criteria, reviewing the literature, critically appraising the articles based on types of study designs, pulling results, and developing recommendations. Evidence from these reviews will be used to develop policy recommendations for various domains within food systems. An informal partnership has been developed with staff from the West Elgin Community Health Centre to begin planning a local food systems network. Members of this partnership may include Central CHC, Oxford CHC, Ontario Federation of Agriculture, Elgin Federation of Agriculture, Oxford Federation of Agriculture, OMAFRA, previous members of the 'Food For All' committee, municipal staff, and organizations that provide programs that support community food security (e.g. gardens, cooking programs, community meals), and interested community members. A Terms of Reference and membership list will be developed. This network would be responsible for establishing a shared vision through a Food Charter, seeking endorsement for this work, conducting a community food assessment, and developing a food system strategy with policy- and community-level solutions. Community-level indicators will be need to developed to measure the success of this work. A partnership with municipal staff and planners will need to be established to advance food access policy efforts in local policy documents such as Official Plans and Master Plans.

For the Nicotine Cessation and Smoke/Vape-Free Housing Policy, we will collaborate with other public health units through the Adult Nicotine Dependence Advisory Committee, the Provincial Cessation and Protection workgroups, the Youth Nicotine Dependence Advisory Committee - Vaping Policy workgroup, the Southwest Tobacco Control Area Network - Cessation Subcommittee. These collaborations will be used to inform mass media campaigns, brief contact intervention training, sharing resources and data surveillance. Additionally, we will be collaborating with individual Public Health units to investigate the feasibility of expanding the Pharmacy Cessation Program under the Public Health Agency of Canada grant. (Possibly Middlesex-London and Grey-Bruce). We will also collaborate with community organizations such as the East Elgin Family Health Team, West Elgin Family Health Team, Central Community Health Centre, Ingersoll Nurse Practitioner-Led Clinic, Oxford Community Health Centre, Ontario Works caseworkers in Oxford and Elgin, Canadian Mental Health Association, the Public Health Agency of Canada, and all

P 1) Menu Labelling

Program Description:

a) Describe the program including:

a1) The target population(s) to be served by the program.

Menu labelling supports the community's right to know about nutrition information when eating out or ordering take-out. Menu labelling also helps people to make healthier food choices when eating out or when ordering take-out, be more aware of foods and drinks sold in different types of food service premises.

a2) Identify the specific requirements under the Chronic Disease Prevention and Well-Being Standard that the program will address.

All regulated food service premises to which the Healthy Menu Choices Act (HMCA) applies are subject to an inspection by Minister of Health (Minister)-appointed inspectors ("inspector(s)") under the HMCA. Boards of health shall enforce the HMCA at all regulated food service premises, including, but not limited to: grocery stores, movie theatres, restaurants,cafeterias, quick service restaurants, and convenience stores with 20 or more locations in Ontario.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Chronic Disease Prevention and Well-Being Standard the program intends to address.
1) Built environment, 2) Healthy eating behaviours, 3) Healthy sexuality, 4) Mental health promotion, 5) Oral health, 6) Physical activity and sedentary behaviour, 7) Sleep, 8) Substance use, 9) UV exposure, 10) Not applicable, 11) Other (Please explain)

2) Healthy eating behaviours

a4) Describe key activities or approaches that the program will utilize.

Inspection of food premises by designated inspectors, in which the HMCA applies. Inspection and enforcment activity will follow what is outlined in the Protocol. Communication with the Ministry of Health's HMCA leadership team is also taking place regarding the delivery of the program. The education of owners and operators is a priority.

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

N/A

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

N/A

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g., resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

N/A

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Substance Use and Injury Prevention, School Health, Healthy Growth and Development), please identify those program standards or indicate N/A.

N/A

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the chronic disease prevention and well-being program over the reporting period.

Inspection completion is monitored in HedgeHog database, SWPH inspection and complaint/investigation software application.

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Expectation is for all inspections required under the HMCA to be completed within the required timeframe as indicated in the Menu Labelling Protocol. Have inspectors conduct an inspection for each new regulated food service premises within one year of opening. If the inspection reveals compliance concerns with the HMCA, additional compliance re-inspections must be undertaken until such time as the inspector is satisfied that the premises is in full

Intervention Descriptions:
Briefly describe the following public health intervention(s).

P 2) Non-Mandatory Oral Health Programs

Program Description:
a) Describe the program including:
a1) The target population(s) to be served by the program.

N/A

a2) Identify the specific requirements under the Chronic Disease Prevention and Well-Being Standard that the program will address.

N/A

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Chronic Disease Prevention and Well-Being Standard the program intends to address.
1) Built environment, 2) Healthy eating behaviours, 3) Healthy sexuality, 4) Mental health promotion, 5) Oral health, 6) Physical activity and sedentary behaviour, 7) Sleep, 8) Substance use, 9) UV exposure, 10) Not applicable, 11) Other (Please explain)

N/A

a4) Describe key activities or approaches that the program will utilize.

N/A

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

N/A

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

N/A

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g., resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

N/A

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Substance Use and Injury Prevention, School Health, Healthy Growth and Development), please identify those program standards or indicate N/A.

N/A

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the chronic disease prevention and well-being program over the reporting period.

N/A

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

N/A

Intervention Descriptions:
Briefly describe the following public health intervention(s).

P 3) Ontario Seniors Dental Care Program

Program Description:
a) Describe the program including:
a1) The target population(s) to be served by the program.

The target population of interest includes individuals aged 65 or over with income disparity (as defined by reported income level) approved for the OSDCP program as per the Ministry of Health's eligibility requirements.

a2) Identify the specific requirements under the Chronic Disease Prevention and Well-Being Standard that the program will address.

The requirement under the Chronic Disease Prevention and Well -Being Standard this program addresses is: 5. The board of health shall provide the Ontario Seniors Dental Care Program in accordance with the Oral Health Protocol, 2018 (or as current).

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Chronic Disease Prevention and Well-Being Standard the program intends to address.
1) Built environment, 2) Healthy eating behaviours, 3) Healthy sexuality, 4) Mental health promotion, 5) Oral health, 6) Physical activity and sedentary behaviour, 7) Sleep, 8) Substance use, 9) UV exposure, 10) Not applicable, 11) Other (Please explain)

5) Oral health

a4) Describe key activities or approaches that the program will utilize.

Activities in this program includes: Clinical services for seniors; Mobile dental services for OSDCP seniors 65+; OSDCP Health system partners education; Promoting mobile dental services; and seniors oral health situational assessment.

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

The number of emergency department (ED) visits among residents over the age of 64 in the region increased sharply following 2018, reaching a total of 168 ED visits in 2019.
Despite the COVID-19 pandemic emerging in 2020, this number has remained relatively unchanged staying at approximately 160 ED visits over 2020 and 2021.

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

The priority populations include low-income seniors (65+) who have never had dental care and seniors with mobility, health or cognitive issues, such as those in LTCH's and retirement homes. Program promotion of OSDCP mobile services in communties outside of our fixed dental clinics. We are hoping to target low-income seniors with transportation barriers.

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g., resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

N/A

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Substance Use and Injury Prevention, School Health, Healthy Growth and Development), please identify those program standards or indicate N/A.

N/A

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the chronic disease prevention and well-being program over the reporting period.

10% more seniors aged 65 or over, with income disparity, will have knowledge about or be enrolled in the Ontario Senior's Dental Care Program.
90% of community based partners including physicians, nurse practitioners and pharmacists know about our mobile clinical dental services and provide information to those who qualify in our region, to encourage additional communities to accept our services.

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce emergency department visits for non-traumatic oral health conditions in seniors by 5% by 2030.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Ontario Senior's Dental Care Program (OSDCP)

The OSDCP aims to enhance access to quality dental care for eligible seniors, ensuring they receive the necessary treatment to prevent emergency hospital visits, mitigate chronic diseases, and enhance overall well-being. Our interventions include clinical services, education and health promotion, as well as oral health navigation, all designed to optimize the quality of life for seniors residing in Oxford and Elgin.

i 2) Oral Health Mobile Services

SWPH will provide treatment to eligible individuals under the Ontario Seniors Dental Care Program (OSDCP) through Oral Health Mobile services. Those facing challenges in accessing services at health unit clinics, such as mobility issues, travel constraints, or financial barriers, can have their needs addressed through our mobile services.

P 4) Tanning Beds

Program Description:
a) Describe the program including:
a1) The target population(s) to be served by the program.

Tanning bed facility operators

a2) Identify the specific requirements under the Chronic Disease Prevention and Well-Being Standard that the program will address.

The requirement this program addresses under the Chronic Disease Prevention and Well-being Standard is: 4. The board of health shall enforce the Skin Cancer Prevention Act (Tanning Beds), 2013 in accordance with the Tanning Beds Protocol, 2018 (or as current).

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Chronic Disease Prevention and Well-Being Standard the program intends to address.
1) Built environment, 2) Healthy eating behaviours, 3) Healthy sexuality, 4) Mental health promotion, 5) Oral health, 6) Physical activity and sedentary behaviour, 7) Sleep, 8) Substance use, 9) UV exposure, 10) Not applicable, 11) Other (Please explain)

N/A

a4) Describe key activities or approaches that the program will utilize.

The activities that this program will utilize include: promptly respond to complaints to non-compliance under the Skin Cancer Prevention Act, conduct inpections on a complaint basis, take action on non-compliance with the act, ensure that operators know where to access signage and make signage available, and collect and miantain inventory of tanning bed facilities.

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

N/A

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

N/A

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g., resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

N/A

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Substance Use and Injury Prevention, School Health, Healthy Growth and Development), please identify those program standards or indicate N/A.

N/A

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the chronic disease prevention and well-being program over the reporting period.

100% of complaints of non-compliance responsed to

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

To achieve 100% compliance among tanning bed operators with the Skin Cander Prevention Act by December 2024.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

P 5) Healthy Eating Behaviours

Program Description:
a) Describe the program including:
a1) The target population(s) to be served by the program.

The target population of interest includes children and youth aged 0-19 years old and individuals aged 12 and above.

a2) Identify the specific requirements under the Chronic Disease Prevention and Well-Being Standard that the program will address.

1. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to chronic diseases and report and disseminate the data and information in accordance with the Population Health Assessment and Surveillance Protocol, 2018 (or as current).
2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses chronic disease risk and protective factors to reduce the burden of illness from chronic diseases in the health unit population.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Chronic Disease Prevention and Well-Being Standard the program intends to address.
1) Built environment, 2) Healthy eating behaviours, 3) Healthy sexuality, 4) Mental health promotion, 5) Oral health, 6) Physical activity and sedentary behaviour, 7) Sleep, 8) Substance use, 9) UV exposure, 10) Not applicable, 11) Other (Please explain)

2) Healthy eating behaviours

a4) Describe key activities or approaches that the program will utilize.

Fostering Positive Relationships with Food in Children: food- and weight-related advocacy in schools and childcare centres; food-neutral approach promotion; let's get cookin' food literacy programming; tower garden training and support in schools and childcare centres; disordered eating and eating disorder prevention in schools; OPHEA Healthy School certification support; food, nutrition and eating support for child care centres; food and eating support for healthy growth and development team; addressing weight bias and situational assessment for children 0-6 years.

Sustainable Food Systems: physical food access policies; food system strategy; plant-based diet policies and practices; and sustainable food system rapid reviews.

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

Fostering Positive Relationships with Food in Children

Relationships with food start developing at a young age. Children spend a large portion of the day in school learning, and how educators talk about food, eating, and bodies can profoundly impact children's lifelong relationships with food (1). Well-intended messages about "healthy eating" can inadvertently cause harm, leading to preoccupation and fear of food (2, 3). How health, food, and nutrition-related messages and practices are communicated and taught in schools can cause harm by perpetuating weight bias and body dissatisfaction, triggering disordered eating behaviours and adversely impacting diet quality (1). In 2019, the frequency of children and youth changing eating habits to manage weight over the last 12 months was significantly greater in females (42.34) aged 12-17 years old living in the SWPH catchment are compared to males (16.40) aged 12-17 years old living in the same area (4). There was no statistical difference in the frequency of changing eating habits to manage weight over the last 12 months between overall youth aged 12-17 years old living in the SWPH catchment (28.70) area compared to overall youth aged 12-17 years old living in Ontario (29.83) (4)

Sustainable Food Systems

Diet-related chronic diseases, such as cardiovascular disease, cancer, and diabetes, are among the leading causes of death in the SWPH region and are associated with a reduced quality of life (1). They are largely preventable through modifiable risk factors, including a diet rich in fruits and vegetables. However, in 2020, the age-standardized rate of self-reported consumption of vegetables and fruits five or more times per day was only 17.9%* (CI 12.0-23.7) among both sexes in the SWPH region (2). This was not statistically different than Ontario's rate (21.3.7%, CI 20.0-22.7). There was no significant difference between reported age groups in the SWPH region: 20-44 y.o., 21.4%, CI 10.3-32.5 (3)*, and 65y.o.+, 22.2%, CI 13.2-31.2 (4)*. There was also no significant difference between the SWPH region and Ontario for these age groups. There was no significant difference between males (15.4%, CI 7.2-23.6) (5)* and females (19.9%, CI 11.9-27.8) (6)* in the SWPH region, or when comparing to Ontario rates (males 17.4, CI 15.7-19.2 (5); females 25%, CI 23.1-26.9 (6)).

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

The priority populations include Schools designated as "priority schools" based on data from the Education Opportunity Index (EOI), which is a priority population for services provided by the Healthy Schools Team. EOI scores are calculated annually by the Ministry of Education and determine which schools present a higher need for support. Schools designated as priority schools have an assigned PHN who supports school health programming, and the RD implements and collaborates with PHNs in priority schools on food-related programming, resources, and policies.

Additionally, priority populations include individuals and households with low incomes, are food insecure and live in areas with limited access to a variety of nutrient-dense foods (predominantly rural areas).

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g., resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

The way that we view food and bodies has a significant impact on our self-esteem, body image and mental health. The activities in this intervention address the root causes that drive eating-related problems, and their associated mental health concerns by helping children and youth develop positive relationships with food and their bodies. Activities will be offered in schools and child care facilities for families and caregivers.

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Substance Use and Injury Prevention, School Health, Healthy Growth and Development), please identify those program standards or indicate N/A.

School Health; Healthy Growth and Development

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the chronic disease prevention and well-being program over the reporting period.

80% of educators and volunteers who complete the Let's Get Cookin' e-learning module training feel confident in offering the program at their school (as indicated by a "yes" response to the last question on the e-learning module quiz).
50% of community partners understand the benefit of multisectoral collaborative action to achieve community food security

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Decrease the proportion of females aged 12-17 years old who change their eating habits to manage weight by 5% by 2030.
Increase the age-standardized rate of residents who consume 5 or more fruits/vegetables per day by 2% by 2030.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Fostering Positive Relationships with Food in Children

Supporting educators and childcare staff in creating supportive food environments and adopting food-neutral approaches to food and nutrition education to foster positive relationships with food among children and youth. Provide food literacy opportunities for children and youth to develop skills through growing, cooking, and exploring food at schools and childcare centres.

i 2) Sustainable Food Systems

Sustainable Food Systems (SFS) deliver community food security and nutrition while safeguarding the economic, social, and environmental foundations necessary to maintain food security and nutrition for future generations.

P 6) Physical Activity

Program Description:
a) Describe the program including:
a1) The target population(s) to be served by the program.

The target populations to be served are grade 5 students and the community.

a2) Identify the specific requirements under the Chronic Disease Prevention and Well-Being Standard that the program will address.

2. The Board of Health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses chronic disease risk and protective factors to reduce the burden of illness from chronic diseases in the health unit population.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Chronic Disease Prevention and Well-Being Standard the program intends to address.
1) Built environment, 2) Healthy eating behaviours, 3) Healthy sexuality, 4) Mental health promotion, 5) Oral health, 6) Physical activity and sedentary behaviour, 7) Sleep, 8) Substance use, 9) UV exposure, 10) Not applicable, 11) Other (Please explain)

Substance use

a4) Describe key activities or approaches that the program will utilize.

Key activities include: Implementation of the Act-i-pass program and incorporation of active transportation local policy into municipal engagement strategy.

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

Rates of physical activity across the lifespan in the SWPH are comparable to those in the province. However, physical activity is a protective factor for preventing youth substance use. We also know that physical activity supports positive mental health and helps prevent chronic diseases. For those reasons, SWPH sees this work as important as mental health and substance use, two key priority areas in our region.
Grade 5 students are the target of the act-i-pass program because research shows that physical activity begins to decrease in children as early as age 9.

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

N/A

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g., resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

As described above, it is well known that physical activity can contrinute to positive mental health.

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Substance Use and Injury Prevention, School Health, Healthy Growth and Development), please identify those program standards or indicate N/A.

N/A

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the chronic disease prevention and well-being program over the reporting period.

35% of grade five students in the region are enrolled in Act-i-pass

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

To increase opportunities for recreation for grade 5 students by December 2025.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

P 7) Built Environment

Program Description:
a) Describe the program including:
a1) The target population(s) to be served by the program.

The target populations include residents of Elgin-St. Thomas and Oxford County.

a2) Identify the specific requirements under the Chronic Disease Prevention and Well-Being Standard that the program will address.

The requirement under the Chronic Disease Prevention and Well-Being Standard this program addresses include: 2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses risk and protective factors to reduce the burden of preventable injuries and substance use in the health unit population.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Chronic Disease Prevention and Well-Being Standard the program intends to address.
1) Built environment, 2) Healthy eating behaviours, 3) Healthy sexuality, 4) Mental health promotion, 5) Oral health, 6) Physical activity and sedentary behaviour, 7) Sleep, 8) Substance use, 9) UV exposure, 10) Not applicable, 11) Other (Please explain)

Healthy eating behaviours, mental health promotion, and physical activity.

a4) Describe key activities or approaches that the program will utilize.

The activities this program will utilize include: engaging in municipal knowledge exchange, supporting local advocacy for land use planning interventions connected to public health outcomes, conducting an environmental scan on social connectivity, and developing a municipal planning strategy and tools.

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

This work is connected to several other program areas throughout the LPHA. There are elements of food systems, active transportation and community connectedness, naturel environments, housing, and substance use (primarily density of alcohol outlets as a focus) addressed through this intervention.

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

The interventions in this plan are universal. However, careful consideration for those living in inequitable situations is central to the strategy. In 2023, a report discussed the intersections of climate change and health equity within local municipal official plans. Designing equitable communities through land use planning interventions has been a focal point of this work.

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g., resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

The connection between social connectivity and mental health is an area of focus in this work in 2024.

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Substance Use and Injury Prevention, School Health, Healthy Growth and Development), please identify those program standards or indicate N/A.

Substance Use and Injury Prevention; Health Equity

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the chronic disease prevention and well-being program over the reporting period.

100% of municipal planning departments have increased knowledge of shared priorities for the build environment

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

To increase the percentage of the SWPH population aged 12+ reporting a strong sense of belonging to the local community by 10% by 2026.

To increase by 25% the number of public health suggestions for official plans, master plans and development being incorporated into final documents by 2028.

Intervention Descriptions:

Briefly describe the following public health intervention(s).

P 8) Mental Health Promotion

Program Description:

a) Describe the program including:

a1) The target population(s) to be served by the program.

The target population of interest is children and youth aged 5 - 19 and adults aged 18-34.

a2) Identify the specific requirements under the Chronic Disease Prevention and Well-Being Standard that the program will address.

1. The Board of Health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to chronic diseases and report and disseminate the data and information in accordance with the Population Health Assessment and Surveillance Protocol, 2018 (or as current).
2. The Board of Health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses chronic disease risk and protective factors to reduce the burden of illness from chronic diseases in the health unit population.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Chronic Disease Prevention and Well-Being Standard the program intends to address.
1) Built environment, 2) Healthy eating behaviours, 3) Healthy sexuality, 4) Mental health promotion, 5) Oral health, 6) Physical activity and sedentary behaviour, 7) Sleep, 8) Substance use, 9) UV exposure, 10) Not applicable, 11) Other (Please explain)

4) Mental Health Promotion

a4) Describe key activities or approaches that the program will utilize.

Mental Health Protection and Promotion in Schools: System Navigation Pathway and Referrals; Mental Health Resource Dissemination; Mental Health Engagement Strategy; Safe and Inclusive Belonging Plan with Schools; School Mental Health Ontario and Public Health Unit Strategy; and Mental Health Skill Building.

Mental Health Promotion: Workplace Mental Health Promotion Strategy; Mental Health Action Plan (MHAP); Multi-sectoral Collaboration for Systems Change; Mental Health Literacy Training; Increase Mental Health Awareness; and Supporting Income Interventions for Poverty Reduction.

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

Mental Health Protection and Promotion in Schools:

Children and youth mental well-being has come into the spotlight since the COVID-19 pandemic, with the pandemic being linked to detrimental mental health outcomes for students across Ontario. Students impacted by the pandemic continue to recover from the lack of developmental opportunities during that time, including social isolation, lack of routine, and school disruptions. Although the pandemic played a significant role in the mental health outcomes of students, it is essential to recognize that student mental health was a concern before the pandemic. As such, mental wellness concerns in students will persist despite the end of pandemic measures. 1 in 2 Canadians will experience a mental illness before their 40th birthday (1). Youth aged 15 – 24 are the most likely of any age group to experience mental illness and substance use disorders (3). 39% of Ontario high school students indicate moderate to severe levels of psychological distress, including symptoms of anxiety and depression (4). 14% of high school students have seriously contemplated suicide, and 4% have attempted (7). Suicide is the second leading cause of mortality in child and youth populations, behind accidental death (8). The long-term effects of mental illness are devastating. Mental illness and substance use disorders are the leading cause of disability in Canada (6).In addition, those with mental illness are less likely to be employed (12). We know that individuals who are unable to achieve adequate levels of income suffer from disproportionate adverse health outcomes, which can become generational trends. Despite the recognition of mental health concerns within child and youth populations, access to services is diminished (10). In January 2020, 28,000 children and youth were on waiting lists for mental health treatment (10). The average wait time for counselling exceeds 67 days, and for more intensive treatment, it is 92 days or more (10). In 2020, wait times for children and youth were 2.5 years for services(12). Over the course of the pandemic, regional police saw an increase in mental health-related calls, and local rates of emergency department visits for mental health concerns increased with the highest rates in youth between the ages of 13 & and 24 years old (13). This indicates that within our region, the absence of adequate acute mental health care for children and youth is resulting in increased reliance on tertiary care centres. 1/3 of emergency department visits were for mental health illnesses by people who have never been assessed and treated for these issues before by a physician. Of note, females aged 10- 24 saw overall increases in self-harm, with 10% increases in emergency department visits and 12% increases in hospitalizations (13). Access to care has become increasingly complex, with 42% of students indicating that they have unmet mental health needs and were unsure where to obtain help (14). Parents have noted increased behavioural difficulties, hyperactivity, and conduct problems in young children (15). At the same time, adolescents were more likely to suffer from anxiety, depression and suicidal ideation, with 47% indicating moderate to severe levels of psychological distress (14). Students facing psychological distress do not necessarily qualify for mental health services if they are not diagnosed with a mental health illness (CITE). This indicates a need for preventative and protective mental health programming focused on reducing the negative impact of adverse childhood experiences. School mental health programming would work to reduce the instances of psychological distress becoming psychological diagnosis and to reduce strain on local mental health services, police services and emergency departments. Additional local school-level data will be available before 2024, and plans will shift to meet the identified local needs.

Mental Health Promotion:

Population mental health has steadily declined in Southwestern Public Health communities. Data for mental health indicators collected by Statistics Canada was collated as the starting point for a population mental health situational assessment. The data was collected for the Southwestern Public Health Unit in 2019/2020, but data from 2015/2016 to 2017/2018 reflected the two separate health units, Elgin St. Thomas and Oxford, before the merger. The following are the mental health indicators which were analyzed. The population of focus was 12 years + (both sexes.): Perceived mental health as very good or excellent; Perceived mental health fair or poor; Perceived life stress, most days quite a bit or extremely stressful; Mood disorders; Sense of belonging to the local community, somewhat strong or very strong; Life satisfaction satisfied or very satisfied. For the indicator of perceived mental health, there was a decline in the population who reported very good or excellent mental health between 2015/2016 and 2017/2018. 73.6% and 72.7% perceived their mental health as very good or excellent in Elgin St. Thomas and Oxford, respectively, in 2015/2016, while 67.3% and 65.1% of the population perceived their mental health as very good or excellent in 2017/2018. This was similar to the trend seen in Ontario, which decreased slightly from 71.1% in

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

The priority populations consist of the students, and the families of school-aged children and youth, who attend our priority schools. These schools are identified using the Educational Opportunities Index which measures social determinants of health such as income, and single-parent households. We also service the school communities of universal schools (schools not indicated as high needs through the Equal Opportunities Index) but at a reduced capacity.

Additionally, priority populations young adults (18-24), older adults, individuals living with homelessness, ethnic minorities, and survivors of suicide, low-income individuals, LGBTQ2S+ communities, Indigenous Peoples, Peoples with disabilities, including those with chronic health conditions.

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g., resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

Schools: SWPH provides mental health promotion in priority schools (as identified through EOI data and in consultation with local school boards) with a focus on belonging, and identity affirmation. Mental health promotion work is achieved through five overlapping strategies: systems navigation and pathway referrals, mental health resource dissemination, family engagement, program delivery within targeted schools, collaborative projects with local school

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Substance Use and Injury Prevention, School Health, Healthy Growth and Development), please identify those program standards or indicate N/A.

Healthy Equity, School Health

Program Indicators:

List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the chronic disease prevention and well-being program over the reporting period.

100% of publicly funded priority schools are aware of the benefit of completing OPHEA Healthy School Certification, with a focus on mental health
100% of Healthy School Team staff will have an improved understanding of how School Mental Health Ontario operates to impact school mental health
50% of identified local employers are knowledgeable of policies supportive of positive mental health
75% of SWPH staff have a greater understanding of various aspects of mental health.

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

35% of students attending publicly funded school boards report "good" or "excellent" mental health by 2030 as measured by school climate surveys
Maintain the percentage of adults ages 18-34 who report excellent or very good Mental Health by 2030

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) Mental Health Protection and Promotion in Schools

This intervention focuses on improving mental health within school populations by taking both a top-down and bottom-up approach. It addresses the immediate needs of individuals within our school communities and the system in which our school communities exist. As in previous plans, it focuses on a sense of belonging and connection by creating and maintaining healthy school environments.

i 2) Mental Health Promotion

This intervention focuses on improving mental health across the life course, applying a comprehensive population mental health promotion approach, primarily on the "promote mental health" tier. It includes utilizing a range of strategies to foster supportive environments to focus on the enhancement of well-being rather than on illness and broadening the focus to include protective factors.

Food Safety

A. Community Needs and Priorities

Please provide a short summary of the following:

a) The key data and information which demonstrates your communities' needs for public health interventions to address food safety.

The 2022 provincial rate of Campylobacter enteritidis is 14.2 per 100,000 population. The 2022 SWPH rate of Campylobacter enteritidis is 28.0 per 100,000 population. The 2022 provincial rate of Salmonellosis is 11.7 per 100,000 population. The 2022 SWPH rate of Salmonellosis is 10.9 per 100,000 population.

b) Your board of health's determination of the local priorities for a program of public health interventions that addresses food safety.

The 2022 SWPH rate of Campylobacter enteritidis is almost twice as high as the 2022 provincial rate. The 2024 food safety program at SWPH aims to prevent the occurance of Campylobacter enteritids through completion of inspections of regulated food premises, food safety training classes, and social media campaigns throughout the year. Food premises wlil undergo risk ratings and all high, moderate and low risk

c) Your boards of health's approach to disclosure of inspection results (onsite posting and website posting) and evaluation of the program.

SWPH fullfills all of the requirements for onsite and online disclosure of inspection results by following the Ontario Public Health Standards. The Health Inspect program at SWPH has onsite signage at facilities. These signs provide a QR code linked to inspection results that can be accessed at point of service. Additionally, the Health Inpect website has facilities in list form or map form with linked to inspection results the

B. Key Partners/Stakeholders

Please provide a high level summary of the specific key internal and external partners you will collaborate with to deliver on this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanism for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include the Foundational Standards Team, Infectious Diseases Team, and the Healthy Schools Team. The Foundational Standards Team supports the development of our program planning to ensure that our program delivery is data focused with a local lens. This includes the development of a situation assessment and forcefield anaylsis. The mechanism for engagement includes working with a Program Planner from the Foundational

External partners include municipal partners who provide information and resources to businesses. SWPH public health inspectors participate in joint inspections with OMAFRA , the MLITSD and the AGCO. Collaboration occurs in the event of joint inspections as well as participation in Southwest Ontario regional regulatory HUB meetings. SWPH connects with the Ministry of Health and neighbouring health units for interpreation and direction support.

P 1) Food Safety Program

Program Description:

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The target population is the general public, people who handle food at home and/or, visit food safety premises, and the owners and operators of food premises in the SWPH region. In 2024, SWPH will be providing food safey educational information in varying languages based on the 2016-2021 census data. This includes translations of our educational materials and food safety signage provided to premises. SWPH also accommodates extra support required during the food handler training exam. In 2024, SWPH will be completing a situation assessment specfically aimed local needs for the food safety program.

The priority population would be those who are at greater risk of complications due to foodborne illness, which include young children, elderly, pregnant individuals, and those who are immunocompromised. In addition, these populations may have other individuals preparing food for them and thus knowldge of safe food handling practice at home is important.

The specific requirements in the Standards includes:
1. The board of health shall: a) Conduct surveillance of suspected and confirmed food-borne illnesses, food premises, and food for public consumption; b) Conduct epidemiological analysis of surveillance data including monitoring oftrends over time, emerging trends, and priority populations; andc) Respond by adapting programs and services in accordance with the Food Safety Protocol, 2018 (or as current).
2. The board of health shall ensure food handlers in food premises have access to training in safe food-handling practices and principles in accordance with the Food Safety Protocol, 2018 (or as current) and the Operational Approaches forFood Safety Guideline, 2018 (or as current).

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce the incidence rate of of food borne illlness, including Campylobacter enteritis, below the provincial rate by 2027.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Food Safety

Follow the inspection requirements as per the OPHS protocol. Provide Food Handler Certification course. Provide food safety education to members of the public.

Healthy Environments

A. Community Needs and Priorities

Please provide a short summary of the following:

a) The key data and information which demonstrates your communities' needs for public health interventions to address healthy environments.

Health Hazards Program

In 2019, SWPH conducted a small radon study (100 test kits) to measure radon levels in private homes in the community and learn about resident knowledge and attitudes surrounding radon risk in SWPH. Twenty-five percent of kits returned were a moderate risk of radon exposure at an average radon concentration of 100-200 becquerels per metre square in the home. Knowledge of radon is high in our community; however, most respondents reported some level of concern about radon in their homes. In 2022, public health inspectors investigated: 20 bed bug complaints, 20 garbage/refuse complaints, 7 excrement complaints, 41 mould complaints, 46 pest/vermin complaints, 1 radon complaint, 15 sewage complaints, and 34 'other' complaints (including indoor air, outdoor air, building structure, and rental complaints).

Healthy Environments and Climate Change

The annual average minimum temperatures for Oxford County and Elgin County-St. Thomas was recorded at 3.2degC and 3.9degC respectively. For both regions, projections show a significant increase in minimum seasonal temperatures. It is anticipated that minimum temperatures in these regions will rise by roughly 5.0degC to 5.5degC during different seasons by the 2080s. Furthermore, it is anticipated that by the 2080s, both Oxford and Elgin County will experience a minimum of 19.6degC to more than 20degC in the summer season under the SSP5-8.5 emissions scenario. In this report, the tropical night refers to the number of days where the lowest temperature during nighttime remains above 20degC. Inadequate nighttime cooling can intensify the stress of hot summer days and heatwaves. The presence of tropical nights can add to the challenge of allowing the body to effectively cool down. This is a serious health risk, especially to vulnerable populations such as the elderly, homeless individuals, and those residing in residences lacking air conditioning. Their risks increase particularly if these heat events persist for more than a few days. By the 2080s under SSP5-8.5, it is anticipated that minimum temperatures during the winter months will approach 0degC. This change may lead to a rise in the frequency of freeze-thaw cycles, potentially resulting in overland flooding caused by the melting of snow and the formation of ice jams in waterways.

b) Your board of health's determination of the local priorities for a program of public health interventions that addresses healthy environments with consideration of the required list of topics identified in the Standards.

Inspection of premises in health hazard program, recreational camps, migrant farm living accomodations and response to all health hazard complaints and requstions for information are local priorities for SWPH as public health interventsion in the OPHS. Providing health education for health hazard issues, including adverse air quality events, is also prioritized.

c) Your boards of health's approach to disclosure of inspection results of recreational camps (onsite posting and website posting) and evaluation of the program.

SWPH fullfills all of the requirements for onsite and online disclosure of inspection results by following the Ontario Public Health Standards. The Health Inspect program at SWPH has onsite signage at facilities. These signs provide a QR code linked to inspection results that can be accessed at point of service. Additionally, the Health Inpect website has facilities in list form or map form with linked to inspection results the

B. Key Partners/Stakeholders

Please provide a high level summary of the specific key internal and external partners you will collaborate with to deliver on this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanism for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include: the Foundational Standards Team, The Chronic Disease & Injury Prevention Team, the infectious Diseases Team, the Corporate Services & Human Resources Team, the Sexual Health Team.

External partners include: municipal partners including by-law and building agencies, Health Canada (radon, indoor air quality), The Ministry of Environment (outdoor air quality), Take Action on Radon, local fire departments, Service Canada, FARMS, Oxford Coalition for Social Justice, Reforest Oxford, IISAN Ingersoll Indigenous Solidarity Awareness Network, Leader of the Environmental Sustainability Plan, Grand River Conservation Authority, City of Woodstock - Parks and Rec, United Way of Oxford, Tillsonburg Chamber of Commerce, YMCA, Southwest Ontario Aboriginal Access Centre (SOAHAC), Harvest Bowl Program, Social Services, Central Elgin, Doug Tarry Homes, YWCA, St. Thomas Public Library, St. Thomas and District Chamber of Commerce

P 1) Health Hazards Program

Program Description:

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

Populations of interest include: low-income residents of SWPH (at risk of higher incidence of health hazards where they live and work); tenants (limited ability to mitigate health hazards where they live); homeowners (radon and indoor air quality); municipal and local stakeholders (city/towns, police, fire: receive referrals from inspectors for health hazard mitigation); owners and operators of recreational camps; children who attend camp; farmers for the conditions of housing units and outbreak management; and workers for their health and safety.

The requirements under the Healthy Environments standards that this program will address include: 1. The board of health shall: a) Conduct surveillance of environmental factors in the community; b) Conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations; and c) Use information obtained to inform healthy environments programs and services in accordance with the Health Hazard Response Protocol, 2018 (or as current); the Healthy Environments and Climate Change Guideline, 2018 (or as current); the Infectious Diseases Protocol, 2018 (or as current); and the Population Health Assessment and Surveillance Protocol, 2018 (or as current); 2. The board of health shall identify risk factors and priority health needs in the built and natural environments; 4. The board of health shall engage in community and multi-sectoral collaboration with municipal and other relevant partners to promote healthy built and natural environments in accordance with the Healthy Environments and Climate Change Guideline, 2018 (or as current); 5. The board of health shall collaborate with community partners to develop effective strategies to reduce exposure to health hazards and promote healthy built and natural environments in accordance with the Health Hazard Response Protocol, 2018 (or as current) and the Healthy Environments and Climate Change Guideline, 2018 (or as current); 6. The board of health shall implement a program of public health interventions to reduce exposure to health hazards and promote healthy built and natural environments; 7. The board of health shall, as part of its strategy to reduce exposure to health hazards and promote healthy natural and built environments, effectively communicate with the public by: a) Adapting and/or supplementing national/provincial health communications strategies where local assessment has identified a need; b) Developing and implementing regional/local communications strategies where local assessment has identified a need; and c) Addressing the following topics based on an assessment of local needs; 8. The board of health shall assess and inspect facilities where there is an elevated risk of illness associated with exposures that are known or suspected to be associated with health hazards in accordance with the Health Hazard Response Protocol, 2018 (or as current); 9. The board of health shall investigate potential health hazards and respond by preventing or reducing exposure to health hazards in accordance with the Health Hazard Response Protocol, 2018 (or as current); 10. The board of health shall ensure 24/7 availability to receive reports of and respond to health hazards in accordance with the Health Hazard Response Protocol, 2018 (or as current);

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce rates of air quality attributed (non-smoking) lung cancers in SWPH by 5% by 2025.
Maintain zero incident of illness associated with recreational camps through 2025.
Maintain zero incidence of waterborne illness from drinking water associated with migrant farm housing into 2025.
Reduce the number of COVID-19 or other novel virus outbreaks in migrant farm housing into 2025.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Health Hazard Response

Conduct surveillance of environmental factors in the community. Collaborate with community partners to develop effective strategies to reduce exposure to health hazards and promote healthy built and natural environments. Investigate potential health hazards and respond by preventing or reducing exposure to health hazards.

i 2) Migrant Farm Housing Inspection Program

Completing routine migrant farm housing inspections, including taking water samples as required, for all known facilities at or above the required inspection frequency. Following up complaints regarding migrant farm worker housing within 24 hours of receiving them, to minimize potential impacts of injury or illness.

i 3) Recreational Camp Inspection Program

Complete annual inspections of recreational camps in the SWPH region.

P 2) Healthy Environments and Climate Change Program

Program Description:

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

Climate Change
Elderly individuals, infants and young children, outdoor workers, physically active people, and those with heart diseases may face an increased vulnerability to extreme temperatures. People with a lack of adequate housing and/or insurance coverage may face increased susceptibility to extreme weather events, leading to increased rates of illnesses and deaths. People who work outdoors or people who are homeless may be at greater risk for exposure to vector-borne diseases. Pregnant women and children are more at risk of food- and water-borne disease outcomes. Minority linguistic communities may encounter limited accessibility to alerts related to outbreaks associated with food and water. Individuals with pre-existing physical health conditions, such as asthma, and heart disease may face increased vulnerability to respiratory outcomes. Infants and children have vulnerable skin and eyes that make them highly susceptible to long-term UVR exposure, people who work outdoors or individuals engaged in physical activities outdoors may experience higher UVR exposure, increasing the risk of adverse health effects. Population features that influence both vulnerability and adaptive capacity, as well as populations of concern from climate change impacts on health include: Gender and sex, Race and ethnicity, Age (including elderly people and children), People with pre-existing conditions (e.g. physical and mental conditions), People who are unemployed or underemployed, People who are lower-levels of formal education, People who are socially isolated, People with low socio-economic status, Occupational groups (e.g. outdoor labourers and first responders), Minority linguistic communities, Rural, urban, and suburban communities, People who are underinsured or uninsured, People who live in high-risk geographic environments (e.g. flood plains, coastal communities), Newcomers to Canada, Indigenous Peoples.

Extreme Heat and Cold Response
There are multiple populations to be served for this intervention. The first is older adults. The population of older adults in Oxford, Elgin, and St. Thomas is estimated to increase to 49,697 by 2025, or 23.1% of the total population. Due to the unique combination of challenges older adults face when adapting to extreme heat, this report recommends for Southwestern Public Health identify older adults as a priority vulnerable population to target for a heat warning education campaign. Additionally, there is an increased number of socially disadvantaged individuals living in Aylmer, Bayham, Malahide, St. Thomas, Tillsonburg, and West Elgin. Consequently, we will allocate additional resources and increase targeted messaging for individuals living in these areas. Immigrants from Mexico living in Elgin County are also a target population and will benefit from customized messaging. Finally, in the SWPH region, a large proportion of individuals work in trades, transport, and equipment operating occupations (19.8%)and manufacturing and utilities (11.7%), and would benefit from targeted messaging in a heat warning education campaign.

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Maintain rates of morbidity from climate-related events to 2040
Maintain the percent of hospitalizations due to heat-related illness by 2030.
Reduce the percent of hospitalizations due to cold-related injury/illness by 5% by 2030.

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) Climate Change

The activities outlined in this plan will serve to increase our community's resilience to climate change through improved collaboration with municipalities and by promoting policies and practices that prioritize climate action and protect health. A SWPH greenhouse gas emissions inventory will be undertaken to identify areas to action to reduce our organization's carbon footprint.

i 2) Extreme Heat and Cold Response

Under the Health Hazard Response Protocol, 2019, public health units are required to prevent and reduce the burden of illness from health hazards in the physical environment, including extreme weather and extreme temperatures. SWPH will receive the heat warnings provided by Environment Canada, issue heat and cold alerts, and communicate appropriate health protection measures.

Healthy Growth and Development

A. Community Needs and Priorities

Please provide a short summary of the following:

a) The key data and information which demonstrates your communities' needs for public health interventions to address healthy growth and development.

Reproductive Health

The average for reported Maternal Mental Health concerns during pregnancy for 25 years is 40.1% in SWPH vs. Ontario's average of 33.9% (PHO Snapshot 2020). The average for Overall Age Maternal Mental Health with reported concerns during pregnancy is 31.8% in SWPH vs. Ontario's average of 21.4% (PHO Snapshot 2020).

Breastfeeding

Intention to breastfeed (offering any breastmilk), measured in pregnancy via BORN, is 1% lower in the SWPH region that in the provincial average. In 2019, Ontario = 94.2%, SWPH = 93.2% Breastfeeding exclusivity and duration rates for SWPH were being measured via the BFI infant surveillance program. Due to demands of Covid and subsequent changes to programming, staffing and priorities, fewer consents to complete the surveys were collected from new mothers in 2020-2022. Findings for these years cannot be considered representative of those mothers who had live births in SWPH region during those years. Surveys between Jan1-Dec 31, 2019: St Thomas site- Consents - 179; Completed 2 mo surveys - 76 (~ 42%); 6 month - 51; 11 month - 54; and 24 month - 16 Wdsk site - Consents - 374; Completed 2 mo surveys - 149 (~ 40%); 6 month - 123; and 12 month - 183 Sites need to have consistent surveys and time points to be representative of SWPH region.

Parenting

The Southwestern Public Health region has seen an increase in "Parents or Parenting Partner with a mental illness", rising from 32% in 2017 to 33.6% as of 2020. (PHO Snapshots).

b) Your board of health's determination of the local priorities for a program of public health interventions that addresses healthy growth and development with consideration of the required list of topics identified in the Standards.

Community status reports and PHO Snapshots provide data to support targeted progamming in collaboration with community partners to reduce inequities and transform systems of care in alignment with the health unit's strategic direction. Priority groups include: 1) pregnant women and mothers under age 25, as they have a higher risk of anxiety and depression and are more likely to have lower breastfeeding rates

c) A description of how other topics for consideration not addressed in the Annual Service Plan were assessed or considered under Healthy Growth and Development.

Requirement 2 is supported through the work reflected under the Oral Health ASP and the Sexual Health ASP. Requirement 3 - School Health is supported through the work reflected in the Healthy Schools ASP. Service planning for the Healthy Babies Healthy Children (HBHC) program that supports the Healthy Growth and Development program is reported to the Ministry of Children, Community and Social Services

B. Key Partners/Stakeholders

Please provide a high level summary of the specific key internal and external partners you will collaborate with to deliver on this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanism for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include: the Foundational Standards Team - help with provision of community status reports, development of indicators, data collections frameworks, evaluation matrixes and reporting templates. Healthy Schools Team - provide resources and support for school readiness. Sexual Health team - provide sexually transmitted infection screening, contraception and health resources. Chronic Disease and Injury Prevention Team - provide smoking

External partners include: St Thomas Elgin General Hospital, Woodstock General Hospital, Physicians, Obstetrician, Midwives, Pre/postnatal nurse practitioner program (PPNP) - East Elgin Family Health Team, SWPH Community partners (EarlyOn Oxford)

P 1) Reproductive Health

Program Description:

a) Describe the program including the population(s) to be served. Please identify the specific requirements under the Standards that the program will address. Include a linkage to identified community needs and priorities.

The population to be served include cient's who are pregnant or contemplating pregnancy and their support persons.

The requirements under the Healthy Growth and Development standards this program will address include: 2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach to support healthy growth and development in the health unit population.

The requirements under the Health Equity standards this program will address include: 2. The board of health shall modify and orient public health interventions to decrease health inequities in accordance with the Health Equity Guideline, 2018 (or as current), and by: a) Engaging priority populations in order to understand their unique needs, histories, cultures, and capacities; and b) Designing strategies to improve the health of the entire population while decreasing the health inequities experienced by priority populations.

The requirements under the Chronic Disease Prevention and Well-being standards this program will address include: 2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses chronic disease risk and protective factors to reduce the burden of illness from chronic diseases in the health unit population. The idenfied need for reproductive health are for those age 25 years of age and younger. The average for reported maternal mental health concerns during pregnancy for those under 25 years of age is 40.1% in SWPH region compared to Ontario at 33.9% (PHO Snapshot

b) If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

High risk client's who are pregnant or contemplating pregnancy. Focus will be on young single parents, young parents (age 25 or younger) and those socially or geographically isolated or have low income or limited formal education.

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), target population, and delivery setting (e.g. schools, community centers, public health units, etc.).

Pregnant individuals are screened for anxiety and depression using the Generalized Anxiety Disorder -7 screen (GAD-&) adn Edinburgh Postpartum Depression Screen to identify areas of concern and provide early mental health interventions through education and/or referral. All staff have been trained on a skill-based approach to assessing a client's mental health to support resiliency building in those identified with risk. Clients experiencing perinatal

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce maternal mental health concerns reported by pregnant women who are younger than 25 by 3% by 2030.
Decrease the incidence of self-reported mental illness during pregnancy by 5% by 2030.

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) Reproductive Health (Preconception, Healthy Pregnancies & Preparation for Parenthood)

Promote preconception health through various social media channels, promote online prenatal class to expectant individuals, deliver in home prenatal education for clients unable to conduct online program, increase completion/submission of prenatal screens to identify at risk individuals early to offer/provide service.

P 2) Breastfeeding

Program Description:

a) Describe the program including the population(s) to be served. Please identify the specific requirements under the Standards that the program will address. Include a linkage to identified community needs and priorities.

The populations to be served include persons (and their partners/families) in the SWPH region who are in the preconception, prenatal, or postpartum period, parents with infants.

The requirements under the Healthy Growth and Development standards that this program will address include: 1. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to healthy growth and development and report and disseminate the data and information in accordance with the Population Health Assessment and Surveillance Protocol, 2018 (or as current); 2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach to support healthy growth and development in the health unit population.

b) If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

Priority populations include families that are at risk according to the HBHC screening tool or any families that reach out for support. The program aims to meet the needs of parents who are young, single, socially or geoprgaphically isolated, or have low income or limited formal education. A health equity approach is incorporated by reducing barriers by providing in-home support and free/reduced cost breastfeeding supplies and partnering with community

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), target population, and delivery setting (e.g. schools, community centers, public health units, etc.).

In-home breastfeeding support alleviates anxiety related to the infant's nutritional requirements and increases confidence in mother's ability to successfully breastfeed the infant. The one on one support also provides the opportuntity to assess and explore the mother's mood. Staff can apply a skill-based approach to the client's mental health and provide additional education or referral.

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Increase the proportion of women in the SWPH region who initiate breastfeeding (any breast milk) to match the provincial rate by 2030
Increase the proportion of women who are exclusively breastfeeding in the SWPH region, at the 2-month time point, by 2% by 2030

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) Breastfeeding (Promotion, Information & Surveillance)

Promote breastfeeding and increase community awareness of available and accessible community breastfeeding supports. Support mothers to breastfeed via the provision of various resources, share evidence-based breastfeeding information , provide in-person education sessions, provide free/reduced-cost breastfeeding supplies.

P 3) Parenting

Program Description:

a) Describe the program including the population(s) to be served. Please identify the specific requirements under the Standards that the program will address. Include a linkage to identified community needs and priorities.

The populations to be served include parents/caregivers and their children before school age (6 years of age).

The requirement under the Healthy Growth and Development standard that this program will address include: 2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach to support healthy growth and development in the health unit population.
Parenting is an area of focus in 2024 for us to better understand our community and needs around parenting education and support. Preliminary data is showing a need to develop programming around adolescent mothers to support increasing protective factors around self confidence in parenting.

b) If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

This program aims to meet the needs of caregivers and/or parents who are young, single, socially, or geographically isolated or have low income or limited formal education. A health equity lens is used to reduce barriers to accessing parenting education and resources. Preliminary data indicates the need to focus on adolescent mothers and the factors to support increasing protective factors around self confidence in parenting.

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), target population, and delivery setting (e.g. schools, community centers, public health units, etc.).

Mental health promotion will be conducted through home visiting, community programming (EarlyON, FreshStart, SWPH delivered Nobody's Perfect) and connecting families with supportive peers and resources.

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

To obtain a 1% decrease in the proportion of the children in SWPH that are rated as vulnerable on one or more domains of the Early Development Instrument by Cycle 7 of the EDI report by 2030. Note: there is a provinical Parenting CoP where there is a working group looking at parenting indicators that can be utilized by public health units across the province to have standardized data to support parenting programming.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Healthy Growth and Development

Promote Healthy Growth and Development services, including website and Know and Grow telephone information line. Deliver Nobody's Perfect, Get Set Learn and Kids Have Stress Too in collaboration with community partners. Collaborate with community partners to deliver parenting education and support and conducting a situational assessment to identify gaps in services to improve delivery.

Immunization

A. Community Needs and Priorities

Please provide a short summary of the following:

a) The key data and information which demonstrates your communities' needs for public health interventions to address immunization.

The following key data and information demonstrates our communities' needs for public health interventions to address immunization:
The OPHS states that priority populations are to be identified by "considering those with health inequities including: Increasing burden of illness; or increased risk for adverse health outcome(s); and/or those who

b) Your board of health's determination of the local priorities for a program of public health interventions that addresses immunization with consideration of the required list of topics identified in the Standards.

The COVID19 pandemic has placed a spotlight on the importance and effectiveness of vaccination for both individual and community health protection. SWPH will use this opportunity to engage our community to encourage and provide clinics to update any outstanding vaccination series for which individuals are eligible with the goal of reducing the burden of / possibility of outbreaks of vaccine preventable diseases in

B. Key Partners/Stakeholders

Please provide a high level summary of the specific key internal and external partners you will collaborate with to deliver on this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanism for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include: The Corporate Services and Human Resources Team, the Infectious Diseases Team, the Foundational Standards Team, the Healthy Growth and Development Team, the Healthy Schools Team and the Sexual Health Team

External partners include: hospitals, long-term care/retirement homes, congregate living settings, community health centres, Oxford EMS, Medavie, physicians, primary care leads, pharmacy leads, Public Health Ontario / Public Health Agency of Canada, OGPMSS (Ontario Government Pharmaceutical and Medical Supply Service)/MOHLTC - vaccine orders and returns, Amish bishops (Elgin and Oxford Communities), Mennonite Community Services - Aylmer, DeBrig radio, Huron Perth Public Health (epidemiologists to assist with dashboard creation of AEFIs in CCM)

P 1) Community Based Immunization Outreach (excluding vaccine administration)

Program Description:

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The target populations include people without a health care provider, Amish and Low German Speaking Mennonite families who are eligible for vaccines and geographic communities with lower vaccination coverage rates

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

To maintain or decrease the rate of pertussis to at or below the provincial average by 2050.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

P 2) COVID-19 Vaccine Program

Program Description:
Describe the program per items and activities described in other Immunization requirements (i.e., Community based Immunization Outreach, Monitoring and Surveillance, Administration and Vaccine Management), including the population(s) to be served, with specifics on priority populations, as well as COVaxON reporting and support. For priority populations identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The populations for this plan include: a) residents of the SWPH region aged 6 months and older; b) parents of children in the SWPH region; c) people who work in, reside in, or visit high-risk congregate settings; and d) primary care providers. Priority populations comprise those individuals at high-risk for Covid-19 related complications or hospitalization and can include: a) Individuals aged 65 years and older, especially those who are residents of long-term care homes, retirement homes, Elder Care Lodges and those aged 18 years and older living in other congregate settings that provide assisted-living and health services, b) Individuals aged 6 months and older who are moderate to severely immunocompromised, and c) individuals who are homeless, under-housed or are considered homebound due to medical/health concerns.

The requirements under the Immunization Standard this program addresses includes: 2. The board of health shall conduct epidemiological analysis of surveillance data for vaccine preventable diseases, vaccine coverage, and adverse events following immunization, including monitoring of trends over time, emerging trends, and priority populations in accordance with the Infectious Diseases Protocol, 2018 (or as current) and the Population Health Assessment and Surveillance Protocol, 2018 (or as current); 4. The board of health shall provide consultation to community partners on immunization and immunization practices, based on local needs and as requested; 5. The board of health shall promote and provide provincially funded immunization programs and services to eligible persons in the health unit, including underserved and priority populations; 6. The board of health shall have a contingency plan to deploy board of health staff capable of providing vaccine preventable diseases outbreak management and control, such as mass immunization, in the event of a community outbreak; 7. The board of health shall provide comprehensive information and education to promote effective inventory management for provincially funded vaccines in accordance with the Vaccine Storage and Handling Protocol, 2018 (or as current). This shall include: a) Training at the time of cold chain inspection; b) Distributing information to new health care providers who handle vaccines; and c) Providing ongoing support to health care providers who handle vaccines, including guidance on effective inventory management; 8. The board of health shall promote appropriate vaccine inventory management in accordance with the Vaccine Storage and Handling Protocol, 2018 (or as current) in all premises where provincially funded vaccines are stored. This shall include: a) Prevention, management, and reporting of cold chain incidences; and b) Prevention, management, and reporting of vaccine wastage; 9. The board of health shall ensure that the storage and distribution of provincially funded vaccines, including to health care providers practicing within the health unit, is in accordance with the Vaccine Storage and Handling Protocol, 2018 (or as current); 10. The board of health shall: a) Promote reporting of adverse events following immunization by health care providers to the local board of health in accordance with the Health Protection and Promotion Act; and b) Monitor, investigate, and document all suspected cases of adverse events following immunization that meet the provincial reporting criteria and promptly report all cases.

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Decrease the incidence of severe illness and hospitalizations due to Covid-19 by 5%, in the SWPH region, by 2025

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) COVID-19 Response

In conjunction with provincial guidance, key activities of this plan include a) promotion that people remain up-to-date with their Covid vaccines, b) distribution of Covid-19 vaccine to our community through clinics and mobile outreach, c) work with external partners, when needed, to support thier vaccination efforts within highest-risk settings i.e. LTCHs, and d) support accurate and timely data entry related to Covid-19 vaccination within the CovaxON database.

P 3) Immunization Monitoring and Surveillance

Program Description:
Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The population to be served includes all residents in our region. The priority populations include Amish, Low German Speaking Mennonites, Healthy Babies Healthy Children clients and their families and anyone who has experienced an AEFI.

The requirements under the Immunization Standard this program addresses includes: 2. The board of health shall conduct epidemiological analysis of surveillance data for vaccine preventable diseases, vaccine coverage, and adverse events following immunization, including monitoring of trends over time, emerging trends, and priority populations in accordance with the Infectious Diseases Protocol, 2018 (or as current) and the Population Health Assessment and Surveillance Protocol, 2018 (or as current); 3. The board of health shall work with community partners to improve public knowledge and confidence in immunization programs and services by: a) Adapting and/or supplementing national/provincial health communications strategies where local assessment has identified a need; b) Developing and implementing regional/local communications strategies where local assessment has identified a need; and c) Addressing the following topics based on an assessment of local needs; 4. The board of health shall provide consultation to community partners on immunization and immunization practices, based on local needs and as requested; 5. The board of health shall promote and provide provincially funded immunization programs and services to eligible persons in the health unit, including underserved and priority populations; 10. The board of health shall: a) Promote reporting of adverse events following immunization by health care providers to the local board of health in accordance with the Health Protection and Promotion Act; and b) Monitor, investigate, and document all suspected cases of adverse events following immunization that meet the provincial reporting criteria and promptly report all cases.

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce the rate of pertussis cases in SWPH to be at or below the provincial average by 2026.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Immunization Administration and Surveillance (incl. AEFIs)

Through vaccine clinics, eligible persons, including the underserved and priority populations, will have access to provincially funded immunizations. Soutwestern Public Health will be prepared to implement emergency immunization clinics as needed. Adverse events following immunizations (AEFIs) are mandated to be investigated by PHUs within 5 days, to determine next steps for vaccination of the impacted individual.

P 4) Vaccine Administration

Program Description:
Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The population to be served are residents 6 months of age and over who are eligible for influenza immunizations. The prioritiy popuations include: children 6 months to 5 years of age; residents and staff of congregate living settings; people over 65 years of age who may be on a fixed income; people who lack transportation or experience other health barriers; people who are from First Nation, Inuit or Metis communities or self-identify as First Nation, Inuit or Metis; people who are members of racialized communties; people who are underhoused; and people who are without Ontario Health Cards.

The requirements under the Immunization Standard this program addresses includes: 3. The board of health shall work with community partners to improve public knowledge and confidence in immunization programs and services by: a) Adapting and/or supplementing national/provincial health communications strategies where local assessment has identified a need; b) Developing and implementing regional/local communications strategies where local assessment has identified a need; and c) Addressing the following topics based on an assessment of local needs; 4. The board of health shall provide consultation to community partners on immunization and immunization practices, based on local needs and as requested; 5. The board of health shall promote and provide provincially funded immunization programs and services to eligible persons in the health unit, including underserved and priority populations; 7. The board of health shall provide comprehensive information and education to promote effective inventory management for provincially funded vaccines in accordance with the Vaccine Storage and Handling Protocol, 2018 (or as current). This shall include: a) Training at the time of cold chain inspection; b) Distributing information to new health care providers who handle vaccines; and c) Providing ongoing support to health care providers who handle vaccines, including guidance on effective inventory management; 8. The board of health shall promote appropriate vaccine inventory management in accordance with the Vaccine Storage and Handling Protocol, 2018 (or as current) in all premises where provincially funded vaccines are stored. This shall include: a) Prevention, management, and reporting of cold chain incidences; and b) Prevention, management, and reporting of vaccine wastage; 9. The board of health shall ensure that the storage and distribution of provincially funded vaccines, including to health care providers practicing within the health unit, is in accordance with the Vaccine Storage and Handling Protocol, 2018 (or as current).

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Decrease the 10 year average yearly incident rate of confirmed influenza cases to be 25 less cases in SWPH than Ontario by 2030.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Universal Influenza Immunization Program

SWPH is responsible for operationalizing all aspects of the Ministry of Health UIIP program including mandated fridge inspections, vaccine management, and reporting for UIIP organizations in the region. Distribution of flu vaccine to health system partners / residents with prioritization on clients vulnerable to influenza or with access challenges.

P 5) Vaccine Management

Program Description:
Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The populations being served include all SWPH Vaccine Preventable Diseases and COVID-19 staff, all SWPH program assistants and health system partners who utilize publically funded vaccines (including flu).

The requirements under the Immunization Standard this program addresses include: 7. The board of health shall provide comprehensive information and education to promote effective inventory management for provincially funded vaccines in accordance with the Vaccine Storage and Handling Protocol, 2018 (or as current). This shall include: a) Training at the time of cold chain inspection; b) Distributing information to new health care providers who handle vaccines; and c) Providing ongoing support to health care providers who handle vaccines, including guidance on effective inventory management; 8. The board of health shall promote appropriate vaccine inventory management in accordance with the Vaccine Storage and Handling Protocol, 2018 (or as current) in all premises where provincially funded vaccines are stored. This shall include: a) Prevention, management, and reporting of cold chain incidences; and b) Prevention, management, and reporting of vaccine wastage; 9. The board of health shall ensure that the storage and distribution of provincially funded vaccines, including to health care providers practicing within the health unit, is in accordance with the Vaccine Storage and Handling Protocol, 2018 (or as current).

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce vaccine wastage from any SWPH related organization to be no more than 3% annually for any one publicly funded product (excluding flu and covid-19 vaccines) by the end of 2029.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Vaccine Inventory, Storage, and Handling (incl. Adverse Storage Conditions)

Maintaining vaccine inventories through proper storage and handling, quality assurance, and proper education. This will limit vaccine wastage within the health unit and the SWPH community partners, while also promoting vaccine safety and efficacy.

Infectious and Communicable Diseases Prevention and Control

A. Community Needs and Priorities

Please provide a short summary of the following:

a) The key data and information which demonstrates your communities' needs for public health interventions to address infectious and communicable diseases.

Vector-Borne Diseases Program

Climate change shows that vectors are either established (West Nile virus vectors in Oxford and Elgin County, black-legged ticks in Elgin County) or moving into our jurisdiction (black-legged ticks in Oxford County). West Nile virus is established in Oxford County; less established in Elgin County. In 2019 SWPH obtained their first designated risk area for black-legged ticks, the ticks capable of transmitting Lyme disease. In 2022, a second risk area was identified. A third area likely to be identified for 2024. Locally-acquired cases of Lyme disease are beginning to increase in the SWPH region.

Sexual Health

Rates of STIs continue to rise as people engage in sexual activity, including increased use of sex and dating apps that increase the likelihood of anonymous sex. One example is infectious syphilis which is on the rise in the SWPH region, with cases increasing overall since 2015/2016, going from 0.0 per 100,000 in 2015 up to 7.4 per 100,000 in 2022. The implications of syphilis extend beyond case numbers and are a concern for all communities in Ontario experiencing a rise in syphilis cases. For example, we have had several infectious syphilis cases tested through prenatal serology, with an increase in congenital syphilis cases. Though males continue to account for the vast majority of cases, cases reported among females have increased, and the male-to-female ratio is decreasing. This change in demographics makes predicting risk factors more difficult. Case finding and early interventions are critical to preventing the spread of infection and implications across multiple levels, from individual to community.

HIV cases continue to arise in our population of people who use substances. Case management and contact tracing can be difficult with this population. Stigma can also prevent individuals from accessing testing and treatment that can help prevent further spread.

The sexual health program also focuses on reducing unwanted pregnancies. Between 2018 and 2022, in the SWPH region, there were an average of 429 live births per year to mothers aged 24 years and under and an average of 34 first births per year to mothers aged 18 and under. While the trend has been decreasing, our local rate of teen births is high compared to the provincial rate.

SWPH's fertility rate for women aged 20-24 is significantly higher at 51.3 per 1,000 compared to the Ontario rate of 20.1 per 1,000. Studies show that the majority (75-82%) of teen pregnancies are unintended and that women aged 20-24 have the highest rate of unintended pregnancy. Unintended pregnancy has a profound impact on youths' physical and emotional health, educational attainment and career aspirations.

Infection Prevention and Control

SWPH Rates of the following enteric diseases are higher than the provincial average: Campylobacteriosis: 64 cases in 2022 at SWPH - rate 28.4/100,000 (provincial rate = 14.2/100,000), Cryptosporidium: 20 cases in 2022 at SWPH - rate 8.9/100,000 (provincial rate = 3.0/100,000), Vero Toxigenic E Coli: 4 cases in 2022 at SWPH - rate 1.8/100,000 (provincial rate = 1.4/100,000). SWPH Rates of the following Vaccine Preventable Diseases are higher than the provincial average: Haemophilus Influenza Disease, all types, invasive: 7 cases in 2022 at SWPH - rate 3.1/100,000 (provincial rate = 1.6/100,000), Pertussis: 59 cases in 2022 at SWPH rate 26.1/100,000 (provincial rate = 0.9/100,000); Pertussis outbreak in South/Central West region with index case July 2022, Streptococcus Pneumoniae, invasive: 34 cases in 2022 at SWPH - rate 15.1/100,000 (provincial rate = 8.4/100,000), Meningicoccal Disease, invasive: 1 case in 2022 at SWPH - rate 0.4/100,000 (provincial rate = 0.2/100,000). Increasing rates of Lyme Disease cases reported to SWPH. Lyme Disease: 34 cases from 2018-2022 in SWPH - rate 3.1/100,000 (provincial rate = 7.7/100,000). Although SWPH is below the provincial average, we've seen a significant increase between 2018 and 2022. There was an increase from 1.89/100,000 in 2018 to 5.76/100,000 in 2022. Lyme disease incidence in Ontario has increased steadily since 2002 as has the geographic range that carries the ticks. In Ontario,

b) Your board of health's determination of the local priorities for a program of public health interventions that addresses infectious and communicable diseases.

Rabies
Rabies is an 100% fatal disease. Wildlife species are most common, in our area, to carry the rabies virus. Having a rural landscape in our area results in potential for domestic animals to come in contact with wild

B. Key Partners/Stakeholders

Please provide a high level summary of the specific key internal and external partners you will collaborate with to deliver on this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanism for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include: the Foundational Standards Team, the Corporate Services and Human Resources Team, the Healthy Schools Team, the Environmental Health Team, the Infectious Diseases Team, the Sexual Health Team and the Vaccine Preventable Team.

External partners include: The Ministry of Environment and Parks and Conservation for larvaciding notice; municipalities for letters of support for stand-by larviciding and number of catch basins; physicians and pharmacists for survey completion; local cities, municipalities, conservation authorities, and townships for potential tick dragging sites; Community health centres (outreach, education, adherence, testing, treatment); Family health teams (education, adherence, testing, treatment); Local hospitals (education, adherence, testing, treatment); Local infectious disease specialists (education, adherence, testing, treatment); Local prenatal specialists OB, gyne, midwifery (education, adherence, testing, treatment; Organizations working with priority populations (outreach, education, adherence, testing, treatment); Local school boards (education, testing, treatment); Committees and working groups: Rainbow coalition, PHAN (knowledge sharing, education, planning, surveillance); school administrators; school-based parent involvement committees; social services and other community-based organizations that serve teens and young females in the most socially vulnerable areas; acute care partners and primary care partners - diagnosing/testing; treating and reporting DoPHS to Public Health (SWPH will collaborate with these partners to gather additional details on DoPHS cases, when needed); acute care settings; infectious diseases specialists/respirologists; Ministry of Natural Resources; police; animal care services; veterinarians; municipalities; Ontario Ministry of Agriculture and Food; Canadian Food Inspection Agency; Ontario Association of Veterinary Technicians and the Canadian Wildlide Health Co-perative.

P 1) Vector-Borne Diseases Program

Program Description:

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The population to be served include the outdoor enthusiasts, hikers, campers, gardeners, health care providers and school-aged children 5-11 years old. The priority populations include homeless and under housed individuals who don't have access to basic necessities such as a shower (removal of ticks as per our standard messaging after coming in from outdoors), are outdoors longer and who may not have the accessible resources such as a family physician or access to our social media posts.

The requirements under the Infectious and Communicable Diseases Prevention and Control standard this program addresses include: 1. The board of health shall conduct population health assessment and surveillance regarding infectious and communicable diseases and their determinants; 3. The board of health shall work with community partners and service providers to determine and address the need for knowledge translation resources and supports in the area of infection prevention and control; 4. The board of health shall work with appropriate partners to increase awareness among relevant community partners, including correctional facilities, health care, and other service providers, of: a) The local epidemiology of communicable diseases and other infectious diseases of public health significance; b) Infection prevention and control practices; and c) Reporting requirements for diseases of public health significance, as specified in the Health Protection and Promotion Act; 5. The board of health shall communicate, in a timely and comprehensive manner, with all relevant health care providers and other partners about urgent and emerging infectious diseases issues; 6. The board of health shall, based on local epidemiology, supplement provincial efforts in managing risk communications to appropriate stakeholders on identified risks associated with infectious diseases and emerging diseases of public health significance; 11. The board of health shall provide public health management of cases, contacts, and outbreaks to minimize the public health risk; 16. The board of health shall develop a local vector-borne management strategy based on surveillance data and emerging trends; 21. The board of health shall ensure 24/7 availability to receive reports of and respond to: a) Infectious diseases of public health significance; b) Potential rabies exposures; and c) Animal cases of avian chlamydiosis, avian influenza, novel influenza, or Echinococcus multilocularis infection.

The requirements under the Population Health Assesment standard this program addresses include: 1. The board of health shall conduct surveillance, including the ongoing collection, collation, analysis, and periodic reporting of population health information, as required by the Health Protection and Promotion Act and in accordance with the Population Health Assessment and Surveillance Protocol, 2018 (or as current); 5. The board of health shall tailor public health programs and services to meet identified local population health needs, including those of priority populations.

The requirements under the Effective Public Health Practice standard this program addresses include: 2. The board of health shall routinely monitor program activities and outcomes to assess and improve the implementation and effectiveness of programs and services, including collection, analysis, and periodic reporting of indicators related to inputs, resources, implementation processes, reach, outputs, and outcomes.

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Maintain an incidence rate of less than the provincial average of confirmed locally-acquired cases of West Nile virus
Maintain an incidence rate of less than the provincial average of probable and confirmed locally-acquired Lyme disease cases
Maintain an incidence rate of less than the provincial average of confirmed locally-acquired cases of eastern equine encephalitis virus

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Vectorborne Diseases Surveillance, Testing, and Education

Monitor traps in SWPH region for mosquito vectors that can transmit diseases of public health significance such as West Nile virus and eastern equine encephalitis virus. Continue with passive surveillance and if needed, active surveillance, of ticks that can transmit diseases of public health significance: Lyme disease and potentially anaplasmosis, babesiosis, and Powassan virus transmitted by blacklegged ticks, pending DOPHS changes. Promote current testing, treatment and prophylaxis guidelines to health care providers including pharmacists who provide prophylaxis. Access to prophylaxis through pharmacists increases access for people that do not have a primary care provider.

P 2) Sexual Health

Program Description:

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The sexual health program aims to prevent sexually transmitted diseases and blood borne infections through case and contact management, clinical services for testing and treatment, community knowledge and outreach, health care provider outreach and raising awareness and reducing stigma for at-risk populations. The sexual health program also aims to reduce unwanted pregnancy, particularly among sexually active teens (aged 15-19 years) and young adults (aged 20-24 years), by improving the knowledge, skills and behaviours that support optimal sexual health throughout life by providing contraceptive education and counselling, pregnancy tests and comprehensive pregnancy counselling and referral.

The priority populations for this program include men who have sex with men (MSM)/2SLGBTQIA+, those who are homeless or underhoused, pregnant women, teens between the age of 15-19 years of age, young adults, people who engage in sex work, people who use drugs and migrant farm workers.

The requirements under the Infectious and Communicable Diseases Prevention and Control standard this program addresses include: 7. The board of health shall use health promotion approaches to increase adoption of healthy behaviours among the population regarding sexual practices and injection drug use to prevent and reduce exposures to sexually transmitted and blood-borne infections by collaborating with and engaging health care providers, community and other relevant partners, and priority populations; 10. The board of health shall collaborate with health care providers and other relevant community partners to: a) Create supportive environments to promote healthy sexual practices, access to sexual health services, and harm reduction programs and services for priority populations; and b) Achieve a comprehensive and consistent approach, based on local assessment and risk surveillance, to address and manage sexually transmitted infections and blood-borne infections; 11. The board of health shall provide public health management of cases, contacts, and outbreaks to minimize the public health risk.

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce the rate of new infectious Syphilis cases to 0.5/100,000 by 2030
Maintain the rate of new HIV cases
Reduce the rate of new HCV cases to at or below the provincial rate by 2030
Reduce the number of live births to teen mothers (aged 15-19) by 20% by 2027

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) Sexually Transmitted and Blood Borne Infections

This program aims to reduce the community and health care burden of STIs and BBIs by decreasing barriers to STI testing, treatment and follow-up. To increase case detection through outreach, a focus on priority populations, and addressing the stigma of STIs, BBIs, in targeted populations. To align with community health care providers to increase the effectiveness of case finding and case management.

i 2) Unplanned Pregnancy

This program aims to assist in preventing unplanned pregnancies, specifically in women 15-19 years old. This will be accomplished by increasing their knowledge of sexual health resources through communication, engagement and collaboration with vulnerable youth and their support network(s) of teachers, school administrators and parents.

P 3) Infection Prevention & Control

Program Description:

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The populations to be served include individuals with a disease of public health significance, childcare operators, congregate settings employees, residents and visitors and personal services setting clients. Priority populations include: Un/under-immunized communities (i.e., Mennonite, Netherlands reform, Amish, etc.); low-income families; homeless and under-housed and high risk working groups (i.e., agricultural, healthcare, foodservice workers, etc.), clients who are physical or mentally vulnerable, homeless/under-housed or experiencing domestic issues residing in congregate settings, people who lack access to primary health care and require treatment or prophylaxis for a disease of public health significance.

The requirments under the Infectious and Communicable Diseases Prevention and Control standard this program addresses include: 1. The board of health shall conduct population health assessment and surveillance regarding infectious and communicable diseases and their determinants; 2. The board of health shall provide public education to increase awareness related to infection prevention and control measures, including respiratory etiquette, and hand hygiene; 3. The board of health shall work with community partners and service providers to determine and address the need for knowledge translation resources and supports in the area of infection prevention and control; 4. The board of health shall work with appropriate partners to increase awareness among relevant community partners, including correctional facilities, health care, and other service providers, of: a) The local epidemiology of communicable diseases and other infectious diseases of public health significance; b) Infection prevention and control practices; and c) Reporting requirements for diseases of public health significance, as specified in the Health Protection and Promotion Act; 5. The board of health shall communicate, in a timely and comprehensive manner, with all relevant health care providers and other partners about urgent and emerging infectious diseases issues; 6. The board of health shall, based on local epidemiology, supplement provincial efforts in managing risk communications to appropriate stakeholders on identified risks associated with infectious diseases and emerging diseases of public health significance; 8. The board of health shall collaborate with health care providers and other relevant partners to ensure access to, or provide based on local assessment, clinical services; 11. The board of health shall provide public health management of cases, contacts, and outbreaks to minimize the public health risk; 15. The board of health shall receive and respond to all reported animal cases of avian chlamydiosis (infection of birds with the causative agent of psittacosis in humans), avian influenza, novel influenza, and Echinococcus multilocularis infection; 17. The board of health shall participate on committees, advisory bodies, or networks that address infection prevention and control practices and policies of, but not limited to, hospitals and long-term care homes; 18. The board of health shall receive reports of complaints regarding infection prevention and control practices and respond to and/or refer to appropriate regulatory bodies, including regulatory colleges, in accordance with applicable provincial legislation; 20. The board of health shall inspect settings associated with risk of infectious diseases of public health significance; 21. The board of health shall ensure 24/7 availability to receive reports of and respond to: a) Infectious diseases of public health significance; b) Potential rabies exposures; and c) Animal cases of avian chlamydiosis, avian influenza, novel influenza, or Echinococcus multilocularis infection.

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce the incidence rate of vaccine preventable diseases (Mumps, Measles, Haemophilus influenzae type B, Varicella (Chickenpox) and Pneumococcal disease) to less than or equal to the provincial average by 2030. Reduce the number of primary and secondary cases of pertussis in the underimmunized population.
Maintain or reduce the incidence rate of communicable diseases and other infectious diseases of public health significance at or below the provincial average by 2030.
Reduce the duration of respiratory and enteric outbreaks in congregate settings by 5% by 2027.
Maintain incidence rate of 0 Hepatitis B (acute) per 100,000 population through to 2028.

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) Community Case and Contact Management of Diseases of Public Health Significance

Minimizing the risk to the public from infectious diseases of public health significance (DOPHS) by public health management of cases and contacts of these diseases. Timely and effective detection (surveillance), identification, and management of exposures and local cases of DOPHS to mitigate outbreaks of communicable diseases.

i 2) Infection Prevention and Control

Provide IPAC information to community partners and general public. Complete proactive IPAC inspections in congregate settings and licensed childcare. Conduct IPAC lapse investigations as per the OPHS and Infection Prevention and Control Complaints Protocol to identify deviations from best practices and ensure correction to prevent transmission of disease.

i 3) Institutional Outbreak Management for Infectious Diseases

Investigate and manage suspect and confirmed outbreaks in hospitals, long-term care homes, childcare centres, retirement homes and other settings in conjunction with the owner/operator/manager of the facility to reduce the duration and severity of outbreaks.

i 4) Personal Services Settings Program

Complete routine and any necessary re-inspections for all personal services settings currently listed in hedgehog database. Following up on complaints received for personal service settings within 24 hours of receiving them. Providing education to owners and operators and the public about safe infection prevent and control practices in Personal Services Setting.

P 4) Tuberculosis Prevention & Control

Program Description:

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The population to be served includes: clients with diagnosed TB disease, suspect TB disease, and TB infection; contact of clients diagnosed with active or suspect infectious TB disease; health care providers (questions about TB diagnostics, referral processes); acute care facilities; newcomers to Canada - PHNs to work with local immigration services, receive referrals from Immigration, Refugees, and Citizenship Canada (TB Medical Surveillance referrals); Agencies (OH&S departments, post-secondary schools).

The requirements under the Infectious and Communicable Diseases Prevention and Control standard this program addresses include: 1. The board of health shall conduct population health assessment and surveillance regarding infectious and communicable diseases and their determinants; 4. The board of health shall work with appropriate partners to increase awareness among relevant community partners, including correctional facilities, health care, and other service providers, of: a) The local epidemiology of communicable diseases and other infectious diseases of public health significance; b) Infection prevention and control practices; and c) Reporting requirements for diseases of public health significance, as specified in the Health Protection and Promotion Act; 5. The board of health shall communicate, in a timely and comprehensive manner, with all relevant health care providers and other partners about urgent and emerging infectious diseases issues; 11. The board of health shall provide public health management of cases, contacts, and outbreaks to minimize the public health risk; 12. The board of health shall facilitate timely identification of active cases of TB and referrals of persons through immigration medical surveillance; 21. The board of health shall ensure 24/7 availability to receive reports of and respond to: a) Infectious diseases of public health significance; b) Potential rabies exposures; and c) Animal cases of avian chlamydiosis, avian influenza, novel influenza, or Echinococcus multilocularis infection.

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Maintain an incidence rate of <2 active cases of tuberculosis (TB) per 100,000 in SWPH region by 2025

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) TB Prevention and Control

Facilitate timely follow-up of cases of tuberculosis disease and systematically identify and prioritize close contacts for follow-up. Promote the early identification of tuberculosis (disease and infection) in the community. Report all cases to the Ministry and conduct epidemiological analysis of cases reported to Public Health.

P 5) Rabies & Zoonotics

Program Description:

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The population of interest include the public and pet owners. The priority populations include all persons with potential exposures to the rabies virus and people living in rural setting where the occurance of wildlife to come into contact with domestic animals is likely to be higher. SWPH provides low cost rabies clinics to promote vaccination of cats and dogs if cost is a barrier.

The requirements under the Infectious and Communicable Diseases Prevention and Control standard this program addresses include: 1. The board of health shall conduct population health assessment and surveillance regarding infectious and communicable diseases and their determinants; 3. The board of health shall work with community partners and service providers to determine and address the need for knowledge translation resources and supports in the area of infection prevention and control; 4. The board of health shall work with appropriate partners to increase awareness among relevant community partners, including correctional facilities, health care, and other service providers, of: a) The local epidemiology of communicable diseases and other infectious diseases of public health significance; b) Infection prevention and control practices; and c) Reporting requirements for diseases of public health significance, as specified in the Health Protection and Promotion Act; 5. The board of health shall communicate, in a timely and comprehensive manner, with all relevant health care providers and other partners about urgent and emerging infectious diseases issues; 6. The board of health shall, based on local epidemiology, supplement provincial efforts in managing risk communications to appropriate stakeholders on identified risks associated with infectious diseases and emerging diseases of public health significance; 11. The board of health shall provide public health management of cases, contacts, and outbreaks to minimize the public health risk; 13. The board of health shall receive and respond to all reported cases of potential rabies exposures received from the public, community partners, and health care providers; 14. The board of health shall address the prevention and control of rabies threats as per a local Rabies Contingency Plan and in consultation with other relevant agencies and orders of government; 16. The board of health shall develop a local vector-borne management strategy based on surveillance data and emerging trends; 21. The board of health shall ensure 24/7 availability to receive reports of and respond to: a) Infectious diseases of public health significance; b) Potential rabies exposures; and c) Animal cases of avian chlamydiosis, avian influenza, novel influenza, or Echinococcus multilocularis infection.

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Maintain an incidence rate of zero for rabies virus in humans until 2026

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) Rabies Investigation Program and Education

The public, community partners, and HCP will report all potential rabies exposures. The Board of Health shall respond to all rabies exposure reports, and provide public health management of cases, contacts, and exposures to minimize public health risk. Provide information on the local risk of rabies and preventative measures to the public, health care providers and community partners.

Safe Water

A. Community Needs and Priorities

Please provide a short summary of the following:

a) The key data and information which demonstrates your communities' needs for public health interventions to address safe water.

2022 rates of common water borne diseases are below. For all but 3, Southwestern Public Health is above the provincial rate. Historical evidence indicates that inspection programs will assist in keeping water borne illnesses, related to drinking water and exposure to recreational water, low. The 2002 Walkerton Inquiry supports this evidence. Inspection database information indicates 314 complains, services an requests between 2018 and 2022 for recreational water facilities. In 2023, visits to the beach water qualtiy information on the SWPH website was the second most commonly visited information, with COVID-19 being the first.

Cryptosporidiosis
ON: 3.0
SWPH: 8.8

Giardiasis
ON: 5.3
SWPH: 3.1

VTEC
ON: 1.4
SWPH: 1.8

Campylobacter enteritis

b) Your board of health's determination of the local priorities for a program of public health interventions that addresses safe water.

SWPH has 147 Small Drinking Water Systems and 94 recreational facilities requiring inspection and for response to complaints and inquiries. Beyond inspection and response issues, the EH team at SWPH provides educational resources to owners and operators as well as the public. 24/7 on-call support to adverse water quality incidents are a priority for SWPH, as mandated in the Ontario Public Health Standards.

c) Your boards of health's approach to disclosure of inspection results (onsite posting and website posting) and evaluation of the program.

SWPH fullfills all of the requirements for onsite and online disclosure of inspection results by following the Ontario Public Health Standards. The Health Inspect program at SWPH has onsite signage at facilities. These signs provide a QR code linked to inspection results that can be accessed at point of service. Additionally, the Health Inpect website has facilities in list form or map form with linked to inspection results the

B. Key Partners/Stakeholders

Please provide a high level summary of the specific key internal and external partners you will collaborate with to deliver on this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanism for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include Infection Disease Control Team and oral health team (for community water fluoride monitoring).

External partners include: Ministry of Environment, Conservation and Parks, Municipal Public Works, Community drop-off/pick-up location representatives, municipalities, ASPHIO and owners/operators of recreational water facilities.

P 1) Drinking Water Program

Program Description:

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The populations to be served include private well water owners and safe drinking water system owners and operators. The priority populations include tenants at rental properties on private wells, mennonites that don't have access to phones and/or internet for information/education, people who have limited access to transportation and are unable to submit samples. The public who visit area public beaches.

The requirements under the Safe Water standard that this program addresses includes: 1. The board of health shall: a) Conduct surveillance of: Drinking water systems and associated illnesses, risk factors, and emerging trends; Public beaches and water-borne illnesses associated with recreational water, risk factors, and emerging trends; and Recreational water facilities; b) Conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations; and c) Use the information obtained to inform safe water programs and services; 2. The board of health shall provide information to private citizens who operate their own private drinking water supplies (e.g., private wells) to promote awareness of how to safely manage their own drinking water systems; 3. The board of health shall ensure the availability of education and training for owners/operators of small drinking water systems and recreational water facilities; 4. The board of health shall increase public awareness of water-borne illnesses and safe drinking water by working with community partners and by: a) Adapting and/or supplementing national/provincial safe drinking water communications strategies, where local assessment has identified a need; and/or b) Developing and implementing regional/local communications strategies where local assessment has identified a need; 5. The board of health shall provide all the components of the Safe Water Program; 6. The board of health shall inform the public about unsafe drinking water conditions and provide the necessary information to respond appropriately; 7. The board of health shall review drinking water quality reports for its municipal drinking water supplies where fluoride is added; 8. The board of health shall ensure 24/7 availability to receive reports of and respond to: a) Adverse events related to safe water, such as reports of adverse drinking water of drinking water systems, governed under the Health Protection and Promotion Act or the Safe Drinking Water Act, 2002; b) Reports of water-borne illnesses or outbreaks; c) Safe water issues arising from floods, fires, power outages, or other situations that may affect water safety; and d) Safe water issues relating to recreational water use including public beaches.

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Maintain the SWPH incidence of waterborne illness related to drinking water below the Ontario incidence rate through 2026.

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) Safe Drinking Water Program

Completing routine Small Drinking Water System Risk Assessments for all known facilities at or above the required inspection frequency. Follow up on adverse drinking water sample results/observations and complaints within 24 hours of receiving them, to minimize potential illness. Promote Health Inspect Southwestern to communicate SDWS inspection results and advisories/orders.

P 2) Recreational Water Program

Program Description:

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Please identify the specific requirements under the Standards that the program will address, describe how a health equity lens has been incorporated, how barriers will be removed or addressed for priority populations, and include a linkage to identified community needs and priorities

The populations to be served include municipalities at the beginning of the beach water sampling season (communication is done via email) and owners and operators of public pools and spas.

The requirements under the Safe Water standard this program addresses include: 1. The board of health shall: a) Conduct surveillance of: Drinking water systems and associated illnesses, risk factors, and emerging trends; Public beaches and water-borne illnesses associated with recreational water, risk factors, and emerging trends; and Recreational water facilities; b) Conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations; and c) Use the information obtained to inform safe water programs and services; 3. The board of health shall ensure the availability of education and training for owners/operators of small drinking water systems and recreational water facilities; 4. The board of health shall increase public awareness of water-borne illnesses and safe drinking water by working with community partners and by: a) Adapting and/or supplementing national/provincial safe drinking water communications strategies, where local assessment has identified a need; and/or b) Developing and implementing regional/local communications strategies where local assessment has identified a need; 5. The board of health shall provide all the components of the Safe Water Program; 8. The board of health shall ensure 24/7 availability to receive reports of and respond to: a) Adverse events related to safe water, such as reports of adverse drinking water of drinking water systems, governed under the Health Protection and Promotion Act or the Safe Drinking Water Act, 2002; b) Reports of water-borne illnesses or outbreaks; c) Safe water issues arising from floods, fires, power outages, or other situations that may affect water safety; and d) Safe water issues relating to recreational water use including public beaches.

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce the incidence rate of waterborne illness and injury related to recreational water use by 10% by 2026.

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) Recreational Water Program

Completing routine recreational water facility inspections for all known recreational facilities at or above the required inspection frequency. Following up suspect waterborne illness and injury complaints within 24 hours of receiving them, to minimize potential impacts of illness and injury. Promote Health Inspect Southwestern to communicate beach status and rec. water facility inspections.

School Health

School Health - Oral Health

A. Community Needs and Priorities

Please provide a short summary of the following:

a) The key data and information which demonstrates your communities' needs for public health interventions to address oral health.

During the 2022/2023 school year, at school entry (JK), about 84% of children screened were caries-free or free from cavities. This decreased to about 74% in SK and to about 55% in grade 2. During the COVID-19 pandemic, there was a decline in HSO services due to the inability to access dental clinical services. The most recent screening results (2019/2020 and 2022/2023) demonstrate a high percentage of children in Elgin-St. Thomas schools were in need of urgent dental treatment in comparison to children in Oxford County.

b) Your board of health's determination of the local priorities for a program of public health interventions that addresses oral health.

Targeted programming in collaboration with community partners, aims to reduce oral health inequities and transform system of care in alignment with the health unit's strategic direction. Priority groups include: Low-German Mennonite chidlren and youth aged 17 and under from low-income families; Amish Mennonite children and youth aged 17 and under; children and youth aged 17 and under from low income families attending non-publically funded

B. Key Partners/Stakeholders

Please provide a high level summary of the specific key internal and external partners you will collaborate with to deliver on this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanism for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include: the Foundational Standards Team, Communications Team, Healthy Schools Team.

External partners for Healthy Smiles Ontario include: the London District Catholic School Board, Thames Valley District School Board, Private School boards, Oxford and Elgin community dental offices, dental fee-for-service providers and Western University Surgical Care Unit (DSCU - new clinic offering services to HSO children). Private dental clinics as external partners, provide services for children 0-17 in our local communities.

External partners for Oral Health Screening & Surveillance include: the Thames Valley District School Board, London District Catholic School Board and various private schools in Oxford and Elgin Counties. Additionally, Family and Children's Services, local dental fee-for-service providers and local community agencies such as MCS, local teen centres and parenting groups are key community partners in which we need to work with/explore our relationship further. The contributing role they play is access to the population which we wish to support through screening and surveillance in Elgin/Oxford counties. The frequency of engagement will be occurring throughout the 2023-2024 school year to promote our work as well as access the population we intend to support.

School Health

P 1) Healthy Smiles Ontario Program

Program Description:

a) Describe the program including the population(s) to be served. Please identify the specific requirements under the Standards that the program will address. Include a linkage to identified community needs and priorities.

The population to be served includes children and youth aged 0-17 with income disparity.

The requirement under the School Health standards this program addresses include: 6. The board of health shall provide the Healthy Smiles Ontario (HSO) Program.

b) If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

The priority populations include Low German Speaking Mennonites who are generally located in Elgin County and Amish populations who are generally located in Oxford County. Both populations experience education and income disparities. We are exploring opportunities to work closely with our priority populations, inlcuding forming alliances with the Amish and Low-German Mennonite community through our public health nurses. We also provide a Healthy Smiles Ontario clinic (dental screening and preventive services) predominantly for the Low-German Mennonite famiies in Aylmer, Ontario at least on a weekly basis. We anticipate delivering preventive services and

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), target population, and delivery setting (e.g. schools, community centers, public health units, etc.).

N/A

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce the rate of day surgeries for caries per 100,000 population in children less than 18 years of age by 5% by 2030.

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) Healthy Smiles Ontario (HS)

The Healthy Smiles Ontario (HSO) program provides access for preventive, routine, and emergency dental services for children and youth aged 17 years and younger. Through clinical services, education and health promotion we aim to achieve improved access and treatment for children and youth in need of financial supports in the Elgin and Oxford region. Examples of activities include: program eligibility assessment and client-level oral health navigation (e.g., clinical and financial eligbility determination, client enrolment support into the various streams of the Healthy Smiles Ontario Program, assisting with finding a dental home); post-screening notification and follow-up; oral health

P 2) Oral Health Assessment and Surveillance

School Health

Program Description:

a) Describe the program including the population(s) to be served. Please identify the specific requirements under the Standards that the program will address. Include a linkage to identified community needs and priorities.

The population of interest includes children and youth aged 17 and younger.

The requirement under the School Health standards this program addresses include: 5. The board of health shall conduct surveillance, oral screening, and report data and information. All publically funded elementary schools in Oxford and Elgin Coutnies are screened. SWPH also attempts to screen all private schools as well. Dental screening resumed in the fall of 2022 and the 2022/2023 school year was completed. Examples of activities include: pre-

b) If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

The priority population in the group of school-aged children being screened include those with financial barriers, and or income disparities, as well as children who attend Low-German and Amish private schools. Collaborating with public health nurses and their church leaders in these communities.

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), target population, and delivery setting (e.g. schools, community centers, public health units, etc.).

N/A

Program Objective:

Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce urgent dental conditions by 5% by 2030 .

Intervention Descriptions:

Briefly describe the following public health intervention(s).

i 1) Oral Health Screening & Surveillance

Activities for this plan include conducting surveillance, oral screening in clinical settings, outreach and schools, and reporting data of the findings relating to children and youth 17 and under. Through screening, access to the Healthy Smiles Ontario (HSO) program for emergency or essential need can be supported and coordinated by the local Public Health Unit in Elgin and Oxford regions.

School Health - Vision

A. Community Needs and Priorities

Please provide a short summary of the following:

a) The key data and information which demonstrates your communities' needs for public health interventions to address vision.

School Health

Globally, approximately 19 million children under the age of 15 years have one or more vision impairments. In the United States, vision impairment is estimated to affect 1%-5% of children. Early detection and treatment of vision problems is important to ensure conditions are not risking permanent vision loss. According to Public Health Ontario (2016), the "prevalence of amblyopia by age 6.5 to 8 years was reported to be lower in children screened more frequently between the ages of 8 to 37 months, compared to those screened less frequently or not at all, although the results were not always statistically significant." The target population for this program inlcudes children in senior kindergarten. In-school vision screening and surveillance has been deferred to a lack of staffing resources to provide this screening program. However visual health information is provided to all junior and senior kindergarten students during dental screenings.

b) Your board of health's determination of the local priorities for a program of public health interventions that addresses vision.

The vision screening and surveilllance in-school program has been derferred this year due to a lack of resources (staffing). However as noted previously, staff are promoting the importance of eye exams and providing system navigation for families with children who may need assistance in accessing optometry services in our community.

B. Key Partners/Stakeholders

Please provide a high level summary of the specific key internal and external partners you will collaborate with to deliver on this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanism for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include: the Healthy School Team and Communications.

External partners include: the Thames Valley District School Board, the London District Catholic School Board and Private schools, optometrists in our region, preschool daycares, SmartHubs and EarlyOn Centers to promote the importance of visual health and visits to optometrists. This service is provided by optometrists as an external partner and thus providing similar programming/services to our prior in-school screenings. Therefore, the role that SWPH may be able to take a more passive role and to promote our external partners so that the goal of children being screened is still achieved for those children in SK in the Elgin/Oxford region.

P 1) Child Visual Health and Vision Screening

Program Description:

a) Describe the program including the population(s) to be served. Please identify the specific requirements under the Standards that the program will address. Include a linkage to identified community needs and priorities.

The population to be served includes school children in Senior Kindergarten (SK).

The requirements under the School Health standard that this program addresses includes: 7. The board of health shall provide, in collaboration with community partners, visual health supports and vision screening services. The vision screening program has been deffered due to a lack of staffing resources, however targeted visual health promotion is being done to reach the target audience.

b) If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

No

School Health

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), target population, and delivery setting (e.g. schools, community centers, public health units, etc.).

N/A

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Increase the percentage of children aged 4 and 5 who receive visual assessments (by an optometrist) to 95% of eligible students by 2030.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Vision

Provide informational resources to promote vision screening/assessments by Optometrists in SK students in all Elgin and Oxford schools to detect risk factors for vision disorders (amblyopia, reduced stereopsis or/strabismus, refractive vision disorder). Collaborate with community partners to help ensure the provision of vision screening/eye exams with an optometrist for SK students in our jurisdiction to detect risk factors for vision disorders.

School Health - Immunization

A. Community Needs and Priorities

Please provide a short summary of the following:

a) The key data and information which demonstrates your communities' needs for public health interventions to address school health immunization.

The community needs are the same from a general viewpoint as across Ontario - the PHU is required to be involved in the immunization record status of children attending school and licensed childcare. Based on the PHO report, we know that across Ontario there has been a decline of UTD immunization coverage of all childhood vaccines throughout the pandemic. While catch-up efforts have shown an increase in coverage, few PHUs saw coverage similar to pre-pandemic levels. Locally, the UTD status amongst 7 year olds saw decrease of over 10% from 2019/20 to 2021/22 school year (as of April 2023) amongst: measles (83.1-70.2), mumps (81.7-70.2), varicella (78.5-68.2), diptheria (81.4-70.2), tetanus (81.4-70.2), pertussis (82.6-70.2), and polio (82.8-70.4). This data may indicate a decrease in vaccination against these diseases or reporting of vaccination status from childhood immunizations. Locally, the UTD status amongst 12 year olds (including those captured in catch up programs) from 2018/19 to 2021/22 school year (as of Aug 2022) saw decreases in Hep B (61.3-54.6), HPV (51.9-46.9), and MenC-ACYW (81.4-73.5). This data likely relates to decreased vaccinations during covid due to lack of school based clinics, as there has drastic increases in UTD status from 2019/20 and 2020/21 school years compared to the catch up rates in those years (ie Hep B rates: 24.4, 9.7, 67.8, 64.0 respectively).

b) Your board of health's determination of the local priorities for a program of public health interventions that addresses school health immunization with consideration of the required list of topics identified in the Standards.

School Health

All students attending school in Oxford, Elgin and St. Thomas will undergo a comprehensive immunization record review in 2024 using the provincial Panorama system.
All schools who support Grade 7 students will be offered on-site, in-school vaccinations for Hepatitis B, Human Papillomavirus and Quadrivalent Meningococcal vaccine in 2024.

c) A description of how other topics for consideration not addressed in the Annual Service Plan were assessed or considered under School Health - Immunization.

Vaccine hesitancy - specific religious groups and cultural groups in Oxford, Elgin and St. Thomas do not vaccinate as per their beliefs. There is an increase in vaccine hesitant populations and anti-immunizers due to mistrust in Public Health systems during and after COVID19. SWPH will work with faith and cultural leaders to engage in discussions about immunizations to support trust building and prevent other vaccine preventable diseases (i.e. pertussis,

B. Key Partners/Stakeholders

Please provide a high level summary of the specific key internal and external partners you will collaborate with to deliver on this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanism for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include: the Healthy School Team

External partners include: Thames Valley District School Board, the London District Catholic School Board, Conseil Scolaire Catholique Providence, Private School Boards, Operators of licensed childcares in Oxford, Elgin and St.Thomas, and Primary Care leads.

P 1) Immunizations for Children in Schools and Licensed Child Care Settings

Program Description:

a) Describe the program including the population(s) to be served. Please identify the specific requirements under the Standards that the program will address. Include a linkage to identified community needs and priorities.

School Health

The population to be served includes children attending child care (ages 1-4 yrs) and children attending schools (4-17 yrs).

The requirements under the School Health standard this program addresses include: 8. The board of health shall enforce the Immunization of School Pupils Act and assess the immunization status of children; 9. The board of health shall work with school boards and schools to identify opportunities to improve public knowledge and confidence in immunization for school-aged children by: a) Adapting and/or supplementing national/provincial health communications strategies, where local assessment has identified a need; b) Developing and implementing regional/local communications strategies, where local assessment has identified a need; and c) Addressing topics based on an assessment of local needs; and 10. The board of health shall promote and provide provincially funded immunization programs to eligible students in the health unit through school-based clinics.

The requirements under the Immunization standard that this program addresses include: 1. The board of health shall, in accordance with the Immunization for Children in Schools and Licensed Child Care Settings Protocol, 2018 (or as current), assess, maintain records, and report on: a) The immunization status of children enrolled in licensed child care settings, as defined in the Child Care and Early Years Act, 2014; b) The immunization status of children attending schools in accordance with the Immunization of School Pupils Act; and c) Immunizations administered at board of health-based clinics as required in accordance with the Immunization for Children in Schools and Licensed Child Care Settings Protocol, 2018 (or as current) and the Infectious Diseases Protocol, 2018 (or as current); 3. The board of health shall work with community partners to improve public knowledge and confidence in immunization programs and services by: a) Adapting and/or supplementing national/provincial health communications strategies where local assessment has identified a need; b) Developing and implementing regional/local communications strategies where local assessment has identified a need; and c) Addressing the following topics based on an assessment of local needs; 4. The board of health shall provide consultation to community partners on immunization and immunization practices, based on local needs and as requested; 5. The board of health shall promote and provide provincially funded immunization programs and services to eligible persons in the health unit, including underserved and priority populations.

b) If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

All licensed childcares in Oxford, Elgin and St. Thomas will have completed record reviews in 2024 to ensure compliance with the CCEYA
All school aged children in Oxford, Elgin and St. Thomas will undergo a comprehensive immunization record review in accordance with ISPA in 2024.

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), target population, and delivery setting (e.g. schools, community centers, public health units, etc.).

N/A

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Increase the immunization coverage (ie up to date rates) for all school based programs (Hep B, HPV, Men-c-acyw) and infant and childhood programs (MMR, Varicella, tetanus, diphtheria, pertussis, polio, Hib, pneumo-c, men-c-c) within the SWPH area to be at or above Ontario rates by 2028.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Immunization for Children in Schools and Licensed Child Care Settings

School Health

Education, promotion, and assessment of the immunization status of children enrolled in licensed childcare settings (as per CCEYA, 2014) and children attending schools (as per ISPA); including suspension orders as required. Immunization clinics will be provided within school settings in the spring 2024 (for 2023 school year) and fall 2024 (for 2024 school year) for publicly funded vaccines.

School Health - Other

A. Community Needs and Priorities

a) Please identify which topics of consideration listed in requirement 4 of the School Health Standard **are being prioritized** by your board of health over the reporting period. Please briefly describe your rationale (i.e., key data and information including but not limited to, local conditions, comparison with provincial rates, acute elevations) to demonstrate why these topics are being prioritized.

SWPH identified 4 shared priorities for our school health programming. These shared priorities were identified through collaboration with our school board partners. The 4 priorities are:
1. Mental health promotion. Schools are reporting increased issues with student emotional dysregulation among their students. According to Children's Mental Health Ontario, approximately 70 per cent of children and youth reported a worsening of their mental health since the start of the pandemic. Children with no previous diagnoses are now experiencing higher rates of depression, anxiety, irritability, and inattention.
2. Substance use prevention. Regional school boards are reporting serious concerns with vaping in both elementary and secondary schools. Data with respect to substance use by youth post pandemic is limited at this time.
3. Health equity and inclusion. The pandemic has disproportionally affected marginalized individuals. The cost of living has been steadily increasing. To further remove and prevent systemic barriers and discriminatory practices.
In addition, additional SWPH resources and supports are directed to priority schools as defined by the Educational Opportunities Index (EOI). The EOI uses SDOH measures such as lone parent status, low income and educational attainment to determine which schools are a higher priority and receive additional services from SWPH.

b) Please briefly describe how the topics for consideration listed in requirement 4 of the School Health Standard **that are not addressed** in the Annual Service Plan were assessed or considered.

The 4 topics noted in a.) are being prioritized. However, emergent issues addressed at schools are inclusive of all topics in OPHS school standard. Those topics are addressed based on local school needs.

c) Considering the concept of proportionate universalism, describe how your board of health determines which school communities to prioritize for engagement and the provision of programs and services.

SWPH uses proportionate universalism to determine the level of services schools receive. This approach focusses on delivering equitable service by delivering a greater volume of service to the schools we know need it the most. This ensures disproportionate pockets of need are met with proportionate care and attention by our team; especially as we know the folks with highest need before COVID were affected the most by COVID's unintended consequences and will have even greater need now as a result.

In order to do this, we have separated schools into 2 categories: lower priority and higher priority. School category is determined by a high score on the Education Opportunities Index which combines factors like qualifying as a low-income household, single parent status and a low-level of parental education (i.e., attainment of less than HS diploma); all of which are factors that, at higher proportions, increase risk for poor health outcomes. High EOI score means high needs so they get more service including mental health programming in schools. In addition, we provide support to our private schools based on our current understanding of their population's SDOH make-up."

School Health

B. Key Partners/Stakeholders

a) Provide a high-level summary of **school board and school partners (e.g., school administrators, school staff)** you will collaborate with to deliver on this Standard. Include a description of the contribution/role of school boards and schools in program and service delivery, the mechanism(s) for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and the frequency of engagement. Please also describe any situations where the programming provided by the school board and / or school partners is sufficient so that you have not had to deliver similar programming under this Standard.

SWPH shares school boards with MLHU. Together the health units and area school boards are working to action the signed partnership declarations and data sharing agreements through our numerous working groups and committees to address our 4 shared priorities noted in question A. a.). The meeting frequency of these committees and working groups varies depending on the tasks at hand. For example, our mental health working group meets monthly as does our data sharing and planning working group. However other groups meet less frequently if they are associated with a time limted deliverables.

b) Provide a high-level summary of **key internal partners and external partners *other than* school board and school partners you will collaborate with to deliver on this Standard (e.g., students, broader school community, parents / guardians, not-for-profit organizations, university partners, researchers, municipalities, etc).** Include a description of the contribution/role of the key internal and other external partners in program and service delivery, the mechanism(s) for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), and the frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include: the Chronic Disease and Injury Prevention Team, the Foundational Standards Team, the Healthy Growth and Development Team, the Infectious Diseases Team, the IPAC Hub Team, the Oral Health and Vision Team, the Sexual Health Team and the Vaccine PReventable Diseases Team.

Other key external partners include the school community which includes parents and caregivers, and school staff to gain insight into the needs of the schools. In terms of the Low German community, we will be working with the Steering Committee from the Low German Community of Practice to improve the way we provide service to our private schools. We will work with provincial working groups to improve standard school resources and programming to improve overall impact.

P 1) Comprehensive School Health

Program Description:

a) Describe the program including:

a1) The target population(s) to be served by the program.

The target populations include: school-aged children, parents and caregivers of school-aged children and the education sector.

a2) Identify the specific requirements under the School Health Standard that the program will address.

School Health

The requirements under the School Health Standard this program addresses include: 1. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to the health of school-aged children and youth and report and disseminate the data and information; 2. The board of health shall provide population health information, including social determinants of health and health inequities, relevant to the school population to school boards and schools to identify public health needs in schools; 3. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach to improve the health of school-aged children and youth; 4. The board of health shall offer support to school boards and schools.

a3) If applicable, identify which topics of consideration listed in requirement 4 of the School Health Standard the program intends to address.
1) Concussions and injury prevention, 2) Healthy eating behaviours and food safety, 3) Healthy sexuality, 4) Immunization, 5) Infectious disease prevention (e.g., tick awareness, rabies prevention, and hand hygiene), 6) Life promotion, suicide risk and prevention, 7) Mental health promotion, 8) Oral health, 9) Physical activity and sedentary behaviour, 10) Road and off-road safety, 11) Substance use and harm reduction, 12) UV exposure, 13) Violence and bullying, 14) Visual Health, 15) Not applicable, 16) Other (Please explain)

1) Concussions and injury prevention, 2) Healthy eating behaviours and food safety, 3) Healthy sexuality, 4) Immunization, 5) Infectious disease prevention (e.g., tick awareness, rabies prevention, and hand hygiene), 6) Life promotion, suicide risk and prevention, 7) Mental health promotion, 8) Oral health, 9) Physical activity and sedentary behaviour, 10) Road and off-road safety, 11) Substance use and harm reduction, 12) UV exposure, 13) Violence

a4) Describe key activities or approaches that the program will utilize.

The approaches taken will align with the Canadian Healthy School Standards and address 4 distinct but inter-related components that comprise the comprehensive school health approach: teaching and learning supports, partnerships and services, healthy school policy, and social and physical environments. Key activities include: priority schools receive intensive school visiting and evidence informed programming based on the a school level

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

Due to COVID-19 recovery, schools were unable to uptake as much school health programming as compared to pre COVID-19 engagement, given competing priorities and strains. The Healthy School Team is now positioned to better respond to needs in our community and have partners who are in a similar state of readiness. Current conversations with local school boards are continuing to encourage a more unified approach to services going forward between local health units (SWPH and the Middlesex London Health Unit [MLHU]). There is a need to provide evidence-informed activities, and to clearly define the role of the Healthy Schools Team as a support to the school system. Additionally, there is a mutually agreed upon need to support recovery in the areas of mental health, family engagement, equity and substance misuse between SWPH, MLHU and local school boards which we plan to address in the substance use, and mental health plans. An ACEs framework has been supported to move this work forward. The "Supporting Documents" section of this program plan has more on the work the Healthy Schools Team has done to develop a plan to focus our service delivery on equity, and consistency across school boards. The Healthy Schools Team is also moving forward on strengthening internal relationships with other teams such as Sexual Health, Vaccine Preventable Disease, Chronic Disease and Injury Prevention, and Healthy Growth and Development through shared team processes and policies, program planning activities, and other opportunities for collaborative efforts to create efficiencies and streamline work as applicable.

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

Priority populations include: children and youth who attend priority schools as defined by the Educational Opportunities Index and private schools including students from Amish and Low German Communities.

School Health

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g., resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

SWPH focuses on tier 1 mental health service in all schools. Area priority schools receive Healthy Relationships Plus Programming for grade 7/8 students. This program has been heavily evaluated via a randomized control trial, cost benefit ananlysis and a local evaluation conducted by the Centre for School Mental Health that examined the effictiveness of our univeral application of the program. The program addresses healthy relationships, impact of media,

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Chronic Disease Prevention and Well-Being, Substance Use and Injury Prevention, Healthy Growth and Development), please identify those Program Standards or indicate N/A.

N/A

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the school health program over the reporting period. Consider the inclusion of indicators that assess both the health of school-aged children and youth and the strength of the board of health's working relationship with school boards and schools, as applicable.

90% of priority school and 50% of universal school administrators are aware of the Healthy School Team resources and services available to them by 2025 as demonstrated by the year end administrator survey

20% increase in family engagement within Healthy School Team programming in schools by 2025 as demonstrated by the documentation tool

20% increase in community organization engagement within Healthy School Team programming in schools by 2025 as demonstrated by the documentation tool

80% of MLHU and SWPH co-branded programs and resources align and are offered consistently across public school boards by 2025 as demonstrated by the year book

50% of priority schools that have worked with the Healthy School Team to increase health focused changes in the school environment by 2025 as demonstrated by the documentation tool

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Increase the percentage of Thames Valley District School Board students that respond yes to 'I feel like I belong' by 2% by 2030

Increase the percentage of London District Catholic School Board students that respond 'agree' to 'I feel like I am part of this school' by 2% by 2030

20% increase in community organization engagement within Health School Team programming in schools by 2025 as demonstrated by the documentation tool

School Health

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Comprehensive School Health

Our approach builds capacity in schools recognizes that belonging is a protective factor for many of the OPHS topics. Actions address 5 distinct but inter-related components that comprise the comprehensive school health approach: teaching and learning, community partnerships, school community engagement, school health in all policies, and social and physical environments.

Substance Use and Injury Prevention

A. Community Needs and Priorities

a) Please identify which topics of consideration listed in requirement 2 of the Substance Use and Injury Prevention Standard **are being prioritized** by your board of health over the reporting period. Please briefly describe your rationale (i.e., key data and information including but not limited to, local conditions, comparison with provincial rates, acute elevations) to demonstrate why these topics are being prioritized.

The topics of consideration listed in requirement 2 of the Substance Use and Injury Prevention Standard being prioritized by SWPH for this reporting period include: comprehensive tobacco control, falls, mental health promotion, and substance use.

The information used to inform the prioritization process included local data of need, evidence on risk and protective factors and feasibility of acting on them, existing community programs and services and gaps, as well as local appetite.

The following are examples of some of the data and evidence used to select topics of focus:
-The local alcohol-related mortality rate in the SWPH region increased between 2018 and 2021, whereas the provincial rate decreased during the same time.
-The burden of health conditions attributed to alcohol and cost of alcohol-related harms were also considered.
-Smoking rates in the SWPH region are significantly higher than Ontario in both adults and youth.
-A polysubstance approach has been considered for cannabis and alcohol because of commonalities in effective strategies to address use. For example, the Planet Youth Model has been shown to be effective is preventing or delaying onset of alcohol, cannabis and tobacco.
- Local rates of opioid-related emergency department visits and hospitalizations have been consistently higher than the provincial rates over time.
-The rate of opioid-related deaths have been similar to or just below the provincial rate. however, data from the last four years shows concerning increasing trends.

b) Please briefly describe how the topics for consideration listed in requirement 2 of the Substance Use and Injury Prevention Standard **that are not addressed** in the Annual Service Plan were assessed or considered.

SWPH collected and analyzed available data in all injury prevention topics in early 2023. Through that process, we learned that hospitalization and ED visits for unintentional injuries in our SWPH region were significantly higher than the province. Falls saw the greatest numbers of the unintentional injury topics across ages but in particular in older adults. When considering the data, potential years of life lost, cost by outcome, existing local programs and services, staff capacity, as well as effective interventions for all injury topics, it was determined that falls would be prioritized. Some of the other injury topics are touched on through our work in the built environment, such as road safety.

Violence and life promotion, suicide risk and prevention have not been prioritized here because of capacity and the knowledge that other community stakeholders are addressing these topics locally. It should be noted the violence will be addressed through the Healthy Growth and Development work on ACES and that SWPH does participate on some committees that address these topics (e.g. Mental Health Network).

Substance Use and Injury Prevention

B. Key Partners/Stakeholders

Please provide a high level summary of the specific key internal and external partners (e.g., community organizations, people with living/lived experience, research institutions, harm reduction agencies) you will collaborate with to deliver on this Standard. Include a description of the contribution/role of these partners in program and service delivery, the mechanisms for engagement (e.g., data sharing agreements, committee tables, working groups, etc.), substances of focus (i.e., alcohol, cannabis, tobacco, opioids and other drugs), and frequency of engagement. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard.

Internal partners include: the Foundational Standards Team, the Healthy Schools Team, the Chronic Disease and Injury Prevention Team, the Infectious Diseases Team and the Healthy Growth and Development Team.

Substance Use and Injury Prevention

Alcohol external partners include: Municipal Staff, OPHA Alcohol Work Group, Regional Polysubstance Group, Health Organizations across Canada (example: B.C's regional health authorities and other Ontario Health Units), Canadian Alcohol Policy Evaluation CoP, government officials (as requested), and researchers. Municipal Staff: Will engage with them to enhance alcohol policy at the municipal level, especially re: Municipal Alcohol Policy. SWPH will engage with them via written letters and in person, as per their preference. We plan to contact them once with information, and will engage as they request after that. OPHA Alcohol Work Group: Will Co-Chair this group, meet monthly, and actively participate in subgroup activities to complete work. This will mostly be done by teams meetings and calls. The work done with this group is the bulk of my activities and facilitates quality and efficient work getting done. Regional Polysubstance Group: Meet monthly, and actively participate in our plan to complete work. Healthy Organizations across Canada (example: B.C's regional health authorities and other Ontario Health Units): To engage with the groups on an as-needed basis when work activities or programs align. This will be done through teams meetings. CAPE CoP: To meet with these partners every other month to stay informed and up to date with Alcohol related policy across the country and globe. This contributes to work getting done and provides great information as to what is best practice and evidence-based. Researchers: To engage with researchers on an as needed basis, incorporating their expertise in my work when needed. This will be done via written emails, letters or teams meetings. They bring a wealth of information and credibility to the work and the activities needing to be completed.

Comprehensive Harm Reduction external partners include: The key external partners that we will collaborate with to deliver work under this plan include: educational institutions, people with lived/living experience, community partner organizations, first responders, non-profit organizations, health care providers, and local municipalities and political partners. Some examples of these collaborators specific to the SWPH region include: TVDSB, LDCSB, MLHU, CHCs, The Nameless, Indwell, CMHATV, YWCA, RHAC, OATC, OHT, Operation Sharing, Grace Cafe / The Annex, and Local Municipalities and Partners (politicians, city employees, law enforcement agencies, EMS, etc.). The contributions/roles of these partners will vary depending on the activities that they will be engaged for. For example, members of the drug and alcohol strategies will be engaged on a regular, on-going basis at committee meetings (typically monthly or bi-monthly). Another example, the ONP site partners, who will have a large role and contribution, and will be engaged regularly by the SH nurses. Some programs and initiatives may be more one-off in nature and therefore there may be less contribution or collaboration with certain partners. Other initiatives that will involve partners may be limited in-scope and require the formation of a working group to brainstorm and plan activities based on the community's need. There is not a situation where the programming provided by external partners is sufficient under the HR program standard, therefore it will be a collaborative effort.

Consumption and Treatment Services (Phase 2) external partners include: a lead community agency, other community organizations, people with lived/living experience, municipal partners, business owners, healthcare providers, landlords, developers, etc. There will be an external committee with community members from multiple sectors. The partner(s) who are willing to explore, apply for, and operate a CTS site will be supported by SWPH, but they will be the main operator.

Needle Syringe Program external partners include: municipal partners in identifying new locations to install a syringe kiosk (as SWPH has many in storage). The Town of Aylmer showed interest in the past. We will also work with NEP satellite sites, mobile outreach and other supply partners to distribute supplies in the community and deliver education sessions. Staff will attend the Oxford and Elgin Drug Strategy Work Group meetings to engage people with lived experience and consider recruiting them for their support with the program. Attending planning meeting with CDIP team for harm reduction planning will look at Naloxone, community bins and Wellkin to further partnerships as two sites within the region, recent Naloxone and NEO training 2022/2023 and keen to further partnerships for substance use prevention and education for youth and families.

Smoke-Free Ontario's external partners include other public health units through the Adult Nicotine Dependence Advisory Committee, the Provincial Cessation and Protection workgroups, the Youth Nicotine Dependence Advisory Committee - Vaping Policy workgroup, the Southwest Tobacco Control Area Network - Cessation Subcommittee. These collaborations will be used to inform mass media campaigns, brief contact intervention training, sharing resources and data surveillance. Additionally, we will be collaborating with individual Public Health Unit's to investigate the feasibility of expanding the Pharmacy Cessation Program under the Public Health Agency of Canada grant.

P 1) Alcohol

Program Description:

a) Describe the program including:

a1) The target population(s) to be served by the program.

Substance Use and Injury Prevention

The target population to be served is people 15+ years of age who drink alcohol.

a2) Identify the specific requirements under the Substance Use and Injury Prevention Standard that the program will address.

The specific requirements under the Substance Use and Injury Prevention standard that this program addresses include: 2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses risk and protective factors to reduce the burden of preventable injuries and substance use in the health unit population.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Substance Use and Injury Prevention Standard the program intends to address.
1) Comprehensive tobacco control, 2) Concussions, 3) Falls, 4) Life promotion, suicide risk and prevention, 5) Mental health promotion, 6) Off-road safety, 7) Road safety, 8) Substance use, 9) Violence, 10 Not applicable, 11) Other (Please explain)

N/A

a4) Describe key activities or approaches that the program will utilize.

Key activities include: Supporting Policy that Decreases Alcohol Harms, Municipal Policy Knowledge Dissemination, New Alcohol Guidance Promotion, and Public Education Regarding Alcohol Harms (Awareness based).

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

Our local rates of use according to self-reported data from the Canadian Community Health Survey, shows 62% of adult respondents in the Southwestern Public Health region report having no-risk or low-risk alcohol use, while about 39% report risky alcohol use, meaning they drink 3 or more alcoholic beverages per week (CCHS, 2020). It should be noted that self-reported data has been shown through research to underestimate the amount people actually drink, sometimes by 50-75%, and that the rate of risky drinking is likely higher (CISUR infographic). Estimates of average annual deaths from health conditions attributable to alcohol was 76 in SW area and 4,330 in Ontario (PHO Burden Report, 2023). Estimates of average annual Emerge Visits from health conditions attributable to alcohol was 3707 in Southwestern area (PHO Burden Report, 2023). SW significantly has more youth of both sexes who have ever had a lifetime drink, compared to Ontario (OSDUHS, 2020). There were significantly more grade 7 and 9 students starting to drink earlier in SW than Ontario. (OSDUHS, 2020) Youth in the SWPH Region perceive it to be Very Easy to get alcohol in the SWPH Region, significantly higher when compared to the Ontario rate. (OSDUHS, 2020) From the 2019-2020 data, Heavy Drinking was significantly higher for age ranges: 25-34 and 45-54 when compared to the 65+ age range in the SWPH Region. (CCHS, 2020) The age range for 45-54 was also significantly higher than Ontario for heavy drinking (CCHS, 2020).

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

Substance Use and Injury Prevention

The priority populations include people of lower socio-economic status and low income, pregnant women and unborn babies, youth, women and men.

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

The connection between alcohol consumption and mental health is well documented. Some use alchol to cope with symptoms of poor mental health and it can also lead to increased anxiety, strss and despression. By addressing the harms related to alcohol, the mental health realted harms are also indirectly addressed.

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Chronic Disease Prevention and Well-Being, School Health), please identify those Program Standards or indicate N/A.

This program also addresses Substance Use in the Chronic Disease Prevention and Well-being standard requirement 2.

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the substance use and/or injury prevention program over the reporting period.

50% of municipalities' staff/ managers are aware of recommendations that will improve their Municipal alcohol policies or bylaws that will decrease harms due to alcohol use (8 out of 16 municipalities)

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce the percentage of the population (15+) that drinks at or above the moderate risk level of 3 or more drinks per week from 39% to 30% by 2035.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Alcohol

Increasing awareness of the negative impacts of alcohol and reducing chronic disease/ injuries related to alcohol. Support and influence Federal, Provincial and Municipal alcohol policy to decrease population level harms.

P 2) Cannabis

Program Description:
a) Describe the program including:
a1) The target population(s) to be served by the program.

Substance Use and Injury Prevention

The primary target population is youth aged 12-18 and adults 18+ and parents/guardians.

a2) Identify the specific requirements under the Substance Use and Injury Prevention Standard that the program will address.

The specific requirements under the Substance Use and Injury Prevention standard that this program addresses include: 2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses risk and protective factors to reduce the burden of preventable injuries and substance use in the health unit population.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Substance Use and Injury Prevention Standard the program intends to address.
1) Comprehensive tobacco control, 2) Concussions, 3) Falls, 4) Life promotion, suicide risk and prevention, 5) Mental health promotion, 6) Off-road safety, 7) Road safety, 8) Substance use, 9) Violence, 10 Not applicable, 11) Other (Please explain)

N/A

a4) Describe key activities or approaches that the program will utilize.

Key activities include: collaborating with regional Polysubstance Working Group on awareness raising of cannabis guidelines, awareness raising on pediatric poisoning for cannabis, Talking Pot with Youth, and Planet Youth Prevention Model (outlined below).

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

According to OSDUHS, 25% of youth used cannabis (any form) in the past 12 months with 8% using one or more times a week in the past 4 weeks in the SWPH region. SWPH youth are starting to use cannabis at the mean age of 15yrs old while the mean age for Ontario youth is 18yrs old. Males were younger than females at 14.91 (14.16-15.66) vs 15.27 (14.73-15.82) with friends as the primary source of access. 13% of youth don’t know the risks of cannabis use while another 13% believe no risks.

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

N/A

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

Substance Use and Injury Prevention

The Planet Youth Model, as outlined below, has a focus on enhancing protective factors that are shared with mental health.

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Chronic Disease Prevention and Well-Being, School Health), please identify those Program Standards or indicate N/A.

N/A

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the substance use and/or injury prevention program over the reporting period.

Social media engagment on awareness posts
Decrease in pedeatric poisoning ER visits

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

To increase awareness of lower-risk cannabis use among adults 18+ by December 2024.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

P 3) Other Drugs

Program Description:
a) Describe the program including:
a1) The target population(s) to be served by the program.

N/A

a2) Identify the specific requirements under the Substance Use and Injury Prevention Standard that the program will address.

N/A

Substance Use and Injury Prevention

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Substance Use and Injury Prevention Standard the program intends to address.
1) Comprehensive tobacco control, 2) Concussions, 3) Falls, 4) Life promotion, suicide risk and prevention, 5) Mental health promotion, 6) Off-road safety, 7) Road safety, 8) Substance use, 9) Violence, 10 Not applicable, 11) Other (Please explain)

N/A

a4) Describe key activities or approaches that the program will utilize.

N/A

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

N/A

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

N/A

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

N/A

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Chronic Disease Prevention and Well-Being, School Health), please identify those Program Standards or indicate N/A.

N/A

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the substance use and/or injury prevention program over the reporting period.

N/A

Substance Use and Injury Prevention

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

N/A

Intervention Descriptions:
Briefly describe the following public health intervention(s).

P 4) Harm Reduction Program Enhancement

Program Description:
a) Describe the program including:
a1) The target population(s) to be served by the program.

The target populations to be served by the program include: people with living/lived experience (who use drugs),

a2) Identify the specific requirements under the Substance Use and Injury Prevention Standard that the program will address.

The specific requirements under the Substance Use and Injury Prevention Standard that this program addresses include: 1. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to injuries and substance use and report and disseminate the data and information; 2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses risk and protective factors to reduce the burden of preventable injuries and substance use in the health unit population; 7. The board of health shall use health promotion approaches to increase adoption of healthy behaviours among the population regarding sexual practices and injection drug use to prevent and reduce exposures to sexually transmitted and blood-borne infections by collaborating with and engaging health care providers, community and other relevant partners, and priority populations.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Substance Use and Injury Prevention Standard the program intends to address.
1) Comprehensive tobacco control, 2) Concussions, 3) Falls, 4) Life promotion, suicide risk and prevention, 5) Mental health promotion, 6) Off-road safety, 7) Road safety, 8) Substance use, 9) Violence, 10 Not applicable, 11) Other (Please explain)

Mental health promotion

a4) Describe key activities or approaches that the program will utilize.

Substance Use and Injury Prevention

Key activities for comprehensive harm reduction include: naloxone distribution, training and partner engagement, drug and alcohol strategies, internal opioid response plan, people with lived experience engagement and retention, anti-stigma training, and harm reduction education and advocacy.

Key activities for consumption and treatment services (phase 2) include: site specific community consultations, assembling an implementation external advisory committee, location deliberation, further data collection, application support, exploration of alternate options to consumption and treatment services.

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

Overall opioid mortality: Opioid deaths per 100,000 people have increased in the SWPH region from the years 2019-2021 (SWPH region – 2019, 8.2; 2020, 13.4; 2021, 21.9), with the peak in 2021 being higher than the provincial rate for that same timeframe (21.9 in SWPH region vs. 19.4 in Ontario as a whole). Based on preliminary 2022 data, the SWPH region experienced a slight decline in opioid-related death rates, although they remain elevated above pre-pandemic rates.

Opioid mortality rates (by age group): Across 2018-2021, the opioid-related mortality rate for the population 65+ and older has consistently been higher in the SWPH region compared to Ontario as a whole (2018; 7.6; 2019; 2.5; 2020; 4.8; 2021; 4.6 in SWPH region compared to Ontario with 2.9 in 2018; 2.3 in 2019; 2.6 in 2020; and 3.9 in 2021).

Opioid mortality rates (by sex): Across 2018-2021, males experienced higher rates of opioid-related deaths in the majority of years for both the SWPH region and Ontario. Rates of opioid-related deaths among females fluctuated from year to year for both regions; in some years, the SWPH region was higher, and in others, Ontario was higher. A similar trend was noted for opioid-related deaths among males, in that year-to-year peaks for this indicator were higher for the SWPH region in some years and Ontario in others.

Accidental opioid mortality proportion (by employment status): Across most years examined (2018, 86.7; 2019, 62.5; 2021,71.4; and 2022, 83.3), the SWPH region had a higher proportion of opioid-related deaths among unemployed individuals compared to Ontario (2018, 50.7; 2019, 49.4; 2021, 56.5; 2022, 52.4).

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

Reported above

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

In Oxford County, the Drug and Alcohol Strategy and Mental Health Network have merged to address both mental health and substance use and the overlapping needs. In Egin St. Thomas, a similar merger of committees is being explored to better meet the needs of priority populations and avoid duplication where interventions are targeting shared risk and protective factors.

Substance Use and Injury Prevention

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Chronic Disease Prevention and Well-Being, School Health), please identify those Program Standards or indicate N/A.

Chronic Disease Prevention and Well-being (Requirement 2); Infectious and Communicable Diseases Prevention and Control (Requirements 7 and 9)

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the substance use and/or injury prevention program over the reporting period.

Increase in community partners engaged in drug and alcohol strategies and shared harm reduction priorities
% increase in social media engagement for posts that aim to increase awareness of harm reduction
55% of municipal partners (in at least one county) agree to move forward with identified recommendations / actions regarding Consumption and Treatment Services

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Decrease the SWPH opioid mortality rate to below the provincial rate by 2029.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Comprehensive Harm Reduction Plan

Enhancing HR efforts internally & within the community through advocacy and policy development; education; Community Sharps Strategies, Mobile Outreach; strategic planning for the adoption of safe supply and Consumption and Treatment Services (CTS); Municipal Drug & Alcohol Strategies; Internal Opioid Response Plan; overdose prevention training; and Naloxone.

i 2) Consumption and Treatment Services (Phase 2)

SWPH will consult and support the next phase of the Consumption and Treatment Services (CTS) project with an external partner (lead organization) to begin to complete the five recommendations outlined in the Feasibility Study Report. This process will include strategic conversations with key community partners, anti-stigma training and public education, site-specific consultations, assemble an implementation committee, exploration of funding models and possibly alternatives to CTS, further data collection and consultations, and application support. This next phase will also be dependent on the Provincial review of CTS sites and the associated funding requirements.

P 5) Needle Syringe Program

Substance Use and Injury Prevention

Program Description:

a) Describe the program including:

a1) The target population(s) to be served by the program.

The Needle Syringe Program is a community-based program that provides access to sterile needles and other drug-use supplies, facilitates the safe disposal of used syringes, and provides links to other important services and programs such as referrals to substance use disorder treatment programs, screening, care and treatment for viral hepatitis and HIV, overdose prevention education and safer injection practices, screening for sexually transmitted infections, Naloxone distribution and education and referral to social, mental and other medical services.

The target population for this program is people who use drugs and people who support individuals who use drugs.

a2) Identify the specific requirements under the Substance Use and Injury Prevention Standard that the program will address.

Substance Use and Injury Prevention -Requirement#2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach to reduce the burden of preventable injuries and substance use in the health unit population.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Substance Use and Injury Prevention Standard the program intends to address.
1) Comprehensive tobacco control, 2) Concussions, 3) Falls, 4) Life promotion, suicide risk and prevention, 5) Mental health promotion, 6) Off-road safety, 7) Road safety, 8) Substance use, 9) Violence, 10 Not applicable, 11) Other (Please explain)

Substance Use

a4) Describe key activities or approaches that the program will utilize.

The Needle Syringe Program includes Mobile Outreach (in partnership with Regional HIV/AIDS Connection), Satellite Sites (in partnership with various community partners and agencies - The Nameless, Inn out of the Cold, The Annex, Grace Cafe, Operation sharing), Needle Syringe Program client visits at fixed sites (Woodstock, St. Thomas), harm reduction supplies for inhalation and injection provided, wound care related to substance use injury assessed during Needle Syringe Program visits, and safe disposal of sharps and biohazardous waste related to substance use in the community.

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

The work of the Needle Syringe Program is closely tied to other harm reduction work happening in the health unit and in the community. We are connected to active drug strategy working groups in two regions and will be doing anti-stigma work with an aim to target different audiences including hospital partners and “fence-sitters” in the general public.

Substance Use and Injury Prevention

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

None

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

SWPH acknowledges that people who use substances regularly experience stigma. Literature suggests there is a link between stigma and mental health. Mental health and mental illness are often discussed with clients accessing our services. Referrals may be made or facilitated as needed.

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Chronic Disease Prevention and Well-Being, School Health), please identify those Program Standards or indicate N/A.

Infectious and Communicable Diseases Prevention and Control (Requirements 7, 9 and 10).

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the substance use and/or injury prevention program over the reporting period.

- 80% of needle exchange clients have increased knowledge of safer injection and inhalation practices
- Increase in the rates of returned harm reduction supplies
- # of new NEP satellite sites brought onboard
- # of inhalation supplies distributed to substance users
- # of syringes distributed to substance users

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce the rate of new Hepatitis C infections to below 30 per 100,000 population by 2025

Maintain the rate of new HIV infections at or below 2.8 per 100,000 population by 2025

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Needle Syringe Program

Substance Use and Injury Prevention

The Needle Syringe Program is a community-based program that provides access to sterile needles and other drug use supplies, facilitates the safe disposal of used syringes, and provides links to other important services and programs such as referrals to substance use disorder treatment programs, screening, care and treatment for viral hepatitis and HIV, overdose prevention education and safer injection practices, screening for sexually transmitted infections, Naloxone distribution and education and referral to social, mental and other medical services.

P 6) Smoke-Free Ontario

Program Description:

a) Describe the program including:

a1) The target population(s) to be served by the program.

The target population to be served by the program includes: individuals over the age of 12 who are current daily smokers, municipalities, business owners and workplaces in achieving compliance with the Smoke Free Ontario laws.

a2) Identify the specific requirements under the Substance Use and Injury Prevention Standard that the program will address.

The specific requirements under the Substance Use and Injury Prevention Standard this program addresses include: 1. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to injuries and substance use and report and disseminate the data and information; 2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses risk and protective factors to reduce the burden of preventable injuries and substance use in the health unit population; 3. The board of health shall enforce the Smoke-Free Ontario Act, 2017.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Substance Use and Injury Prevention Standard the program intends to address.
1) Comprehensive tobacco control, 2) Concussions, 3) Falls, 4) Life promotion, suicide risk and prevention, 5) Mental health promotion, 6) Off-road safety, 7) Road safety, 8) Substance use, 9) Violence, 10 Not applicable, 11) Other (Please explain)

N/A

a4) Describe key activities or approaches that the program will utilize.

Key activities that this program will utilize include: providing support with the implementation on smoke/vape-free policy within multi-unit housing; Youth Access Inspections; SFOA Compliance Inspections; Complaints response; SFOA Promotion; and collaborating with TCAN partners to promote exisiting community and virtual smoking cessation servies.

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

Substance Use and Injury Prevention

Youth smoking rates were significantly higher in SWPH region compared to Ontario according to the 2019 Ontario Student Drug use and Health Survey. Grade 7-12 youth in SWPH region, 9.6% reported past year smoking, compared to the Ontario rate of 5%.

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

The priority populations include low-income individuals currently receiving Ontario Works or Ontario Disability Support Program benefits.

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

Youth vaping has been a growing concern in our area schools. SWPH will create a diversion program for youth caught vaping or smoking on school property that centers education and building skills in youth, and considers aspects of youth mental health.

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Chronic Disease Prevention and Well-Being, School Health), please identify those Program Standards or indicate N/A.

N/A

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the substance use and/or injury prevention program over the reporting period.

80% of Secondary school administrators know about the Smoke Free Ontario Act and support from Enforcement.
100% of mandated SFOA inspections completed

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Reduce the proportion of current daily smokers aged 12+ by 5% by 2035.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Nicotine Cessation and Smoke/Vape-Free Housing Policy

Enhance policy and practice to increase access to treatment for tobacco and e-cigarette use and reduce second-hand smoke exposure.

Substance Use and Injury Prevention

i 2) Smoke-Free Ontario Act Enforcement

Tobacco smoke and vapour protocols Tobacco Enforcement Officers complete mandatory SFOA (2017), youth access, display and promotion inspections required for all tobacco and electronic cigarette retailers, mandatory inspections with schools and hospitals, and respond to all SFOA complaints or inquiries. Provide education and support around the SFOA (2017)

P 7) Substance Use

Program Description:
a) Describe the program including:
a1) The target population(s) to be served by the program.

The target population is adolescents and youth aged 11-25 years of age.

a2) Identify the specific requirements under the Substance Use and Injury Prevention Standard that the program will address.

The requirement under the Substance Use and Injury Prevention Standard this program addresses includes: 1. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to injuries and substance use and report and disseminate the data and information.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Substance Use and Injury Prevention Standard the program intends to address.
1) Comprehensive tobacco control, 2) Concussions, 3) Falls, 4) Life promotion, suicide risk and prevention, 5) Mental health promotion, 6) Off-road safety, 7) Road safety, 8) Substance use, 9) Violence, 10 Not applicable, 11) Other (Please explain)

Mental health promotion and comprehensive tobacco control

a4) Describe key activities or approaches that the program will utilize.

The key activities this program will utilize include: Planet Youth Model implementation, school supportive programming, school vaping policies and practice, provincial and federal policies for substance prevention and cannabis prevention

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

Substance Use and Injury Prevention

The proportion of youth in the SWPH region that used an electronic cigarette (of any type) at least once in a lifetime is 42% compared to 31% for Ontario youth, with 14% of them using it 1 or more times a day compared to 7.87% Provincially. In comparison, 20.8% of youth report ever smoking tobacco products in their lifetime. Of those using e-cigarettes, 23% are using ones with nicotine compared to 14% Provincially. The main reasons for youth vaping is stress, anxiety and to relax, this finding is consistent across data sources; addiction and fun/like it alternates as the second and third reasons on different data sources; flavours/taste ranks lower than stress/anxiety or addiction. Perception of vaping with youth is the majority do not see it as 'cool', however, 48% of youth who vape report that their peers approve of vaping. The majority of youth see vaping as harmful. Harm increases with frequency and duration of use. The majority of youth perceive vapes as easy to obtain with online sales and direct retailer purchasing as the number one source. The average age of initiation for smoking tobacco is 15yrs which is the same as the Provincial age of initiation for smoking, with no current data on age of initiation for youth vaping.

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

The priority population of interest for this plan is teens and youth aged 11-18 (Grade 6-12).

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

The Planet Youth Model aims to enhance protective factors and address risk factors for youth substance use. Substance use and mental health have many shared risk and protective factors. Therefore, by taking that approach in our community, we also anticipate there will be positive outcomes for youth mental health.

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Chronic Disease Prevention and Well-Being, School Health), please identify those Program Standards or indicate N/A.

Chronic Disease Prevention and Well-being (Requirement #2)

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the substance use and/or injury prevention program over the reporting period.

80% of local stakeholders to gain knowledge of the Planet Youth Model (PYM) and the importance of primary prevention for youth substance prevention.

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Increase the age of initiation of substance use in our region from 14yrs for alcohol, 16yrs for tobacco, and 15yrs for cannabis to 19yrs by 2035.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

Substance Use and Injury Prevention

i 1) Primary Prevention of Substance Use

Increase the local, provincial and federal engagement and endorsement of the Planet Youth model (PYM) for substance prevention in youth. Mobilize action tables to implement local data collection/monitoring, distribution and solutions that meet the timely needs of the results. Support protective factor programs and policies that align with the PYM domains (peers, family, rec & leisure, schools).

P 8) Injury Prevention

Program Description:

a) Describe the program including:

a1) The target population(s) to be served by the program.

The target population of interest is older adults (65+).

a2) Identify the specific requirements under the Substance Use and Injury Prevention Standard that the program will address.

2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses chronic disease risk and protective factors to reduce the burden of illness from chronic diseases in the health unit population.

a3) If applicable, identify which topics of consideration listed in requirement 2 of the Substance Use and Injury Prevention Standard the program intends to address.
1) Comprehensive tobacco control, 2) Concussions, 3) Falls, 4) Life promotion, suicide risk and prevention, 5) Mental health promotion, 6) Off-road safety, 7) Road safety, 8) Substance use, 9) Violence, 10 Not applicable, 11) Other (Please explain)

Mental health promotion

a4) Describe key activities or approaches that the program will utilize.

Age Friendly Strategy Update & Implementation; Official & Master Plan Reviews; Primary Care Provider Support & Education; Community Care Support & Education.

a5) Provide any further contextual information as needed (i.e., links to relevant community needs and priorities).

Substance Use and Injury Prevention

Overall for 2020, Southwestern Public Health's age standardized rate (per 100,000) for hospitalization from unintentional injuries is 650.8. The rate for Emergency Department visits for unintentional injuries is 11,884.7. These are both significantly higher than Ontario at 439.6 and 7294.8 and the group of comparable health units at 556.8 and 10, 826. The rate of hospitalization for intentional injuries is 119.9 which is significantly higher than Ontario at 67.7 and our comparable health units at 98, but not in every age category. The rate for Emergency Department visits for all intentional injuries is 379.4. This is significantly higher than Ontario at 304.9 but also significantly lower than our comparable health units at 431. Our biggest concern for intentional injuries is in the 0-44 age groups, but overall the numbers for unintentional injuries are much worse. Looking at our data for unintentional injuries, we are the 4th worst health unit region in the province. Falls has the highest numbers and is our top priority for injury, specifically older adults 65+. Land transport collisions are also a considerable burden given the traumatic injury they can cause and the lost years of life, and specifically vulnerable road users are at highest risk which also includes older adults as pedestrians. Public Health Ontario has recently done work with new indicators for older adult falls so a recent data review was completed and is attached to this plan under supporting documents. It shows that for Southwestern Public Heath, 30% of ED visits and 45% of hospitalizations for falls occurred in the home. Falls resulting in hospitalization that occurred in the home occurred at a 10% higher rate than in Ontario. Among females and males, falls resulting in ED visits and hospitalization occurred most commonly in the home. Also, Females ages 85+ experienced falls resulting in an ED visit and hospitalization at the HIGHEST rate. Improvements in health status and longer life expectancy have contributed to rapid growth in the number and proportion of older adults in our generation. The number and proportion of older people are expected to continue to rise, and our local situation from our last health status report shows our older adult population is higher compared to the province, and is also expected to continue to rise. Aging populations are expected to present ongoing significant challenges to, and require innovative solutions from communities and health care, social, political, and fiscal systems. Starting from a definition of healthy aging as “the process of developing and maintaining the functional ability that enables well-being in older age”, the World Health Organization set out a broad public health agenda to: a) align health systems with the needs of older persons; b) develop systems of long-term-care, and c) create physical and social environments that are age-friendly.

b) If a priority population or multiple priority populations have been identified for this program, please provide data and informational details that informed your decision, unless previously reported. Describe how interventions were modified and oriented to decrease health inequities for these priority populations.

The highest priority population for falls is females over the age of 85 with a low income and who live alone.

c) Describe how mental health promotion will be addressed, including specific approaches, topic of focus (e.g. resiliency building, healthy relationships, social connectedness, etc.), priority population, and delivery setting (e.g., schools, community centers, public health units, etc.).

As part the work in the area of age-friendly communities, SWPH will collaborate with local partners and community members to implement activities that improve social connectedness and sense of belonging among older adults.

d) As a program may address more than one Program Standard, if this program is intended to meet requirements under additional Program Standards (e.g., Chronic Disease Prevention and Well-Being, School Health), please identify those Program Standards or indicate N/A.

Substance Use and Injury Prevention

Program Indicators:
List and describe locally developed indicators (existing and/or new) that the board of health will use to monitor and measure the success of the substance use and/or injury prevention program over the reporting period.

75% of municipalities' planners know about the policy statements affecting age friendly communities.
50% of community paramedicine programs in SWPH region incoporate fall prevention screening into program for higher risk community dwelling older adults

Substance Use and Injury Prevention

Program Objective:
Describe the expected objectives of the program and what you expect to achieve, within specific timelines.

Decrease the rates of hospitalizations due to falls in older adults (65+) in the Southwestern Public Health region by 2% by 2030.

Intervention Descriptions:
Briefly describe the following public health intervention(s).

i 1) Older Adult Fall Prevention

Influence healthy public policy to create supportive built, natural, and social environments for older adults through an age friendly strategy and municipal collaboration on official and master plans. Provide education and support for primary care providers and community agencies who work with older adults and/or provide fall prevention programming.

Staff Allocation to Programs

Program		Associate Medical Officer of Health	Chief Nursing Officer	Program Director	Program Manager/ Supervisor	Project Officer	Public Health Nurse	Registered Nurse	Registered Practical Nurse	Nurse Practitioner	Social Determinants of Health Nurse	Infection Prevention and Control Nurse	Public Health Inspector	Dentist	Dental Hygienist	Dental Assistant	Health Promoter	Nutritionist
Total Population Health Assessment	F.T.E.#			0.10	0.25													
	$			15,052	31,542													
Total Health Equity	F.T.E.#						1.50										1.00	
	$						138,921										77,618	
Total Effective Public Health Practice	F.T.E.#				0.25													
	$				31,542													
Total Emergency Management	F.T.E.#				1.00													
	$				94,697													
Total Chronic Disease Prevention and Well-Being	F.T.E.#			0.50	0.80		3.50								1.40	1.00	2.50	
	$			75,259	98,178		324,149								111,969	55,930	181,608	
Validation	Unalloc. F.T.E.	-	-	-	0.50	-	1.00	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	60,328	-	92,614	-	-	-	-	-	-	-	-	-	-	-
Menu Labelling	F.T.E.#																	
	$																	
Non-Mandatory Oral Health Programs	F.T.E.#																	
	$																	
Ontario Seniors Dental Care Program	F.T.E.#				0.30										1.40	1.00		
	$				37,850										111,969	55,930		
Tanning Beds	F.T.E.#																	
	$																	
Healthy Eating Behaviours	F.T.E.#																	
	$																	
Physical Activity	F.T.E.#						1.00											
	$						92,614											
Built Environment	F.T.E.#			0.50			1.00										0.50	
	$			75,259			92,614										36,655	
Mental Health Promotion	F.T.E.#						0.50										2.00	
	$						46,307										144,953	
Total Food Safety	F.T.E.#				0.40								3.00					
	$				50,467								255,917					
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Food Safety Program	F.T.E.#				0.40								3.00					
	$				50,467								255,917					
Total Healthy Environments	F.T.E.#				0.20								4.00				1.00	
	$				25,233								404,282				79,433	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Health Hazards Program	F.T.E.#				0.15								3.00			-		
	$				18,925								314,973					
Healthy Environments and Climate Change Program	F.T.E.#				0.05								1.00				1.00	
	$				6,308								89,309				79,433	
Total Healthy Growth and Development	F.T.E.#				0.50		9.50										0.50	
	$				63,084		860,547										35,152	

Staff Allocation to Programs

Program		Dietitian	Epidemiologist	Program Coordinator	Program Support Staff	SFOA Inspector	Tobacco Control Coordinator/ Manager	TCAN Coordinator	Youth Development Specialist	Youth Engagement Coordinator	Other SFO staff	Student	Communications Staff	Program Evaluator	Data Analyst	Other Program Staff	Total	% of Bilingual FTEs
Total Population Health Assessment	F.T.E.#		2.00									0.29			0.50		**3.14**	0.00%
	$		188,243									9,828			32,971		**277,636**	
Total Health Equity	F.T.E.#																**2.50**	0.00%
	$																**216,539**	
Total Effective Public Health Practice	F.T.E.#															2.00	**2.25**	0.00%
	$															189,661	**221,203**	
Total Emergency Management	F.T.E.#																**1.00**	0.00%
	$																**94,697**	
Total Chronic Disease Prevention and Well-Being	F.T.E.#	1.00			0.20												**10.90**	
	$	81,494			10,875												**939,462**	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**1.50**	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**152,942**	
Menu Labelling	F.T.E.#																-	
	$																-	
Non-Mandatory Oral Health Programs	F.T.E.#																-	
	$																-	
Ontario Seniors Dental Care Program	F.T.E.#				0.20												**2.90**	0.00%
	$				10,875												**216,624**	
Tanning Beds	F.T.E.#																-	
	$																-	
Healthy Eating Behaviours	F.T.E.#	1.00															**1.00**	0.00%
	$	81,494															**81,494**	
Physical Activity	F.T.E.#																**1.00**	0.00%
	$																**92,614**	
Built Environment	F.T.E.#																**2.00**	0.00%
	$																**204,528**	
Mental Health Promotion	F.T.E.#																**2.50**	0.00%
	$																**191,260**	
Total Food Safety	F.T.E.#				0.50												**3.90**	
	$				27,187												**333,571**	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Food Safety Program	F.T.E.#				0.50												**3.90**	0.00%
	$				27,187												**333,571**	
Total Healthy Environments	F.T.E.#				1.50												**6.70**	
	$				81,562												**590,510**	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Health Hazards Program	F.T.E.#				1.50												**4.65**	0.00%
	$				81,562												**415,460**	
Healthy Environments and Climate Change Program	F.T.E.#																**2.05**	0.00%
	$																**175,050**	
Total Healthy Growth and Development	F.T.E.#				0.75												**11.25**	
	$				39,549												**998,332**	

Staff Allocation to Programs

Program		Associate Medical Officer of Health	Chief Nursing Officer	Program Director	Program Manager/ Supervisor	Project Officer	Public Health Nurse	Registered Nurse	Registered Practical Nurse	Nurse Practitioner	Social Determinants of Health Nurse	Infection Prevention and Control Nurse	Public Health Inspector	Dentist	Dental Hygienist	Dental Assistant	Health Promoter	Nutritionist
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Reproductive Health	F.T.E.#				0.10		4.20										0.25	
	$				12,617		386,037										17,576	
Breastfeeding	F.T.E.#				0.10		3.00											
	$				12,617		261,497											
Parenting	F.T.E.#				0.30		2.30										0.25	
	$				37,850		213,013										17,576	
Total Immunization	F.T.E.#			0.80	0.50													
	$			120,414	64,084													
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Community Based Immunization Outreach (excluding vaccine administration)	F.T.E.#																	
	$																	
COVID-19 Vaccine Program	F.T.E.#																	
	$																	
Immunization Monitoring and Surveillance	F.T.E.#			0.15	0.50													
	$			22,578	64,084													
Vaccine Administration	F.T.E.#			0.05														
	$			7,526														
Vaccine Management	F.T.E.#			0.60	-													
	$			90,310	-													
Total Infectious and Communicable Diseases Prevention and Control	F.T.E.#			0.40	2.70		14.30						8.40				0.50	
	$			60,207	340,656		1,266,805						747,452				35,153	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vector-Borne Diseases Program	F.T.E.#				0.05								1.40					
	$				6,308								122,288					
Sexual Health	F.T.E.#			0.20	0.50		6.30										0.50	
	$			30,103	63,084		555,852										35,153	
Infection Prevention & Control	F.T.E.#				2.00		7.50						6.00					
	$				252,339		664,646						535,855					
Tuberculosis Prevention & Control	F.T.E.#			0.10			0.50											
	$			15,052			46,307											
Rabies & Zoonotics	F.T.E.#			0.10	0.15								1.00					
	$			15,052	18,925								89,309					
Total Safe Water	F.T.E.#				0.20								1.00					
	$				25,234								89,309					
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Drinking Water Program	F.T.E.#				0.20								1.00					
	$				25,234								89,309					
Recreational Water Program	F.T.E.#																	
	$																	
Total School Health - Oral Health	F.T.E.#			0.60	0.70										3.60	5.00		
	$			90,311	88,317										263,872	301,437		

Staff Allocation to Programs

Program		Dietitian	Epidemiologist	Program Coordinator	Program Support Staff	SFOA Inspector	Tobacco Control Coordinator/ Manager	TCAN Coordinator	Youth Development Specialist	Youth Engagement Coordinator	Other SFO staff	Student	Communications Staff	Program Evaluator	Data Analyst	Other Program Staff	Total	% of Bilingual FTEs
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Reproductive Health	F.T.E.#				0.25												4.80	0.00%
	$				13,183												429,413	
Breastfeeding	F.T.E.#				0.25												3.35	0.00%
	$				13,183												287,297	
Parenting	F.T.E.#				0.25												3.10	0.00%
	$				13,183												281,622	
Total Immunization	F.T.E.#				2.00												3.30	
	$				108,750												293,248	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Community Based Immunization Outreach (excluding vaccine administration)	F.T.E.#																-	
	$																-	
COVID-19 Vaccine Program	F.T.E.#																-	
	$																-	
Immunization Monitoring and Surveillance	F.T.E.#																0.65	0.00%
	$																86,662	
Vaccine Administration	F.T.E.#				2.00												2.05	0.00%
	$				108,750												116,276	
Vaccine Management	F.T.E.#																0.60	0.00%
	$																90,310	
Total Infectious and Communicable Diseases Prevention and Control	F.T.E.#				3.40							0.29					29.99	
	$				184,875							9,828					2,644,976	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Vector-Borne Diseases Program	F.T.E.#											0.29					1.74	0.00%
	$											9,828					138,424	
Sexual Health	F.T.E.#				2.00												9.50	0.00%
	$				108,750												792,942	
Infection Prevention & Control	F.T.E.#				1.40												16.90	0.00%
	$				76,125												1,528,965	
Tuberculosis Prevention & Control	F.T.E.#																0.60	0.00%
	$																61,359	
Rabies & Zoonotics	F.T.E.#																1.25	0.00%
	$																123,286	
Total Safe Water	F.T.E.#																1.20	
	$																114,543	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Drinking Water Program	F.T.E.#																1.20	0.00%
	$																114,543	
Recreational Water Program	F.T.E.#																-	
	$																-	
Total School Health - Oral Health	F.T.E.#				1.80												11.70	
	$				97,875												841,812	

Staff Allocation to Programs

Program		Associate Medical Officer of Health	Chief Nursing Officer	Program Director	Program Manager/ Supervisor	Project Officer	Public Health Nurse	Registered Nurse	Registered Practical Nurse	Nurse Practitioner	Social Determinants of Health Nurse	Infection Prevention and Control Nurse	Public Health Inspector	Dentist	Dental Hygienist	Dental Assistant	Health Promoter	Nutritionist
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Healthy Smiles Ontario Program	F.T.E.#			0.50	0.40										2.30	3.75		
	$			75,259	50,467										171,925	220,631		
Oral Health Assessment and Surveillance	F.T.E.#			0.10	0.30										1.30	1.25		
	$			15,052	37,850										91,947	80,806		
Total School Health - Vision	F.T.E.#																	
	$																	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Child Visual Health and Vision Screening	F.T.E.#																	
	$																	
Total School Health - Immunization	F.T.E.#				0.50		9.45											
	$				64,084		786,045											
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Immunizations for Children in Schools and Licensed Child Care Settings	F.T.E.#				0.50		9.45											
	$				64,084		786,045											
Total School Health - Other	F.T.E.#			0.25	1.00		9.50										1.00	
	$			37,629	126,168		840,749										79,433	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Comprehensive School Health	F.T.E.#			0.25	1.00		9.50										1.00	
	$			37,629	126,168		840,749										79,433	
Total Substance Use and Injury Prevention	F.T.E.#			0.25	1.00		2.00										3.50	
	$			37,629	120,656		185,228										270,128	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Alcohol	F.T.E.#																	
	$																	
Cannabis	F.T.E.#																	
	$																	
Other Drugs	F.T.E.#																	
	$																	
Harm Reduction Program Enhancement	F.T.E.#				0.25												1.00	
	$				30,164												76,288	
Needle Syringe Program	F.T.E.#																	
	$																	
Smoke-Free Ontario	F.T.E.#				0.25												0.50	
	$				30,164												39,717	
Substance Use	F.T.E.#			0.25			1.00										2.00	
	$			37,629			92,614										154,123	
Injury Prevention	F.T.E.#				0.50		1.00											
	$				60,328		92,614											
Grand Total	F.T.E.#	-	-	**2.90**	**10.00**	-	**49.75**	-	-	-	-	-	**16.40**	-	**5.00**	**6.00**	**10.00**	-

Staff Allocation to Programs

Program		Dietitian	Epidemiologist	Program Coordinator	Program Support Staff	SFOA Inspector	Tobacco Control Coordinator/ Manager	TCAN Coordinator	Youth Development Specialist	Youth Engagement Coordinator	Other SFO staff	Student	Communications Staff	Program Evaluator	Data Analyst	Other Program Staff	Total	% of Bilingual FTEs
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Healthy Smiles Ontario Program	F.T.E.#				1.00												7.95	0.00%
	$				54,375												572,657	
Oral Health Assessment and Surveillance	F.T.E.#				0.80												3.75	0.00%
	$				43,500												269,155	
Total School Health - Vision	F.T.E.#																-	
	$																-	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Child Visual Health and Vision Screening	F.T.E.#																-	
	$																-	
Total School Health - Immunization	F.T.E.#				2.00												11.95	
	$				108,750												958,879	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Immunizations for Children in Schools and Licensed Child Care Settings	F.T.E.#				2.00												11.95	0.00%
	$				108,750												958,879	
Total School Health - Other	F.T.E.#	1.00			1.00												13.75	
	$	81,494			54,375												1,219,848	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Comprehensive School Health	F.T.E.#	1.00			1.00												13.75	0.00%
	$	81,494			54,375												1,219,848	
Total Substance Use and Injury Prevention	F.T.E.#				0.80	1.50										0.09	9.14	
	$				39,817	81,697										2,698	737,853	
Validation	Unalloc. F.T.E.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
	Unalloc.$	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Alcohol	F.T.E.#																-	
	$																-	
Cannabis	F.T.E.#																-	
	$																-	
Other Drugs	F.T.E.#																-	
	$																-	
Harm Reduction Program Enhancement	F.T.E.#																1.25	0.00%
	$																106,452	
Needle Syringe Program	F.T.E.#																-	
	$																-	
Smoke-Free Ontario	F.T.E.#				0.50	1.50										0.09	2.84	0.00%
	$				24,829	81,697										2,698	179,105	
Substance Use	F.T.E.#				0.30												3.55	0.00%
	$				14,988												299,354	
Injury Prevention	F.T.E.#																1.50	
	$																152,942	
Grand Total	F.T.E.#	2.00	2.00	-	13.95	1.50	-	-	-	-	-	0.58	-	-	0.50	2.09	122.67	

Staff Allocation to Programs

Program		Associate Medical Officer of Health	Chief Nursing Officer	Program Director	Program Manager/ Supervisor	Project Officer	Public Health Nurse	Registered Nurse	Registered Practical Nurse	Nurse Practitioner	Social Determinants of Health Nurse	Infection Prevention and Control Nurse	Public Health Inspector	Dentist	Dental Hygienist	Dental Assistant	Health Promoter	Nutritionist
Grand Total	$	-	-	**436,501**	**1,223,942**	-	**4,402,444**	-	-	-	-	-	**1,496,960**	-	**375,841**	**357,367**	**758,525**	-

Staff Allocation to Programs

Program		Dietitian	Epidemiologist	Program Coordinator	Program Support Staff	SFOA Inspector	Tobacco Control Coordinator/ Manager	TCAN Coordinator	Youth Development Specialist	Youth Engagement Coordinator	Other SFO staff	Student	Communications Staff	Program Evaluator	Data Analyst	Other Program Staff	Total	% of Bilingual FTEs
Grand Total	$	162,988	188,243	-	753,615	81,697	-	-	-	-	-	19,656	-	-	32,971	192,359	10,483,109	

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

MOH & Administrative Staff

Position Titles	F.T.E.#	$
Medical Officer of Health	1.00	242,000
Chief Executive Officer	1.00	236,165
Director/ Business Administrator	2.00	301,034
Manager/Supervisor	4.00	379,410
Secretarial/Admin Staff	4.00	280,670
Financial Staff	3.00	205,280
I & IT Staff	1.00	92,205
Communications Manager/Media Coordinator	4.00	343,501
Volunteer Coordinator	-	-
Human Resources Staff/Coordinator	1.00	75,636
Maintenance/Caretaker/Custodian/Security	-	-

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

MOH & Administrative Staff

Other Administrative Staff	3.00	159,116
Total	**24.00**	**2,315,017**

Allocation of Expenditures

% of Benefits	

Population Health Assessment	Expenditures									Sources of Funding					
	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Total Population Health Assessment	277,636	82,571	70					13,746	**374,023**	374,023					**374,023**

Health Equity	Expenditures									Sources of Funding					
	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Total Health Equity	216,539	65,811				3,000		15,915	**301,265**	301,265					**301,265**

Effective Public Health Practice	Expenditures									Sources of Funding					
	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Total Effective Public Health Practice	221,203	67,228	55					34,500	**322,986**	322,986					**322,986**

Emergency Management	Expenditures									Sources of Funding					
	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Total Emergency Management	94,697	28,780	130					2,800	**126,407**	126,407					**126,407**

Allocation of Expenditures

Chronic Disease Prevention and Well-Being	Expenditures									Sources of Funding					
Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Ontario Seniors Dental Care Program (100%)	Mandatory Programs (Cost-Shared)				Total Funding Sources
Menu Labelling	-	-							-						-
Non-Mandatory Oral Health Programs	-	-							-						-
Ontario Seniors Dental Care Program	216,624	65,836	2,680	21,235		937,630	(12,500)	345,700	**1,577,205**	1,577,205					**1,577,205**
Tanning Beds	-	-							-						-
Healthy Eating Behaviours	81,494	24,768	695			1,500		1,320	**109,777**		109,777				**109,777**
Physical Activity	92,614	28,147	465					1,501	**122,727**	-	122,727				**122,727**
Built Environment	204,528	62,160	990					2,330	**270,008**		270,008				**270,008**
Mental Health Promotion	191,260	58,128	525			12,800		3,500	**266,213**		266,213				**266,213**
Total Chronic Disease Prevention and Well-Being	**786,520**	**239,039**	**5,355**	**21,235**	**-**	**951,930**	**(12,500)**	**354,351**	**2,345,930**	**1,577,205**	**768,725**	**-**	**-**	**-**	**2,345,930**

Food Safety	Expenditures									Sources of Funding					
Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Food Safety Program	333,571	101,376	16,785			41,000	(1,875)	16,600	**507,457**	507,457					**507,457**
Total Food Safety	**333,571**	**101,376**	**16,785**	**-**	**-**	**41,000**	**(1,875)**	**16,600**	**507,457**	**507,457**	**-**	**-**	**-**	**-**	**507,457**

Healthy Environments	Expenditures	Sources of Funding

Allocation of Expenditures

Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Health Hazards Program	415,460	110,660	15,800				(9,700)	7,901	**540,121**	540,121					**540,121**
Healthy Environments and Climate Change Program	175,050	53,201	4,520			75,000		37,501	**345,272**	345,272					**345,272**
Total Healthy Environments	**590,510**	**163,861**	**20,320**	**-**	**-**	**75,000**	**(9,700)**	**45,402**	**885,393**	**885,393**	**-**	**-**	**-**	**-**	**885,393**

Healthy Growth and Development	Expenditures									Sources of Funding					
Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Reproductive Health	429,413	130,507	6,590					60,400	**626,910**	626,910					**626,910**
Breastfeeding	287,297	87,315	7,120					14,350	**396,082**	396,082					**396,082**
Parenting	281,622	85,590	8,715					13,941	**389,868**	389,868					**389,868**
Total Healthy Growth and Development	**998,332**	**303,412**	**22,425**	**-**	**-**	**-**	**-**	**88,691**	**1,412,860**	**1,412,860**	**-**	**-**	**-**	**-**	**1,412,860**

Immunization	Expenditures									Sources of Funding					
Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Community Based Immunization Outreach (excluding vaccine administration)	-	-							**-**						**-**
COVID-19 Vaccine Program	-	-	-	-	-	-	-	-	**-**						**-**
Immunization Monitoring and Surveillance	86,662	26,338	500					7,074	**120,574**	120,574					**120,574**

Allocation of Expenditures

Vaccine Administration	116,276	35,338	1,380				(500)	5,050	**157,544**	157,544					**157,544**
Vaccine Management	90,310	27,447	625			15,000			**133,382**	133,382					**133,382**
Total Immunization	**293,248**	**89,123**	**2,505**	**-**	**-**	**15,000**	**(500)**	**12,124**	**411,500**	**411,500**	**-**	**-**	**-**	**-**	**411,500**

Infectious and Communicable Diseases Prevention and Control	**Expenditures**									**Sources of Funding**					
Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Vector-Borne Diseases Program	138,424	30,338	7,490			43,000		6,110	**225,362**	225,362					**225,362**
Sexual Health	792,942	240,990	1,155			42,150	(34,000)	74,650	**1,117,887**	1,117,887					**1,117,887**
Infection Prevention & Control	1,528,965	464,680	8,000			50,500		27,967	**2,080,112**	2,080,112					**2,080,112**
Tuberculosis Prevention & Control	61,359	18,648	40			4,000		6,450	**90,497**	90,497					**90,497**
Rabies & Zoonotics	123,286	37,469	7,530			1,200		6,800	**176,285**	176,285					**176,285**
Total Infectious and Communicable Diseases Prevention and Control	**2,644,976**	**792,125**	**24,215**	**-**	**-**	**140,850**	**(34,000)**	**121,977**	**3,690,143**	**3,690,143**	**-**	**-**	**-**	**-**	**3,690,143**

Safe Water	**Expenditures**									**Sources of Funding**					
Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Drinking Water Program	114,543	34,812	5,165					9,269	**163,789**	163,789					**163,789**
Recreational Water Program	-	-							**-**						**-**
Total Safe Water	**114,543**	**34,812**	**5,165**	**-**	**-**	**-**	**-**	**9,269**	**163,789**	**163,789**	**-**	**-**	**-**	**-**	**163,789**

Allocation of Expenditures

School Health - Oral Health	Expenditures									Sources of Funding					
Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Healthy Smiles Ontario Program	572,657	174,041	4,010					109,250	**859,958**	859,958					**859,958**
Oral Health Assessment and Surveillance	269,155	81,801	1,990					11,401	**364,347**	364,347					**364,347**
Total School Health - Oral Health	**841,812**	**255,842**	**6,000**	**-**	**-**	**-**	**-**	**120,651**	**1,224,305**	**1,224,305**	**-**	**-**	**-**	**-**	**1,224,305**

School Health - Vision	Expenditures									Sources of Funding					
Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures						Total Funding Sources
Child Visual Health and Vision Screening	-	-	-	-	-	-	-	-	**-**	-	-	-	-	-	**-**
Total School Health - Vision	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

School Health - Immunization	Expenditures									Sources of Funding					
Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Immunizations for Children in Schools and Licensed Child Care Settings	958,879	291,421	5,575				(20,000)	39,000	**1,274,875**	1,274,875					**1,274,875**
Total School Health - Immunization	**958,879**	**291,421**	**5,575**	**-**	**-**	**-**	**(20,000)**	**39,000**	**1,274,875**	**1,274,875**	**-**	**-**	**-**	**-**	**1,274,875**

School Health - Other	Expenditures	Sources of Funding

Allocation of Expenditures

Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Comprehensive School Health	1,219,848	370,735	27,780			-		21,170	**1,639,533**	1,639,533					**1,639,533**
Total School Health - Other	**1,219,848**	**370,735**	**27,780**	**-**	**-**	**-**	**-**	**21,170**	**1,639,533**	**1,639,533**	**-**	**-**	**-**	**-**	**1,639,533**

Substance Use and Injury Prevention	Expenditures									Sources of Funding					
Program	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Alcohol	-	-							**-**						**-**
Cannabis	-	-							**-**						**-**
Other Drugs	-	-							**-**						**-**
Harm Reduction Program Enhancement	106,452	32,353	1,015			22,200		19,500	**181,520**	181,520					**181,520**
Needle Syringe Program	-	-						51,200	**51,200**	51,200					**51,200**
Smoke-Free Ontario	179,105	53,937	2,435			3,800		7,075	**246,352**	246,352					**246,352**
Substance Use	299,354	90,952	2,170			15,000		22,331	**429,807**	429,807					**429,807**
Injury Prevention	152,942	46,482	980					5,000	**205,404**	205,404					**205,404**
Total Substance Use and Injury Prevention	**737,853**	**223,724**	**6,600**	**-**	**-**	**41,000**	**-**	**105,106**	**1,114,283**	**1,114,283**	**-**	**-**	**-**	**-**	**1,114,283**

Indirect Costs	Expenditures	Sources of Funding

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

Allocation of Expenditures

	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Total Expenditures	Mandatory Programs (Cost-Shared)					Total Funding Sources
Total Indirect Costs	2,315,017	703,578	5,845	1,456,245		930,300	(57,000)	978,511	**6,332,496**	6,332,496					**6,332,496**
Grand Total	**12,645,184**	**3,813,438**	**148,825**	**1,477,480**	**-**	**2,198,080**	**(135,575)**	**1,979,813**	**22,127,245**						**22,127,245**

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

Budget Summary

Base Funding

Source of Funding	Board of Health Approved Budget (at 100%) ($) A	Ministry Approved Allocation ($) B	Provincial Share (%) C = B / A	Municipal Contribution ($) D = A - B	Municipal Share (%) E = 1 - C
Mandatory Programs (Cost-Shared)	20,550,040	11,196,700	54.49%	9,353,340	45.51%
Ontario Seniors Dental Care Program (100%)	1,577,205	1,061,100			
Total	**22,127,245**	**12,257,800**			

Summary of Expenditures by Standard

Standards	Total Board of Health	Salaries and Wages	Benefits	Travel	Building Occupancy	Municipal Charges	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures
Direct Costs									
Population Health Assessment	374,023	277,636	82,571	70	-	-	-	-	13,746
Health Equity	301,265	216,539	65,811	-	-	-	3,000	-	15,915
Effective Public Health Practice	322,986	221,203	67,228	55	-	-	-	-	34,500
Emergency Management	126,407	94,697	28,780	130	-	-	-	-	2,800
Chronic Disease Prevention and Well-Being	2,345,930	786,520	239,039	5,355	21,235	-	951,930	(12,500)	354,351
Food Safety	507,457	333,571	101,376	16,785	-	-	41,000	(1,875)	16,600
Healthy Environments	885,393	590,510	163,861	20,320	-	-	75,000	(9,700)	45,402
Healthy Growth and Development	1,412,860	998,332	303,412	22,425	-	-	-	-	88,691
Immunization	411,500	293,248	89,123	2,505	-	-	15,000	(500)	12,124
Infectious and Communicable Diseases Prevention and Control	3,690,143	2,644,976	792,125	24,215	-	-	140,850	(34,000)	121,977
Safe Water	163,789	114,543	34,812	5,165	-	-	-	-	9,269
School Health	4,138,713	3,020,539	917,998	39,355	-	-	-	(20,000)	180,821
Substance Use and Injury Prevention	1,114,283	737,853	223,724	6,600	-	-	41,000	-	105,106
Total Direct Costs	15,794,749	**10,330,167**	**3,109,860**	**142,980**	**21,235**	-	**1,267,780**	**(78,575)**	**1,001,302**
Indirect Costs									
Indirect Costs	6,332,496	2,315,017	703,578	5,845	1,456,245	-	930,300	(57,000)	978,511
Total Expenditures	22,127,245	**12,645,184**	**3,813,438**	**148,825**	**1,477,480**	-	**2,198,080**	**(135,575)**	**1,979,813**

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

Budget Summary

Staff Allocation by Standard

Position Title	Total Board of Health		Population Health Assessment		Health Equity		Effective Public Health Practice		Emergency Management		Chronic Disease Prevention and Well-Being		Food Safety		Healthy Environments		Healthy Growth and Development		Immunization		Infectious and Communicable Diseases Prevention and Control		Safe Water		School Health		Substance Use and Injury Prevention	
Program Staff	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$	F.T.E. #	$
Associate Medical Officer of Health	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Chief Nursing Officer	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Program Director	2.90	436,501	0.10	15,052	-	-	-	-	-	-	0.50	75,259	-	-	-	-	-	-	0.80	120,414	0.40	60,207	-	-	0.85	127,940	0.25	37,629
Program Manager/Supervisor	10.00	1,223,942	0.25	31,542	-	-	0.25	31,542	1.00	94,697	0.80	98,178	0.40	50,467	0.20	25,233	0.50	63,084	0.50	64,084	2.70	340,656	0.20	25,234	2.20	278,569	1.00	120,656
Project Officer	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Public Health Nurse	49.75	4,402,444	-	-	1.50	138,921	-	-	-	-	3.50	324,149	-	-	-	-	9.50	860,547	-	-	14.30	1,266,805	-	-	18.95	1,626,794	2.00	185,228
Registered Nurse	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Registered Practical Nurse	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Nurse Practitioner	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Social Determinants of Health Nurse	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Infection Prevention and Control Nurse	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Public Health Inspector	16.40	1,496,960	-	-	-	-	-	-	-	-	-	-	3.00	255,917	4.00	404,282	-	-	-	-	8.40	747,452	1.00	89,309	-	-	-	-
Dentist	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Dental Hygienist	5.00	375,841	-	-	-	-	-	-	-	-	1.40	111,969	-	-	-	-	-	-	-	-	-	-	-	-	3.60	263,872	-	-
Dental Assistant	6.00	357,367	-	-	-	-	-	-	-	-	1.00	55,930	-	-	-	-	-	-	-	-	-	-	-	-	5.00	301,437	-	-
Health Promoter	10.00	758,525	-	-	1.00	77,618	-	-	-	-	2.50	181,608	-	-	1.00	79,433	0.50	35,152	-	-	0.50	35,153	-	-	1.00	79,433	3.50	270,128
Nutritionist	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Dietitian	2.00	162,988	-	-	-	-	-	-	-	-	1.00	81,494	-	-	-	-	-	-	-	-	-	-	-	-	1.00	81,494	-	-
Epidemiologist	2.00	188,243	2.00	188,243	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Program Coordinator	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Program Support Staff	13.95	753,615	-	-	-	-	-	-	-	-	0.20	10,875	0.50	27,187	1.50	81,562	0.75	39,549	2.00	108,750	3.40	184,875	-	-	4.80	261,000	0.80	39,817
SFOA Inspector	1.50	81,697	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1.50	81,697
Tobacco Control Coordinator/Manager	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TCAN Coordinator	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Youth Development Specialist	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Youth Engagement Coordinator	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other SFO staff	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Student	0.58	19,656	0.29	9,828	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.29	9,828	-	-	-	-	-	-
Communications Staff	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Program Evaluator	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Data Analyst	0.50	32,971	0.50	32,971	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Program Staff	2.09	192,359	-	-	-	-	2.00	189,661	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.09	2,698
Total Program Staff	**122.67**	**10,483,109**	**3.14**	**277,636**	**2.50**	**216,539**	**2.25**	**221,203**	**1.00**	**94,697**	**10.90**	**939,462**	**3.90**	**333,571**	**6.70**	**590,510**	**11.25**	**998,332**	**3.30**	**293,248**	**29.99**	**2,644,976**	**1.20**	**114,543**	**37.40**	**3,020,539**	**9.14**	**737,853**

MOH & Administrative Staff	F.T.E. #	$
Medical Officer of Health	1.00	242,000
Chief Executive Officer	1.00	236,165
Director/ Business Administrator	2.00	301,034
Manager/Supervisor	4.00	379,410
Secretarial/Admin Staff	4.00	280,670
Financial Staff	3.00	205,280
I & IT Staff	1.00	92,205
Communications Manager/Media Coordinator	4.00	343,501
Volunteer Coordinator	-	-
Human Resources Staff/Coordinator	1.00	75,636

Budget Summary

Maintenance/Caretaker/Custodian/Security	-	-
Other Administrative Staff	3.00	159,116
Total MOH & Administrative Staff	**24.00**	**2,315,017**
Total Staffing	**146.67**	**12,798,126**

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

Board of Health Membership

#	Member First Name	Member Last Name	Type of Appointment		Identify Municipality (if applicable)
			(Municipal / Provincial)	If Municipal (Council / Citizen Representative)	
1	Joe	Preston	Municipal	Council	City of St. Thomas
2	Jim	Herbert	Municipal	Council	City of St. Thomas
3	Bernia	Martin	Municipal	Council	Oxford County
4	David	Mayberry	Municipal	Council	Oxford County
5	Mark	Peterson	Municipal	Council	Oxford County
6	Marcus	Ryan	Municipal	Council	Oxford County
7	Jack	Couckuyt	Municipal	Council	Elgin County
8	Grant	Jones	Municipal	Council	Elgin County
9	Lee	Rowden	Provincial		
10	Davin	Shinedling	Provincial		
11	David	Warden	Provincial		
12	Catherine	Agar	Provincial		
13	Stephen	Molnar	Provincial		

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

Apportionment of Board of Health Costs

Method of Apportionment
Population
if Other please explain

#	Municipality Name	% Share
1	City of St. Thomas	19.79%
2	County of Oxford	56.24%
3	County of Elgin	23.97%
	Total: (Must be 100.00%)	**100.00%**

2024 Annual Service Plan and Budget Submission

Board of Health for the Oxford Elgin St. Thomas Health Unit

Certification

Position	Name	Date Approved
Board of Health Chair	Bernia Martin	March 7, 2024
Medical Officer of Health / Chief Executive Officer	David Smith, Acting CEO	March 7, 2024
Business Administrator (Verifies that the budget data provided in the Annual Service Plan and Budget Submission is accurate)	Monica Nusink	March 7, 2024

By submitting the budget and request for funding, the board of health is certifying that all costs and information submitted in this document are accurate, and conform with categories specified as eligible.