BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
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AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, January 23, 2025 at 7 p.m.
MLHU Board Room – CitiPlaza
110-355 Wellington Street
London, ON N6A 3N7

MISSION - MIDDLESEX-LONDON HEALTH UNIT

The mission of the Middlesex-London Health Unit is to promote and protect the health of our community.

MEMBERS OF THE BOARD OF HEALTH

Matthew Newton-Reid
Michael Steele
Peter Cuddy
Aina DeViet
Skylar Franke
Michael McGuire
Selomon Menghsha
Howard Shears
Michelle Smibert
Dr. Alexander Summers (Medical Officer of Health, ex-officio member)
Emily Williams (Chief Executive Officer, ex-officio member)

SECRETARY

To be determined for 2025

TREASURER

To be determined for 2025

REFLECTION ON RECONCILIATION

MEETING PROCEDURES

DISCLOSURE OF PECUNIARY INTEREST

APPROVAL OF AGENDA

MINUTES

Approve: December 12, 2024 – Board of Health meeting

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Meeting Procedures						
1		**X**	**X**	Election of 2025 Board of Health Executive (Report No. 01-25)	Appendix A	To fulfill the election/appointment of Chair/Vice Chair, Secretary, Treasurer and approve the 2025 Board of Health reporting calendar. Lead: Emily Williams, Outgoing Secretary and Treasurer
2		**X**	**X**	Appointment of 2025 Board of Health Committees (Report No. 02-25)	Appendix A	To appoint members to the Standing Committees of the Board of Health. Lead(s): 2025 Secretary and Treasurer
3		**X**	**X**	Amending the 2025 Board of Health and Committee Schedule (Report No. 03-25)	Appendix A	To seek approval from the Board of Health to amend the 2025 Board and Committee meeting schedule. Lead(s): 2025 Secretary and Treasurer
Reports and Agenda Items						
4	**X**		**X**	Taking Action for Reconciliation Plan Implementation Progress Report (Report No. 04-25)		To provide the Board of Health with updates on the Health Unit's Taking Action of Reconciliation Plan. Lead: Sarah Maaten, Director, Public Health Foundations Presenting: Christian Daboud, Manager, Health Equity and Indigenous Reconciliation Delegates: Ida Cornelius, Health Administrator, Oneida Health Centre and Kim Fisher – Health Director, Chippewas of the Thames First Nation Health Centre

5			**X**	2025 Health Promotion Priorities (Report No. 05-25)	Appendix A Appendix B	To provide information to the Board of Health on the Health Unit's Health Promotion priorities for 2025. Lead: Jennifer Proulx, Director, Family and Community Health and Dr. Alexander Summers, Medical Officer of Health
6			**X**	A Framework to Support Healthy Public Policy: The Built, Natural, and Social Environments (Report No. 06-25)	Appendix A Appendix B Appendix C Appendix D Appendix E	To provide information to the Board of Health on the Health Unit's framework for supporting the built environment within the community. Lead: Jennifer Proulx, Director, Family and Community Health Presenting: Sarah Neil, Public Health Nurse and Heather Thomas, Health Promotion Specialist
7			**X**	Submission to Health Canada on the Proposed Tobacco Cost Recovery Framework (Report No. 07-25)	Appendix A	To provide the Board of Health with a submission made to Health Canada in late 2024 on the proposed tobacco cost recovery framework. Lead: Jennifer Proulx, Director, Family and Community Health Presenting: Linda Stobo, Manager, Social Marketing and Health System Partnerships
8			**X**	Current Public Health Issues (Verbal Update)		To provide an update on current public health issues in the Middlesex-London region. Lead: Dr. Alexander Summers, Medical Officer of Health
9			**X**	Medical Officer of Health Activity Report for December (Report No. 08-25)		To provide an update on the activities of the Medical Officer of Health since the last Board of Health meeting. Lead: Dr. Alexander Summers, Medical Officer of Health

10			**X**	Chief Executive Officer Activity Report for December (Report No. 09-25)		To provide an update on the activities of the Chief Executive Officer since the last Board of Health meeting. Lead: Emily Williams, Chief Executive Officer
11			**X**	Board Chair and Vice-Chair Activity Report for November and December (Report No. 10-25)		To provide an update on the activities of the Board of Health Chair and Vice-Chair since November. Leads: 2024 Board Chair Matthew (Matt) Newton-Reid and 2024 Vice-Chair Michael (Mike) Steele
Correspondence						
12			**X**	January Correspondence		To receive items a) through d) for information: a) Public Health Sudbury and Districts re: *Calling for the Selection of Indigenous Municipal and Provincial Appointees for Board of Health for Public Health Sudbury and Districts* b) Ontario Ministry of Health re: *Strengthening Public Health Updates* c) Peterborough Public Health re: *Federal Strategy to Address Severity and Prevalence of Household Food Insecurity* d) Middlesex-London Board of Health External Landscape for January

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is Thursday, February 20, 2025 at 7 p.m.

CLOSED SESSION

The Middlesex-London Board of Health will move into a closed session to approve previous confidential Board of Health minutes and to discuss matters which pertain to one or more of the following, as per section 239(2) of the *Municipal Act, 2001, S.O. 2001, c. 25*:

(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.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, December 12, 2024, 7 p.m.
Microsoft Teams

MEMBERS PRESENT: Matthew Newton-Reid (Chair)
Michael Steele (Vice-Chair)
Michelle Smibert
Selomon Menghsha
Aina DeViet
Howard Shears
Skylar Franke
Peter Cuddy
Dr. Alexander Summers, Medical Officer of Health (ex-officio)
Emily Williams, Chief Executive Officer (ex-officio)

REGRETS: Michael McGuire

OTHERS PRESENT: Stephanie Egelton, Executive Assistant to the Board of Health (recorder)
Mary Lou Albanese, Director, Environmental Health, Infectious Diseases and Clinical Services
Sarah Maaten, Director, Public Health Foundations
Ryan Fawcett, Associate Director, Operations/Privacy Officer
Cynthia Bos, Associate Director, Human Resources and Labour Relations
Kim Loupos, Public Health Dietitian
Darrell Jutzi, Manager, Municipal and Community Health Promotion
Abha Solanki, End User Support Analyst, Information Technology

Chair Matthew Newton-Reid called the meeting to order at **7 p.m.**

Dr. Alexander Summers, Medical Officer of Health noted that this Board of Health meeting is the last for Mary Lou Albanese, Director, Environmental Health, Infectious Diseases and Clinical Services before she retires at the end of the year.

Chair Newton-Reid recognized M. Albanese for her dedication to the organization.

DISCLOSURES OF PECUNIARY INTEREST

Chair Newton-Reid inquired if there were any disclosures of pecuniary interest. None were declared.

APPROVAL OF AGENDA

Chair Newton-Reid noted that there would be an update regarding the meeting that Vice-Chair Michael Steele had with Toronto Public Health Board Chair, Chris Moise.

It was moved by **M. Steele, seconded by P. Cuddy,** *that the **AGENDA** for the December 12, 2024 Board of Health meeting be approved as amended.*

Carried

APPROVAL OF MINUTES

It was moved by **P. Cuddy, seconded by M. Smibert,** *that the Board of Health:*

1) *Approve the minutes of the November 21, 2024 Special Board of Health meeting; and*
2) *Approve the minutes of the November 21, 2024 Board of Health meeting.*

Carried

It was moved by **A. DeViet, seconded by M. Smibert,** *that the **MINUTES** of the November 28, 2024 Performance Appraisal Committee meeting be received.*

Carried

NEW BUSINESS

2025 Middlesex-London Health Unit Budget (Report No. 81-24)

Emily Williams, Chief Executive Officer presented the draft 2025 Middlesex-London Health Unit Budget to the Board of Health for approval. E. Williams noted that the Board has seen previous reports regarding budgetary and funding matters in 2024.

Context for the 2025 Budget

- The Ontario Ministry of Health is providing a 1% increase to public health base funding in 2025.
- The Board of Health approved an additional 3% increase from municipalities (City of London and County of Middlesex) for 2025 to avoid lay-offs and further reductions in services later in 2024.
- The 2024 financial experience included high demand faced by several teams (vaccine, infectious disease and environmental health) and challenges in meeting gapping targets.
- In 2025, it is noted that there will be negotiations with both unions (Ontario Nurses Association and Canadian Union of Public Employees).

Strategy for the 2025 Budget

E. Williams noted that to build the 2025 budget, staff used the following strategies:

- Utilized the increased funding to address inflationary and current budget pressures such as overtime, on-call and shift premium costs;
- Avoiding lay-offs and reviewing all role vacancies for potential elimination based on service requirements;
- Reassigning staff to address teams with high demands; and
- Reducing the organizational gap to an attainable amount.

Budget Components

E. Williams reminded the Board that the Health Unit's budget is composed of two (2) companies – MLHU and MLHU2.

MLHU (January to December programs)

The majority of programs are called "Shared Funded Programs" and are cost-shared between the Ministry of Health and municipalities. The "100% Funded Programs" are the Ontario Senior Dental Care Program (funded by the Ministry of Health) and the Cannabis Legalization Implementation Funding (funded by the City of London).

MLHU2 (April to March programs)

There are four (4) programs in MLHU2: Smart Start for Babies (funded by the Public Health Agency of Canada), Best Beginnings – Healthy Babies, Healthy Children (funded by the Ontario Ministry of Children, Community and Social Services, Library Shared Services (funded by Public Health Ontario) and FoodNet Canada (funded by the Public Health Agency of Canada).

Shared Funded Program Highlights
There is a revenue increase of $850,220, which includes an additional 3% from the funding municipalities.

Staffing-related changes include: eliminating 1 Registered Dietitian position (a retirement), eliminating 1 Part-time Marketing Coordinator position (temporary contract role), integrating salary increase assumptions, increasing on-call, over-time and shift premiums, and some recovery for shared funded programs due to the increase in funding for Healthy Babies, Healthy Children (in MLHU2).

There are benefits related changes with savings from the Health Unit's new benefits provider starting January 1, 2025 (awarded through the Request for Proposal process). There is also an increase in retiree benefits to align with actual budgeted funds.

General expenses have had inflationary increases integrated, such as insurance, translation and software costs.

The gapping budget is also going to be decreased to $441,244.

100% Funded Program Highlights
There is no change to revenue for the 100% funded programs.

Within the Ontario Seniors Dental Care Program, there is an increase in staffing and decrease in general expenses. The goal is to meet increased demand and capacity created by two (2) additional operatories in London (Citi Plaza) and four (4) in Strathroy.

Within the Cannabis Legalization Implementation Fund (CLIF), the funds from the City of London are carried over until fully used. It is expected these funds will end in 2025. The temporary Tobacco Enforcement Officer staff will continue until funding is depleted.

MLHU2 Program Highlights
The Ontario Ministry of Children, Community and Social Services increased funding for Healthy Babies, Healthy Children by $304,000. This resulted in an investment of 1.0 Public Health Nurse, 0.6 Registered Practical Nurse and 0.5 Program Assistant.

For the other programs, increases in staffing expenses mean a decrease in program expenses required to administer programs. E. Williams noted that follow-up with funders is underway to ensure understanding of pressures and request inflationary increases.

There were no questions or discussion.

It was moved by **P. Cuddy, seconded by H. Shears,** *that the Board of Health:*

1) *Receive Report No. 81-24 re: "2025 Middlesex-London Health Unit Budget" for information; and*
2) *Approve the 2025 Budget as outlined in Appendix A.*

Carried

Monitoring Food Affordability and Implications for Public Policy and Action 2024 (Report No. 82-24)

Sarah Maaten, Director, Public Health Foundations introduced Kim Loupos, Public Health Dietitian to present the 2024 Food Affordability and Implications for Public Policy and Action report.

K. Loupos explained that the current Ontario Public Health Standards require monitoring local food affordability (Population Health Assessment and Surveillance Protocol). This activity is led by the Health Unit's Municipal and Community Health Promotion Team.

There are 3 main components to this activity:

1) Monitoring local food insecurity rates as reported in the Canadian Income Survey;
2) Monitoring local food costs utilizing the Ontario Nutritious Food Basket survey; and
3) Comparing local food and rental costs to local incomes utilizing tools developed by the Ontario Dietitians in Public Health with support from Public Health Ontario.

The current food insecurity rate in Middlesex-London is the highest rate reported since the Canadian Income Survey started measuring food insecurity in 2019. In 2023, 25% of households in Middlesex-London (1 in 4 households) were food insecure. The 2023 rate represents a statistically significant increase from 2022. In 2022, 17.5% of households (1 in 6 households) were food insecure. Nearly 44,000 more Middlesex-London residents lived in food insecure households in 2023 as compared to 2022. In 2023, over 150,000 Middlesex-London residents lived in food insecure households, as compared to less than 110,000 in 2022.

K. Loupos explained the process of monitoring food affordability locally. To monitor food affordability, local food and rental costs from May 2024 were compared to a variety of household and income scenarios. The scenarios include food and rent only and are not inclusive of other needs, such as utilities, phone, transportation and personal care items. A key indicator for food insecurity is the average monthly cost of a nutritious diet as a proportion of household income. Households with low incomes spend up to 47% of their after-tax income on food, whereas households with adequate incomes only spend approximately 12%.

In 2024, a single person receiving Ontario Works (OW) needed $522 per month just to pay for rent and food, an additional $102 more than in 2023. A single person in the Ontario Disability Support Program (ODSP) also does not have enough funds to pay for rent and food; however, this person is doing slightly better than in 2023. This indicates that indexing ODSP rates to Ontario's Consumer Price Index, which started in July 2023 is having an impact. OW rate increases are not indexed to inflation.

K. Loupos explained that food insecurity is a key social determinant of health and action is needed across all levels of government. The Health Unit's food affordability data is shared with government, municipalities, community partners, and the wider community, and used in a variety of ways. The food costs are used by the Ontario Living Wage Network to help calculate the regional living wage. The data is also shared by our partners in community reports, such as London Community Foundation's 2024 Vital Signs Report. K. Loupos reminded that the Board of Health has previously sent letters to the federal government in support of basic income and to the provincial government in support of increased social assistance rates.

K. Loupos noted that Health Unit staff are exploring the development of a municipal primer about food insecurity as an important local public health issue and actions municipalities can take to address it.

Board Member Skylar Franke inquired on what the municipal primer would look like in addition to the infographic attached with the report. K. Loupos explained that some of the information for the primer would come from the infographic and expanding on what local municipalities can do from an advocacy standpoint with resources. K. Loupos added that Dieticians across Ontario are working towards developing

this primer. Dr. Alexander Summers, Medical Officer of Health added that resources such as primers are tools that can be provided to municipalities to promote healthy public policy development. In January, the Board will be hearing how the Municipal and Community Health Promotion team is integrating into the municipal planning process such as the City of London's Mobility Master Plan and informing healthy public policy.

It was moved by **S. Franke, seconded by A. DeViet,** *that the Board of Health:*

1) *Receive Report No. 82-24 re: "Monitoring Food Affordability and Implications for Public Policy and Action 2024" for information; and*
2) *Direct staff to forward Report No. 82-24 re: "Monitoring Food Affordability and Implications for Public Policy and Action 2024" to Ontario boards of health, the City of London, Middlesex County, and appropriate community agencies.*

Carried

Middlesex London Food Policy Council Restructuring (Report No. 83-24)

S. Maaten introduced Darrell Jutzi, Manager, Municipal and Community Health Promotion to provide an update on the Health Unit's involvement with the Middlesex-London Food Policy Council.

D. Jutzi explained that the Middlesex-London Food Policy Council was established in 2016 and the Health Unit has supported this work since its creation. The Council includes members from all areas of the food system, from food production to distribution, government advocacy and food waste. The Council collaborates to address food related challenges and opportunities to promote a safe, healthy, equitable, ecologically responsible and economically viable food system.

The Food Policy Council has evolved since its creation and there was a need to review its structure to ensure that the Council maximizes their skills and capacity to benefit the work of the Council. Prior to the Council's restructuring, the administrative role had been previously held by a Heath Unit Dietitian – administrative duties will now be conducted by the newly hired Community Food Systems Facilitator. The Dietician's role will shift from primarily administrative duties to focusing on the delivery of public health interventions, including Community and Partner Mobilization and Healthy Public Policy Development. This change will enhance the Council's ability to expand outreach with new and potential partners and coordinate efforts of the Council to respond to community need through collective impact. The Health Unit Dietitian will also have some increased capacity in their work at the Health Unit.

Board Member Michelle Smibert commented that she had been a member of the Middlesex-London Food Policy Council for two (2) years and noted the current Dietitian has been an amazing resource for the Council. M. Smibert thanked the Health Unit for its collaboration with the Food Policy Council.

Dr. Summers noted for the Board of Health's information that historically, a member of the Board participates in the Middlesex-London Food Policy Council. The Food Policy Council has been asked for clarification by the Health Unit to determine if a senior staff member, Board Member or another employee satisfies the requirement, with a response pending in the Council's Terms of Reference review.

Chair Newton-Reid requested if Dr. Summers or M. Smibert could inquire if the Middlesex-London Food Policy Council could attend a future Board of Health meeting to provide information on their work or present their Annual Report for more clarity and context.

It was moved by **M. Smibert, seconded by S. Menghsha,** *that the Board of Health receive Report No. 83-24 re: "Middlesex London Food Policy Council Restructuring" for information.*

Carried

MLHU Ontario Living Wage Network Certification (Report No. 84-24)

E. Williams introduced Cynthia Bos, Associate Director, Human Resources and Labour Relations to present the Health Unit's Living Wage Certification report.

C. Bos noted that the Health Unit is a living wage employer and has been certified as such. The living wage for London, Elgin and Oxford has increased to $19.50 per hour. This increase does require an increase in the wages of our Student Test Shoppers and some of our contracted services such as security, to maintain the certification. The increase in wages for the Student Test Shoppers will be effective January 1, 2025 and the increase for contracted services will be effective within six (6) months. The Health Unit's commitment to being a living wage employer aligns with equity values and compensation practices.

Chair Newton-Reid requested C. Bos to highlight the anticipated cost to the Health Unit to sustain certification for the year. C. Bos stated that the additional cost is $6,941.

Board Member S. Franke noted that she is happy that the Middlesex-London Health Unit is a living wage employer and hopes to see other agencies within the City of London and the City of London itself adopt this certification.

It was moved by **S. Franke, seconded by P. Cuddy,** *that the Board of Health receive Report No. 84-24 re: "MLHU Ontario Living Wage Network Certification" for information.*

Carried

Client Relations Process (Report No. 85-24)

E. Williams introduced Ryan Fawcett, Associate Director, Operations/Privacy Officer to present the client relations process to the Board of Health.

R. Fawcett explained that this client relations framework is to ensure that the Health Unit is following the *Excellent Care for All Act*, which states that all health agencies have a mechanism to receive and respond to client feedback. The process will ensure that client interactions are managed effectively, transparently and consistently. The framework will apply to all leaders, employees and healthcare providers within the agency. Staff will also commit to providing data to the Board of Health at least twice a year. The next steps include enhanced training for teams. Staff will continue to review and refine as more about the process is learned.

There were no questions or discussion.

It was moved by **M. Steele, seconded by A. DeViet,** *that the Board of Health receive Report No. 85-24 re: "Client Relations Process" for information.*

Carried

Current Public Health Issues (Verbal Report)

Dr. Summers provided the Board of Health with an update on current public health issues.

<u>Respiratory Season Update</u>
The Middlesex-London region is seeing significant activity of COVID-19, RSV and emerging activity from influenza. COVID-19 has yet to follow the typical seasonality of respiratory illnesses – it is the highest in the winter but is still present in the spring and summer. COVID-19 remains present in the community and the vaccine is available at pharmacies within Middlesex-London and the Health Unit for younger children. Vaccination uptake in Middlesex-London is significantly lower across Ontario than it

was after the pandemic. For those under the age of 30, less than 5% of the population has received a COVID-19 vaccine this fall.

The influenza vaccine program at this time does not have real time data for coverage and will be provided later in the year. Influenza is emerging but is still very low with regards to how much it is transmitting in the community. Dr. Summers encouraged those who have not received a vaccine to receive one for their protection.

Respiratory syncytial virus (RSV) has also been present in the community, as a relatively unexposed cohort of children got exposed to RSV at once, resulting in a number of hospitalizations. This year, we have vaccines available for infants under 1, pregnant persons, and adults over the age of the age of 60.

Legislative Updates: Health Protection and Promotion Act and Office of the Chief Medical Officer of Health

There have been some announced changes to the *Health Protection and Promotion Act*. The provincial government recently tabled legislative updates that if passed will result in some changes.

The first is the approval of voluntary mergers across the province of certain public health units as of January 1, 2025. The Board of Health has had several discussions regarding mergers of public health units. It was announced that on January 1, there will be a creation of four new health units reducing the totality of public health units in the province from 34 to 29. The changes are as follows:

- Porcupine Health Unit + Timiskaming Health Unit are now Northeastern Health Unit
- Brant County Health Unit + Haldimand-Norfolk Health Unit are now Grand Erie Health Unit
- Haliburton, Kawartha & Pine Ridge District Health Unit + Peterborough County-City Health Unit are now Haliburton, Kawartha, Northumberland & Peterborough Area Health Unit
- Hastings & Prince Edward Counties Health Unit + Kingston, Frontenac and Lennox & Addington Health Unit + Leeds, Grenville and Lanark District Health Unit are now South East Health Unit

It is anticipated that these public health units will take time to transition and will be in transition for a few years. It has been confirmed they will be receiving temporary funds for the transition.

The second change to the legislation relates to regulations as they apply to public pool owners, and residential pool and spa owners. These are refinements to practices that are already happening but now will be reflected in legislation.

The third change is a shift to the legislative authorities of a Medical Officer of Health under Section 22 of the *Health Protection and Promotion Act*. Section 22 gives Medical Officers of Health the authority to order individuals, businesses, or agencies to do certain actions to reduce infectious disease or communicable disease spread. Within this section, there is a tool called a "class order" which can be applied for many individuals or organizations. A class order was rarely used prior to the pandemic. It was first put into effect during the 2003 SARS outbreak. Through the COVID-19 pandemic, it was used mainly to stop the spread of COVID-19 through different avenues. With the changes to the legislation, the use of a class order will require consultation with the Chief Medical Officer of Health to ensure consistency, however it could be seen as a reduction in the autonomy of a Medical Officer of Health.

MLHU in the News

There is a phenomenon called "walking pneumonia" that has increased across Canada. Walking pneumonia is a catch all syndromic term that refers to a milder presentation of inflammation of the lungs or pneumonia that can be caused by several different viral and bacterial organisms. It can often cause mild symptoms through a bacteria called mycoplasma pneumonia. The Health Unit does not do case and contact management for this illness, but it is tracked at a laboratory level. In Ontario, mycoplasma pneumonia has risen from less than 1% to over 18% and requires a different antibiotic to treat.

It was moved by **P. Cuddy, seconded by H. Shears,** *that the Board of Health receive the verbal report re: Current Public Health Issues for information.*

Carried

Medical Officer of Health Activity Report for November (Report No. 86-24)

Dr. Summers presented his activity report for November. There were no questions or discussion.

It was moved by **M. Smibert, seconded by S. Franke,** *that the Board of Health receive Report No. 86-24 re: "Medical Officer of Health Activity Report for November" for information.*

Carried

Chief Executive Officer Activity Report for October and November (Report No. 87-24)

E. Williams presented her activity report for October and November. There were no questions or discussion.

It was moved by **S. Franke, seconded by A. DeViet,** *that the Board of Health receive Report No. 87-24 re: "Chief Executive Officer Activity Report for October and November" for information.*

Carried

CORRESPONDENCE

It was moved by **P. Cuddy, seconded by M. Smibert,** *that the Board of Health receive items a) through e) for information:*

a) *Peterborough Public Health re: Support for the Walport Report and Sustained Investment and Reporting on Provincial Emergency Preparedness*
b) *Middlesex-London Board of Health External Landscape – December 2024*
c) *Kingston, Frontenac, Lennox and Addington Public Health re: Harm Reduction in Ontario*
d) *Peterborough Public Health re: Support for a Provincial Immunization Registry*
e) *Kingston, Frontenac, Lennox and Addington Public Health re: Health Canada Radon Guideline*

Carried

It was moved by **M. Steele, seconded by S. Franke,** *that the Board of Health endorse item f) re: Community Drug and Alcohol Committee re: Letter to Ontario Chief Medical Officer of Health*

Carried

Vice-Chair Steele provided an update to the Board on the meeting held with Board Chair Chris Moise (Toronto Public Health). It was noted that Board Chair Moise reached out to Board Chairs in Ontario requesting conversations regarding closures of consumption and treatment sites, and the request for support to the Province of Ontario.

Chair Newton-Reid and Vice-Chair Steele provided context to London's consumption and treatment site and noted that the location on York Street was just outside of the 200 metre distance threshold from a school or daycare centre as outlined within the *Safer Streets, Stronger Communities Act*. The concern noted by Chair Newton-Reid and Vice-Chair Steele was that sharing public dissent could potentially cause political rifts and retaliation, which could challenge the future of the York Street location.

In Toronto, there are five consumption and treatment sites, four of which fall within the 200 metres requirement, which means that only one will be allowed to continue under the new legislation. Chair Moise wanted to stress that this is not just a Toronto matter, it is an all of Ontario matter. He was encouraging

Boards of Health to take action and specifically to write a letter to the Province, so that it was documented that public health are in support of safe consumption sites.

Board Chair Moise was supportive of the Health Unit's active and continued engagement with Members of Provincial Parliament but noted his desire for Boards of Health to submit written letters to the Province. At this time, the Board Chair and Vice-Chair are not recommending a letter from the Board of Health be written to the Province of Ontario until more information is known, to avoid political challenges and to continue working as partners with Members of Provincial Parliament.

Board Member S. Franke inquired if there have been coordinated responses through the Association of Local Public Health Agencies (alPHa) regarding the closure of consumption and treatment sites in Ontario. Dr. Summers noted that alPHa has not initiated action around this particular topic at this time. There is a working group on opioid use that is actively discussing action. In addition, the Chief Medical Officer of Health Annual Report from last year does speak highly to the utility in need for a comprehensive set of tools to respond to the drug crisis, including harm reduction services like consumption and treatment facilities, needle syringe programs and naloxone distribution. The broader community groups who work with people who suffer from addiction, associated with drugs is struggling from some of the rapid changes to the types of services that are happening. Locally, the Community Drug and Alcohol Committee's last meeting was focused on conversations with the Chief of London Police and members of its executive team on how to support a therapeutic approach to the legislative changes that are happening. Dr. Summers noted that there is still ongoing uncertainty around how to respond at this time.

Vice-Chair Steele added that he is empathetic for the Toronto situation in that closing their consumption and treatment sites, and then prosecuting those who use drugs in public, is a vicious cycle. Vice-Chair Steele further noted that in the external landscape for this month, there was a news article regarding the Canadian Mental Health Association locally that has applied for a HART hub for London, which may create changes. Vice-Chair Steele showed gratitude that London's consumption and treatment site on York Street remains open to provide support.

It was moved by **P. Cuddy, seconded by M. Smibert,** *that the Board of Health receive the verbal update re: Meeting with Toronto Public Health Board Chair for information.*

Carried

OTHER BUSINESS

The next meeting of the Middlesex-London Board of Health is Thursday, January 23, 2025 at 7 p.m.

CLOSED SESSION

At **8:04 p.m.,** it was moved by **P. Cuddy, seconded by A. DeViet,** *that the Board of Health will move into a closed session to consider matters regarding personal matters about an identifiable individual, including municipal or local board employees, labour relations or employee negotiations, litigation or potential litigation, including matters before administrative tribunals affecting the municipality or local board, advice that is subject to solicitor-client privilege, including communications necessary for that purpose and to approve previous closed session Board of Health minutes.*

Carried

At **8:35 p.m.,** it was moved by **H. Shears, seconded by M. Smibert,** *that the Board of Health return to public session from closed session.*

Carried

ADJOURNMENT

At **8**:**35 p.m.,** it was moved by **S. Franke, seconded by A. DeViet,** *that the meeting be adjourned.*

Carried

_____	_____
MATTHEW NEWTON-REID	**EMILY WILLIAMS**
Chair	**Secretary**

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 01-25

TO: Chair and Members of the Board of Health

FROM: Emily Williams, 2024 Secretary and 2024 Treasurer

DATE: 2025 January 23

ELECTION OF 2025 BOARD OF HEALTH EXECUTIVE

Recommendation

It is recommended that the Board of Health:

1) *Receive Report No. 01-25 re: "Election of 2025 Board of Health Executive" for information;*
2) *Appoint a Chair for the 2025 term;*
3) *Appoint a Vice-Chair for the 2025 term;*
4) *Appoint a Secretary for the Board of Health for 2025 term; and*
5) *Appoint a Treasurer for the Board of Health for the 2025 term*

Report Highlights

- Per Board of Health By-law No. 3, Section 18.0 notes that the Board must elect by majority vote a Chair, Vice-Chair, Secretary and Treasurer.
- The outgoing 2024 Board of Health Executive is:
  - Matt Newton-Reid – Chair
  - Mike Steele – Vice-Chair
  - Emily Williams – Secretary
  - Emily Williams – Treasurer

Board Membership Update

The Board of Health consists of the following Members:

- Five provincial appointees (two vacancies): Mike Steele, Selomon Menghsha and Howard Shears
- Three City of London appointees: Matt Newton-Reid, Peter Cuddy and Skylar Franke
- Three Middlesex County appointees: Aina DeViet, Michelle Smibert and Mike McGuire

The appointment list of the current Board of Health membership can be found in Appendix A.

Procedures for the First Meeting of the Year

Board of Health By-law No. 3 regulates the proceedings of the Board. Section 18.0 of this By-law addresses Elections and the Appointment of Committees:

> *18.1 At the first meeting of each calendar year the Board shall elect by a majority vote a Chair, Vice-Chair, Secretary, and Treasurer for that year.*
>
> *18.2 The Chair of the Board shall be selected by the voting members to serve for a term of one year. The Chair may be nominated to serve for a consecutive term.*
>
> *18.3 The Vice-Chair, Secretary, and Treasurer shall be elected for a one-year term.*
>
> *18.4 The Secretary and Treasurer are separate roles that may be performed by any member (appointed and/or ex-officio) of the Board of Health with the requisite skill set. This will be determined on an annual basis in accordance with the appropriate by-law procedure.*
>
> *18.5 At the first meeting of each calendar year, the Board shall appoint the representative or representatives required to be appointed annually at the first meeting by the Board to other Boards, bodies, or commissions where appropriate.*
>
> *18.6 The Board may appoint committees from time to time to consider such matters as specified by the Board (e.g., Finance and Facilities, Governance, Medical Officer of Health and Chief Executive Officer Performance Review etc.).*

Election of Executive Officers

Chair: As per the current By-law No. 3, Section 18.2, as stated above, the Chair is selected by the voting members to serve for a term of one year. The Chair may be nominated to serve for a consecutive term. The Chair for 2024 was Matt Newton-Reid, a City of London appointee.

Vice-Chair: By-law No. 3, Section 18.3 stipulates that the Vice-Chair is elected for a one-year term. The Vice-Chair for 2024 was Mike Steele, a provincial appointee.

Secretary: By-law No. 3, Section 18.3 stipulates that the Secretary is elected for a one-year term. By-law No. 3, Section 18.4 states that the Secretary role may be performed by any member (appointed and/or ex-officio) of the Board with the requisite skill set. The Secretary for 2024 was Emily Williams, Chief Executive Officer.

Treasurer: By-law No. 3, Section 18.3 stipulates that the Treasurer is elected for a one-year term. By-law No. 3, Section 18.4 states that the Treasurer role may be performed by any member (appointed and/or ex-officio) of the Board with the requisite skill set. The Treasurer for 2024 was Emily Williams, Chief Executive Officer.

This report was prepared by the 2024 Secretary and Treasurer, Board of Health.

Emily Williams, BScN, RN, MBA, CHE
Secretary and Treasurer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The fiduciary requirements and good governance and management practices as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Middlesex-London Board of Health
Appointed Member Listing

First Name	Last Name	Appointed By	First Appointed	Term Expires on
Matthew	Newton-Reid	City of London	December 1, 2018	November 14, 2026
Aina	DeViet	County of Middlesex	December 18, 2018	November 14, 2026
Michael	Steele	Province of Ontario	December 10, 2020	December 9, 2026
Selomon	Menghsha	Province of Ontario	September 16, 2021	September 15, 2026
Skylar	Franke	City of London	November 22, 2022	November 14, 2026
Peter	Cuddy	City of London	November 22, 2022	November 14, 2026
Michelle	Smibert	County of Middlesex	December 13, 2022	November 14, 2026
Michael	McGuire	County of Middlesex	December 13, 2022	November 14, 2026
Howard	Shears	Province of Ontario	October 26, 2023	October 25, 2027

Last updated 1/16/2025

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 02-25

TO: Chair and Members of the Board of Health

FROM: Emily Williams, 2024 Secretary and 2024 Treasurer

DATE: 2025 January 23

APPOINTMENT OF 2025 BOARD OF HEALTH COMMITTEES

Recommendation

It is recommended that the Board of Health:

1) *Receive Report No. 02-25 re: "Appointment of 2025 Board of Health Committees" for information;*
2) *Approve the appointment of members to the following committees:*
    a. *Finance and Facilities*
    b. *Performance Appraisal*
3) *Approve disbanding of the Governance Committee;*
4) *Approve striking of the Quality and Governance Committee; and*
5) *Approve the 2025 Board of Health and Committee Reporting Calendar (Appendix A).*

Report Highlights

- Per Board of Health By-law No. 3, Section 18.0 notes that the Board may strike and appoint committees for such matters defined by the Board. Currently, there are three committees:
    - Finance and Facilities;
    - Governance; and
    - Performance Appraisal
- It is proposed that the Governance Committee be disbanded for 2025 and a new committee called the Quality and Governance Committee be struck.
- A draft reporting calendar as Appendix A has also been affixed for the Board's consideration, with reporting for the proposed new Committee (Quality and Governance included as well).

Board Membership Update

The Board of Health consists of the following Members:

- **Five provincial appointees (two vacancies):** Mike Steele, Selomon Menghsha and Howard Shears
- **Three City of London appointees:** Matt Newton-Reid, Peter Cuddy and Skylar Franke

- **Three Middlesex County appointees:** Aina DeViet, Michelle Smibert and Mike McGuire

Procedures for the First Meeting of the Year

Board of Health By-law No. 3 regulates the proceedings of the Board. Section 18.0 of this By-law addresses Elections and the Appointment of Committees.

> *18.6 - The Board may appoint committees from time to time to consider such matters as specified by the Board (e.g., Finance and Facilities, Governance, Medical Officer of Health and Chief Executive Officer Performance Review etc.).*

A draft reporting calendar as Appendix A has also been affixed for the Board's consideration.

Establishment of Standing Committees

Under Section 2.1(b) of Board of Health Policy G-280 (Board Size and Composition), the Board determines whether it wishes to establish one or more standing committees at its first meeting of the year. The Board of Health currently has three standing committees: Finance and Facilities, Governance and MOH and CEO Performance Appraisal. It is proposed that for 2025, the Governance Committee be disbanded and a new committee be struck, called the Quality and Governance Committee.

New Quality and Governance Committee

Staff are proposing to the Board of Health to introduce a new committee called the Quality and Governance Committee. This committee would include policy review that the Governance Committee conducted, with the addition of providing the Committee (to the Board) quality-related reporting such as strategic planning, organizational performance, privacy statistics and risk management.

The Quality and Governance Committee tentatively would consist of:
- One (1) provincial appointed member;
- One (1) City of London appointed member;
- One (1) County of Middlesex appointed member;
- Chair of the Board; and
- Vice Chair of the Board

The first proposed meeting of the Quality and Governance Committee would be on Thursday, February 20 at 6 p.m. If the Board approves the striking of this new committee, full Terms of Reference would be provided at the first meeting.

Finance and Facilities Committee

The Finance and Facilities Committee consists of:
- One (1) provincial appointed member;
- One (1) City of London appointed member;
- One (1) County of Middlesex appointed member;
- Chair of the Board; and
- Vice Chair of the Board

The Finance and Facilities Committee serves the Board of Health in an advisory and monitoring role in relation to the administration and risk management of the organization's finances and facilities.

The Finance and Facilities meeting cadence is being proposed to be amended. The first meeting would tentatively be held on Thursday, March 20 at 6 p.m.

Performance Appraisal Committee

The Performance Appraisal Committee serves to evaluate the performance of the Medical Officer of Health (MOH) and Chief Executive Officer (CEO). The committee's role is to assist and advise the Board of Health on how the MOH and CEO's performance reflects the health unit's values, vision, mission, mandate, and policies, and contributes to the achievement of the strategic goals.

The first meeting of the Performance Appraisal Committee will be in Q2, at the call of the Chair.

All Board of Health members may attend committee meetings, but only Committee members may vote.

This report was prepared by the 2024 Secretary and Treasurer, Board of Health.

Emily Williams, BScN, RN, MBA, CHE
Secretary and Treasurer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The fiduciary requirements and good governance and management practices as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.

2025 Middlesex-London Board of Health Reporting Calendar - DRAFT

Q1 2025: January 1 – March 31

Meetings: January, February, March

Finance and Facilities

- Review Terms of Reference
- Public Sector Salary Disclosure
- Review and Recommend Board of Health Remuneration
- Q4 Financial Update, Financial Borrowing and Factual Certificate Update

Quality and Governance

- Review Insurance Coverage
- Annual Privacy Program Update
- Q4 Risk Registry
- Annual Declarations – Confidentiality and Conflict of Interest
- Q4 Strategic Plan Update
- Q4 Performance Reporting
- Activity Reports – CEO, MOH, Board Chair
- Review Governance By-laws and Policies

Public Health Program Standards

- As required

Q2 2025: April 1 – June 30

Meetings: April, May

Finance and Facilities

- Q1 Financial Update, Financial Borrowing and Factual Certificate Update
- Review and Recommend – Audited Financial Statements for MLHU
- Recommend Budget Parameters, Planning Assumptions and Municipal Funding Targets
- Review Funding and Service Level Agreements
- Review and Recommend Budget Process
- Visa and Accounts Payable Update

Quality and Governance

- Occupational Health and Safety Program Update
- Q1 Risk Registry
- Review Governance By-laws and Policies
- Initiate Board of Health Self-Assessment (2025)
- Review Governance Policies and By-Laws
- Q1 Strategic Plan Update
- Annual Service Plan
- Annual Report and Attestation
- Q1 Performance Reporting
- Activity Reports – CEO, MOH, Board Chair

Public Health Program Standards

- Nurse Family Partnership Annual Report

MOH/CEO Performance Appraisal

- Initiate Terms of Reference Review (2025)
- Confirm Performance Appraisal process, supporting documents required and timelines for the year
- Chair of the Board to conduct meetings with Board Members
- Select Consultant to facilitate Performance Appraisal process via external and internal survey

Q3 2025: July 1 – September 30	Q4 2025: October 1 – December 31
Meetings: July and September **Finance and Facilities** • Q2 Financial Update, Financial Borrowing and Factual Certificate Update • Review and Recommend Audited Financial Statements for April 1 to March 31 Programs • Review Multi-Year Budget **Quality and Governance** • Q2 Risk Registry • Q2 Strategic Plan Update • Report on Board of Health Self-Assessment (2025) • Q2 Performance Reporting • Review Governance By-laws and Policies • Activity Reports – CEO, MOH, Board Chair **Public Health Program Standards** • As required **MOH/CEO Performance Appraisal** • Debrief with Consultant • Chair of the Board to conduct open office hours with direct reports • Review Performance Appraisal Reports	**Meetings: October, November, December** **Finance and Facilities** • Q3 Financial Update, Financial Borrowing and Factual Certificate Update • Review and Recommend Final Board of Health Budget • Review Employee Benefits Coverage **Quality and Governance** • Q3 Risk Registry • Q3 Performance Reporting • Q3 Strategic Plan Update • Board of Health Orientation • Activity Reports – CEO, MOH, Board Chair **Public Health Program Standards** • 2024-2025 Respiratory Season Update • Immunization of School Pupils Act Compliance Report • Monitoring Food Affordability **MOH/CEO Performance Appraisal** • Report Performance Appraisal Reports to the Board of Health • Report Performance Appraisal Reports to MOH and CEO

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 03-25

TO: Chair and Members of the Board of Health

FROM: Emily Williams, 2024 Secretary and 2024 Treasurer

DATE: 2025 January 23

AMENDING THE 2025 BOARD MEETING SCHEDULE

Recommendation

It is recommended that the Board of Health:

1) *Receive Report No. 03-25 re: "Amending the 2025 Board Meeting Schedule for information;*
2) *Amend the 2025 Board Meeting Schedule to cancel the June 19, 2025 Board of Health meeting; and*
3) *Amend the cadence of the Finance and Facilities Committee meetings, Governance Committee meetings and Quality and Governance Committee meetings as outlined in Appendix A.*

Report Highlights

- The Board of Health approved the 2025 Board and Committee Meeting schedule at the October 17, 2024 meeting.
- The Association of Local Public Health Agencies (alPHa) have since posted that the Annual General Meeting (AGM) and Conference will be held in-person from June 18-20, 2025.
- The June Board meeting is currently scheduled for June 19, 2025 and due to the timing of the alPHa AGM, it is being proposed to cancel the June Board of Health meeting.
- It is also being proposed to amend the 2025 meeting schedule to shift the cadence of the Finance and Facilities Committee, introduce the cadence for the Quality and Governance Committee and remove the Governance Committee.
- A draft amended 2025 Board and Committee meeting calendar is affixed as Appendix A.

Background

The Board of Health approved the 2025 Board and Committee Meeting Schedule at the October 17, 2024 Board meeting (Report No. 69-24). The Board sets the annual schedule of meetings a year in advance for efficient planning of business for the Board and staff.

Amendments to the 2025 schedule

It was noted that in December 2024, the Association of Local Public Health Agencies (alPHa) confirmed that the 2025 Annual General Meeting and Conference will be held June 18-20, 2025 in-person. It is proposed that the June Board meeting be cancelled as dates in June for a Board meeting may conflict with other external meetings for Board members and staff members. It is anticipated that Board business that originally would have been presented in June would be presented in July instead.

With the proposed introduction of the Quality and Governance Committee, it is being proposed to the Board that the new Committee start in February and meet quarterly, offsetting the Finance and Facilities Committee, which would begin to meet in March.

A draft amended 2025 Board and Committee meeting calendar is affixed as Appendix A.

Next Steps

The Board of Health must provide approval to amend meeting dates as these dates have been approved. Once approved, an amended schedule would be circulated to the Board and staff, along with on the Health Unit's website.

This report was prepared by the 2024 Secretary and Treasurer, Board of Health.

Emily Williams, BScN, RN, MBA, CHE
Secretary and Treasurer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The fiduciary requirements and good governance and management practices as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.

2025 Middlesex-London Board of Health and Committee Meetings - AMENDED		
Type of Meeting	**Materials Due Date**	**Date and Time of Meeting**
Regular Board	Thursday, January 9	Thursday, January 23 at 7 p.m.
Quality and Governance	Thursday, February 6	Thursday, February 20 at 6 p.m.
Regular Board	Thursday, February 6	Thursday, February 20 at 7 p.m.
Finance and Facilities	Thursday, March 6	Thursday, March 20 at 6 p.m.
Regular Board	Thursday, March 6	Thursday, March 20 at 7 p.m.
Regular Board	Thursday, April 10	Thursday, April 24 at 7 p.m.
Quality and Governance	Thursday, May 8	Thursday, May 22 at 6 p.m.
Regular Board	Thursday, May 8	Thursday, May 22 at 7 p.m.
Finance and Facilities	Thursday, July 10	Thursday, July 24 at 6 p.m.
Regular Board	Thursday, July 10	Thursday, July 24 at 7 p.m.
Quality and Governance	Thursday, September 4	Thursday, September 18 at 6 p.m.
Regular Board	Thursday, September 4	Thursday, September 18 at 7 p.m.
Finance and Facilities	Thursday, October 2	Thursday, October 16 at 6 p.m.
Regular Board	Thursday, October 2	Thursday, October 16 at 7 p.m.
Quality and Governance	Thursday, November 6	Thursday, November 20 at 6 p.m.
Regular Board	Thursday, November 6	Thursday, November 20 at 7 p.m.
Finance and Facilities	Thursday, November 27	Thursday, December 11 at 6 p.m.
Regular Board	Thursday, November 27	Thursday, December 11 at 7 p.m.

All meetings will be held at the Middlesex-London Health Unit Board Room, 110-355 Wellington Street (Citi Plaza) in London unless otherwise specified.

Performance Appraisal Committee Meetings will be held at the call of the Chair.

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 04-25

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2025 January 23

TAKING ACTION FOR RECONCILIATION PLAN IMPLEMENTATION PROGRESS REPORT

Recommendation

It is recommended that the Board of Health receive Report No.04-25 re: "Taking Action for Reconciliation Plan Implementation Progress Report" for information.

Report Highlights

- Earnest and ongoing implementation of the Taking Action for Reconciliation Plan (TAFR) is progressing well through the prioritization of relationship building and collaboration towards common public health goals with Indigenous partners and Indigenous led organizations.
- A significant milestone is the development of a memorandum of understanding (MOU) that outlines how the Oneida Health Centre and the MLHU will work together to share information to prevent the transmission of communicable diseases.
- The TAFR demonstrates the MLHU's commitment to reconciliation.

Background

The Middlesex-London Health Unit's (MLHU) Taking Action for Reconciliation plan (TAFR) was developed in response to a collective commitment to enact the Truth and Reconciliation Commission (TRC) of Canada's 94 Calls to Action. Local perspectives obtained through dialogue with representatives of local Indigenous-led organizations and individuals resulted in recommendations to guide the MLHU's reconciliation activities. The Board approved the TAFR plan on September 20, 2018.

MLHU serves urban and on-reserve communities within Middlesex-London and adjacent localities through collaboration with Indigenous-led organizations including Atlohsa Family Healing Services, the Southwest Ontario Aboriginal Health Access Centre (SOAHAC), the N'Amerind Friendship Centre, and the health centres within the Chippewas of the Thames First Nation, the Munsee-Delaware Nation and the Oneida Nation of the Thames.

Relationships with Indigenous partners both benefited and were strained by the pandemic response. The MLHU's Health Equity and Reconciliation Team (HEART) received feedback that our collaborative COVID-19 response efforts were effective and demonstrated the potential of continuing the collaborative relationship. However, MLHU also learned in late 2021 that relationships were not sufficiently nurtured post-pandemic. Immediately, MLHU took this feedback as an opportunity to reinvigorate the organization's TAFR plan and began working on the implementation of the 65 recommendations within seven groupings:

1. Relationships

MLHU has prioritized building respectful and trusting relationships with First Nations communities and with Indigenous-led organizations through frequent, consistent and purposeful interaction. Key engagement activities include:

- Coordinated, regular in-person and virtual meetings with colleagues from First Nation Health Centres. The terms of reference have been co-developed with the goals of mutual capacity building, coordination of shared public health mandates, and documenting collaborative processes.
- Regular communication with urban Indigenous-led organizations. This serves to amplify their organizational messages, support increased access to services such as vaccination clinics, and contribute to MLHU's learning and capacity building efforts.

2. Governance

The MLHU is committed to supporting Indigenous partners in building their capacity for unique self-determination and sovereignty goals related to public health. A highlight of this work has been the exploration of infectious disease control responsibilities. In collaboration with Oneida Health Centre partners, the Associate Medical Officer of Health (AMOH) has drafted a memorandum of understanding (MOU) that outlines how the Oneida Health Centre and the MLHU will work together to share information to prevent the transmission of communicable diseases. MLHU is also working with Munsee-Delaware and Chippewas Nations to develop similar MOUs.

3. Awareness and Education

Awareness and education are prerequisites to meaningful engagement and relationship building and are the foundation to mobilize staff to take action. In the annual observance of Indigenous Solidarity Day and National Day for Truth and Reconciliation there are activities like lunch-and-learns and staff participation in events organized by Indigenous partners.

4. Workforce Development

Human Resources (HR) and the HEART have created an Employment Equity Policy to reduce implicit bias in hiring and develop hiring targets (Report No. 43-23). The aim is to foster a culture of inclusivity, respect, empathy, and safety for all staff, including Indigenous identifying staff.

5. Supportive Environments

The Staff Equity, Diversity and Inclusion Advisory Committee and Indigenous Cultural Practices policy, including procedures for smudging, support the MLHU's efforts to create physical and psychological spaces where Indigenous staff, partners and clients feel respected, heard and have a sense of belonging.

6. Research

The MLHU collects social determinants of health (SDOH) data for advancing Indigenous Health. In 2023, several teams began collecting Indigenous identity from clients as part of their demographic questions. Implementation engaged Indigenous partners at every step. This data

now informs a key performance indicator in the new organizational performance management system. In the future, Indigenous identity data will be linked to health outcome metrics to better understand local health inequities to inform resource allocation. The process is guided by Indigenous partners with the hopes of developing robust data governance approaches that incorporate the principles of ownership, control, access and possession (OCAP®).

7. Equitable Access and Service Delivery

The HEART has been coordinating collaborative efforts with urban and on-reserve Indigenous organizations to increase equitable access to MLHU services and to improve referral pathways. For example, the Vaccine Preventable Diseases team has offered mobile vaccine clinics and supports to increase vaccine access to both urban and on-reserve communities. The Healthy Babies Healthy Children program is working with First Nation Health Centres to increase mutual capacity to serve Indigenous moms and babies.

The ongoing implementation of these seven groupings of TAFR recommendations is ensuring that the MLHU is meeting requirements of the Health Equity Guideline, 2018. Specifically, the capacity to assess and report on health inequities experienced by local Indigenous populations is being increased through SDOH and Indigenous identity data collection initiatives. Regular and consistent engagement, focused on building relationships, mutual capacity, and trust, is leading to modifications in MLHU services to better address the unique needs of each local first nation and urban Indigenous populations. Collaboration with Indigenous-led organizations across sectors is increasing capacity to work collaboratively and reduce access inequities. Additionally, MOUs, policies, and procedures are being co-developed to ensure that progress towards reducing health inequities is sustainable.

Next Steps

In 2025, engagement efforts will focus on sustaining the relationships built, finalizing and implementing the MOUs currently in negotiation and exploring ways to support Indigenous-led urban organizations.

Regarding data collection and analysis, data governance mechanisms that align with OCAP® principles will be explored and developed in collaboration with Indigenous partners. Additionally, efforts will be made to identify local health inequities through the disaggregation of health outcome data by Indigenous identity.

This report was written by the Health Equity and Reconciliation Team, within the Public Health Foundations Division.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Health Equity standard as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan: We have strong relationships with our partners and are trusted by our community. Direction 1.1: Facilitate meaningful and trusting relationships with prioritized equity-deserving groups, specifically Black and Indigenous communities

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically to all TAFR recommendation groupings and ABRP recommendations advancing Race Based Data Collection and Use, Employee Systems to Support Black Employees and Cross Sectoral Collaboration.

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 05-25

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2025 January 23

2025 HEALTH PROMOTION PRIORITIES

Recommendation

It is recommended that the Board of Health receive Report No. 05-25 re: "2025 Health Promotion Priorities" for information.

Report Highlights

- A prioritization framework was developed to strategically identify programs or topics within the Ontario Public Health Standards to be the target of health promotion-oriented interventions.
- Prioritized areas of focus have been identified for 2025.
- Relevant MLHU teams are engaging in developing and implementing operational plans to address prioritized areas in 2025.
- The prioritization framework and process will continue to be evaluated and revised with a goal of broadening engagement and consultation moving forward.
- Priorities for 2025 are affixed as Appendix B, with definitions of health promotion-oriented interventions found in Appendix A.

Background

The Middlesex-London Health Unit (MLHU) faced significant budget pressures in 2024 resulting in an inability to sustain its previous levels of service. Given the magnitude of the disinvestments and the approved priorities of the agency, a new organizational structure for the MLHU was required.

This presented an opportunity to structure the agency around the public health interventions it delivers, providing multiple benefits, including: enhanced clarity of the work of the agency; an increased emphasis on the skills required to do the work, and an alignment of skills with the work; opportunities to strategically target certain issues, utilizing the full suite of adequately resourced interventions to maximize impact; and greater ability to adapt to changes in priority topics. Organized in this way, MLHU teams are able to employ interventions to target prioritized issues, depending on the burden of illness, the community context, and the policy landscape.

A prioritization framework was developed to strategically identify programs or topics within the Ontario Public Health Standards, 2021 (OPHS) to be the target of health promotion-oriented interventions, namely:

- Communication and Social Marketing,
- Education and Skill Building,
- Healthy Public Policy Development, and
- Community and Partner Mobilization.

Definitions of these interventions are provided in Appendix A.

The prioritization framework is rooted in the National Collaborating Centre's Model for Evidence Informed Decision-Making and includes application of public health expertise with consideration of the local community context, municipal and provincial political climates, and availability of public health resources. Prioritized areas are validated by population health assessment data and peer-review and grey literature as needed. Key questions that guide this process include:

- Does this topic represent a **significant burden of illness** in or risk to our community?
- Can progress in this area make a big **impact** on the health of the community?
- Is this topic a **provincial and/or municipal priority**?
- Can a **local public health agency intervention** be applied effectively to this topic?
- Which **health promotion-oriented interventions** best address this topic?
- Are **equity-deserving groups disproportionally impacted** by this topic?

Health Promotion Priorities for 2025

As part of the MLHU's Organizational Processes and Reporting Cadence, the Senior Leadership Team began the process of identifying 2025 health promotion priorities in July and August of 2024, including consultation with Divisional Leadership teams. Appendix B outlines prioritized OPHS programs or topics to be addressed using health promotion-oriented interventions in 2025.

Next Steps

Relevant teams are engaging in the development and implementation of operational plans to address health promotion prioritized areas of focus for 2025. The Senior Leadership team will continue to evaluate and revise the prioritization framework and process with a goal of broadening engagement and consultation moving forward.

This report was prepared by the Family and Community Health Division.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Population Health Assessment, Health Equity and Effective Public Health Practice Foundational standards and the Program Standards as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The *Health Protection and Promotion Act, 1990*
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
  - Client and Community Confidence (Directions 1.1, 1.2)
  - Program Excellence (Direction 2.1)
  - Organizational Excellence (Direction 4.1)

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically recommendations specifically recommendations Access and Report (4,5,6,7,8); Modify and Orient (9,10,11,14,16,17,19); Partner with Other Sectors (21,22,23,24,26); Engage Healthy Public Policy (33,37); Governance and Leadership (43,45) in the *Anti-Black Racism Plan* and recommendations Awareness and Education; Supportive Environments; Relationships; Governance; Equitable Access and Service Delivery in the *Taking Action for Reconciliation* report.

Definitions of Health Promotion-Oriented Interventions

Communication and Social Marketing

Communication activities involve creating and disseminating health information for the public and community partners using multi-media approaches including website, print resources, newsletters, social media, and other media channels. Social marketing activities focus on influencing behaviour within a specific target population, with some overall benefit to society as well as the individual. Activities within this intervention aim to gather and use target population insights to develop targeted communication materials that increase knowledge and change attitudes, beliefs, and practices in order to prevent disease and promote and protect the health of individuals and populations.

Education and Skill Building

Education and Skill Building involves the development and implementation of one-on-one or one-to-small group educational activities that are designed to increase participants' knowledge and improve behaviour, attitudes, and skills. Activities within this intervention are tailored to the target population, and present information on health benefits/threats. They also provide specific tools and/or strategies to build capacity and support behavior change in an appropriate setting. This intervention could be delivered in person, through online group seminars, or through self-directed online learning and includes "train the trainer" models.

Healthy Public Policy Development

Healthy Public Policy Development involves ensuring issues of public health importance are on the agenda of policy makers both internal and external to the health sector. This intervention promotes health and health equity through improving social, environmental, and economic conditions. Activities include identifying and developing policy options for public health issues; providing evidence-based feedback on the health impacts of policies; assessing and establishing a plan for resolution; determining needed resources; evaluating policy decisions; and providing technical assistance to develop or change laws, rules and regulations, ordinances, and policies. This intervention works at the local, provincial, and federal levels of government, as well as public institutions. For a local public health agency, this is primarily focused on the local level.

Community and Partner Mobilization

Community and Partner Mobilization involves bringing people and organizations together in a structured way to achieve individual, population, and/or systemic changes. Collective impact is built on the premise that organizations can be more successful in achieving largescale social change if they coordinate their efforts across sectors, rather than working in isolation on interventions with similar aims. Activities include developing and maintaining partnerships, coalition building and participation, community organizing and engagement, and cross-sector collaboration, all with the purpose of sharing information, coordinating activities, and sharing/mobilizing resources to achieve a common goal.

Health Promotion Priorities 2025

Program Name	Healthy Public Policy Development Intervention Name	Community and Partner Mobilization Intervention Name	Communication and Social Marketing Intervention Name	Education and Skill Building Intervention Name
Healthy Environments and Climate Change	**Primary** • Healthy Environments Policy Development	**Yes** • Healthy Environments Mobilization		
Active Transportation and Built Environment	**Primary** • Active Transportation Policy Development	**Yes** • Active Transportation Mobilization		
Food Systems and Nutrition	**Secondary** • Food Systems Policy Development	**Yes** • Harvest Bucks Mobilization • Food Systems Mobilization		
Alcohol	**Primary** • Alcohol Regional/Provincial Policy Development • Alcohol Municipal Policy Development	**Yes** • Alcohol Regional Mobilization • Alcohol Municipal Mobilization	**Yes** • Alcohol Communications	
Cannabis		**Yes** • Cannabis Municipal Mobilization		
Opioids (Harm Reduction Program Enhancement)	**Primary** • Opioids Policy Development	**Yes** • Opioids Regional Mobilization • Opioids Municipal Mobilization	**Yes** • Opioids Communications	
Other Drugs		**Yes** • Other Drugs Mobilization		
Tobacco and Vapour Products	**Secondary** • Tobacco and Vapour Products Regional / Provincial Policy Development	**Yes** • Tobacco and Vapour Product Mobilization • Smoke-Free Ontario Mobilization	**Yes** • Tobacco and Vapour Products Communications	**Yes** • Tobacco and Vapour Products Education and Skill Building
Early Childhood Development	**Primary** • Early Childhood Development Policy Development	**Yes** • Early Childhood Development Mobilization		

Program Name	**Healthy Public Policy Development** Intervention Name	**Community and Partner Mobilization** Intervention Name	**Communication and Social Marketing** Intervention Name	**Education and Skill Building** Intervention Name
Community-Based Immunization Outreach			**Yes** • Community Immunization Communications	
Poverty Reduction	**Secondary** • Poverty Reduction Policy Development			
Sexually Transmitted and Blood-Borne Disease			**Yes** • STBBD Communications	
Intimate Partner Violence Prevention	**Secondary** • IPV Prevention Policy Development	**Yes** • IPV Prevention Mobilization		
Comprehensive School Health	**Primary** • School Health Policy Development	**Yes** • School Health Mobilization		**Yes** • School Health Education and Skill Building
Health Systems Reorientation		**Yes** • Health System Reorientation Mobilization		
Healthy Pregnancies				**Yes** • Smart Start for Babies • Online Health Education
Infectious Disease Control				**Yes** • Community IPAC Education (IDC) • Institutional IPAC Education (IDC)

- Note: Priorities are subject to change depending on external factors (e.g. Priorities of funders, municipal and provincial government; policy window opening; change in epidemiologic trends).

Healthy Public Policy Development:

Primary vs. Secondary vs. Non-Priorities

- Primary priorities: Allocation of resources for proactive and reactive healthy public policy work is prioritized to these programs.
- Secondary priorities: As time and resources allow, proactive work can be completed in these programs; however, reactive work for the primary priorities would be prioritized over proactive work on the secondary priorities.
- Non-priorities: Staff do not generally engage in proactive work in these programs. However, there remains opportunity for reactive action for non-priorities as resources allow.

Primary program priorities

- Healthy Environments and Climate Change
- Active Transportation and Built Environment
- Alcohol
- Opioids (Harm Reduction Program Enhancement*)
- Early Childhood Development
- Comprehensive School Health

Secondary program Priorities

- Food Systems and Nutrition
- Tobacco and Vapour Products (Smoke Free Ontario*)
- Intimate Partner Violence Prevention
- Poverty Reduction

Community and Partner Mobilization

Priorities vs. Non-Priorities

- Community and Partner Mobilization is a distinct intervention, where the goal is coalition building for the sake of collective impact. Partners are important to the delivery of all public health interventions, but partnership engagement for the purposes of delivering another intervention is not included as Community and Partner Mobilization.
- The identified priorities programs are specifically related to Community and Partner Mobilization as an intervention.

Program Priorities

- Healthy Environments and Climate Change
- Active Transportation and Built Environment
- Food Systems and Nutrition
- Alcohol
- Cannabis
- Opioids
- Other Drugs
- Early Childhood Development

- Community-Based Immunization Outreach
- Tobacco and Vapour Products
- Intimate Partner Violence Prevention
- Comprehensive School Health
- Health Systems Reorientation

Communication and Social Marketing

Priorities vs. Non-Priorities

- Priority programs will be the focus of comprehensive communication and social marketing campaigns.
- There will continue to be opportunity, as resources allow, for teams to work with the Communications team to deliver well-scoped Communications products related to their programs and interventions. However, these will be of a lower magnitude or size.

Program Priorities

- Alcohol
- Opioids
- Community-Based Immunization Outreach
- Sexually Transmitted and Blood-Borne Disease
- Tobacco and Vapour Products

Education and Skill Building

Program Priorities

- Tobacco and Vapour Products
- Comprehensive School Health
- Healthy Pregnancies
- Infectious Disease Control

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 06-25

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2025 January 23

A FRAMEWORK TO SUPPORT HEALTHY PUBLIC POLICY: THE BUILT, NATURAL, AND SOCIAL ENVIRONMENTS

Recommendation

It is recommended that the Board of Health receive Report No. 06-25 re: "A Framework to Support Healthy Public Policy: The Built, Natural, and Social Environments" for information.

Report Highlights

- The Middlesex-London Health Unit (MLHU) promotes healthy built, natural, and social environments using domains which focus on neighbourhood design, transportation networks, green and natural spaces, housing, and food systems.
- A framework highlighting the built, natural, and social environments translates complex information and concepts into evidence-informed public health practice that will inform healthy public policy development, community plans, projects, and strategies.
- A framework will improve our partners' understanding of how MLHU engages in the municipal planning process and how our work aligns with the five domains in the built, natural, and social environments.

Background

Public health work is broad and varied. Our efforts in health promotion contribute to improved health outcomes and equity for the population. Under the current Ontario Public Health Standards (OPHS), 2021, health units are mandated to support the creation of healthy public policy to reduce exposure to health hazards, promote the development of healthy built, and natural environments, reduce the burden of chronic disease, and improve well-being.[1]

The Middlesex-London Health Unit (MLHU) has a history of being involved in the municipal planning process, informing the development of healthy public policy to facilitate positive community health outcomes.[2-6] Within the municipal planning agenda, public health could be involved at various stages to provide relevant health perspectives while informing and promoting healthy public policy development. Public health can provide health evidence, inform public

engagement, attend public participation meetings, and contribute to advisory committee meetings.[2,4] Being involved at the early stages of planning and participating at the highest level possible within the planning process can have the greatest impact.[2,4] It is important for public health to determine which plans they need to consult on and the level of their involvement based on local capacity and the community and political context.[2] Appendix A: MLHU's Involvement in the Municipal Planning Process, summarizes how the MLHU could participate in response to municipal planning activities.

Municipal Strategic Planning Activities

The City of London has identified the Middlesex-London Health Unit as a reporting lead for five actions outlined in the City of London 2023-2027 Implementation Plan,[7] which operationalizes the City of London Strategic Plan for 2023-2027.[8] MLHU was assigned the responsibility of developing and implementing a framework to inform and incorporate health evidence for municipal planning purposes, and monitor and communicate the health impacts of climate change on London residents (Appendix B). Relevant areas of focus of the Implementation Plan (i.e., Wellbeing and Safety; Climate Action and Sustainable Growth) and their associated actions connect with the MLHU's mandate. As such, there is need to describe how the MLHU can fulfill its obligations to the City of London.

The MLHU has strong relationships with Middlesex County staff, and continues to explore expanded opportunities to support planning activities.

Built, Natural, and Social Environments Framework

The places where we live, play, learn, work, and age can shape the overall health of individuals and communities.[4,5] While built and natural environments are places that can influence health and well-being, individual and community health are also impacted by the social environment. The social environment considers the relationships individuals have and will have with the place, as well as relevant overarching systems and policies (e.g., access and equality; community health, safety, and wellbeing; civic engagement; economic opportunities).[9,10,11] When designing communities, consideration of all three aspects helps create supportive environments that promote and protect health. Definitions for the built, natural, and social environments are found in Appendix C.

Though the MLHU has participated in the municipal planning process over the years, there has been no specific framework to guide or articulate the nature of MLHU's involvement in this process. To articulate this work, the MLHU adapted the B.C. Centre for Disease Control's Healthy Built Environment Framework[4] and incorporated a social environment lens as outlined in the Healthy Social Environment Framework.[10] Guiding principles of the new MLHU framework include equity, sustainability, and social connection. Collectively, these contribute to the creation of inclusive, resilient, and thriving communities.

The MLHU's "A Framework for the Built, Natural, and Social Environments" (Appendix D) outlines five key domains to support healthy public policy development:

1. **Neighbourhood Design:** Recommending and supporting compact, complete, and connected neighbourhoods.

2. **Housing:** Recommending and supporting a mix of quality housing options that are safe, affordable, accessible, and supportive of aging in place.
3. **Food Systems:** Recommending increasing access to and affordability of a variety of local food options while supporting the cycle of food from production to waste and protecting agricultural land.
4. **Green and Natural Spaces:** Recommending maximizing opportunities for safe and easy access to green and natural spaces while mitigating and adapting to climate change.
5. **Transportation Networks:** Recommending and supporting transportation networks that prioritize sustainable mobility options that are safe, affordable, and accessible for all ages and abilities.

Within each domain, additional components (i.e., service environments, social infrastructure, local economy, arts and culture, recreation, civic engagement) will be employed to ensure that the social connection, equity, and sustainability are consistently reflected within places.

Next Steps

The framework will facilitate the initiation of internal and external evidence-informed conversations about the built, natural, and social environments and will help to determine priorities for policy positions, briefing documents, reports, and presentations. For example, the MLHU will prepare evidence reports highlighting each of the framework's five domains, commencing with Transportation Networks. These evidence reports, accompanied by infographics, will be shared with municipal and community partners. The framework will also be used to integrate health evidence within the municipal planning process and inform community plans, projects, and strategies. References for this report are found in Appendix E.

This report was written by the Municipal and Community Health Promotion Team of the Family and Community Health Division.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Health Equity foundational standard and the Chronic Disease Prevention and Well-Being and Healthy Environments standards as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The *Planning Act* and Provincial Policy Statement.
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
  - Client and Community Confidence (Directions 1.1, 1.2)
  - Program Excellence (Direction 2.1)
  - Organizational Excellence (Direction 4.1)

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically recommendations Access and Report (5,6,7,8); Modify and Orient (9,10,11,14,16,17,19); Partner with Other Sectors (21,22,23,24,26); Engage Healthy Public Policy (33,37); Governance and Leadership (45) in the *Anti-Black Racism Plan* and recommendations Awareness and Education; Supportive Environments; Relationships; Governance; Equitable Access and Service Delivery in the *Taking Action for Reconciliation* report.

Middlesex-London Health Unit's Involvement in the Municipal Planning Process

While there is merit in providing public health input at various stages of the planning policy process, participating early in the process and at the highest level can have the greatest impact. The following table provides an overview of the various levels of the municipal planning policy process and outlines where the Middlesex-London Health Unit (MLHU) could be involved and how (based on capacity and resources). When providing input, MLHU's Built, Natural, and Social Environments Framework will be utilized.

PLANNING POLICY FRAMEWORK	HEALTH UNIT ROLE	TYPE OF CONTRIBUTION	PROVIDE HEALTH EVIDENCE / DATA		TIMING OF INPUT		
			YES	NO	INITIATION	DURING	END
PROVINCIAL STATUTES	• Participate on provincial agencies working group to inform commentary (as appropriate)	• Provide written comments coordinated through provincial agencies (as appropriate)					
PROVINCIAL POLICIES							
OFFICIAL PLANS	• Participate on Technical Agency Committee and/or project team • Attend public participation meetings (as appropriate) • Inform and support community engagement	• Provide ongoing feedback through working groups, committees and/or project teams to support decisions and recommendations • Contribute to presentations on key public health areas of focus • Provide written comments to draft and final official plan content					
SECONDARY PLANS	• Participate on Technical Agency Committee and/or project team • Attend public participation meetings (as appropriate) • Inform and support community engagement	• Provide ongoing feedback through working groups, committees and/or project teams to support decisions and recommendations • Contribute to presentations on key public health areas of focus • Provide written comments on content for draft and final plans					
MASTER PLANS	• Participate on Technical Agency Committee and/or project team • Attend public participation meetings (as appropriate) • Inform and support community engagement	• Provide ongoing feedback through working groups, committees and/or project teams to support decision and recommendations • Contribute to presentation on key public health areas of focus • Provide written comments on draft and final plan content					
LAND USE CONTROLS	• Receive, review, and monitor outcomes of plans (depending on criteria)						

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Overview of the Planning Policy Framework

The following table is meant to provide an overview of the planning policy framework and an outline of the purpose and function of each policy level. Although the framework covers a wide range of elements, only certain aspects apply to the Middlesex-London context.

PLANNING POLICY FRAMEWORK		EXAMPLE
PROVINCIAL STATUTES	• A legislated document which must be enacted without interpretation • Statutes are to be enacted through provincial policies • Some statutes apply province-wide statutes, while others apply only to specific geographic areas	**Province-Wide** • *Ontario Planning & Development Act (1994)* • *Planning Act* **Specific Geographic Areas** • *Places to Grow Act (2005)* • *Oak Ridges Moraine Conservation Act (2001)* • *Niagara Escarpment Planning & Development Act*
PROVINCIAL POLICIES	• A statutory document outlining actionable policies to achieve the statute • Policies can be interpreted based on the condition and context • Some policies apply province-wide, while others apply only to specific geographic areas	**Province-Wide** • Provincial Policy Statement (PPS) • Localized Development Plans **Specific Geographic Areas** • Oak Ridges Moraine Conservation Plan • Niagara Escarpment Plan
OFFICIAL PLANS	• A statutory document required by the *Planning Act* and Provincial Policy Statement • Makes the public aware of general land use planning policies • Makes sure growth is coordinated and meets community needs • Demonstrates how land will be used • Helps decide where various municipal services will be implemented • Provides a framework for zoning by-laws to set standards • Provides a way to evaluate and settle conflicting land uses	• Single Tier Municipal Official Plan • Upper Tier Municipal Official Plan • Lower Tier Municipal Official Plan
SECONDARY PLANS	• Adapts and implements the objectives, policies, land use designations, and overall approaches of the Official Plan to specifically address local contexts • Establishes local development policies unique to a specific area	• Area Secondary Plans
MASTER PLANS	• Provides a comprehensive long-term plan of action for key municipal servicing issues • No statutory impact on a community without reinforcement from the Official Plan • Sometimes, additional more 'topic-specific' master plans are developed to provide further clarification on high-level service topics	• Transportation / Mobility Master Plan • Parks & Recreation Master Plan • Trails Master Plan • Sustainability Master Plan • Water / Wastewater Master Plan • Cultural Heritage Master Plan • Downtown Master Plan
LAND USE CONTROLS	• How the Official Plan policies are implemented, monitored and enforced • All recommendations that trigger the use of these tools will need to ensure consistency with the Official Plan • All municipalities are required to have a zoning-by-law and other land-use control documents • However, it is up to the municipality whether to implement an interim control by-law or site plan control	• Site Plans • Subdivision Controls • Zoning By-Law • Minister's Zoning Order • Consents • Plan of Subdivision • Holding By-Law • Community Benefit Charges By-Law

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Implementation of the City of London Strategic Plan – MLHU Involvement

Area of Focus	Outcome	Outcome Description	Strategy	Action by MLHU	Timeline
Reconciliation, Equity, Accessibility, and Inclusion	Outcome 1: The City of London enhances the confidence of Indigenous Peoples by furthering truth and reconciliation efforts.	1.1 Establishment of new and strengthening current relationships with local First Nation and urban Indigenous communities and Indigenous-serving organizations.	Strategy A: Support Indigenous-led actions and initiatives that move the City of London and its agencies, boards, and commissions closer towards addressing injustices, and collective healing.	Implement prioritized recommendations of the Middlesex-London Health Unit's *Taking Action for Reconciliation* plan.	Annual/ Ongoing
Reconciliation, Equity, Accessibility, and Inclusion	Outcome 1: The City of London enhances the confidence of Indigenous Peoples by furthering truth and reconciliation efforts.	1.1 Establishment of new and strengthening current relationships with local First Nation and urban Indigenous communities and Indigenous-serving organizations.	Strategy A: Support Indigenous-led actions and initiatives that move the City of London and its agencies, boards, and commissions closer towards addressing injustices, and collective healing.	Continue to build and implement processes to better integrate public health service delivery between local First Nation Health Centres and the Middlesex-London Health Unit based on Indigenous population health need.	Annual/ Ongoing
Wellbeing and Safety	Outcome 1: London has safe, vibrant, and healthy neighbourhoods and communities.	1.1 Londoners feel safe across the city, in the core, and in their neighbourhoods and communities.	Strategy F: Design and plan communities with evidence-informed health and safety tools and principles.	Develop and implement a Middlesex-London Health Unit (MLHU) framework to inform and incorporate	Annual/ Ongoing

Area of Focus	Outcome	Outcome Description	Strategy	Action by MLHU	Timeline
				health evidence for urban planning purposes.	
Wellbeing and Safety	Outcome 1: London has safe, vibrant, and healthy neighbourhoods and communities.	1.9 Improved health equity across neighbourhoods.	Strategy A: Continue to apply a health equity lens to the delivery of MLHU programs and services.	Continue to apply a health equity lens to the delivery of Middlesex-London Health Unit programs and services.	Annual/ Ongoing
Climate Action and Sustainable Growth	Outcome 2: London is one of the greenest and most resilient cities in Canada in alignment with the Council-declared climate emergency and the Climate Emergency Action Plan.	2.2 London is more resilient and better prepared for the impacts of a changing climate.	Strategy D: Coordinate collecting and sharing environment and climate data to support evidence-informed decision making.	Develop and implement a Middlesex-London Health Unit framework to monitor and communicate the health impacts of climate change on London residents.	Annual/ Ongoing

Definitions

Built Environment: The built environment refers to the human-made surroundings (e.g., buildings, roads, parks, and other infrastructure) where people live, work, learn, and play.[1,2,3] It shapes how people interact with their surroundings and can impact their health and quality of life.[1,2,3]

Natural Environment: "Natural spaces and features that are protected and incorporated into the built surroundings and accessible to people." [4, p.2]

Social Environment: Social environments include the underlying social, cultural, and economic context within which we live, work, play, learn, and age.[5] It consists of "the interpersonal elements of our environments and encompasses all the structures and processes we create, relationships we have, and actions we take to organize and improve our lives." [5, p.1] "The social environment is present at multiple levels, is people and relationship-centered, is comprised of multiple interconnected features, and is influenced by power relations." [5, p.1] It represents the strength of social networks within a particular community.[5]

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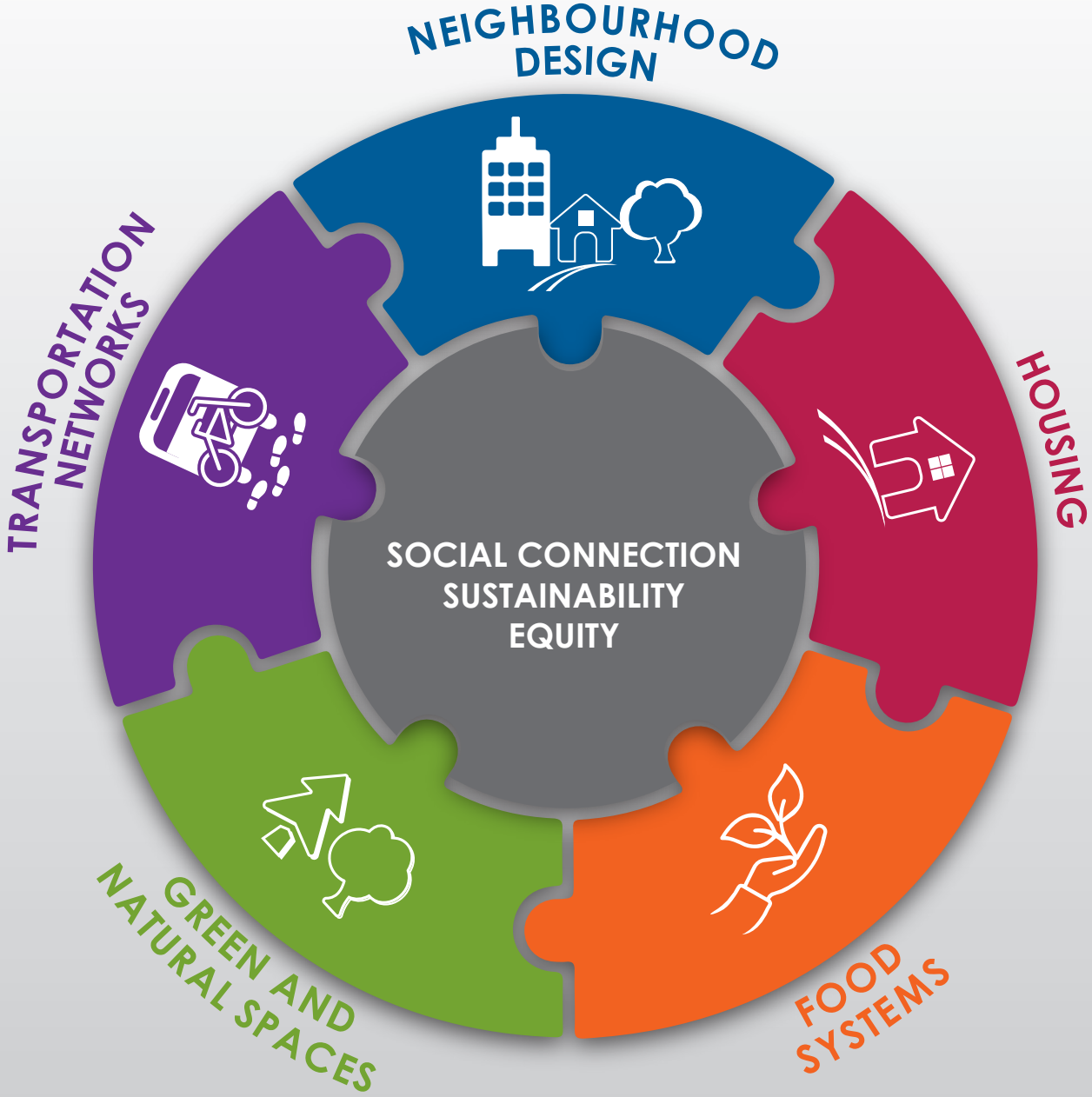
A Framework for the Built, Natural, and Social Environments



Adapted with permission from 1) BC Centre for Disease Control. Healthy Built Environment Linkages Toolkit: making the links between design, planning and health, Version 2.0. Vancouver, B.C., Canada: Provincial Health Services Authority, Population and Public Health; 2018; and 2) BC Centre for Disease Control, Provincial Health Services Authority. Healthy Social Environments Framework (Version 1). 2020. Vancouver, B.C., Canada.

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NEIGHBOURHOOD DESIGN

Neighbourhoods that are designed to be compact, complete, and connected to make it easy to access daily needs.

TRANSPORTATION NETWORKS

Transportation networks prioritizing sustainable mobility options that are safe, affordable, and accessible for all ages and abilities.

GREEN AND NATURAL SPACES

Maximizing opportunities for safe and easy access to green and natural spaces while also mitigating and adapting to climate change.

FOOD SYSTEMS

Increasing access to and affordability of a variety of local food options while supporting the cycle of food from production to waste and protecting agricultural land.

HOUSING

A mix of quality housing options that are safe, affordable, accessible, and supportive of aging in place.

GUIDING PRINCIPLES

Social connection, sustainability, and equity are the guiding principles that collectively can contribute to the creation of inclusive, resilient, and thriving communities.

Adapted with permission from 1) BC Centre for Disease Control. Healthy Built Environment Linkages Toolkit: making the links between design, planning and health, Version 2.0. Vancouver, B.C., Canada: Provincial Health Services Authority, Population and Public Health; 2018; and 2) BC Centre for Disease Control, Provincial Health Services Authority. Healthy Social Environments Framework (Version 1). 2020. Vancouver, B.C., Canada.

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 07-24

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2025 January 23

SUBMISSION TO HEALTH CANADA ON THE PROPOSED TOBACCO COST RECOVERY FRAMEWORK

Recommendation

It is recommended that the Board of Health receive Report No. 07-25 re: "Submission to Health Canada on the Proposed Tobacco Cost Recovery Framework" for information.

Report Highlights

- The Government of Canada has proposed a Tobacco Annual Regulatory Charge under a cost recovery framework, applied to commercial tobacco manufacturers and importers.
- The proposed cost recovery regulations aim to shift the $66 million cost of the federal tobacco control strategy from taxpayers to the commercial tobacco product industries.
- Tobacco use is the leading preventable cause of premature death in Canada, with an estimated 600 smoking-related deaths annually in the Middlesex-London region (MLHU, 2023).
- Youth vaping prevalence is rising, with 29% of high school students having tried vaping and nearly 12% of grades 10-12 students reporting daily use (CSTADS, 2021-2022).
- MLHU staff submitted feedback by the October 10, 2024 deadline, attached as Appendix A, recommending the simultaneous implementation of a cost recovery framework and regulatory charge for commercial tobacco and vapour product manufacturers and importers.

Background

Tobacco use remains a significant public health concern, causing preventable deaths and imposing substantial economic costs in Canada. In 2023, 3.56 million Canadians smoked, down from 3.8 million in 2022, while vaping rates surged from 1.26 million users in 2022 to 1.9 million in 2023.

The Government of Canada's Tobacco Cost Recovery Framework seeks to recover costs associated with the implementation of the federal tobacco control strategy through annual charges to manufacturers and importers of commercial tobacco products. This framework will fund regulatory development and enforcement, research, cessation programs, and mass communication initiatives.

Summary of Recommendations

Health Canada proposes that the implementation of the Tobacco Cost Recovery Framework and annual regulatory charge be divided into two phases, beginning first with commercial tobacco product manufacturers and importers. The second phase would recover costs from vapour product manufacturers and importers. In response to Health Canada's call, Middlesex-London Health Unit staff submitted feedback, attached as Appendix A, by the deadline of October 10, 2024.

The Middlesex-London Health Unit's recommendations include:

- The implementation of the Tobacco Annual Regulatory Charge on or before October 1, 2025, with payments due by October 31, 2025.
- Strengthening the framework to recover costs from both commercial tobacco and vapour product manufacturers and importers simultaneously, as has been done in the United States for 15 years.
- Expanding the use of funds recovered through the framework to strengthen vaping prevention strategies, to reduce youth access and initiation, to support cessation efforts, and to mitigate nicotine addiction.
- Ensuring minimal delay with the implementation of the second phase of cost recovery given the rapid rise in youth vaping, if unable to implement both phases simultaneously.

This report was written by the Social Marketing and Health System Partnerships Team, within the Family and Community Health Division.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Substance Use and Injury Prevention Standard as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The *Tobacco and Vaping Products Act*.
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
  - Our public health programs are effective, grounded in evidence and equity.
- **This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's** Anti-Black Racism Plan and Taking Action for Reconciliation, specifically recommendation *"Create Supportive Environments – ensure the use of culturally-respectful terminology".*

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

October 9, 2024

Tobacco Control Directorate
Controlled Substances and Cannabis Branch
Health Canada
150 Tunney's Pasture Driveway
Address Locator # 0302A
Ottawa, ON K1A 0K9
Email: tcr-rct@hc-sc.gc.ca

Re: Consultation – Tobacco Cost Recovery 2024

To Whom it May Concern;

The Middlesex-London Health Unit appreciates the Government of Canada's leadership in addressing the burden of commercial tobacco use, and its commitment to prevent tobacco-related disease and death. The introduction of an annual charge applied to tobacco product manufacturers and importers through a cost recovery regime is a necessary measure, and we welcome the opportunity to provide feedback on the proposed cost recovery framework, published in August 2024.

The Middlesex-London Health Unit strongly supports the federal regulatory proposal to implement a Tobacco Annual Regulatory Charge, holding the tobacco industry accountable for the health harms associated with commercial tobacco product use. Tobacco use remains the leading preventable cause of premature death in Canada[i], costing the government billions of dollars, including health care costs, lost productivity, criminal justice, and other costs[ii]. In 2023, there were 3.56 million people in Canada who smoke, down from 3.8 million people in 2022. Unfortunately, with this small decrease in the number of Canadians who smoke came an alarming increase in the number of Canadians who vape, from 1.26 million in 2022 to 1.9 million in 2023[iii]. The research has proven that vaping devices and other emerging nicotine products from the commercial tobacco and vapour product industry increase nicotine addiction in youth and young adults who do not smoke. Annually, it is estimated that smoking is attributable to roughly 600 deaths per year in the Middlesex-London region[iv].

The implementation of the proposed *Tobacco Charges Regulations* would enable Health Canada to recover federal tobacco control strategy costs, including enforcement, regulatory development, research, cessation, mass communication initiatives, and other programs. To manage the financial, health, and societal burden of tobacco and vapour product use, dedicated funds to prevention strategies are warranted. The proposal does not clearly specify whether October 1, 2025 or October 1, 2026 would be the date of effect for the issuance of the first invoice; it is essential that the regulation come into force as soon as possible, with invoices for the annual charge sent to manufacturers on or before October 1, 2025, with payment due by October 31, 2025.

Currently, Canada's Tobacco Strategy is paid for by Canadian taxpayers; however, the cost recovery framework would shift the cost of this $66 million-dollar strategy from tax payers to the manufacturers and importers of commercial tobacco products through annual fees. The government has indicated that the cost recovery fee will be implemented in two phases, with tobacco manufacturer (and importer) and vapour product manufacturer (and importer) cost recovery mechanisms initiating at

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different times. Timing for the second phase of cost recovery have not been clearly articulated. The Middlesex-London Health Unit encourages Health Canada to strengthen the current proposal so that commercial tobacco and vapour product-related expenditures in Canada's federal strategy are recovered simultaneously. There is precedence for this approach given that this has been an established practice in the United States for 15 years. Youth vaping is an issue of public health significance with prevalence rising at an alarming rate in recent years. According to the 2021-2022 Canadian Student Tobacco, Alcohol and Drugs Survey, 29% of Canadian high school students have tried vaping, and nearly 12% of students in grades 10-12 report vaping daily.[v] Should the government proceed with a two-phase implementation strategy, the Middlesex-London Health Unit strongly recommends that the vapour product cost recovery framework be implemented with minimal delay.

In Canada, tobacco companies have implemented massive windfall price increases on average of $31.80 per carton of 200 cigarettes over the 10-year period 2014-2023 inclusive, resulting in incremental revenue of about $2 billion per year. With the exponential growth of the e-cigarette and vape market in Canada, tobacco and vaping product manufacturers and importers can afford to pay annual fees to recover the costs of a comprehensive and renewed smoking, vaping, and nicotine federal strategy. To reach Canada's goal of tobacco prevalence being less than 5% by 2035, it is imperative that the cost recovery framework be used to strengthen the capacity of the federal government, with the support of its provincial and local government partners, to deliver a comprehensive tobacco, vapour, and emerging nicotine product control program.

The Middlesex-London Health Unit supports the strengthening and enactment of a Tobacco Annual Regulatory Charge without delay. We remain committed to prevent youth initiation of commercial tobacco and vapor product use, to protect people from exposure to second-hand smoke and vapor, and to encourage people to quit. We look forward to working with our partners at the local, provincial, and federal levels to reduce the burden of health harms related to nicotine addiction, vapour, and commercial tobacco product use.

Sincerely,

Dr. Joanne Kearon
Acting Medical Officer of Health
Middlesex-London Health Unit
joanne.kearon@mlhu.on.ca

Emily Williams
Chief Executive Officer
Middlesex-London Health Unit
emily.williams@mlhu.on.ca

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[i] Statistics Canada. Current Smoking Trends. Health at a Glance. Retrieved from: https://www150.statcan.gc.ca/n1/en/pub/82-624-x/2012001/article/11676-eng.pdf?st=wDqqRWTv

[ii] Canadian Substance Use Costs and Harms. 2023. Retrieved from: https://csuch.ca/documents/reports/english/Canadian-Substance-Use-Costs-and-Harms-Report-2023-en.pdf?_cldee=8uPMv0K93rNcHishHRhr7tA7XfJvF_ZHNkCjPFI70b8BPLtPpKaKGXNcadCt2D-p&recipientid=contact-66dfe5925e63e8118145480fcff4b5b1-2b1aa57329714146a59ce192d976ddac&esid=1d1b0e51-8ecd-ed11-a7c6-000d3a09c3d2

[iii] Statistics Canada. Table 13-10-0905-01 Health indicator statistics, annual estimates.

[iv] Ontario Health and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Burden of Health Conditions Attributable to Smoking and Alcohol by Public Health Unit in Ontario. Toronto: King's Printer for Ontario; 2023. Retrieved from: https://www.publichealthontario.ca/-/media/Documents/B/2023/burden-health-smoking-alcohol-report.pdf?rev=2bbb255245404a3599a1e11e0f34709c&sc_lang=en

[v] Canadian Student Tobacco, Alcohol and Drug Survey (2021-2022). Government of Canada.

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 08-25

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health

DATE: 2025 January 23

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT FOR DECEMBER

Recommendation

It is recommended that the Board of Health receive Report No. 08-25 re: "Medical Officer of Health Activity Report for December" for information.

The following report highlights the activities of the Medical Officer of Health for the period of November 29, 2024 – January 9, 2025.

The Medical Officer of Health provides oversight of all public health programs at the Middlesex-London Health Unit and co-chairs the Senior Leadership Team. The Medical Officer of Health participates in a wide range of external and internal meetings, along with liaising with community partners and municipal and provincial stakeholders.

The Medical Officer of Health, along with other team members, continues to host a weekly Middlesex-London Health Unit (MLHU) Staff Town Hall.

The Medical Officer of Health also participated in the following meetings:

Public Health Excellence– *These meeting(s) reflect the MOH's work regarding public health threats and issues; population health measures; the use of health status data; evidence-informed decision making; and the delivery of mandated and locally needed public health services as measured by accountability indicators*

December 2 Chaired an internal planning meeting with regards to the Middlesex-London Community Drug and Alcohol Committee.

December 3 Chaired an internal planning meeting with regards to forming the Middlesex-London Health System Emergency Management Table.

December 4 Co-Chaired the Middlesex-London Community Drug and Alcohol Committee Meeting.

December 5 Attended the inaugural meeting of the internal School Health Coordination Committee.

December 9 Attended the inaugural meeting of the internal Substance Use Coordination Committee.

December 12 Participated in an internal meeting regarding the City of London Mobility Master Plan.

December 16 Participated in a meeting regarding tobacco enforcement, facilitated by the Ministry of Health.

Participated in a call regarding H5 influenza, facilitated by the Ministry of Health.

Community Engagement, Partner Relations, and System Leadership – *These meeting(s) reflect the MOH's representation of the Health Unit in the community and engagement with local, provincial and national stakeholders both in health and community arenas, along with engagements with local media.*

December 2 Attended a Ministry of Health update meeting facilitated by the Ministry of Health.

December 3 Attended the Middlesex-London Ontario Health Team Governance Sub-Committee Meeting.

December 4 With Jennifer Proulx, Director, Family and Community Health, Darrell Jutzi, Manager, Municipal and Community Health Promotion, and Anita Cramp, Manager, School Health, met with representatives of Thames Valley District School Board to discuss changes to the Middlesex-London Health Unit's programming in schools.

December 5 Participated in the City of London Whole of Community Response, Health and Homelessness Strategy and Accountability Table meeting.

December 6 With Jennifer Proulx, Director, Family and Community Health, attended a tour of the London Food Bank.

December 9 Participated in an introductory call with Marnie MacKinnon, Director for Quality and Quality Improvement, Public Health Ontario.

Participated in a call with Dr. Azim Kasmani, Medical Officer of Health, Niagara Region Public Health, regarding key performance indicators.

Participated in a "The Ontario Public Health Conference" (TOPHC) Planning Committee meeting.

Interview with Reta Ismail, CTV News, regarding “walking pneumonia” in Middlesex-London.

December 10 Attended the inaugural meeting of Middlesex County Council.

Participated in the December Public Health Sector Coordination Table, facilitated by the Ministry of Health.

December 12 Participated in a TOPHC Planning Committee meeting.

Interview with Mike Stubbs, Global TV/980 CFPL, regarding whooping cough respiratory season vaccinations.

With Jennifer Proulx, Director, Family and Community Health, Darrell Jutzi, Manager, Municipal and Community Health Promotion, and Anita Cramp, Manager, School Health, met with representatives of London District Catholic School Board to discuss changes to the Middlesex-London Health Unit’s programming in schools.

December 13 Participated in a call with Dr. Michael Finkelstein, Deputy Medical Officer of Health, Toronto Public Health, regarding health promotion.

December 16 Participated in the County of Middlesex’s 2024 Emergency Management meeting.

Attended the monthly meeting of the Southwestern Ontario Medical Officers of Health and Associate Medical Officers of Health.

December 19 Participated in a call with Dr. Mehdi Aloosh, Medical Officer of Health, Windsor-Essex County Health Unit.

Participated in an introductory call with Member of Parliament Lianne Rood.

Met with Sean Warren, London InterCommunity Health Centre.

January 7 Meeting with Director of Education at Conseil scolaire Viamonde to discuss changes to school health program.

January 8 Meeting with Maritia Gully, Director, Population and Public Health Assessment at Island Health to discuss community engagement tracking.

Employee Engagement and Teaching – *These meeting(s) reflect on how the MOH creates a positive work environment, engages with employees, and supports employee education, leadership development, mentorship, graduate student teaching, medical students or resident teaching activities.*

December 11 Attended the Staff Day Celebration.

December 18 Met with a medical student to provide mentorship.

January 6 Greeting new employees to the Health Unit at orientation.

January 8 Met with a medical student to provide mentorship.

Organizational Excellence – *These meeting(s) reflect on how the MOH is ensuring the optimal performance of the organization, including prudent management of human and financial resources, effective business processes, responsive risk management and good governance.*

December 4 Attended the December Board of Health Agenda Review and Executive meeting.

December 12 Attended the December Board of Health meeting.

December 19 Chaired a meeting to finalize the business impact assessment for continuity of operations planning.

Attended the quarterly meeting with the Ontario Nurses Association (ONA).

Attended the monthly touch base meeting with the Board of Health Chair.

January 7 With the Chief Executive Officer, met with members of the Public Health Foundations and Strategy, Planning and Performance Team to discuss the strategic plan.

This report was prepared by the Medical Officer of Health.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Good Governance and Management Practices Domain as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically the Governance and Leadership (ABRP) section.

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 09-25

TO: Chair and Members of the Board of Health

FROM: Emily Williams, Chief Executive Officer

DATE: 2025 January 23

CHIEF EXECUTIVE OFFICER ACTIVITY REPORT FOR DECEMBER

Recommendation

It is recommended that the Board of Health receive Report No. 09-25 re: "Chief Executive Officer Activity Report for December" for information.

The following report highlights the activities of the Chief Executive Officer (CEO) for the period of November 29, 2024 – January 9, 2025.

Standing meetings include weekly Corporate Services leadership team meetings, Senior Leadership Team meetings, MLHU Leadership Team meetings, Virtual Staff Town Hall meetings, bi-weekly R3 meetings, monthly check ins with the Director, Public Health Foundations, weekly check ins with the Corporate Services leaders and the Medical Officer of Health.

The Chief Executive Officer provided Director On-Call coverage from December 9-15.

The Chief Executive Officer was on vacation on November 29, from December 23-29, 2024, December 31, 2024- January 3, 2025.

The Chief Executive Officer also attended the following meetings:

Employee Engagement and Learning – *These meeting(s) reflect on how the Chief Executive Officer influences the Health Unit's organizational capacity, climate and culture and the contributions made to enable engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning:*

December 2 Chaired the MLHU Leadership Team December Pre-Planning meeting to establish the upcoming meeting agenda.

December 6 Attended a meeting to discuss the Corporate Social Responsibility Policy recommendations for the upcoming 2025 year.

Attended the Virtual Annual Staff Day Town Hall to recognize staff celebrating long-service awards.

December 9 Attended an introductory meeting with the new Finance Comptroller.

December 11 Attended the Staff Day Celebration at Citi Plaza in recognition and celebration of the great work of all staff at the MLHU.

December 12 Attended a meeting to discuss the Corporate Social Responsibility Policy recommendations for the upcoming 2025 year.

December 19 With the Medical Officer of Health and Associate Director, Human Resources and Labour Relations, attended a quarterly touch base with union partner Ontario Nurses Association.

Governance – *This meeting(s) reflect on how the Chief Executive Officer influences the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the Health Unit's mission and vision. This also reflects on the Chief Executive Officer's responsibility for actions, decision and policies that impact the Health Unit's ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health:*

December 2 As part of the Continuity of Operations plan (COOP), which is a sub-plan of the MLHU Emergency Response Plan, attended a meeting to discuss the Continuity of Operations Plan for Finance functions with Public Health Foundation staff.

December 3 As part of the Continuity of Operations plan (COOP), which is a sub-plan of the Emergency Response Plan, attended a meeting to finalize the Continuity of Operations Plan for Finance functions with Public Health Foundation staff.

Attended a meeting to discuss the MLHU 2026-2030 Strategic Plan Development Process.

December 4 Attended the Board of Health December agenda review and Executive meeting.

December 5 As part of key finance deliverables, completed the weekly cheque run with the Financial Coordinator to process payments for vendors.

December 6 Attended a series of accounting support meetings to review the progress on the MLHU 2025 budget, audited financial statements, and other key finance deliverables.

December 9 Attended an accounting support meeting to discuss the MLHU 2025 Budget.

December 10 Attended an accounting support meeting to discuss the MLHU 2025 Budget.

December 11 Attended a meeting to discuss the Healthy Babies and Healthy Children Budget.

Met with the Board of Health Chair for a monthly one-on-one meeting.

December 12 Attended the monthly Ministry of Health Public Health Funding Updates meeting.

As part of key finance deliverables, completed the weekly cheque run with the Financial Coordinator to process payments for vendors.

Attended a meeting to discuss MLHU's budget for Ontario Seniors Dental Care Program (OSDCP).

Attended the December Board of Health meeting.

December 13 Attended an accounting support meeting to review the progress on the audited financial statements, and other key finance deliverables.

Attended an accounting support meeting to discuss MLHU's MOH Compensation Application.

December 19 Attended a meeting with the Ministry of Health Finance representative to discuss MLHU's In Year One Time funding request.

As part of key finance deliverables, completed the weekly cheque run with the Financial Coordinator to process payments for vendors.

December 30 As part of key finance deliverables, completed the weekly cheque run with the Financial Coordinator to process payments for vendors.

January 7 Attended a meeting to discuss the MLHU 2026-2030 Strategic Plan Development Process.

January 8 Attended a meeting to discuss planning for collective bargaining.

Attended two accounting support meetings to discuss the MLHU 2025 Budget.

Attended a meeting to discuss MLHU's delegation for the Rural Ontario Municipal Association conference.

January 9 Attended a meeting to discuss the MLHU 2025 Budget.

Personal and Professional Development – *This area reflects on how the CEO is conducting their own personal and professional development.*

December 6 Attended a "Failing Forward" group coaching webinar presented by the Canadian College of Health Leaders which focuses on leaning into Failure to Drive Successes and how to embrace failure as a powerful tool for growth.

December 11 Provided training for MLHU's finance software 'Management Reporter' to another leader in the organization.

This report was prepared by the Chief Executive Officer.

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Good Governance and Management Practices Domain as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically the Governance and Leadership (ABRP) section.

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 10-25

TO: Members of the Board of Health

FROM: Matthew Newton-Reid, 2024 Board of Health Chair
Michael Steele, 2024 Board of Health Vice-Chair

DATE: 2025 January 23

BOARD OF HEALTH CHAIR AND VICE-CHAIR ACTIVITY REPORT FOR NOVEMBER AND DECEMBER 2024

Recommendation

It is recommended that the Board of Health receive Report No. 10-25 re: "Board of Health Chair and Vice-Chair Activity Report for November and December 2024" for information.

The following report highlights activities of the Middlesex-London Health Unit's Board of Health Chair and Vice-Chair for the period of November 11, 2024 – January 9, 2025.

Categories for the Board Chair's Activity Report are outlined in Governance Policy G-270 - Roles and Responsibilities of Individual Board Members, Appendix B (Chair and Vice-Chair Responsibilities).

Leadership - *Guides and directs Board processes, centering the work of the Board on the organization's mission, vision and strategic direction*

December 2	The Board Vice-Chair and the Associate Director, Operations attended KPMG Service Review Training at the London Public Library
December 9	Attended the 2024 Service Awards and provided greetings to staff
December 10	The Board Chair and Board Vice-Chair, with the Executive Assistant met with Board Chair Chris Moise (Toronto Public Health) to discuss consumption and treatment centre closures
December 11	The Board Chair and Board Vice-Chair attended the Staff Day celebration at the Health Unit

December 16 The Board Chair and Board Vice-Chair met with a Board Member to discuss meeting matters

Agendas - *Establishes agendas for Board meetings, in collaboration with the Medical Officer of Health (MOH) and Chief Executive Officer (CEO).*

November 14 Participated in the monthly agenda review meeting with the Medical Officer of Health, Chief Executive Officer and Executive Assistant

December 4 Participated in the monthly agenda review meeting with the Medical Officer of Health, Chief Executive Officer and Executive Assistant

Meeting Management - *Presides over Board meetings in a manner that encourages participation and information sharing while moving the Board toward timely closure and prudent decision-making*

November 21 The Board Vice-Chair presided over the November Special and Regular Board of Health meetings

December 12 The Board Chair presided over the December Board of Health meeting

MOH and CEO Relationship - *Serves as the Board's central point of official communication with the MOH and CEO. Develops a positive, collaborative relationship with the MOH and CEO, including acting as a sounding Board for the MOH and CEO on emerging issues and alternative courses of action. Stays up to date about the organization and determines when an issue needs to be brought to the attention of the full Board or a committee*

November 14 Participated in the monthly executive meeting with the Medical Officer of Health and Chief Executive Officer

November 20 Monthly meeting between the Chief Executive Officer and Board Chair

December 4 Participated in the monthly executive meeting with the Medical Officer of Health and Chief Executive Officer

December 11 Monthly meeting between the Chief Executive Officer and Board Chair

December 18 Monthly meeting between the Executive Assistant and Board Chair

December 19 Monthly meeting between the Medical Officer of Health and Board Chair

Committee Attendance - *Serves as ex-officio voting members of all committees*

November 28 Participated in the Performance Appraisal Committee meeting

This report was jointly prepared by the 2024 Board of Health Chair and 2024 Vice-Chair.

Matthew Newton-Reid
Board of Health Chair

Michael Steele
Board of Health Vice-Chair

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The good governance and management standard as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically the Governance and Leadership (ABRP), Governance (TAFR) and Awareness/Education (TAFR) sections.

Public Health
Santé publique
SUDBURY & DISTRICTS

December 5, 2024

VIA ELECTRONIC MAIL

Honourable Minister Sylvia Jones
Minister of Health
Ministry of Health
5th Floor, 777 Bay Street
Toronto, ON M5G 2C8

Dear Minister Jones:

Re: Calling for the Selection of Indigenous Municipal and Provincial Appointees for Board of Health for Public Health Sudbury & Districts

On behalf of the Board of Health for Public Health Sudbury & Districts, I am writing to inform you of a recently adopted Board motion that calls for the appointment of Indigenous person(s) to the Board of Health when vacancies arise. Specifically, at its meeting on June 20, 2024, the Board of Health carried the following motion # 41-24,

> *WHEREAS the Board of Health for Public Health Sudbury & Districts is committed to ensuring all people in its service area, including Indigenous peoples and communities, have equal opportunities for health; and,*
>
> *WHEREAS on June 15, 2023, the Board of Health passed Motion #37-23 Indigenous Engagement Governance Reconciliation Framework which supports the advancement of the Indigenous Engagement Strategy at the governance level; and,*
>
> *WHEREAS Public Health Sudbury & Districts Indigenous Engagement Strategy's Strategic Direction 1 led to a commitment to promote the selection of Indigenous municipal and provincial appointees to the Board of Health;*

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Sudbury East / Sudbury-Est
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Espanola
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phsd.ca

THEREFORE BE IT RESOLVED THAT the Board of Health call upon the municipalities in the service area to advocate for the appointment of qualified Indigenous persons, who are grounded in community, have lived experience, are from this territory and reside in Public Health Sudbury & Districts; and

THAT the Board of Health call upon the municipalities in the service area to appoint qualified Indigenous persons, who are grounded in community, have lived experience, are from this territory and reside in Public Health Sudbury & Districts, where more than one representative appointment exists; and

THAT the Board of Health call upon the Province of Ontario to appoint qualified Indigenous persons, who are grounded in community, have lived experience, are from this territory and reside in Public Health Sudbury & Districts.

In Public Health Sudbury & District's service area, the total population of Indigenous people is 27,600, which is 14% of the population of the district. Of these individuals, 5,700 reside in the 13 First Nations in the district. The remaining are considered urban Indigenous people.[1] Indigenous people disproportionately experience "poorer reported physical and mental health status, and a higher prevalence of chronic conditions (e.g., asthma and diabetes) as well as disabilities compared to non-Indigenous people" (Hahmann & Kumar, 2022; Hahmann et al., 2019). In addition, the life expectancy of First Nations people, Métis and Inuit has been shown to be consistently and significantly lower than that of the non-Indigenous population (Tjepkema et al., 2019)," [2] as a direct result of the Canadian government's colonial policies, which have had a reverberating impact on today's systems.

The Board of Health, which governs Public Health Sudbury & Districts, plays a crucial role in addressing the health disparities faced by the Indigenous population. Its primary focus on planning and policy development, fiscal arrangements and labour relations, and accountability and reporting to the Ministry, positions it with a responsibility in this issue. The Board of Health's endorsement of The Indigenous Engagement Governance ReconciliAction Framework, in June 2023 was a significant step in our commitment to reconciliation. The framework's first strategic direction is to inform our work through Indigenous community voices and information. The Board understands that it is imperative to the health of Indigenous peoples that appropriate representatives are present when decisions about Indigenous peoples are made. Having Indigenous representation on the Board of Health, will ensure alignment with this commitment. We also hope that it will

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[1] Statistics Canada (2022) 2021Census

[2] Yangzom, K., Masoud, H., & Hahmann, T. (2023). Primary health care access among First Nations people living off reserve, Métis and Inuit, 2017 to 2020. Ottawa, Canada: Statistics Canada. Primary health care access among First Nations people living off reserve, Métis and Inuit, 2017 to 2020 (statcan.gc.ca)

contribute to answering the Truth and Reconciliation: Call to Action 23, which calls upon all levels of government to "Increase the number of [Indigenous] professionals working in the health-care field." [3]

There is currently one vacancy for a provincial appointee to our Board of Health according to the Public Appointments Secretariat[4]. We request that your Ministry appoint an Indigenous Provincial appointee to this Board of Health position. Doing so would help advance reconciliation immensely, while also improving the health of a key population group. To facilitate such an appointment, we request that the Public Appointments Secretariat begin to advertise that position, noting a requirement for applicants to be of Indigenous background. Public Health will be pleased to work with local Indigenous candidates to encourage them to submit applications through the Public Appointment Secretariat.

Should your government wish to explore this further, we would be pleased to meet with the Chief Medical Officer of Health's team or others within your Ministry, as well as the Public Appointments Secretariat to begin to move this forward.

Thank you to your government for its commitment to improving the health of Indigenous people, and your partnership as we work towards reconciliation.

Sincerely,

René Lapierre
Chair, Board of Health

cc: Dr. M. M. Hirji, Acting Medical Officer of Health and Chief Executive Officer
Dr. Kieran Moore, Chief Medical Officer of Health, Ministry of Health
Dr. Fiona Kouyoumdjian, Associate Chief Medical Officer of Health, Office of the Chief Medical Officer of Health, Ministry of Health
Public Appointment Secretariat

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[3] **National Center for Truth and Reconciliation. (2015).** ***Truth and Reconciliation Commission of Canada: Calls to Action*****.** **https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf**

[4] **Public Appointments Secretariat: Health Unit Board—Sudbury and District. https://www.pas.gov.on.ca/Home/Agency/316**

Nicole Visschedyk, Director of Indigenous Strategy and Engagement,Public Health Ontario
France Gélinas, Member of Provincial Parliament, Nickel Belt
Jamie West, Member of Provincial Parliament, Sudbury
Michael Mantha, Member of Provincial Parliament, Algoma – Manitoulin
Association of Local Public Health Agencies
Ontario Boards of Health

Correspondence B

Ontario

Ministry of Health

Office of Chief Medical Officer of Health, Public Health

Box 12
Toronto, ON M7A 1N3

Fax.: 416 325-8412

Ministère de la Santé

Bureau du médecin hygiéniste en chef, santé publique

Boîte à lettres 12
Toronto, ON M7A 1N3

Téléc. :416 325-8412

December 23, 2024

To: Medical Officers of Health and Chief Executive Officers

Re: Strengthening Public Health Updates

Dear Colleagues,

Further to the memo from Dr. Kieran Moore dated December 11, 2024, I am writing to share an update on the planned release and implementation of the revised Ontario Public Health Standards (OPHS) as well as public health funding.

The sector provided valuable input throughout the OPHS consultation, and the ministry is working to address and incorporate your feedback as well as exploring additional opportunities to further clarify responsibilities to reduce the workload burden at the local level.

The ministry recognizes boards of health require time to plan for the implementation of the revised OPHS. **Therefore, the revised OPHS and incorporated documents will be released to the sector by August 2025, with an effective date of January 2, 2026**.

Throughout 2025 the ministry will explore implementation supports via sector engagement, such as the OPHS Review Table.

The current OPHS and incorporated protocols and guidelines remain in effect, please find the current standards here.

As part of the Strengthening Public Health initiative, the ministry is providing growth base funding of 1% for three calendar years (2024, 2025, and 2026) to address the urgent need for stabilization while change processes are underway and undertaking a review of the provincial funding methodology for public health.

The ministry thanks everyone who participated in public health funding review engagement sessions over the summer, and we look forward to sharing more information on next steps, including timelines, as it is available.

Thank you for your continued collaboration in strengthening public health in Ontario. If you have any questions, please contact ophs.protocols.moh@ontario.ca.

Sincerely,

Elizabeth Walker
Executive Lead, Office of the Chief Medical Officer of Health, Public Health

c: Dr. Kieran Moore, MD, CCFP(EM), FCFP, MPH, DTM&H, FRCPC, FCAHS, Chief Medical Officer of Health and Assistant Deputy Minister, Public Health

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December 24, 2024

The Honourable Jenna Sudds
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Government of Canada
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The Honourable Mark Holland
Minister of Health
Government of Canada
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Dear Honourable Ministers:

Re: Federal Strategy to Address Severity and Prevalence of Household Food Insecurity

At its December 11, 2024 meeting, the Board of Health for Peterborough Public Health received a presentation and report on the concerning impacts of household food insecurity on mental and physical health of community members, including families with children.

Household food insecurity refers to inadequate or insecure access to food due to financial constraints.[1] In Peterborough County and City, nearly 1 in 5 households faced food insecurity between 2021-2023.[2] Across the ten provinces between 2021-2023, there has been an increase in both prevalence and severity of food insecurity.[3] The rate of severe food insecurity has almost doubled, meaning that a growing number of Canadians are reducing their food intake, skipping meals, and even going for days without eating, because they don't have enough money for food.[3, 4] For every four children facing food insecurity in 2023, three of them lived in moderate or severely food insecure households, forced to make compromises in quality/quantity of food, or miss meals due to not enough money for food.[3, 4] This trend of increasing severity is alarming, due to the association between higher severity of food insecurity and more serious health consequences, such as early mortality.[5] Food insecurity can also have negative, long-lasting impacts on child health and well-being.[5]

Household food insecurity is an income problem that requires income solutions.[6] While there are several policies that support incomes of Canadians, there is evidence that these policies could be more effectively designed to reduce household food insecurity. For example, evidence demonstrates that when the Canada Child Benefit (CCB) was introduced in 2016, it lowered the severity of food insecurity especially for households with the lowest incomes.[7] However, research also indicates that the Canada Child Benefit could be designed to address household food insecurity more effectively.[8] Below are examples of specific recommendations from networks and researchers across Canada:

- **Increase CCB for lowest income families:**
  Increasing the child benefit for the lowest income families could help to address food insecurity prevalence and severity. Organizations and networks such as Campaign 2000, Children First Canada, PROOF Food Insecurity Policy Research, and Ontario Dietitians in Public Health have recommended supplements to the CCB, and/or increasing CCB, to protect children from poverty and improve child health:
    - Campaign 2000 and PROOF recommended introduction of a CCB end of poverty supplement to significantly decrease child poverty and improve children's health, in a Submission to the Standing Committee on Health (HESA) on Children's Health.[9]
    - The Ontario Dietitians in Public Health recommended the following in the 2023 federal pre-budget consultation: "That the government increase the Canada Child Benefit (CCB) amount for low-income families." [10]
    - Campaign 2000 and the 2024 Raising Canada report recommend development of a non-taxable Canada Child Benefit End of Poverty Supplement (CCB-EndPov) for families experiencing deep poverty, which would provide an additional $8,500 per year to a family with an earned income of less than $19,000 for the first child, and scaled reductions for additional children."[11, 12]

- **Remove the reduction in CCB for children ages 6-18:**
  Research conducted by PROOF Food Insecurity Policy Research at the University of Toronto indicated that matching CCB amounts provided for children under 6, with those for children 6 and over for families with the greatest risk of food insecurity, would create a reduction in the probability of food insecurity for these families.[8]
    - The Ontario Dietitians in Public Health recommended the following in their 2023 federal pre-budget consultation submission: "That the government equal CCB amounts for families with children over 6 years old so that they are not receiving less when their children turn 6."[13]

The example of the Canada Child Benefit demonstrates the importance of designing income policies to address household food insecurity, for maximum impact. A federal food insecurity strategy could allow for income policies to be intentionally designed for this purpose. It is important to note that costs for goods and services have had large increases in 2022 and 2023,[14] when some of the above recommendations were developed. An effective food insecurity strategy should ensure that sufficient income is provided to cover basic needs, in the midst of inflation.

Food insecurity and income strategies should also address Indigenous Food Sovereignty. Indigenous health inequities are connected with complex historical and ongoing acts of colonization, and restricted access to traditional lands, water, and food sources. Indigenous Peoples strengths, resilience, and wisdom should be supported through allyship towards Indigenous self-determination, Food Sovereignty, and positive community-led changes.

Thank you for your attention and for exploring how income policies may be intentionally designed to address household food insecurity, and support the health and well-being of children, families, and communities.

Sincerely,

Original signed by

Councillor Joy Lachica
Chair, Board of Health

cc: Local MPs
Chief Keith Knott, Curve Lake First Nation
Chief Laurie Carr, Hiawatha First Nation
Association of Local Public Health Agencies
Ontario Boards of Health

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BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Middlesex-London Board of Health
External Landscape Review – January 2024

The purpose of this briefing note is to inform MLHU Board of Health members about what is happening in the world of public health and impacts to the work of the MLHU and Board. This includes governance and legislative changes, news from other local public units, external reports on important public health matters, learning opportunities and MLHU events. **Please note that items listed on this correspondence are to inform Board members and are not necessarily an endorsement.**

Local Public Health News

Ontario Approves Transition of Nine Drug Injection Sites into Treatment Hubs

On January 2, the Province of Ontario announced that nine (9) former consumption and treatment sites would be turned into HART hubs by March 31, 2025. These hubs will be eligible, on average, to receive up to four times more funding to support treatment and recovery under the model than they receive from the province as a consumption site. To assist with transitioning, the sites will also receive one-time funding for start-up costs.

These hubs are located in Toronto, Ottawa, Hamilton, Kitchener, Guelph and Thunder Bay.

To read the full news release, please visit the Ontario Government's newsroom.

Toronto Board of Health stands up against Ontario's closure of supervised consumption sites

On December 19, 2024, Toronto Board of Health called a special meeting to direct the Board's Medical Officer of Health to support a legal challenge against the Ontario government's decision to shut down five supervised consumption sites in Toronto.

The Board Report titled "HL20.1 - Supporting the Legal Challenge of the Community Care and Recovery Act". The legal challenge being brought forward by The Neighbourhood Group and two safe consumption site users argues that the *Community Care and Recovery Act* violates the rights and freedoms of people who use drugs, including the right to protection from cruel and unusual punishment and the right to life, liberty and security of the person. It also argues that the provincial government has overstepped into federal jurisdiction by enacting the *Community Care and Recovery Act*.

In addition to directing the Medical Officer of Health to provide evidence in support of the legal application, the Board of Health voted to advise parties before the deadline of January 10, 2025. The next board meeting is scheduled for January 20, which would have caused the Board to miss the deadline.

To read the full article, please visit the Toronto Star's website.

Impact to MLHU Board of Health
The consumption and treatment site in London (Carepoint) at 446 York Street is not impacted by these changes at this time. The Middlesex-London Health Unit and the Regional HIV/AIDS Connection (operators of Carepoint) continue to support members of the community who use services at Carepoint.

National, Provincial and Local Public Health Advocacy

Joint Statement from the Co-Chairs of the Special Advisory Committee on Toxic Drug Poisonings – Latest National Data on Substance-Related Harms

On December 23, 2024, the co-chairs of the federal, provincial, and territorial Special Advisory Committee on Toxic Drug Poisonings Dr. Theresa Tam, Canada's Chief

Public Health Officer and Dr. Sudit Ranade, Yukon's Chief Medical Officer of Health issued the release of the latest surveillance data on opioid and stimulant-related harms in Canada from January 2016 to June 2024.

From January to June 2024, there were 3,787 opioid-related deaths, representing an average of 21 deaths every day. During this same period, there were 2,846 hospitalizations (16 per day) for opioid-related poisoning, 18,792 emergency medical services (EMS) responses (104 per day) to suspected opioid-related poisoning, and 13,287 (73 per day) emergency department visits for opioid-related poisoning. While these figures are lower compared to the same period in 2023, the data is considered preliminary and subject to change as updated information comes in from the provinces and territories, such as completed death investigations.

To read the media release, visit the Public Health Agency of Canada's newsroom.

Impact to MLHU Board of Health
Surveillance data on opioid harms in Middlesex-London reflect similar patterns to those seen at the national level. The MLHU and the Community Drug and Alcohol Committee of Middlesex-London will also continue to monitor data and trends regarding opioids.

Report from the Association of Municipalities of Ontario: Municipalities Under Pressure: The Growing Human and Financial Cost of Ontario's Homelessness Crisis

On January 9, the Association of Municipalities of Ontario (AMO) a comprehensive report titled "Municipalities Under Pressure: The Growing Human and Financial Cost of Ontario's Homelessness Crisis" that reveals the unprecedented and growing toll of homelessness on individuals, families, communities, and governments.

The study's findings indicate that Ontario is at a tipping point in its homelessness crisis. More than 80,000 Ontarians were known to be homeless in 2024, a number that has grown by more than 25 per cent since 2022. Without significant intervention, homelessness in Ontario could double in the next decade, and reach nearly 300,000 people in an economic downturn. The crisis stems from decades of underinvestment in deeply affordable housing, income support and mental health and addictions treatment, combined with escalating economic pressures on communities.

The report proposes a fundamentally new approach that focuses on long-term housing solutions over temporary emergency measures and enforcement. AMO urges provincial and federal governments to take significant, long-term action on affordable housing, mental health and addictions services, and income supports to fix homelessness and improve communities' economic foundations and quality of life.

To review the full report, please visit AMO's website.

Impact to MLHU Board of Health
The Board of Health acknowledges that homelessness within Middlesex-London has risen, and was exacerbated by challenges within the COVID-19 pandemic. The Health Unit continues to work with partners on the matter.