

City of Hamilton PUBLIC HEALTH COMMITTEE AGENDA

Meeting #: 23-008

Date: August 16, 2023

Time: 9:30 a.m.

Location: Council Chambers

Hamilton City Hall

71 Main Street West

Matt Gauthier, Legislative Coordinator (905) 546-2424 ext. 6437

- 1. CEREMONIAL ACTIVITIES
- 2. APPROVAL OF AGENDA

(Added Items, if applicable, will be noted with *)

- 3. DECLARATIONS OF INTEREST
- 4. APPROVAL OF MINUTES OF PREVIOUS MEETING
 - 4.1 June 12, 2023
- 5. COMMUNICATIONS
 - 5.1 Correspondence from Ann-Marie Kungl, Board of Health Chair, Simcoe Muskoka District Health Unit respecting the Simcoe Muskoka District Health Unit 2024 Budget

Recommendation: Be received.

5.2 Correspondence from David Marshall, Board of Health Chair, Haliburton, Kawartha, Pine Ridge District Health Unit respecting the the Haliburton, Kawartha, Pine Ridge District Health Unit 2024 Budget

Recommendation: Be received.

5.3 Correspondence from Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer, Public Health Sudbury and Districts respecting Bill 103, Smoke-Free Ontario Amendment Act (Vaping is not for Kids), 2023

Recommendation: Be endorsed.

5.4 Correspondence from Cynthia St. John, President, Association of Ontario Public Health Business Administrators respecting Support for the Recommendations in Dr. Moore's 2022 Annual Report and Calling for Sustained Public Health Funding Levels

Recommendation: Be received.

5.5 Correspondence from Dr. Vera Etches, Medical Officer of Health, Ottawa Public Health, respecting the State of Ottawa's Health 2023 Report and new Strategic Plan 2023-2027

Recommendation: Be received.

5.6 Correspondence from Dr. Charles Gardner, President, Association of Local Public Health Agencies, respecting Public Health Matters - A Business Case for Local Public Health

Recommendation: Be received.

- 6. DELEGATION REQUESTS
- 7. DELEGATIONS
- 8. STAFF PRESENTATIONS
 - 8.1 Public Health Services Indigenous Health Strategy (BOH23026) (City Wide)
- 9. CONSENT ITEMS
 - 9.1 Food Advisory Committee Minutes
 - a. January 14, 2020
 - b. February 11, 2020
 - c. March 10, 2020
 - d. May 11, 2021
 - e. June 8, 2021
 - f. August 10, 2021

Members of the public can contact the Clerk's Office to acquire the documents considered at this meeting, in an alternate format.

- g. September 14, 2021
- h. October 12, 2021
- i. November 9, 2021
- j. December 14, 2021
- k. January 11, 2022
- I. June 14, 2022
- m. June 6, 2023 (No Quorum Report)
- 9.2 Public Health Services 2022 Annual Performance and Accountability Report (BOH23024) (City Wide)

10. DISCUSSION ITEMS

- 10.1 Mental Health Outreach Program and Hamilton Public Library Partnership (BOH23027) (City Wide)
- 10.2 Supervised Consumption Site Evaluation Framework (BOH23025) (City Wide)
- 10.3 2023 Public Health Services Organizational Risk Management Plan (BOH23022) (City Wide)
- 11. MOTIONS
- 12. NOTICES OF MOTION
- 13. GENERAL INFORMATION / OTHER BUSINESS
- 14. PRIVATE AND CONFIDENTIAL
- 15. ADJOURNMENT



PUBLIC HEALTH COMMITTEE (Formerly the Board of Health) **MINUTES 23-007**

9:30 a.m.

Monday, June 12, 2023

Council Chambers, City Hall, 2nd Floor 71 Main Street West, Hamilton, Ontario

Present: Mayor A. Horwath (Chair)

Councillor M. Wilson (Vice-Chair)

Councillors C. Cassar, B. Clark, J.P. Danko, M. Francis, T. Hwang, T. Jackson, C. Kroetsch, T. McMeekin, N. Nann, E. Pauls, M.

Spadafora, M. Tadeson, A. Wilson

Absent with

Regrets: Councillor J. Beattie - Personal

THE FOLLOWING ITEMS WERE REFERRED TO THE BOARD OF HEALTH FOR **CONSIDERATION:**

1. Collective Impact: Healthy and Safe Communities and the Greater Hamilton Health Network 2023 Update (BOH23020) (City Wide) (Item 8.1)

(Hwang/A. Wilson)

That Report BOH23020, respecting Collective Impact: Healthy and Safe Communities and the Greater Hamilton Health Network 2023 Update, be received

Result: Motion CARRIED by a vote of 14 to 0, as follows:

Yes Mayor Andrea Horwath

 Ward 10 Absent Councillor Jeff Beattie - Ward 12 Councillor Craig Cassar Yes Yes - Ward 9 Councillor Brad Clark

Yes - Ward 8 Councillor John-Paul Danko

Yes - Ward 5 Councillor Matt Francis Yes - Ward 4 Councillor Tammy Hwang Yes - Ward 6 Councillor Tom Jackson

Councillor Cameron Kroetsch Yes - Ward 2 Yes Ward 15 Councillor Ted McMeekin

- Ward 3 Councillor Nrinder Nann Yes

Absent	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

2. Hamilton Opioid Action Plan (BOH23021) (City Wide) (Item 8.2)

(Nann/A. Wilson)

- (a) That the Hamilton Opioid Action Plan, attached as Appendix "A" to Report BOH23021, be approved;
- (b) That the Public Health Services budgeted complement be increased by 1.0 FTE Health Strategy Specialist, with funding for the 2023 costs of \$39,048 to come first from any Public Health Services levy funded surplus, then from the Public Health Services Reserve (112219), and that the 2024 operating cost of \$116,760 be included in the 2024 Tax Operating Budget;
- (c) That a one-year drug checking and surveillance system pilot be implemented *in a manner satisfactory to the City Solicitor and that staff report back to the Public Health Committee in Q3 2024*, at a cost of \$118,000 to be funded in 2023, first from any Public Health Services levy funded surplus, then from Public Health Services Reserve (112219), and that the 2024 operating costs of \$60,000 be included in the 2024 Tax Operating Budget;
- (d) That an 18 month pilot be implemented to provide a supervised consumption site in a men's shelter by Housing Services through a Call for Applicants, for a total cost of \$667,000 and that the cost of \$120,000 for 2023 be funded from first from any Healthy and Safe Communities departmental levy funded surplus, then from Public Health Services Reserve (112219), and that the costs of \$547,000 be included in the 2024 and 2025 Tax Operating Budget;
- (e) That Public Health Services conduct an evaluation of the pilot men's shelter supervised consumption site and report back in Q4 2024; and
- (f) That the General Manager, Healthy and Safe Communities Department or delegate be authorized and directed, on behalf of the City of Hamilton, to enter into, execute and administer all agreements and documents necessary to implement the Call for Applicants for a shelter based supervised consumption space, including but not limited to spending caps, benefit frequency limits, or other controls necessary to ensure costs are contained within the approved budget.

Result: MAIN Motion, As Amended, CARRIED by a vote of 13 to 0, as follows:

Yes Mayor Andrea Horwath Absent - Ward 10 Councillor Jeff Beattie - Ward 12 Councillor Craig Cassar Yes Yes Ward 9 Councillor Brad Clark Yes - Ward 8 Councillor John-Paul Danko Yes - Ward 5 Councillor Matt Francis Yes - Ward 4 Councillor Tammy Hwang Yes - Ward 6 Councillor Tom Jackson Yes - Ward 2 Councillor Cameron Kroetsch Yes Ward 15 Councillor Ted McMeekin - Ward 3 Councillor Nrinder Nann Yes Ward 7 Councillor Esther Pauls Absent Ward 14 Councillor Mike Spadafora Absent Yes - Ward 11 Councillor Mark Tadeson - Ward 13 Councillor Alex Wilson Yes Yes Ward 1 Councillor Maureen Wilson

3. Cold Alert Threshold Review (BOH23005(a)) (City Wide) (Item 10.1)

(Tadeson/McMeekin)

- (a) That thresholds for Cold Alerts issued by the Medical Officer of Health remain at -15°C or -20 windchill; and
- (b) That the City's annual Winter Response Strategy, which is being developed to support individuals experiencing homelessness during winter months be provided independent of Cold Alerts issued by the Medical Officer of Health.

Result: Motion CARRIED by a vote of 11 to 0, as follows:

Mayor Andrea Horwath Absent - Ward 10 Councillor Jeff Beattie Absent Yes - Ward 12 Councillor Craig Cassar Yes - Ward 9 Councillor Brad Clark Yes - Ward 8 Councillor John-Paul Danko Yes - Ward 5 **Councillor Matt Francis** Yes - Ward 4 Councillor Tammy Hwang - Ward 6 Councillor Tom Jackson Yes Yes - Ward 2 Councillor Cameron Kroetsch Councillor Ted McMeekin Yes - Ward 15 - Ward 3 Councillor Nrinder Nann Absent Ward 7 Absent Councillor Esther Pauls Absent - Ward 14 Councillor Mike Spadafora - Ward 11 Councillor Mark Tadeson Yes Yes - Ward 13 Councillor Alex Wilson Yes Ward 1 Councillor Maureen Wilson

FOR INFORMATION:

(a) CEREMONIAL ACTIVITES (Item 1)

(i) Public Health Services 150th Anniversary (Item 1.1)

Dr. Richardson, Medical Officer of Health, addressed the Committee to provide remarks celebrating Public Health Services 150th Anniversary.

(b) CHANGES TO THE AGENDA (Item 2)

The Committee Clerk advised the Committee that there were no changes to the agenda.

(A. Wilson/Tadeson)

That the agenda for the June 12, 2023 Public Health Committee be approved, as presented.

Result: Motion CARRIED by a vote of 12 to 0, as follows:

Yes	-	Mayor And	Irea Horwath
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 15	Councillor Ted McMeekin
Absent	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(c) DECLARATIONS OF INTEREST (Item 3)

There were no declarations of interest.

(d) APPROVAL OF MINUTES OF PREVIOUS MEETING (Item 4)

(Nann/Spadafora)

That the following Minutes of the Public Health Committee be approved, as presented:

- (i) May 1, 2023 (Item 4.1)
- (ii) May 15, 2023 Special PHC (Item 4.2)

Result: Motion CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor And	rea Horwath
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(e) COMMUNICATIONS (Item 5)

(i) (Pauls/Hwang)

That the following Communication items be approved, as presented:

(a) Correspondence from Middlesex-London Health Unit, respecting Monitoring Food Affordability and Implications for Public Policy and Action (Item 5.1)

Recommendation: Be Received.

(b) Correspondence from Huron Perth Public Health, respecting a Request for Immediate Funding for Student Nutrition Programs and to Increase Funding for Future School Years (Item 5.2)

Recommendation: Be Endorsed.

(c) Correspondence from Huron Perth Public Health, respecting Federal School Food Policy (Item 5.3)

Recommendation: Be Endorsed.

(d) Correspondence from Public Health Sudbury and Districts respecting Bill 93, Joshua's Law (Lifejackets for Life), 2023 (Item 5.4)

Recommendation: Be Endorsed.

(e) Correspondence from Timiskaming Health Unit respecting Addressing Household Food Insecurity in Ontario (Item 5.5)

Recommendation: Be Endorsed.

(f) Correspondence from Chatham-Kent Public Health respecting Universal, No-cost Coverage for all Prescription Contraceptive Options to all People Living in Ontario (Item 5.6)

Recommendation: Be Endorsed.

(g) Correspondence from Peterborough Public Health respecting Public Health 2024 Budget (Item 5.7)

Recommendation: Be Received.

Result: Motion CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor And	lrea Horwath
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(f) STAFF PRESENTATIONS (Item 8)

(i) Collective Impact: Healthy and Safe Communities and the Greater Hamilton Health Network 2023 Update (BOH23020) (City Wide) (Item 8.1)

Dr. Richardson, Medical Officer of Health, and Melissa McCallum, Executive Director, Greater Hamilton Health Network, addressed the Committee respecting Collective Impact: Healthy and Safe Communities and the Greater Hamilton Health Network 2023 Update, with the aid of a PowerPoint presentation.

(Tadeson/Horwath)

That the presentation respecting Report BOH23020, Collective Impact: Healthy and Safe Communities and the Greater Hamilton Health Network 2023 Update, be received

Result: Motion CARRIED by a vote of 14 to 0, as follows:

Yes	-	Mayor And	lrea Horwath
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Absent	-	Ward 7	Councillor Esther Pauls
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

For disposition of this matter, please refer to Item 1.

(ii) Hamilton Opioid Action Plan (BOH23021) (City Wide) (Item 8.2)

Dr. Richardson, Medical Officer of Health, introduced Melissa Biksa, Manager, Mental Health and Harm Reduction and Dr. Mark Cachia, Public Health & Preventive Medicine Resident, who addressed the Committee respecting the Hamilton Opioid Action Plan, with the aid of a PowerPoint presentation.

(Hwang/McMeekin)

That the presentation respecting Report BOH23021, Hamilton Opioid Action Plan, be received.

Result: Motion CARRIED by a vote of 12 to 0, as follows:

Yes	-	Mayor And	lrea Horwath
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Absent	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(Nann/A. Wilson)

- (a) That the Hamilton Opioid Action Plan, attached as Appendix "A" to Report BOH23021, be approved;
- (b) That the Public Health Services budgeted complement be increased by 1.0 FTE Health Strategy Specialist, with funding for the 2023 costs of \$39,048 to come first from any Public Health Services levy funded surplus, then from the Public Health Services Reserve (112219), and that the 2024 operating cost of \$116,760 be included in the 2024 Tax Operating Budget;
- (c) That a one-year drug checking and surveillance system pilot be implemented at a cost of \$118,000 to be funded in 2023, first from any Public Health Services levy funded surplus, then from Public Health Services Reserve (112219), and that the 2024 operating costs of \$60,000 be included in the 2024 Tax Operating Budget;
- (d) That an 18 month pilot be implemented to provide a supervised consumption site in a men's shelter by Housing Services through a Call for Applicants, for a total cost of \$667,000 and that the cost of \$120,000 for 2023 be funded from first from any Healthy and Safe Communities departmental levy funded surplus, then from Public Health Services Reserve (112219), and that the costs of \$547,000 be included in the 2024

and 2025 Tax Operating Budget;

- (e) That Public Health Services conduct an evaluation of the pilot men's shelter supervised consumption site and report back in Q4 2024; and
- (f) That the General Manager, Healthy and Safe Communities Department or delegate be authorized and directed, on behalf of the City of Hamilton, to enter into, execute and administer all agreements and documents necessary to implement the Call for Applicants for a shelter based supervised consumption space, including but not limited to spending caps, benefit frequency limits, or other controls necessary to ensure costs are contained within the approved budget.

(Clark/Danko)

That sub-section (c) to Report BOH23021, respecting Hamilton Opioid Action Plan, **be amended**, by adding the words "**in a manner satisfactory to the City Solicitor"**, as follows:

(c) That a one-year drug checking and surveillance system pilot be implemented *in a manner satisfactory to the City Solicitor* at a cost of \$118,000 to be funded in 2023, first from any Public Health Services levy funded surplus, then from Public Health Services Reserve (112219), and that the 2024 operating costs of \$60,000 be included in the 2024 Tax Operating Budget;

Result: AMENDMENT, CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor And	drea Horwath
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Absent	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

(Clark/Danko)

That sub-section (c) to Report BOH23021, respecting Hamilton Opioid Action Plan, *be further amended*, by adding the words "*and that staff report back to the Public Health Committee in Q3 2024"*, as follows:

(c) That a one-year drug checking and surveillance system pilot be implemented in *a manner satisfactory to the City Solicitor and that staff report back to the Public Health Committee in Q3 2024,* at a cost of \$118,000 to be funded in 2023, first from any Public Health Services levy funded surplus, then from Public Health Services Reserve (112219), and that the 2024 operating costs of \$60,000 be included in the 2024 Tax Operating Budget;

Result: AMENDMENT, CARRIED by a vote of 13 to 1, as follows:

Yes	-	Mayor And	Irea Horwath
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Yes	-	Ward 3	Councillor Nrinder Nann
Absent	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
No	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

For disposition of this matter, please refer to Item 2.

(g) MOTIONS (Item 11)

(i) Air Pollution & Mental Health Impacts (Item 11.1)

In Councillor Nann's absence the Committee was advised that the following motion will be considered at the July 12th Public Health Committee meeting:

WHEREAS, emerging data points to a connection between air pollution and mental and neurological health impacts;

WHEREAS, Hamilton Public Health does not currently collected data on air pollution and it's links to mental and neurological health outcomes;

WHEREAS, Hamilton Public Health does not currently have the resources to collect, analyze, and report to Public Health Committee on this data; and

WHEREAS, Hamilton Public Health regularly benefits from partnership with academics and other health research institutions where there are intersecting areas of interest.

THEREFORE, BE IT RESOLVED:

- (a) That Public Health Staff be directed to identify the resources required to develop, in partnership with the Centre for Addictions and Mental Health (CAMH), McMaster University and other local stakeholders, a suite of evidence informed indicators that can be used locally to monitor the impact of air pollution on mental and neurological health outcomes for future Health Check reports;
- (b) That staff report back to Public Health Committee on the identified resources needed by the start of Q4 2023, so that any staffing and/or financial needs can be identified for inclusion in the 2024 Budget; and
- (c) That staff include this information in future Health Check reports to Public Health Committee by the beginning of 2025 and annually thereafter.

(h) GENERAL INFORMATION / OTHER BUSINESS (Item 13)

(i) Amendments to the Outstanding Business List (Item 13.1):

(Clark/McMeekin)

That the amendments to the Outstanding Business List, be approved, as follows:

(a) Items Considered Complete and Needing to be Removed (Item 13.1(a)):

(i) Clean Air Hamilton Annual Progress Report 2021 (BOH230010) (Item 13.1(a)(a))

OBL Item: 2023-D

Date Added: March 20, 2023 (BOH Report 23-003 - Item 1) Date Completed: May 1, 2023 (PHC Report 23-005 - Item 1) (ii) Modelling Morbidity and Mortality using the Hamilton Airshed Modelling System (BOH18016(a)) (Item 13.1(a)(b))

OBL Item: 2023-E

Date Added: March 20, 2023 (BOH Report 23-003 - Item 2) Date Completed: May 1, 2023 (PHC Report 23-005 - Item 2)

(b) Items Requiring a New Due Date (Item 13.1(b)):

(i) Municipal Actions to Reduce Harms Associated with Alcohol Use (BOH19032) (Item 13.1(b)(a))

OBL Item: 2019-V

Current Due Date: July 2023

Proposed Due Date: September 2023

(ii) Child & Adolescent Services 2021-2022 Budget and Base Funding Increase of Five Percent (BOH 21010) (City Wide) (Item 13.1(b)(b))

OBL Item: 2021-G

Current Due Date: April 2023

Proposed Due Date: September 2023

(c) Item to be Referred to the Public Works Committee (Item 13.1(c)):

(i) Correspondence from Dr. Penny Sutcliffe, Medical Officer of health and Chief Executive Officer, Public Health Sudbury & Districts, respecting Physical Literacy for Healthy Active Children (Daily School Route) (Item 13.1(c)(a))

OBL Item: 2023-B

Result: Motion CARRIED by a vote of 11 to 0, as follows:

Absent	-	Mayor And	drea Horwath
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Absent	-	Ward 3	Councillor Nrinder Nann
Absent	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson

Yes - Ward 13 Councillor Alex Wilson Yes - Ward 1 Councillor Maureen Wilson

(i) ADJOURNMENT (Item 15)

(Jackson/Tadeson)

That, there being no further business, the Public Health Committee be adjourned at 1:14 p.m.

Result: Motion CARRIED by a vote of 11 to 0, as follows:

Absent	-	Mayor And	rea Horwath
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 8	Councillor John-Paul Danko
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 15	Councillor Ted McMeekin
Absent	-	Ward 3	Councillor Nrinder Nann
Absent	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 1	Councillor Maureen Wilson

Respectfully submitted,

Councillor Maureen Wilson Chair, Public Health Committee

Matt Gauthier Legislative Coordinator Office of the City Clerk





The Honourable Sylvia Jones
Deputy Premier and Minister of Health
Ministry of Health
777 Bay Street, Floor 5
Toronto, ON M7A 2J3

Email to: sylvia.jones@ontario.ca

Re: Simcoe Muskoka District Health Unit 2024 Budget

Dear Minister Jones,

On behalf of the Board of Health for the Simcoe Muskoka District Health Unit (SMDHU), I wish to express appreciation for the Ontario government's investment in public health during the COVID-19 pandemic, the most extraordinary emergency response of our lifetime. Public health remains a cornerstone of the health system during pandemics and at other times, providing cost-effective services that have reduced overall provincial health care costs and kept many people out of emergency departments and hospitals, while at the same time maintaining a healthy and productive population.

Sufficient, predictable, and timely provincial funding into the future is vital to maintaining these essential cost-saving services. The <u>Public Health Resilience in Ontario</u> report and the <u>2023 pre-budget submission</u> of the Association of Local Public Health Agencies (alPHa), as well as the 2022 Annual Report from the Chief Medical Officer of Health (<u>Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics</u>) have spoken to the great value of the Province's ongoing investment in local public health.

The provincial Mitigation Funding of \$2.2 million provides a very important contribution to the Province's overall grant to the budget for SMDHU, which is vitally important in maintaining the Board's full range of services to the communities it serves. In addition, ongoing dedicated funding for COVID-19 would allow SMDHU to continue to respond to COVID-19 as a disease of public health significance in accordance with the provincial guidelines.

Specifically the continuation of these funds would help to ensure that residents and visitors of Simcoe Muskoka receive a full range of essential public health programs and services that have kept Ontarians out of hospitals, such as food safety inspections to prevent foodborne illness, ensuring safe drinking water to prevent community-wide outbreaks, supporting parents and families for healthy growth and development, tobacco control to prevent lung cancer and chronic obstructive pulmonary disease, promoting healthy nutrition to prevent diabetes and cardiovascular disease, improving mental health in school children, immunization against vaccine-preventable diseases, and preparations for future public health emergencies, to name but a few. Funding would also support SMDHU's continued presence throughout our region such that public health services are accessible to all via various modalities, including in our local offices and by ready phone contact.

Given the impacts identified above and the value achieved through ongoing funding from the Province for local public health services in our communities of Simcoe County, the District of Muskoka, and the Cities of Barrie and Orillia, the Board urges that the Province include its Mitigation Funding within its base funding grant commencing in 2024, and also continue funding for the COVID-19 response (vaccination and outbreak management). In this context, the Board notes and supports alPHa's position for a return to the provision of 75% of the funding by the Province for the base budgets of local public health units.

To maintain the public health services that are essential to the health of our communities, it is critical that local public health agencies be adequately resourced by the Province, now and into the future.

Sincerely,

ORIGINAL Signed By:

Ann-Marie Kungl Chair, Board of Health Simcoe Muskoka District Health Unit

cc: Councils of the Simcoe Muskoka obligated municipalities
Association of Local Public Health Agencies
Ontario Boards of Health in Ontario
MPPs of Simcoe Muskoka



July 3, 2023

Honourable Sylvia Jones, Deputy Premier and Minister of Health Province of Ontario Hepburn Block 10th Floor 80 Grosvenor Street Toronto, ON M7A 1E9 Sent via email: Sylvia.Jones@pc.ola.org

HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT

HEALTH UNIT

Dear Minister Jones,

I want to begin by thanking you and your government for your continued commitment to keeping the health and safety of Ontarians a top priority. Your steadfast financial support for public health units throughout the COVID-19 pandemic was critical to ensuring our ongoing ability to meet the needs of our communities.

On behalf of the Board of Health for Haliburton, Kawartha, Pine Ridge District Health Unit (HKPRDHU), I am writing to you to share our concerns about significant funding shortfalls anticipated for 2024.

The Province of Ontario invested significant funds across the health sector to support the response to the COVID-19 pandemic. The success of preventing the spread of COVID-19 through vaccination and other public health measures is something to celebrate. Given that COVID-19 is no longer a public health emergency of international concern, it is understandable that the scope and scale of interventions and financial support provided by the Province is pared back.

We are aware that several one-time buckets of funding are planned to end throughout 2023. This includes the School Focused Nurses Initiative, COVID-19 Extraordinary Funding, and Mitigation Funding. This leaves public health units to respond to increased community needs that arose during the pandemic (such as drug poisonings), address public health service back-logs (such as immunizations), and continue to manage COVID-19 as an endemic infectious disease using a base budget that is essentially the same as it was in 2018.

The end of the above-mentioned one-time funding, coupled with increased operational costs due to inflation, means that HKPRDHU will be challenged to meet the growing needs of our communities and the continued expanding requirements of the Ontario Public Health Standards (OPHS). Our anticipated financial shortfall to maintain our existing programs, assuming that Mitigation funding is continued, is estimated at \$1.9 million. To illustrate the gap in funding solely related to inflationary pressures, had the consumer price index been applied annually since 2018 to the HKPRDHU base budget, the provincial portion of our base budget for mandatory programs would be \$14,728.994 (an increase of \$2.7 million dollars).

Although one-time funding enabled health units to address urgent needs arising in a timely fashion, the lack of sufficient, predictable funding is a barrier to establishing a permanent strong and resilient public health system. Strong infrastructure for local public health is paramount to ensuring that Ontario is ready for the next surge in COVID-19, the next pandemic, the next extreme weather event, or the next emerging health hazard.

Protection · Promotion · Prevention

Now, more than ever, our communities need a robust public health system. While the threat of COVID-19 has dimmed, the need for an agile public health response to infectious disease threats was clearly articulated in the Chief Medical Officer of Health report for 2022 (insert link to Being Ready).

Public health units are a fundamental part of the solution to address the current challenges faced in primary and acute care. By preventing the spread of infectious diseases, preventing illnesses associated with environmental exposures, and preventing chronic diseases through policy development and health promotion, public health units keep people out of emergency departments and out of hospitals. Investing in public health is a long-term, sustainable approach to building a strong health care system.

For the above reasons, the Board of Health for HKPRDHU urges the provincial government to demonstrate their ongoing support for public health by increasing the provincial contribution to mandatory programs and continuing Mitigation funding. Should Mitigation funding end, we urge the provincial government to reverse the 70/30 policy decision made in 2019.

As we look to a future that holds a strong, resilient health system for all Ontarians, we urge the Province to provide the necessary supports for the recovery and strengthening of public health in a comprehensive and sustainable way.

Respectfully,

BOARD OF HEALTH FOR THE HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

David Marshall, Chair, Board of Health

DE/nb

Cc (via email): The Hon. Doug Ford, Premier

Laurie Scott, MPP Haliburton-Kawartha Lakes-Brock David Piccini, MPP Northumberland-Peterborough South Dr. Kieran Moore, Ontario Chief Medical Officer of Health Loretta Ryan, Association of Local Public Health Agencies



June 28, 2023

VIA ELECTRONIC MAIL

The Honourable Doug Ford Premier of Ontario Legislative Building Queen's Park Toronto ON M7A 1A1

Dear Premier Ford:

Re: Bill 103, Smoke-Free Ontario Amendment Act (Vaping is not for Kids), 2023

Teen vaping has increased steadily across the nation and within Sudbury and districts since 2017. There are significant health risks associated with vaping and nicotine use including lung damage, changes to the brain, dependence or addiction, difficulty learning, and increased anxiety and stress. Furthermore, there is an increased risk for future tobacco cigarette use among youth who vape (Ontario Agency for Health Protection and Promotion, 2018).

Bill 103 aims to prevent youth from starting to vape and seeks to decrease vaping rates through a number of important actions, including prohibiting the promotion of vapour products, and raising the minimum age for purchasing vapour products.

At its meeting on June 15, 2023, the Board of Health carried the following resolution #35-23:

WHEREAS vaping poses substantial health risks linked to the development of chronic illness, addiction, polysubstance use, as well as risks for injury and death; and

WHEREAS vaping rates among youth have grown with 30.6% of Grade 7 to 12 students in Northern Ontario reporting having used electronic cigarettes(vaping) in 2019, compared with 22.7% for the province; and

WHEREAS Board of Health motion <u>48-19</u> noted the Board's longstanding history of proactive and effective action to prevent tobacco and emerging product use and urged the adoption of a comprehensive tobacco and e-cigarette strategy; and

Sudbury

1300 rue Paris Street Sudbury ON P3E 3A3 t: 705.522.9200 f: 705.522.5182

Elm Place

10 rue Elm Street Unit / Unité 130 Sudbury ON P3C 5N3 t: 705.522.9200 f: 705.677.9611

Sudbury East / Sudbury-Est

1 rue King Street Box / Boîte 58 St.-Charles ON POM 2W0 t: 705.222.9201 f: 705.867.0474

Espanola

800 rue Centre Street Unit / Unité 100 C Espanola ON P5E 1J3 t: 705.222.9202 f: 705.869.5583

Île Manitoulin Island

6163 Highway / Route 542 Box / Boîte 87 Mindemoya ON POP 1S0 t: 705.370.9200 f: 705.377.5580

Chapleau

34 rue Birch Street Box / Boîte 485 Chapleau ON POM 1K0 t: 705.860.9200 f: 705.864.0820

toll-free / sans frais

1.866.522.9200

phsd.ca



The Honourable Doug Ford June 28, 2023 Page 2

WHEREAS <u>Bill 103 – Smoke-Free Ontario Amendment Act (Vaping is not for Kids)</u>, 2023 aims to prevent youth from initiating vaping and decrease the current usage of vaping products by targeting legislation changes, including banning the retail of flavoured vaping products, increasing minimum purchasing age to 21, and prohibiting the promotion of vapor products;

THEREFORE, BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts endorse Bill 103 - Smoke Free Ontario Amendment Act (Vaping is not for Kids), 2023; and

FURTHER THAT this endorsement be shared with relevant stakeholders.

Vaping among youth is a complex public health issue that requires immediate action. This suggests that a single intervention or approach will be insufficient to address the high rates of vaping among youth. At Public Health Sudbury & Districts, our efforts in addressing youth vaping involve a multi-faceted, comprehensive, upstream, and strengths-based approach that supports positive youth development. Strategies are community and school-driven and influence risk and protective factors associated with vaping. The strategies include education, policy development, prevention programs, research, collaboration, and enforcement activities, fostering the development of supportive social and physical environments in which youth can thrive and flourish. Yet, this is just one piece in a comprehensive approach addressing youth vaping.

The legislative solutions of Bill 103 are designed to make vaping less available and desirable for youth to address the increase in rates of vaping and to prevent the associated harms of vaping.

We thank you for your attention to this important health promotion initiative, and we continue to look forward to opportunities to work together to promote and protect the health for everyone.

Sincerely,

Penny Sutcliffe, MD, MHSc, FRCPC

Medical Officer of Health and Chief Executive Officer

cc: France Gélinas, Member of Provincial Parliament, Nickel Belt
Dr. Kieran Moore, Chief Medical Officer of Health
Honourable Sylvia Jones, Deputy Premier and Minister of Health
Honourable Michael Parsa, Minister of Children, Community and Social Services
Honourable Steve Clark, Minister of Municipal Affairs and Housing
All Ontario boards of Health
Association of Local Public Health Agencies



ASSOCIATION OF ONTARIO PUBLIC HEALTH BUSINESS ADMINISTRATORS

July 7, 2023

The Honourable Sylvia Jones
Deputy Premier and Minister of Health
Ministry of Health

Delivered via email: Sylvia.Jones@ontario.ca

Dr. Kieran Moore Chief Medical Officer of Health Ministry of Health

Delivered via email: Kieran.Moore1@ontario.ca

Dear Minister Jones and Dr. Moore,

On behalf of the Association of Ontario Public Health Business Administrators (AOPHBA), I write to you to express our interest in sharing our collective wisdom and experience to strengthen our public health system, enabling it to be responsive to growing demand and complexity, and accountable to Ontarians for the public dollars it spends. Our Association membership is comprised of business leaders in the 34 public health units across Ontario.

The AOPHBA wishes to acknowledge the Province of Ontario's support both past and on-going, in relation to the COVID-19 Pandemic. Whether through one-time funding for COVID-19 activities including case and contact management, enforcement, vaccination, the school-focused nurses initiative or through guidance documents, messaging, provision of cold storage units, information technology applications such as CCM and COVAX, your support allowed public health to increase capacity and our ability to respond to the ever-changing pressures of the COVID-19 pandemic. We also wish to acknowledge the exhaustive efforts of our public health units' public health professionals that went above and beyond to care for their communities. But our collective work is far from over. We now need to regroup and reflect upon the learnings of the COVID-19 Pandemic. Dr. Moore's 2022 Annual Report, Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics, rightly points to a call for action to be prepared to protect ourselves from future health threats, but also to invest in building a strong and resilient system and communities that create the best possible health for all. Preparedness is an on-going process, not an end state.

Above all, to be effective in reducing the demand on the health care system while simultaneously building an adaptive and resilient public health system that is responsive to threats to population health, sustainable and stable funding is required. Sustainable and stable funding will not only allow public health units to meet the requirements of the Ontario Public Health Standards (OPHS), but also the increased demand caused by the COVID-19 pandemic as well as build on current capacity to respond to emergent public health issues. The 2024 budget year presents a substantial risk to the capacity of public health units with the discontinuance of mitigation funding, rising operating costs, and increased and ongoing work involving COVID-19. Head count reductions of highly valued health professionals will be required to address these pressures, negatively impacting our ability to meet the requirements of the OPHS.



ASSOCIATION OF ONTARIO PUBLIC HEALTH BUSINESS ADMINISTRATORS

We know that a balanced approach is necessary, managing the health care needs of today and preparing for the disease threats of tomorrow. Recognizing that there are always fiscal limitations, AOPHBA appreciates the need to ensure the system is designed to optimize the use of every dollar invested in public health. Our members have a keen interest and unique knowledge-base to contribute to system-wide or regional planning for an improved public health system, in particular with respect to administrative effectiveness and efficiency.

Dr. Moore's 2022 Annual Report states "To be ready for the next outbreak, Ontario's public health sector must take a collective, forward-thinking approach to pandemic planning. It must make sustained investments in strengthening sector and system, community, and societal readiness." We encourage you to create sustained public health funding levels that are supportive of public health's response to the requirements of the Ontario Public Health Standards, including sector and system readiness to emerging public health issues. We are eager for the opportunity to collaborate on the strengthening of public health and offer our collective wisdom and experience to create a strong, effective, and efficient public health system for the future.

Our Association Executive would be pleased to meet with you, in person, to discuss this matter of mutual importance and we are available at your convenience.

Sincerely,

Cynthia St. John President

ejochia St. John

Association of Ontario Public Health Business Administrators (AOPHBA)

C: The Hon. Doug Ford, Premier

AOPHBA Membership

Association of Local Public Health Agencies (alPHa) Board of Directors

Ontario Boards of Health

Association of Municipalities of Ontario (AMO)

Dr. Catherine Zahn, Deputy Minister of Health

From: <u>allhealthunits</u> on behalf of <u>Blais</u>, <u>Diane</u>

To: <u>allhealthunits</u>

Cc: Keyes, Cameron; Jansson, Phil; Tam, Pauline

Subject: [allhealthunits] OPH State of Ottawa's Health 2023 Report and new Strategic Plan 2023-2027 | Le rapport sur

l'état de santé de la population d'Ottawa 2023 et Plan stratégique 2023 - 2027 de SPO

Date: Tuesday, July 25, 2023 11:19:34 AM

Sent on behalf of Dr. Vera Etches / Envoyé de la part de la Dre Vera Etches

La version française suit

Att: Ontario Boards of Health, Ontario Health Units

Dear Partner in Health,

On behalf of the Ottawa Board of Health and Ottawa Public Health (OPH), I am pleased to share the <u>State of Ottawa's Health 2023 Report</u> and <u>Ottawa Public Health's Strategic Plan for 2023-2027</u>. These two reports were presented to the Ottawa Board of Health at its June 19th meeting.

State of Ottawa's Health 2023 Report

Monitoring the health status of the growing population in Ottawa provides valuable information to OPH, community members and our partners. Population-level data allows us to see where we were and where we are heading, and to set priorities for improvement, drawing on the strengths in our community to promote and protect people's health in Ottawa.

The Report serves as a valuable resource for OPH and community partners to help plan or enhance programs and services, identify strategic priorities, identify gaps and monitor changes in the health of people living in Ottawa.

In this year's Report, emergent themes identified included health impacts on those with less advantage, impacts of COVID-19 on mental health and substance use health, injury as leading cause of emergency room visits, and infectious disease.

This report will help to guide the Ottawa Board of Health's strategic priorities, provide evidence for current public health funding and accountability agreements, and inform programming and services for OPH and our community partners.

Equity, Prevention and Impact: Ottawa Public Health's Strategic Plan for 2023-2027

The Ottawa Public Health 2023-2027 Strategic Plan continues work advanced during the pandemic. This includes prioritizing the needs of Ottawa's diverse communities, eliminating barriers to achieving health and wellbeing, and recognizing the importance of building genuine and lasting relationships with partners and residents to shape relevant and effective approaches.

The Strategy demonstrates Ottawa Public Health's commitment to equity, prevention, and impact to guide its efforts in achieving the Strategic Goals.

It also provides a framework to collaboratively examine and influence the systemic barriers to health and wellbeing in Ottawa and addresses key public health challenges. It builds on the previous Strategic Plan, with a focus on renewing our vision, mission, commitments, and goals in response to current and emerging public health challenges and evidence.

A variety of inputs were gathered and analyzed to support the strategic planning process, including consultations with staff, community members, and partners, as well as a review of Ottawa's latest heath status report and other literature.

Please feel free to contact us at OPHPartnerRelations@ottawa.ca should you have any questions.

Sincerely,

Vera Etches MD, MHSc, CCFP, FRCPC Medical Officer of Health / Médecin chef en santé publique Ottawa Public Health / Santé publique Ottawa

Cher partenaire en matière de santé,

Au nom du Conseil de santé d'Ottawa et de Santé publique Ottawa (SPO), j'ai le plaisir de vous présenter le rapport sur l'état de santé d'Ottawa 2023 et son plan stratégique pour 2023-2027. Ces deux rapports ont été présentés au Conseil de santé d'Ottawa à sa réunion du 19 juin.

Rapport de l'État de santé de la population d'Ottawa 2023

Le rapport de l'état de santé de la population croissante d'Ottawa fournit des renseignements précieux à SPO, aux membres de la communauté et à nos partenaires. Les données démographiques nous permettent de voir où nous en étions et où nous nous dirigeons et de définir des priorités pour améliorer la situation, en nous appuyant sur les points forts de notre communauté pour promouvoir et protéger la santé de la population d'Ottawa.

Ce rapport constitue une ressource précieuse pour SPO et ses partenaires communautaires. Il les aide à planifier ou à améliorer les programmes et les services, à définir les priorités stratégiques, à repérer les lacunes et à suivre l'évolution de l'état de santé des personnes qui vivent à Ottawa.

Dans le rapport de cette année, les thèmes émergents identifiés sont les répercussions sur la santé des personnes les moins favorisées, les répercussions de la COVID-19 sur la santé mentale et la santé liée à la consommation de substances, les blessures en tant que principale cause de visites à l'urgence et les maladies infectieuses.

Ce rapport contribuera à orienter les priorités stratégiques du Conseil de santé d'Ottawa, à fournir des preuves pour le financement actuel de la santé publique et les accords de responsabilité et à élaborer la programmation et les services de SPO et de ses partenaires communautaires.

Équité, prévention, retombées : <u>Plan stratégique</u> de Santé publique Ottawa pour 2023 - 2027

Le Plan stratégique 2023-2027 de Santé publique Ottawa poursuit le travail amorcé durant la pandémie. Il s'agit notamment d'accorder la priorité aux besoins des communautés diverses d'Ottawa, d'éliminer les obstacles à l'atteinte des objectifs de santé et de bien-être et de reconnaître l'importance d'établir des relations sincères et durables avec les partenaires et les résidents pour façonner des approches pertinentes et efficaces.

La <u>stratégie</u> témoigne du dévouement de Santé publique Ottawa envers l'équité, la prévention et les retombées pour orienter nos efforts alors que nous œuvrons en partenariat en vue d'atteindre nos objectifs stratégiques.

Elle offre un cadre visant à examiner et influencer en toute collaboration les obstacles systémiques à la santé et au bienêtre à Ottawa et à relever les principaux défis de santé publique. Il tire parti du précédent Plan stratégique, en mettant l'accent sur le renouvellement de notre vision, notre mission, nos engagements et nos objectifs en réponse aux défis et aux constats actuels et émergents de la santé publique.

Nous avons rassemblé et analysé un large éventail d'opinions diverses pour appuyer le processus de planification stratégique, et avons notamment mené des consultations auprès du personnel, des membres de la communauté et de nos partenaires comme vous, en plus de procéder à un examen du plus récent rapport sur l'état de santé d'Ottawa et d'autre littérature.

N'hésitez pas à nous contacter par courriel à <u>RelationsPartenairesSPO@ottawa.ca</u> si vous avez des questions.

Meilleures salutations,

Vera Etches MD, MHSc, CCFP, FRCPC Medical Officer of Health / Médecin chef en santé publique Ottawa Public Health / Santé publique Ottawa

This e-mail originates from the City of Ottawa e-mail system. Any distribution, use or copying of this e-mail or the information it contains by other than the intended recipient(s) is unauthorized. Thank you.

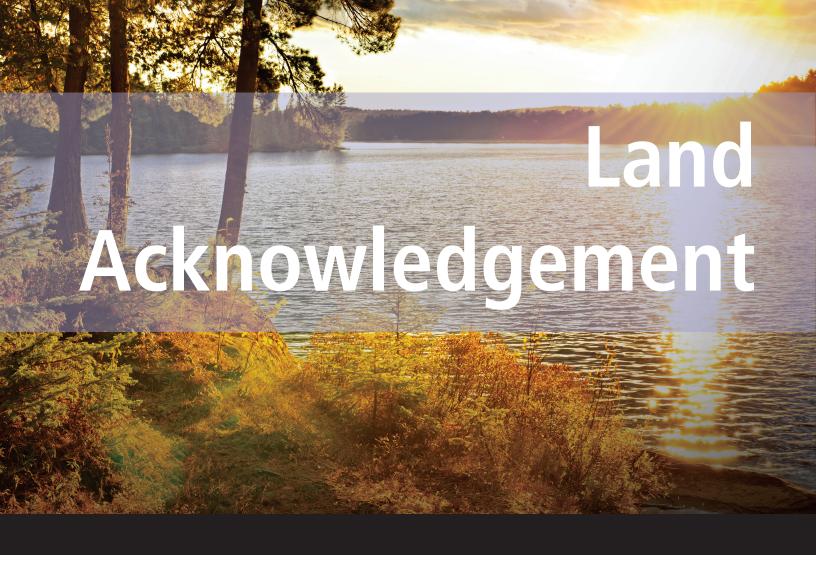
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Odàwàng kì ombàkonigàde ega wìkàd kà mìgiwàniwang Màmìwininì Aishinàbe-wakì.

Pimàdizìg Màmìwininì Anishinàbeg kàgigekamig kì abig ondaje akìng. Odanishinàbewiziwiniwà obimàdjiwowiniwà ogì nanegàdjichigàdànàwà nanàj ako nongom iyo abinàs.

Kichi Odenaw Odàwàng okikàdjìyàwàn pimàdizìn Màmìwininì Anishinàben kaye okikàdjitònàwà iyo akì. Ottawa is built on unceded Algonquin Anishinabe territory.

The peoples of the Algonquin Anishinabe Nation have lived on this territory for millennia. Their culture and presence have nurtured and continue to nurture this place.

The City of Ottawa honours the peoples and the land of the Algonquin Anishinabe Nation.



MESSAGE FROM OTTAWA PUBLIC HEALTH'S MEDICAL OFFICER OF HEALTH

Monitoring the health status of the growing population in Ottawa provides valuable information to Ottawa Public Health (OPH), community members and our partners. Population-level data allows us to see where we were and where we are heading, and to set priorities for improvement, drawing on the strengths in our community to promote and protect people's health in Ottawa.

This report provides a high-level overview of the health of the population in Ottawa, considering demographic health indicators, social determinants of health, and disease. This report will help:

- Guide the Ottawa Board of Health's strategic priorities,
- Provide evidence for current public health funding and accountability agreements, and
- Inform programming and services for OPH and our community partners.



Based on the evidence presented in this report, there is an ongoing need to continue to work towards improving overall population health while collectively working to narrow the health equity gap for equity-deserving groups. The health priorities that stand out continue to be mental health and substance use health, chronic and infectious diseases.

Working collaboratively with partners and community members creates opportunities to establish common goals, increase the consistency of existing efforts, and intensify innovation for greater collective impact on the health of people living in Ottawa.

The findings of this report are intended to be used by the many community organizations and partners that work to keep people in Ottawa healthy by preventing disease and promoting well-being. I am grateful to the OPH team for their hard work, collaboration, and dedication to basing their work on the latest data of health needs. We are committed to ongoing work with communities facing greater barriers to health to address gaps in current available data and to understand peoples' experiences beyond what is reflected in the numbers.

Sincerely,

Dr. Vera Etches

Medical Officer of Health, Ottawa Public Health

ACKNOWLEDGEMENTS

Producing this report has been a collaborative effort by staff from many programs and services at Ottawa Public Health. Special thanks go to all staff who contributed to the successful production of this report.

The analysis and written interpretation of the indicators profiled in the report were carried out by team members of the Epidemiology and Evidence team at Ottawa Public Health:

Amanda Bergeron (Epidemiologist), Melanie Fournier (Program Planning and Evaluation Officer), Dara Spatz Friedman (Epidemiologist), Shannon Harding (Epidemiologist), Ann Jolly (Epidemiologist), Cameron McDermaid (Senior Epidemiologist), Catherine Millar (Health Information Analyst), Katherine Russell (Epidemiologist), Sarah Wallingford (Epidemiologist), and Jacqueline Willmore (Epidemiologist).

Report formatting and graphics design: Guylaine Chartier (Health Graphics Designer)

Several individuals contributed to their expertise to this report. For their support and expert contribution, we would like to thank the following:

Amira Ali (Public Health Program Manager), Dr. Laura Bourns (Associate Medical Officer of Health), Dr. Vera Etches (Medical Officer of Health), Dr. Michelle Foote (Associate Medical Office of Health), Cameron Keyes (Director, Knowledge Exchange, Planning and Quality), Dr. Brent Moloughney (Deputy Medical Officer of Health), Aideen Reynolds (Public Health Supervisor), Dr. Monir Taha (Associate Medical Officer of Health), Julie Turnbull (Public Health Nurse).

Please use the following citation when referencing this document:

Ottawa Public Health. State of Ottawa's Health: 2023 Report. Ottawa (ON): Ottawa Public Health; 2023.

For additional copies of the report, please visit https://www.ottawapublichealth.ca/en/reports-research-and-statistics/general-population-health.aspx

GLOSSARY, ABBREVIATIONS AND ACRONYMS

2SLGBTQQIA+: Two-spirit, lesbian, gay, bisexual, trans, queer, questioning, intersex and asexual. The plus sign acknowledges the many sexual and gender minority people who don't see themselves in the umbrella acronym and prefer other identity terms such as pansexual or gender-free.

BMI: Body Mass Index

BORN: Better Outcomes Registry & Network

CCHS: Canadian Community Health Survey

CHEO: Children's Hospital of Eastern Ontario

COVID-19: coronavirus disease of 2019

CPE: Carbapenamase-producing Enterobacteriaceae

DTaP: diphtheria, tetanus and acellular pertussis vaccine

(for infants)

GBOMSM: gay, bisexual and other men who have sex

with men

ED: Emergency Department

EDI: Early Development Indicator

HPV: Human Papilloma Virus

iGAS: invasive group A Streptococcal disease

IMD: invasive meningococcal disease

IPD: invasive pneumococcal disease

iPHIS: integrated Public Health Information System

IPV: inactivated poliovirus vaccine

ISPA: Immunization of School Pupils Act

LTBI: latent tuberculosis infection

LIM-AT: after-tax low income measure

MBM: Market Basket Measure

Men-C-C: meningococcal conjugate type C vaccine

MCV4: quadrivalent meningococcal conjugate vaccine

MMR: measles, mumps and rubella vaccine

MOH: Ministry of Health

mpox: the disease previously referred to as monkeypox

ONS: Ottawa Neighbourhood Study

OPH: Ottawa Public Health

OPHS: Ontario Public Health Standards

OSDUHS: Ontario Student Drug Use and Health Survey

PHAC: Public Health Agency of Canada

PHO: Public Health Ontario

Pneu-C-13: pneumococcal conjugate 13 vaccine

RPEP: rabies post-exposure prophylaxis

RSV: respiratory syncytial virus

SES: socioeconomic status

STBBI: sexually transmitted and blood-borne infections

TB: tuberculosis

Tdap: tetanus, diphtheria and acellular pertussis vaccine

(for adolescents and adults)

Var: varicella virus vaccine

VTEC: verotoxin-producing E. Coli

WNV: West Nile virus



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EXECUTIVE SUMMARY

This report examines the demographic profile of Ottawa residents and evaluates measures of overall population-level health and factors that can contribute to disease prevention. It offers insight into various indicators that impact health, including social determinants of health, immunization, infant and child health and development, as well as individual behaviours. The report also provides an overview of the challenges posed by chronic and infectious diseases in the community.

The report serves as a valuable resource for Ottawa Public Health (OPH) and community partners to help plan or enhance programs and services, identify strategic priorities, identify gaps, and monitor changes in the health of people living in Ottawa.

Highlights of the report include the following:

Changes in demographics and population health implications

Ottawa is a growing city with changing demographics that will play a critical role in shaping population health planning.

- The population of Ottawa has increased by approximately 17% since the 2016 Census. The largest proportion of residents are 25 to 29 years old. In the coming decades, the greatest growth will occur among those 20 to 49 and those 65 and over. By 2030, it is estimated that older adults, aged 65 and over, will account for 20% of the population. This shift in demographics has significant implications for health resource planning to support an aging population.
- Ottawa is becoming more diverse with a 7% increase in people who identify as being from a racialized group in 2021 (35%) compared to 2016 (28%). This underscores the importance of continuing ongoing work to support and address the unique health needs of racialized groups within Ottawa.

Social determinants of health and their impact on health equity

The health of people is influenced by a range of factors beyond just health care and behaviours. Social determinants of health like income, systemic racism, the lack of adequate housing and stable employment, to name a few, shape the health inequities in society. These factors are often outside the realm of personal choice and are imposed or reinforced societally. In this report, the effects of social determinants of health include:

- The disproportionate effects of COVID-19: In the first year of the pandemic, the rate of COVID-19 was more than double in the least advantaged neighbourhoods. COVID-19-related hospitalization and death rates were almost 3 times higher in the least advantaged neighbourhoods compared to those with the most advantage throughout the pandemic.
- The challenges to equitable vaccination against COVID-19: neighbourhoods that are more socioeconomically advantaged generally had higher levels of COVID-19 vaccination compared to those with lower socioeconomic advantage.
- The effect of income on many measures of health: self-rated health and mental health is approximately 20% lower in neighbourhoods with the lowest socioeconomic advantage compared to those with the most advantage.
- The impact of neighbourhood socioeconomic status on measures of school readiness in children: the percentage of children vulnerable in at least one Early Development Instrument (EDI)ⁱ domain ranged from 4% to 52% across Ottawa neighbourhoods, with the prevalence of vulnerability generally increasing in neighbourhoods with lower socioeconomic status. For example, approximately half of children in the neighbourhoods of Carlington, Sandy Hill and Greenboro East are vulnerable in at least one EDI domain.

The EDI is a population-based measure of children's developmental health at school entry across five domains, which in turn are divided into 16 sub-domains



- The lack of access to regular medical providers:
 14% of the people living in Ottawa, or approximately 122,000 people, do not have access to a regular health care provider. This proportion is higher among people who have immigrated in the past 10 years with 38% not having access to a regular health care provider.
- The inequitable impact of chronic disease:
 while leading causes of hospitalizations are
 similar across neighbourhoods regardless of
 socioeconomic advantage, hospitalization rates are
 between 15 to 30% higher in the neighbourhoods
 with lowest socioeconomic advantage compared
 to those with the highest advantage.

Ottawa Public Health has continued to build relationships with key partners and community members, making inroads to better support communities' COVID-19 response and prevention. OPH is also advocating for better collection of social determinants of health data to improve system transparency, to reduce inequities, and better monitor population health outcomes.

Mental health and substance use health

The COVID-19 pandemic has amplified the pre-existing mental health and substance use health challenges experienced by many people in Ottawa:

- An estimated 60% of people living in Ottawa rated their mental health as very good or excellent in 2019/2020, an approximate 8 to 10% decrease from previous years. 12%, or approximately 100,600 people, rated their mental health as fair to poor.
- Self-rated mental health tends to be lowest among females, people aged 20 to 44, those in the two lowest income quintiles, those who rent their home and those living alone.
- The COVID-19 pandemic created additional strains on mental health and substance use health.
 In October of 2020, only 28% of people who responded to a population survey rated their men-

- tal health as very good or excellent. This improved to 43% by November of 2021 but was still lower than the estimates prior to the pandemic. Also in November of 2021, about a quarter (24%) also reported that in the past two weeks they wanted to reach out for mental health support but did not know where to turn.
- Self-harm is among the leading causes of injury-related hospitalizations among those aged 15 to 44. This is similar to what has been seen in previous reports.
- Emergency department visits for opioid-related overdoses among residents of Ottawa more than doubled from 443 in 2019 to 982 in 2021 highlighting the impact of COVID-19 on opioid use. Similarly, deaths more than doubled from 65 in 2019 to 148 in 2021, exacerbating an increase in opioid-related harms that began in 2017.

Chronic disease, injury and health-related behaviours

The health of Ottawa residents is influenced by chronic conditions/diseases and associated risk factors, which are shaped by social determinants of health, as well as individual circumstances and behaviours:

- Residents of Ottawa aged 18 and older identify arthritis (16%), high blood pressure (16%), anxiety (10%) and mood disorders (10%) as their most common chronic conditions. By age 65 and older, arthritis (43%), high blood pressure (41%), heart disease (20%) and diabetes (16%) are most common.
- Cardiovascular disease, endocrine, nutritional and metabolic diseases, genitourinary disease and digestive diseases are the most common causes of hospitalizations for chronic diseases.
- Injuries are the leading cause of emergency department (ED) visits and the fifth most common cause of hospitalizations.
- Smoking rates continue to decline. An estimated 9% of residents of Ottawa aged 19 and older reported they are current smokers, down from 15% in 2017/2018. An estimated 3% of students in



- grades 7 through 12 reported smoking a cigarette in the past year.
- Using the new alcohol use risk guidelines developed by the Canadian Centre on Substance Use and Addiction, 69% of the people in Ottawa aged 19 and older are at no or low risk of alcohol related harms, 15% are at moderate risk and 16% are at high risk. Among those in grades 7 to 12, 32% had consumed alcohol in the past year.
- In the most recent estimates from 2017/2018, 67% of adults over the age of 18 identified that they met the Canadian Physical Activity Guidelines. In 2019, 21% of children aged 5 to 11had an active day on one or two days in the past week; 19% were active 3 or 4 days; and 21% were active at least 5 days in the past week. In 2021, 29% of students in grades 7 to 12 reported having between one and three active days in the past week, 37% were active 5 or 6 days, and 18% were active every day in the past week.
- In Ottawa, 58% of people aged 18 and older report a height and weight that would classify them as being overweight or obese. This is relatively unchanged over the past 5 years but the percent of the population who is overweight and obese has increased over the past 15 years. This percentage is higher among men and those aged 45 and older.
- In 2020, the proportion of people in Ottawa who were screened for breast and cervical cancer has decreased and there is an increasing proportion of those overdue for colorectal cancer screening.

Infectious diseases

Ottawa Public Health reports on diseases of public health significance to help identify disease trends, and track and manage disease outbreaks. Infectious disease, particularly new and re-emerging disease, is an important health risk for the people living in Ottawa and can impact health systems and society. Early detection and mitigation is a critical part of the public health response to infectious diseases.

 COVID-19 has been the most significant infectious disease challenge in recent history, with respect to both the direct effects of the disease including

- hospitalizations and deaths, and indirect impacts on mental health, well-being and society at large. Through the end of 2022, 88,012 people were confirmed positive for COVID-19 infection; 3,464 people were hospitalized, and 1,001 died, due to their infection. COVID-19 also challenged existing population health and health services like childhood immunization, access to primary care services, routine vaccinations and health related screenings.
- A global outbreak of mpox (pronounced "em-pox" and formerly known as "monkeypox") occurred in 2022 which included countries that have not historically reported mpox cases. The first person with mpox was reported in Ottawa in May 2022 and a total of 42 people in Ottawa were diagnosed between May and September 2022. The incidence of mpox in Ottawa was lower than the average of Ontario-less-Ottawa in 2022, which was driven by a high number of cases in Toronto.
- The rate of tuberculosis in Ottawa has increased slightly over the last six years from 4.6 to 5.5 per 100,000 people and is higher than the average for Ontario-less-Ottawa (4.6 per 100,000).
- Influenza activity was very low during the pandemic, then increased during fall 2022 for a shorter but more intense season that disproportionately impacted children and youth compared to pre-pandemic years. As of mid-March 2023, 870 people in Ottawa tested positive for influenza, slightly above the pre-pandemic average of 833, and 40% were under age 20 years.
- The incidence of sexually transmitted and bloodborne infections decreased during the pandemic, which could be attributed to factors such as reduced testing, as well as fewer sexual contacts due to public health measures. Recently, rates have begun to rebound to pre-pandemic levels.
- OPH is actively preparing for the possible re-emergence of measles due to outbreaks occurring worldwide and a pandemic-related decrease in population vaccine coverage in young people in Ottawa. OPH is drawing on expertise gained from its experiences with COVID-19 as well as past responses to inform its preparations for measles prevention and control.

INTRODUCTION

A detailed understanding of the population of Ottawa creates the foundation upon which the work of Ottawa Public Health (OPH) is built. Understanding not only the health of the people living in Ottawa, but also individual behaviours, living conditions, and life experiences is essential for improving the health of the people who live here. The City of Ottawa combines the diversity that comes from a population of over a million people, with a large area that varies from rural farmland to a downtown urban core. This report both celebrates that diversity, and highlights where there are differences in health among different populations in Ottawa.

This report is a resource for OPH and health partners to help plan or enhance programs and services, identify strategic priorities, identify gaps, and monitor changes in the health of people living in Ottawa. This report also fulfills the requirement for public health units to assess and report on population health, as stipulated in the Ontario Public Health Standards.ⁱⁱ

The report is intended to be interpreted at the City of Ottawa level. While it provides information about specific groups, such as those living in low income or who identify as racialized, many data sources do not include information on social determinants of health or not all indicators can be estimated for all groups of interest. Similarly, many estimates cannot be reported for neighbourhoods or other small geographical areas because they become unreliable due to survey coverage or small sample size. OPH works with our partners at the Ottawa Neighbourhood Study to provide robust health measures estimates by neighbourhood. This is important to note because health inequities in Ottawa exist and are closely tied to social determinants of health such as economic advantage and racialization. ¹ The COVID-19 pandemic underscored the importance of these factors as areas in Ottawa with low economic advantage or greater populations of people who are racialized bore a higher health burden of disease from COVID-19.2 OPH has been working to collect social determinants of health data for people who tested positive for COVID-19 or were immunized with a COVID-19 vaccine and building this framework into our data systems. OPH has also been advocating for the inclusion of social determinants of health data in other data systems used by health units across Ontario. OPH also works with community members and partners to collaboratively advance efforts to address the population health concerns of equity-deserving groups.

COVID-19 has directly affected indicators and measures of health status. For example, in Canada, emergency department visits dropped to about half the usual number in the spring of 2020, rebounding by summer but still lower than pre-pandemic levels.3 This is likely due to public health directives at the time or people's willingness to seek care at an emergency department. Similarly, indicators such as self-rated mental health have been influenced by the pandemic, as will be shown in this report. This may include effects like increased worry, a disruption in social connectedness and social networks, as well as decreased access to mental health care or support. Survey data from the Canadian Community Health Survey (CCHS) is from the 2019/2020 calendar years so includes some data pre-dating COVID-19 and some in the early parts of the pandemic. While some effects of COVID-19 on indicators like mental health may be temporary, it is important to acknowledge the effects of the pandemic beyond disease incidence and to keep this effect in mind when interpreting the findings in this report.

The health conditions and indicators mentioned in this report include those that provide insight into the health of people living in Ottawa and have recent and robust data sources. Missing from this report are the most recent estimates of leading causes of death or other details of mortality for the population in Ottawa. At the time this report was prepared, vital statistics data was only available to 2015 and did not present a contemporary view of mortality in Ottawa, nor did it provide an update beyond what is available on the OPH website.ⁱⁱⁱ More recent mortality data will be analysed and published at a future date.

iii Ottawa public health Morbidity and mortality data can be found at https://www.ottawapublichealth.ca/en/reports-research-and-statistics/morbidity-mortality-quality-of-life.aspx#Leading-Causes-of-Emergency-Department-Visits-Hospitalizations-and-Death-Overall-and-by-Sex



The Ontario Public Health Standards identify the minimum expectations for public health programs and services to be delivered by Ontario's 34 boards of health and are available at https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/

DATA NOTES

Data were analyzed using Stata v17 or PowerBI (ver Feb 2023).

Footnotes are shown with Arabic numerals (1, 20, 45) and References are shown with Roman numerals (*i*, *xx*, *xlv*).

In this document, percentages (proportions) are rounded to the nearest whole number e.g. 11.7% is rounded to 12%. Rates are expressed with 1 decimal point e.g. 12.1 per 100,000.

The symbol * denotes that the estimate should be interpreted with caution due to high variability in responses. Some results are suppressed due to unreliability.

Where comparisons by subgroup are made, only statistically significant differences (differences that are unlikely due to chance) are shown unless an explicit comparison (e.g Ottawa to the rest of Ontario) is intended.

Point estimates are provided with 95% confidence intervals. The 95% confidence interval includes the true value 95 times out of 100. E.g. If the point estimate for the percentage of youth using alcohol is 58% (95%CI: 44%, 70%), then the range from 44% to 70% will contain the true population value 95% of the time. The narrower the confidence interval is, the more precise the estimate.

A single number for the confidence interval in graphs and tables is the difference between the upper or lower limit of the confidence interval and the point estimate. For example a confidence interval of 1.2% means the lower limit is 1.2% below the point estimate and the upper limit is 1.2% above the point estimate. If two numbers appear, these represent the lower and upper limits of the confidence interval.

Estimates for "Ontario-less-Ottawa" do not include Ottawa counts/responses in the numerator or denominator. Any differences between Ottawa and Ontario-less-Ottawa should be interpreted as Ottawa being different from the average of individuals across Ontario excluding those individuals from the Ottawa area.

Estimates may vary from other sources. Analysis in this report includes a category for "Don't know or refused" if the estimate for this group is 5% or higher. Other sources may not report on this group regardless of its estimated size.

Income data from the Canadian Community Health Survey is described by income quintiles. This is based on the derived variable in a distribution of people in each health region in deciles (ten categories including approximately the same percentage of people for each province) based on the adjusted ratio of their total household income to the low income cut-off corresponding to their household and community size. It provides, for each respondent, a relative measure of their household income to the household incomes of all other respondents in the same health region. In this report, quintile 1 is the highest income and quintile 5, the lowest.

The neighbourhood socioeconomic status (SES) index is based on neighbourhood-level measures from the 2016 Census including the prevalence of lone-parent families, unemployment rate, education levels, and income.⁴ Based on this SES index, the neighbourhoods have been divided into five groups or "quintiles." Quintile 5 indicates that a neighbourhood is among those with the lowest socioeconomic advantage and Quintile 1 represents the most socioeconomically advantaged neighbourhoods.

The language in this report is rooted in the original data source. Some language may not be representative of OPH's preferred language and was used for consistency with its original data source. The terminology "male" and "female," for example, are associated with sex assigned at birth whereas gender identity is related to how individuals define and experience their gender, how they move through the world, and how others perceive them as gendered people. Ottawa Public Health recognizes that individuals can identify their gender identity in a multitude of ways, however, this report at times uses terminology that does not align with this as many data sources continue to use sex assigned at birth and biological traits. The terms "racialized population" or "racialized groups" in 2021 Census products are

used in this report but are still defined by the concept of "visible minority" from the Employment Equity Act. This definition uses specific groups and does not include Indigenous peoples as a "visible minority." ⁵ Statistics Canada is currently reviewing this concept. iv

Cancer incidence estimates in this report are based on data and information provided by Ontario Health. The analysis, conclusions, opinions and statements expressed herein are those of the author(s) and not necessarily those of Ontario Health.

Data from the Ontario Student Drug Use and Health Survey data in this report from the Ontario Student Drug Use and Health Survey, conducted by the Centre for Addiction and Mental Health and administered by the Institute for Social Research, and York University are solely the responsibility of the authors and do not necessarily represent the official view of the Centre for Addiction and Mental Health.

Chapter 1

Describing the people who live in Ottawa



POPULATION

In 2023, an estimated 1,095,575 people live in Ottawa,⁶ a 17% increase from the 2016 Census.⁷ The median age of Ottawa residents is 39 years.⁸ The largest proportion of residents are 25 to 29 years old (Figure 1). In the coming decades, the greatest growth will occur among those 20 to 49 and those 65 and over, and by 2030, it is estimated that older adults, aged 65 and over, will account for 20% of the population. The increasing proportion of older adults means individuals in Ottawa will have higher health service needs into the future. It also increases the dependency ratio, the proportion of the non-working population that needs to be supported by the working age population. The City of Ottawa growth projections for the Official Plan estimate that the dependency ratio will increase from 46.2 in 2018 to 58.6 in 2046.⁹

Slightly more than half (51%) of Ottawa residents are women+; and the remaining 49% are men+.¹⁰ Statistics Canada categorizes women+ as women and girls, as well as some persons who are non-binary persons and men+ as men and boys, as well as some persons who are non-binary.

LIFE EXPECTANCY AT BIRTH

Life expectancy at birth for someone living in Ottawa who was born during 2015 to 2017 is estimated to be 83.7 years overall, 81.9 years for men and 85.3 years for women. These estimates have not changed substantively since 2011.¹¹ It is not yet known to what extent Ottawa life expectancy estimates may become influenced by the excess mortality seen in Canada during the pandemic.¹²

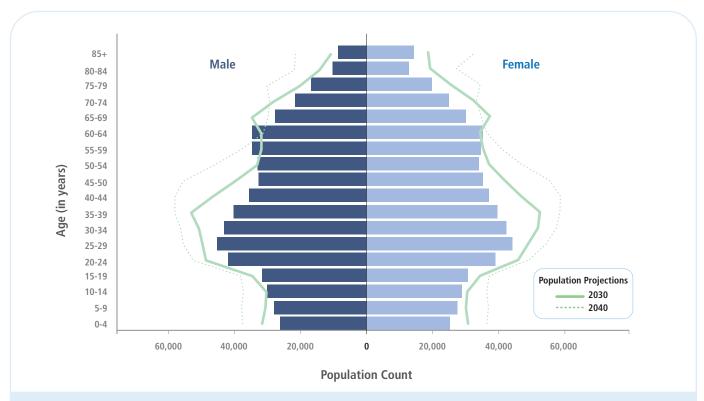


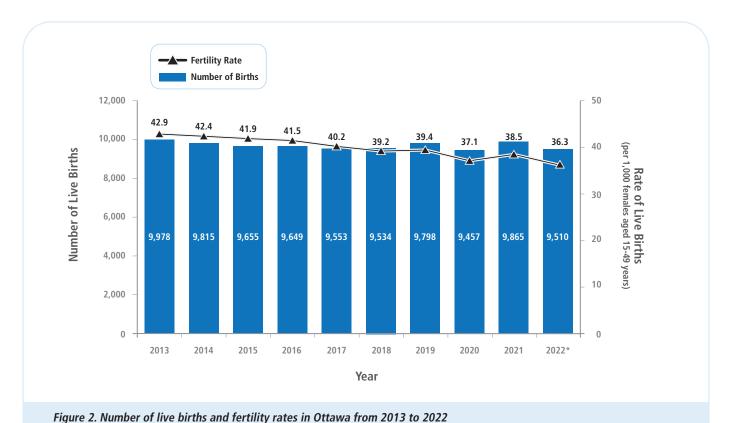
Figure 1. Population distribution as counts, for males and females, City of Ottawa, 2023, 2030 and 2040

Source: Population Projections. Ottawa. Ontario Ministry of Health, IntelliHEALTH Ontario. Extracted January 27, 2023. *Note: The Ministry of Health enumerates population estimates for "males" and "females," not men and women.

BIRTH RATES

In 2021, there were 9,865 live births to females living in Ottawa. The fertility rate (number of live births per 1,000 females aged 15 to 49 years) has declined over the past 10 years from 42.9 births per 1,000 females in 2013 to 38.5 births per 1,000 females in 2021, and preliminary 2022 birth data show another decline to 36.5 births per 1,000 females (Figure 2).

Fertility rates were highest among women aged 30 to 34 years, followed by women aged 35 to 39 years and women aged 25 to 29 years. The number and rate of live births among teenagers dropped 60% from 158 births in 2013 to 64 births in 2020. This was similar in 2021 with 57 live births and 2022 with 60 live births (2022 data is preliminary). In 2021, 97% of births were singletons and 3% were multiples (Figure 3).



Sources: Births – Better Outcomes Registry & Network (BORN) Ontario. Extracted March 14, 2023;
Population Projections. Ottawa. Ontario Ministry of Health, IntelliHEALTH Ontario. Extracted January 27, 2023

*Note: 2022 data are preliminary and are likely incomplete.

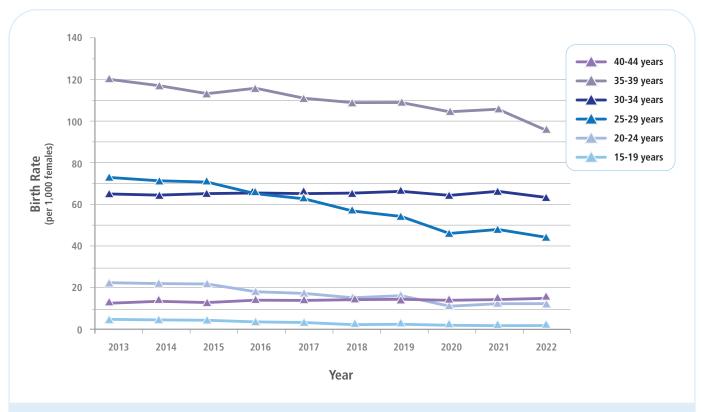


Figure 3. Age-specific fertility rates in Ottawa from 2013 to 2022

Source: Better Outcomes Registry & Network (BORN) Ontario. Extracted March 14, 2023.

Note: 2022 data are preliminary and are likely incomplete.

OFFICIAL AND NON-OFFICIAL LANGUAGES SPOKEN

In 2021, 61% of people living in Ottawa spoke English only, 1% spoke French only, 36% spoke English and French, and 2% spoke neither English nor French.¹³ This is not substantively different from the previous two censuses.

Nearly one quarter (23%) of people's mother tongue is a language other than English or French. The top three mother tongue languages for people whose mother tongue is a language other than English or French are Arabic (16%), Chinese (12%), and Spanish (5%).

ORIGIN AND IDENTITY

Indigenous

According to the 2021 Census, 3% of the population in Ottawa identified as Indigenous, including First Nations (North American Indian), Inuk (Inuit) and Métis. ¹⁴ This estimate is similar to what was observed in 2016, although likely an underestimate of the actual Indigenous population living in Ottawa. Of note, OPH has implemented a Reconcili-ACTION plan and continues to actively work with Indigenous partners and community members to support actions that foster and promote Indigenous rights and reconciliation. This includes a commitment to data governance principles that support the safe and respectful collection, use, and disclosure of data.

Racialized Groups

In 2021, 35% of the population living in Ottawa identified as racialized, a 7% increase compared to 2016 (28%). Black, Middle Eastern, and South Asian were the most frequently reported racialized groups.

Immigration Status and Country of Origin

About a quarter (26%) of the 2021 population living in Ottawa were born outside of Canada¹⁵ and is relatively unchanged from the 2016 Census (24%).¹⁶ Among Canadian immigrants living in Ottawa, half immigrated within the last 20 years, with 5% immigrating within the last five years. At time of immigration, the majority of people were between 25 and 44 years old. Most recent newcomers came from Asia, Africa, the Americas, and Europe (Table 1 / Figure 4).

Table 1. Top continents and countries of origin of recent (i.e. within the last 5 years) newcomers to Ottawa, 2021.¹⁷

Origin	2016-21 (Count)	2016-21 (Percentage)	
Asia	25,825	54%	
India	5,645	12%	
Africa	12,725	27%	
Nigeria	1,790	4%	
The Americas	5,050	11%	
United States	1,565	3%	
Europe	3,380	8%	
United Kingdom	710	1%	

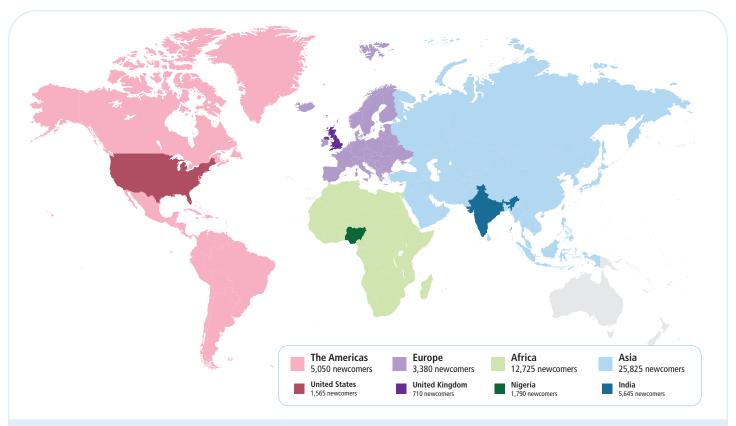


Figure 4. Infographic based on data extracted from Statistics Canada

Source: Statistics Canada. 2023. (table). Census Profile. 2021 Census of Population. Statistics Canada Catalogue no. 98-316-X2021001. Ottawa. Released February 8, 2023.

https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E (accessed March 8, 2023)

Chapter 2

What is influencing our health?



The following section describes many factors and behaviours that affect health. This includes social determinants of health like income, education, employment, and housing, as well as behaviours that have an impact on health like physical activity, smoking and alcohol use. Some of these factors are often outside the realm of personal choice and are imposed or reinforced societally. Often behaviours may be influenced or constrained by these social determinants of health.

INDIVIDUAL AND HOUSEHOLD INCOME

The median after-tax individual income for people living in Ottawa over 15 years of age was \$44,000 in 2020, ¹⁸ up 18% from \$37,136 in 2015. This increase exceeded cumulative inflation over the same time period (10%). ¹⁹ The median after-tax household income was \$88,000 in 2020, up only 2% from \$85,981 in 2015. This increase was less than the rate of inflation.

The estimated cost of living for a family of two adults and two children was \$50,355 in Ottawa in 2021, a 9% increase over five years from 2017 (\$46,123). This estimate, called the Market Basket Measure (MBM), considers the cost of clothing, food, footwear, transportation, shelter, and other expenses.²⁰

Individuals living in low income

Close to 89,000 individuals, or 9% of people in Ottawa, lived in low income in 2020, adjusting for household size using the after-tax low income measure (LIM-AT^v). This is a decrease from 13% in 2015.²¹ Because this low income estimate is determined after tax, to better represent the income available to a household, part of the decrease in the prevalence of low income may be a result of pandemic relief benefits and changes in child-benefit payments in 2021.²² Those aged 18- to

64-year-olds were less likely to live in low income in 2020 (8%) than those aged 17 and under (11%) or individuals 65 years and older (9%).

EDUCATION

People in Ottawa are well-educated with three quarters (77%) of adults (aged 25 to 64 years) holding a postsecondary education certificate, diploma or degree, 18% hold a high school diploma or equivalent, and only 5% not having completed high school. This is a higher proportion that hold a postsecondary education (77% vs 75%) compared to 2016.^{23, 24}

EMPLOYMENT

Unemployment has improved since the earliest years of the pandemic. In 2022, monthly unemployment ranged from 3% to 6%, which is lower compared to the first two years of the COVID-19 pandemic (2020 monthly range: 4% to 10%; 2021 monthly range: 5% to 13%).²⁵

HOUSING

Housing is an absolute necessity for living a healthy life. Living in unsafe, unaffordable, or insecure housing increases the risk of many health issues. ²⁶ A home is more than simply shelter; it can also be a source of security, dignity and identity. Canada's residential housing accounts for over one-fifth of our national wealth. ²⁷ While the share of renters is growing at over twice the pace as owners, the difference in net worth growth between homeowners and renters continues to increase. The net worth of homeowners more than doubled from \$323,700 in 1999 to \$685,400 in 2019, while the net worth of renters of all ages rose from \$14,600 to \$24,000 in the same time period.

v The Low-income measure, after tax, refers to a fixed percentage (50%) of median-adjusted after-tax income of private households. The household after-tax income is adjusted by an equivalence scale to take economies of scale into account. This adjustment for different household sizes reflects the fact that a household's needs increase, but at a decreasing rate, as the number of members increases.



Affordable Housing

In 2021, 42% of renter households paid 30% or more of their household income on shelter costs compared to 14% of owner households.²⁸

In October of 2022, Ottawa had a vacancy rate of 2% in apartment structures of three units or more. Average rent of a 2-bedroom unit was \$1,625 per month, a 5% increase from the previous year.²⁹ Rent increases were highest among turnover rentals, with 2-bedroom units having a 17% increase as of October 2022 compared to 2021.

COMMUNITY BELONGING

A sense of community belonging and social connectedness is associated with both physical and mental health. People with a strong sense of community belonging tend to rate their self-perceived general and mental health higher than the people who do not.³⁰ In Ottawa, 69% of people had a somewhat to very strong sense of community belonging in 2019 to 2020 which is similar to past years. This sense of belonging tends to be highest in those over 19 years of age and somewhat lower in renters versus owners (63% versus 72%) and single people versus families with children (59% versus 74%).³¹

In terms of school connectedness and belonging, in 2021, three quarters (74%) of grade 7 to 12 students reported they liked school, 71% reported they felt part of their school, and 88% reported feeling safe at their school (all similar to the rest of Ontario and to 2019) (Figure 5). However, only two-thirds (65%) of Ottawa students reported feeling close to people at their school in 2021, which was lower than in the rest of Ontario and in 2019 (74% and 80%, respectively). Not all students reported feeling close to people at their school. A higher percentage of students said they did not feel close to people in their school among those in grades 9 to 12

compared to grades 7 and 8 (37% vs. 25%), or were of socioeconomic disadvantage compared to socioeconomic advantage (54% vs. 27%) or identified with another gender identity (78%) compared to men/boys (28%) and women/girls (36%).^{32, 33}

FOOD SECURITY

Food insecurity is the insufficient or unreliable access to food due to financial constraints and ranges from marginal to severe food insecurity.³⁴ Food insecurity continues to persist in Ottawa. Three-year estimates from the 2018, 2019, and 2020 Canadian Income Survey indicate that 13% of Ottawa households face food insecurity, with approximately 4% being marginally food insecure, 6% being moderately food insecure and 3% being severely food insecure.³⁵ In Ottawa, the monthly cost of a nutritious food basket^{vi} for a family of four in 2022 is \$1,088.³⁶

In 2019, 10%* of Ottawa students in grade 7 to 12 reported always or often going to bed or to school hungry because there was not enough food at home. This estimate was significantly higher than the rest of Ontario (6%). Most recent estimates for Ottawa are not reportable; however, in Ontario 3%* of grade 7 to 12 students reported always or often going to bed or school hungry in 2021.^{37, 38}

Approximately one fifth (22%) of students reported eating fruits and vegetables four or more times per day in 2021, while 52% reported eating them two to three times and 17% reported eating them less than twice daily. This was similar to the rest of Ontario and to 2019. Students of socioeconomic disadvantage were significantly less likely to report consuming fruits and vegetables four or more times daily than were those of socioeconomic advantage (13%* vs. 25%).

vi For more information on the calculation of the nutritious food basket, see https://www.ottawapublichealth.ca/en/public-health-topics/food-insecurity.
aspx#2022-Nutritious-Food-Basket



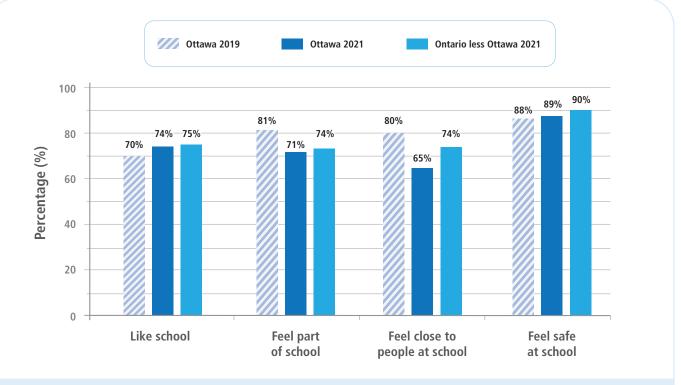


Figure 5. Percentage of students in grades 7 to 12 who reported school connectedness in the past year in Ottawa, 2019 and 2021, and Ontario-less-Ottawa, 2021.

Sources: Ottawa Public Health. Public Health Monitoring of Risk Factors in Ontario –Ontario Student Drug Use and Health Survey (2021), Centre for Addiction and Mental Health; Ottawa Public Health. Public Health Monitoring of Risk Factors in Ontario –Ontario Student Drug Use and Health Survey (2019), Centre for Addiction and Mental Health.

ACCESS TO A HEALTH CARE PROVIDER

Access to a high-quality health care system is a social determinant of health and a basic human right.³⁹ In Ottawa, 86% of residents aged 12 and older stated they had a regular health care provider they could visit or talk to when they needed care or advice about their health.⁴⁰ This was lower than the rest of Ontario where 90% said they had access to a regular health care provider. This means that in Ottawa about 14% of the population (approximately 122,000) did not have access to a regular health care provider. Access to a regular health provider was highest among older age groups, those in highest income quintiles, those living rurally and homeowners (Figure 6). It was lowest among people who had immigrated within the past 10 years (62%).

In Ottawa, 65% of residents with a regular health care provider thought they could get immediate care for a minor problem within three days. However, an estimated 189,000 thought they would wait between 4 days to two weeks and a further 59,800 thought they'd wait two weeks or more. Approximately 2 out of 3 (64%) rated the coordination between levels of care as very good to excellent where such care was required. Thirteen percent of those with a regular health care provider and where coordinated care was required (approximately 39,800) thought coordination was fair to poor.

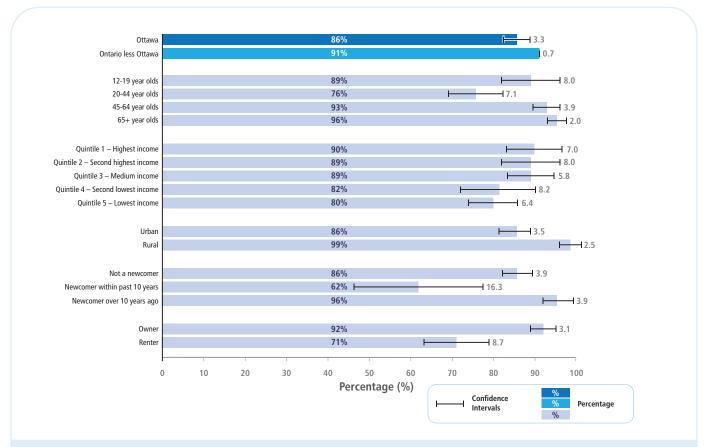


Figure 6. Percent of population aged 12 and older who stated they had access to a regular health care provider by subgroup, 2019-2020.

Source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health

CHILDHOOD IMMUNIZATION

vii

Immunization through vaccination is a key public health and primary care initiative to prevent illness, disability, and death from vaccine preventable diseases. As part of the National Immunization Strategy, vaccination coverage goals for vaccine preventable diseases have been set according to international standards and best practices to minimize the harms associated with these diseases. ⁴¹ High immunization coverage is essential for the effective prevention and control of vaccine preventable diseases.

For children and youth there are nine diseases (diphtheria, tetanus, polio, pertussis, meningococcal disease, measles, mumps, rubella, and varicellavii) for which vaccination coverage is required to attend school in Ontario under the Immunization of School Pupils Act (ISPA). ISPA-required immunizations are primarily given by community health care providers except for ones given by the public health unit as part of the school-based immunization program (see School-based Immunization section on page 18).

Under ISPA, immunizations administered by community providers are to be reported to Ottawa Public Health by families. OPH sends personalized letters to parents and caregivers, on an annual basis, to remind them to report their children's immunizations to OPH.

Routine Childhood Immunizations

Pre-pandemic Routine Childhood Immunization Coverage

Immunization coverage rates in the 2018-19 school year for all immunizations required under ISPA among 7-year-olds and 17-year-olds living in Ottawa were 80% and 71%, respectively.⁴² Rates among 7-year-olds surpassed national coverage goals of 95% for rubella and meningo-coccal C conjugate (MenCC) and were below the goals for diphtheria, tetanus, polio, pertussis, measles, mumps, Haemophilius influenza type B (Hib), viii pneumococcal disease, ix and varicella (Figure 7). Among 17-year-olds living in Ottawa, pre-pandemic coverage rates were below national goals of 90% for diphtheria, tetanus, and pertussis. These coverage estimates are limited to immunizations reported to public health.

COVID-19 Pandemic Impacts on Immunization Coverage

Decreases in vaccine coverage rates can increase the risk of vaccine preventable diseases like measles, particularly as travel to countries experiencing outbreaks increases. Coverage for measles vaccination, for both first and second doses, has steadily declined globally since the beginning of the COVID-19 pandemic, putting many children at risk of this serious and highly contagious disease. Both the World Health Organization and the Pan-American Health Organization have issued statements regarding the increased risk of measles globally. 43, 44

In Ottawa, the COVID-19 pandemic has substantially disrupted access to routine childhood and school-based immunizations. The closure of primary care offices and schools, the shift to virtual care, stay-at-home orders, early retirement of health care providers, and the diversion of public health resources to COVID-19 activities, like case management and mass immunization, have all impacted vaccination rates.

The pandemic has also impacted the reporting of immunizations to OPH. OPH's typical ISPA surveillance activities to remind families to report childhood immunizations were paused from March 2020 until the current school year (2022-23). As a result, the primary source for immunization information for children and youth in Ontario is incomplete and underestimates current coverage rates. ISPA surveillance activities are currently underway for students born in 2015 (~7-years-old) and 2005 (~17-years-old) and as a result both immunization and reporting rates are improving. Coverage rates for these birth cohorts will be explored once ISPA surveillance is complete at the end of the current school year.

Assessing the Gap in Routine Childhood Immunizations due to the Pandemic

Given the current limitations of the immunization records system for estimating vaccination coverage, we conducted an analysis of vaccine distribution data to estimate the impact of the pandemic on routine childhood immunization rates.

OPH is the sole distributor of routine childhood vaccines to immunizers in the health unit's catchment area. The trends in vaccine distribution over time were used to make inferences about vaccination coverage. Overall, we found that the volume of routine childhood vaccine doses distributed by OPH was at an all-time low in March 2020. Although distribution volumes are gradually recovering, they have not yet reached pre-pandemic levels.

Distribution volumes varied by vaccine product. Based on the relative differences in distributed vaccines over time (Figure 8) and the estimated population of children and youth due for specific vaccines (based on a routine schedule), the estimated total number of doses of routine immunizations missed between 2020 and 2022 among children and youth in Ottawa was over 40,000. Of these, approximately 15,000 were missed doses of vaccines which protect against measles.

viii Not an ISPA-designated disease.

ix Not an ISPA-designated disease.



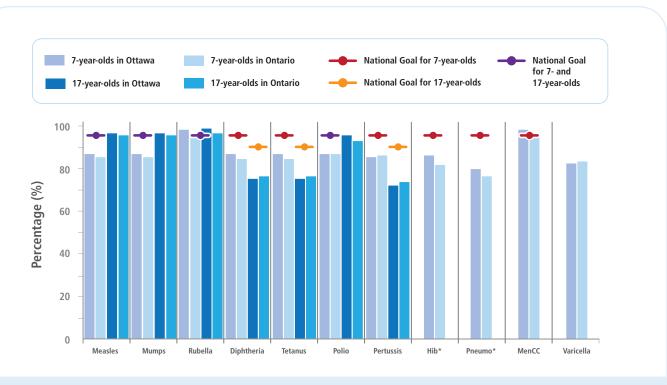


Figure 7. Immunization coverage rates for school year 2018-19 among 7- and 17-year-olds in Ottawa, and national coverage goals, by disease.

Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Immunization coverage report for school pupils in Ontario: 2018–19 school year. Toronto, ON: Queen's Printer for Ontario; 2020.

* Note: Hib and pneumococcal disease are not ISPA-designated diseases. Coverage estimates reflect the proportion of students who received all recommended doses for their age by August 31, 2019.

Childhood vaccines typically administered up to age 1, such as DTaP-IPV-Hib, x saw little to no change in the total annual number of doses distributed during 2020-22 compared to pre-pandemic, while other vaccines had lower distribution (Figure 8). Distribution volumes of MMR (given at 1 year), MMR-Var (4 to 6 years), Tdap-IPV (4 to 6 years), and Tdap (14 to 16 years) dropped by 27% to 47% in 2020 compared to pre-pandemic, with only Tdap-IPV returning to pre-pandemic volumes in 2022. MMR, MMR-Var, and Tdap still trail pre-pandemic volumes, not unsubstantially (by 23%, 9%, and 20%, respectively in 2022) (Table 2). As a result, not only is there a backlog of children and youth needing these immunizations due to initial pandemic closures, but the number who are not covered for measles, mumps, rubella, varicella, tetanus, diphtheria, and pertussis, continues to grow. To clear the backlog, above average rates of vaccine distribution

and administration are needed. OPH has informed primary care providers, caregivers and parents of the importance of childhood vaccines and is attempting to reduce barriers. Enhanced access to vaccination through neighbourhood hubs, community clinics and organized catch-up school-based clinics for some vaccinations have been prioritized to address this issue.

School-based Immunizations (Hepatitis B, HPV and Meningococcal Vaccines)

There are three vaccines which are part of Ontario's publicly funded school-based immunization program, typically delivered by public health to grade 7 students (~12-year-olds): hepatitis B, human papilloma virus (HPV), and quadrivalent meningococcal conjugate C (MCV4). Only MCV4 is required under ISPA.

x For a description of which diseases are covered by which vaccine product, refer to Table 2

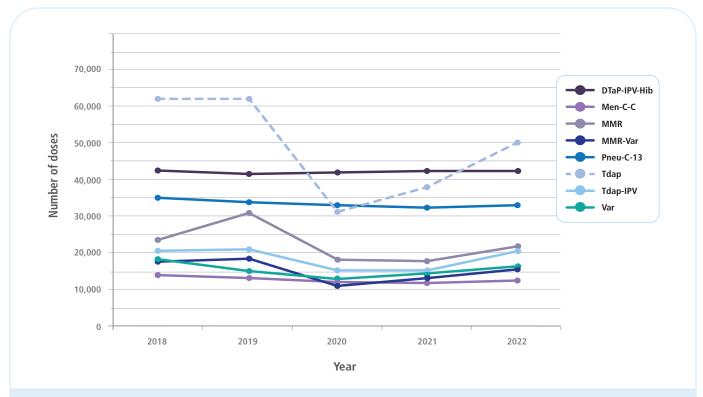


Figure 8. Total annual volume of vaccine doses distributed by OPH by vaccine product, 2018-2022.

Source: Panorama, Ontario Ministry of Health. Extracted on January 31, 2023.

Table 2. Percentage difference in annual volume of doses distributed compared to the pre-pandemic 2-year average (2018-19), by vaccine product and year.

Vaccine Product	Diseases Covered by Vaccine	2020	2021	2022
DTap-IPV-Hib	Diphtheria, tetanus, pertussis, polio, Haemophilus influenza B	-1%	-1%	-1%
Men-C-C	Meningococcal disease	-12%	-18%	-8%
MMR	Measles, mumps, rubella	-34%	-36%	-23%
MMR-Var	Measles, mumps, rubella, varicella	-31%	-20%	-9%
Pneu-C-13	Pneumococcal disease	-4%	-5%	-3%
Tdap	Diphtheria, tetanus, pertussis	-47%	-39%	-20%
Tdap-IPV	Diphtheria, tetanus, pertussis, polio	-27%	-27%	-1%
Var	Varicella	-18%	-12%	-1%

Source: Panorama, Ontario Ministry of Health. Extracted on January 31, 2023

Note: For the percentage difference in doses, the distribution volumes for each pandemic year (2020, 2021 and 2022) were compared to the average distributions from the two most recent pre-pandemic years (2018 and 2019) to account for year-to-year variability in distributions.

Pre-pandemic rates for school-based immunization coverage for school year 2018-19, among 12-year-old students in Ottawa, were 75% for hepatitis B, 67% for HPV, and 88% for MCV4.45 In the following two school years (2019-20, 2020-21), when the COVID-19 pandemic altered or altogether halted the delivery of the school-based immunizations program, coverage rates fell dramatically. OPH returned to providing these vaccines at school clinics in the 2021-22 school year. However, vaccination uptake continued to be impacted by the isolation requirements for COVID-19 cases and contacts, which kept students out of school when vaccines were being offered. The expansion of COVID-19 immunization eligibility to 12 to 17 year-olds (May 2021), also limited the administration of other vaccines due to the recommendation not to co-administer vaccines within two weeks of each other. 46 As a result, coverage rates among 12-year-olds remained lower in 2021-22 compared to pre-pandemic (Figure 9).⁴⁷

To help students catch up on missed school-based vaccinations throughout the pandemic the student eligibility for HPV and hepatitis B vaccines was expanded provincially up to age 18. OPH began offering these vaccines to both grade 7 and 8 students at school-based clinics, as well as running targeted high school catch-up clinics for grade 9 to 12 students who may have missed them. These catch-up efforts are improving coverage in impacted cohorts, but rates remain lower than pre-pandemic.⁴⁸

EARLY CHILD DEVELOPMENT

From birth to six years there are critical periods during which particular physical, emotional, social, language, and communication skills are developed. The Early Development Instrument (EDI) is a population-based measure of children's developmental health at school entry across five domains, which in turn are divided into 16 sub-domains. Five EDI cycles have been completed in Ottawa, starting in 2005/06. For more information on previous cycles of the EDI in Ottawa, please refer to the Our Kids, Their Story...Snapshot of Developmental Health at School Entry in Ottawa 2005-2015 report published

by the Parent Resource Centre (PRC). More recent data is based on correspondence with the PRC and analysis by Ottawa Public Health.

In the most recent cycle (Cycle 5 – 2017/18), 28% of senior kindergarten (SK) children in Ottawa were found to be vulnerable in at least one of the five EDI domains. ⁴⁹ This percentage has increased significantly since the previous EDI cycle (26%) but is lower than the provincial average (30%). In all five EDI domains, the percentage of vulnerable SK children in Ottawa was lower than the Ontario average.

When looking at specific domains, the percentage of vulnerable SK children in the Physical Health and Well-Being and the Language and Cognitive Development domains has increased since the previous cycle in Ottawa. However, there were improvements with a lower percentage of vulnerable SK children in the Communication Skills and General Knowledge domain (Table 3).

The percentage of children vulnerable in at least one EDI domain ranged from 4% to 52% across Ottawa neighbourhoods. The percentage of children vulnerable in at least one EDI domain generally increases with decreasing neighbourhood socioeconomic status. Neighbourhoods with a high proportion of children vulnerable in at least one EDI domain include: Carlington (52%), Sandy Hill (51%), Greenboro East (49.5%), Hunt Club East (46%), Bells Corners West (46%), Carleton Heights – Rideauview (44%).

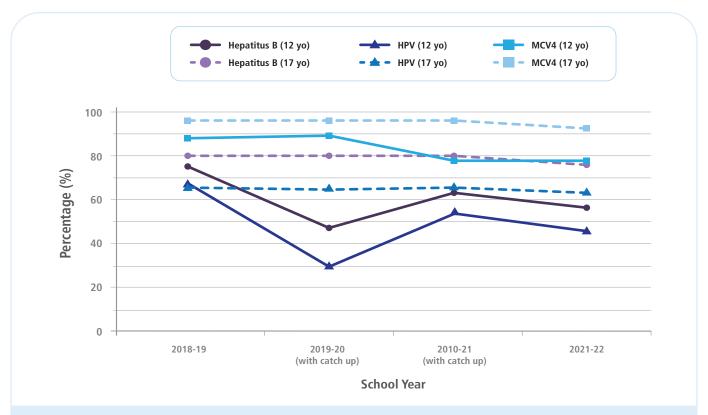


Figure 9. Immunization coverage rates for hepatitis B, HPV, and MCV4, among 12- and 17-year-olds in Ottawa by school year, 2018-19 to 2021-22.

Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Immunization coverage for school-based programs in Ontario: 2019-20, 2020-21 and 2021-2022 school years with impact of catch-up programs. Toronto, ON: King's Printer for Ontario; 2023.

Note: Coverage estimates reflect the proportion of students who completed a series and received all recommended doses for their age by August 31 of the school year. For 2019-20 and 2020-21, estimates include immunizations received up to August 31, 2022, as part of immunization catch-up efforts.

Table 3. Percentage of senior kindergarten (SK) children vulnerable by Early Development Instrument (EDI) domain, in at least 1 EDI domain, and change from cycle 4 to 5 in Ottawa.

EDI Domain	Cycle 4 (2014/15)	Cycle 5 (2017/18)	Change from Previous Cycle
Vulnerable in Physical Health and Well-being	12.6%	13.9%	Increase 🛕
Vulnerable in Social Competence	9.0%	8.6%	No change —
Vulnerable in Emotional Maturity	11.6%	10.9%	No change —
Vulnerable in Language and Cognitive Development	6.6%	7.8%	Increase
Vulnerable in Communication Skills and General Knowledge	9.7%	8.6%	Decrease V
Vulnerable in at Least One EDI Domain	26.1%	27.9%	Increase 🛕

Source: Parent Resource Centre. (2021). EDI by ONS Gen2 C1 to C5 Vuln by Domain (Parent Resource Centre) [Data File Prepared by PRC and Analysed by OPH in February 2023]. PRC.

PHYSICAL ACTIVITY, SEDENTARY BEHAVIOUR AND SLEEP

Physical Activity and Sedentary Behaviour

Regular physical activity is an important component of health. In addition to decreasing stress, and building or maintaining strength, balance, flexibility and coordination for healthy aging, physical activity helps prevent many chronic diseases including cancer, obesity, hypertension, heart disease and type 2 diabetes.

In 2017-2018, 67%⁵³ of Ottawa adults stated that they met the Canadian Physical Activity Guidelines for adults aged 18 to 64 years of having at least 150 minutes of moderate to vigorous-intensity aerobic physical activity per week, in bouts of 10 minutes or more.xi This was higher than the rest of Ontario (55%). Activity levels were higher among males, those under the age of 65, those with an English mother-tongue and those with post-secondary education (Figure 10).

The Canadian 24-Hour Movement Guidelines for Children and Youth recommend that children and youth accumulate at least 60 minutes per day of moderate to vigorous physical activity, defined as activity that causes a person to sweat at least a little or to breathe harder. An "active day" is referred to as a day during which this goal is met.

Children who use physically active forms of transportation such as walking or biking, may accumulate more active days per week compared to those who use motorized transport (inactive transportation). In addition to health benefits, active transportation is beneficial to the environment and to increasing social ties around the community.^{54, 55}

In 2019, 13% of children in Ottawa aged 5 to 11 years used active forms of transportation to travel to school, 12% used a mix of active and inactive transportation and 75% used inactive forms of transportation to get to school. Among youth aged 12 to 17 years, 11%* used active transportation to get to school, 15% used a mix of active and inactive transportation and 74% used inactive forms of transportation.⁵⁶

Twenty-three percent of children in Ottawa aged 5 to 11 years were reported by their parent/caregiver as not having an active day on any day in a previous week; 21% had an active day on one or two days in the past week; 19% were active 3 or 4 days; and 21% were active least 5 days in the past week.⁵⁷

Of Ottawa students in grades 7 to 12 in 2021, 7% reported not having any active day in the previous week; 29% reported having between one and three active days in the past week, 37% were active 5 or 6 days, and 18% were active every day in the past week. These estimates were not different from the rest of Ontario nor from 2019. Male students (22%) were significantly more likely to meet the movement guidelines than were females (15%). 58, 59

Screen Time

In 2021, approximately three quarters (73%) of Ottawa students (grades 7 to 12) reported spending more than two hours per day engaging in recreational screen time (e.g., watching tv, playing video games, texting, surfing the Internet, etc.). This was similar to students from the rest of Ontario (79%) and in 2019 (77%). Students in grade 9 to 12 compared to those in grade 7 and 8 (74% vs. 63%), as well as those with socioeconomic disadvantage compared to those with socioeconomic advantage (84% vs. 72%) were significantly more likely to engage in two or more hours of daily recreational screen time. ^{60, 61}

xi This is one criteria of the Canadian 24-Hour Movement Guidelines, but does not include light physical activity and muscle strengthening activities. https://csepquidelines.ca/quidelines/adults-18-64/



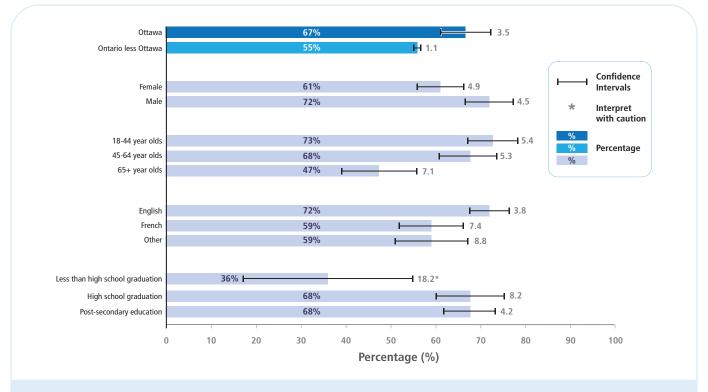


Figure 10. Percent of the population aged 18 years and older that met the Canadian Physical Activities guidelines by subgroup, 2017-2018.

Source: Canadian Community Health Survey 2017-2018, Statistics Canada, Share File, Ontario Ministry of Health

Sleep

Sleep is an integral part of the Canadian 24-Hour Movement Guidelines, which recommend that preschoolers aged 3 to 4 years get between 10 and 13 hours of sleep including naps, children aged 5 to 13 years get between 9 and 11 hours of uninterrupted sleep per night, while youth aged 14 to 17 years should get 8 to 10 hours of sleep per night.

The majority of preschoolers in Ottawa, aged 3 to 4 years (88%) and of school-aged children aged 5 to 11 years (84%), met the recommended sleep guidelines in 2019.⁶² Estimates from 2021 are not reportable. Only half (50%) of Ottawa students in grades 7 to 12 met the recommended sleep guidelines in 2021, which was similar to the rest of Ontario but significantly lower than in Ottawa in

2019 (60%). Students with socioeconomic advantage were significantly more likely to meet the guidelines than those without socioeconomic advantage (47% vs. 29%*).^{63, 64}

CANCER SCREENING

Screening for cancer helps find pre-cancerous changes or cancer may be detected earlier which can help treatments be more successful. In Ottawa in 2020, rates of breast cancer^{xii} and cervical screening^{xiii} participation decreased (Figure 11) and more people were overdue for colorectal cancer screening (Figure 12), xiv most probably due to the COVID-19 pandemic.

xii Percentage of Ontario screen-eligible people, aged 50-74, who completed at least one mammogram within a 30-month period as of December 31, of the report year.

xiii Percentage of Ontario screen-eligible people, 21-69 years old, who completed at least one Pap test in a 42-month period as of December 31, of the report year.

xiv Percentage of Ontario screen-eligible people, 50-74 years old, who were overdue for colorectal screening as of December 31, of the report year

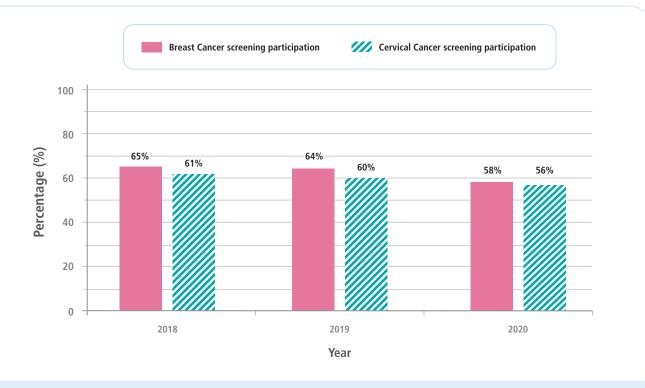


Figure 11. Breast cancer and cervical screening participation as a percent of screen-eligible residents of Ottawa 2018-2020.

Source: Ontario Health (Cancer Care Ontario). Ontario Cancer Profiles [Internet]. 2021 March 30, 2023. Available from: https://cancercareontario.ca/ontariocancerprofiles.

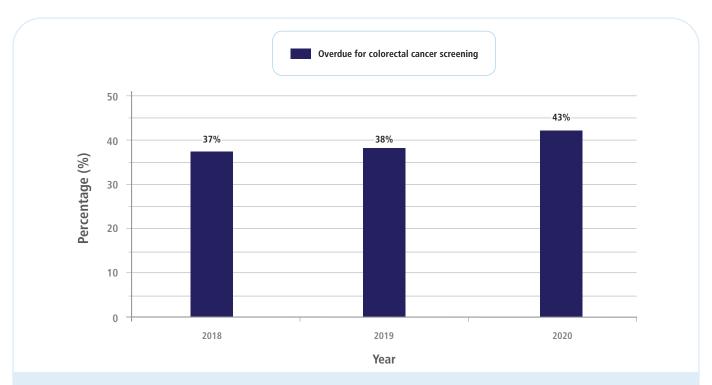


Figure 12. Percent of those screen-eligible people in Ottawa overdue for colorectal cancer screening 2018-2020.

Source: Ontario Health (Cancer Care Ontario). Ontario Cancer Profiles [Internet]. 2021 March 30, 2023. Available from: https://cancercareontario.ca/ontariocancerprofiles.

OVERWEIGHT AND OBESITY

Obesity is a complex health issue with a multitude of causes and contributors that are multifaceted. At a population level, the prevalence of obesity is measured using Body Mass Index (BMI). BMI is a common tool used to classify individuals according to the health risks associated to a weight status to measure the risk of health outcomes in populations. BMI is calculated by dividing body weight by the square root of the person's height.

In Ottawa, 58% of residents aged 18 and older report a height and weight that would classify them as being overweight or obese. This percentage is higher among men and those aged 45 and older (Figure 13). The percent of the population who is classified as overweight or obese has been increasing over the past 15 years, but there has been little change in the past 5 years (Figure 14).

In 2019/2020, over half (54%) of children in Ottawa (ages 5 to 11 years) were reported by their parent/caregiver to have a height and weight that would classify them as not being overweight or obese and at least one-fifth (22%) as being overweight or obese in 2019. A further 24% parents/caregivers of children ages 5 to 11 did not provide enough information to determine their child's BMI.⁶⁶

In 2021, three in five (59%) grade 7 to 12 students reported a healthy weight (BMI = 18.5-24.9), while 14%* were overweight (BMI = 25.0-29.9) and 11%* were obese (BMI \geq 30.0). Just 3%* of students reported a BMI that put them at risk of being underweight (BMI <18.5). These estimates were similar to the rest of Ontario and to 2019. Students of socioeconomic disadvantage were significantly less likely to report being a healthy weight than those of socioeconomic advantage (51% vs. 64%). $^{67, 68}$

Sugar Sweetened Beverages

Consumption of sugar-sweetened beverages (SSBs) such as soft drinks, fruit drinks, sports and energy drinks, and sweetened milks is one of the dietary factors contributing to excess weight, obesity and the onset of chronic disease in both children and adults.⁶⁹

In 2021, 70% of Ottawa students in grades 7 to 12 reported drinking at least one SSB in the past 7 days, which was not different from the rest of Ontario but significantly lower than in 2019 (78%). In addition, 11% of students reported drinking at least one SSB daily, which again was not different to the rest of Ontario or from 2019.^{70, 71}

SUBSTANCE USE HEALTH

Substance use health refers to health associated with the consumption of alcohol, cannabis, opioids or other substances. Improving substance use health reduces the harms associated with substance use which can prevent injury, illness or death. Like physical and mental health, substance use health can fluctuate on a day-to-day basis, as circumstances change. Individuals deal with stressors and challenges differently. Some people may find themselves consuming more substances or experiencing challenges with their substance use during times of increased stress. The context of substance use health has also changed, as evidenced by the worsening opioid crisis and the increased toxicity of the unregulated drug supply due to fentanyl.

Opioids

Although the harms from substances such as opioids are not new; their impact has reached crisis proportions in many countries, including Canada. This section uses emergency department visits, hospitalizations and deaths as a proxy for opioid-related overdoses. However, it is important to note that not all people who experience an overdose seek care or have a fatal outcome; meaning that this data underestimates the true health burden of opioids and the overdose crisis.

The overdose crisis is present in Ottawa; while hospitalization rates for residents of Ottawa have remained relatively unchanged between 2016 and 2021, rates of emergency department visits more than tripled from 25 per 100,000 population (243 visits) in 2016 to 92 per 100,000 population (982 visits) in 2021. Death rates increased similarly from 4 deaths per 100,000 (41 deaths) in 2016 to 14 per 100,000

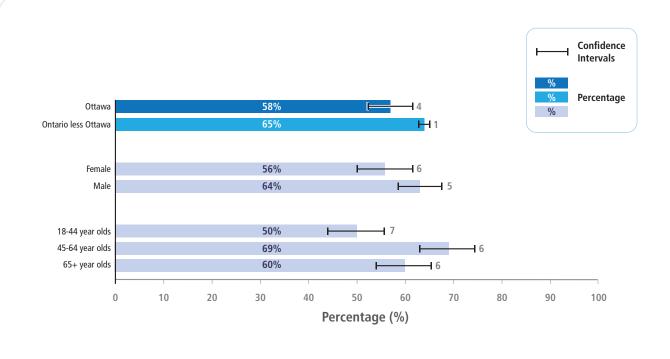


Figure 13. Percent of population aged 18 and older with a BMI estimate of overweight or obese in 2019-2020 by region, sex and age.

Source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health

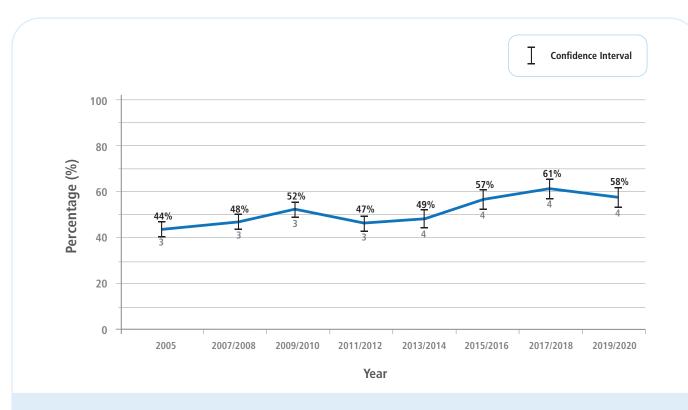


Figure 14. Percent of the adult population aged 18 and older who are classified as overweight or obese. 2005 to 2019/2020. Source: Canadian Community Health Survey 2005-2019/2020, Statistics Canada, Share File, Ontario Ministry of Health

(148 deaths) in 2021. Preliminary data from 2022 (Q1-Q2) indicate that opioid-related morbidity and mortality remain higher than what was observed pre-pandemic (Figure 15)⁷²

Rates of opioid-related emergency department (ED) visits in Ottawa from 2003 until 2016 were similar for males and females but increased markedly among males after 2017. Rates of opioid-related deaths were higher in males, with more than twice the rate of deaths compared to females in 2021. Hospitalization rates have fluctuated over time (2003-2021) ranging from 3.2 per 100,000 to 12.8 per 100,000 and averaged higher in females. However, the average hospitalization rate since 2016 has been highest for males.

Across age groups, from 2003 to 2021, opioid-related mortality rates were highest among residents of Ottawa aged 25 to 44 and 45 to 65 years. Hospitalization rates in 2020 and 2021 have also been highest among those aged 25 to 44 years old. Prior to the pandemic, rates had been highest among those 65 years and older. Rates for ED visits by age have fluctuated over time but were highest among younger residents (15 to 24 and 25 to 44 years old) from 2014 to 2021.

The impact of the pandemic on opioids has been seen in Ottawa. Supervised consumption and treatment services treated more than twice as many non-fatal overdoses in 2021 compared to 2020 (1707 vs. 505).⁷³ Needle and syringe program sites also had more than five times as many visits for harm reduction supplies and/or services in 2021 compared to 2017 (147,144 vs. 29,441).⁷⁴

In Ottawa, the most common type of opioid found at death continues to be fentanyl in 83% of deaths and deaths were predominately accidental in nature. ⁷⁵ This is not different than what is seen in Ontario. In Ottawa, 72% of opioid overdose deaths from January 2018 to June of 2021 involved a stimulant like cocaine as a direct contributor to the death. ⁷⁶

Alcohol

In 2022, new <u>alcohol use risk guidelines</u> were developed by the Canadian Centre on Substance Use and Addiction.⁷⁷ These guidelines changed to a continuum of risk (no/low, moderate and high) rather than the 2011 guideline which was a threshold of exceeding or not exceeding the guidelines. The 2022 guidelines attribute no or low risk to two drinks or less per week, moderate risk to more than two to six drinks per week and high risk to more than six drinks per week.

Using the new threshold, an estimated 69% of the population aged 19 and older in Ottawa are at no or low risk of alcohol related harms, 15% are at moderate risk and 16% are at high risk. 78 Figure 16 shows the percent of the population aged 19 and older in Ottawa who are at no or low risk. Those most likely to be at no or low risk include females, those with neither French or English as a mother tongue, those in lowest income, those with less than a high school education, and those from racialized communities (Figure 17).

Binge drinking, defined as more than 5 drinks on one occasion for males or more than 4 on one occasion for females, has health and safety risks including alcohol poisoning, risk of injury or violence, unplanned sex, worsening of mental health conditions, and suicide. ⁷⁹ This is in addition to the risk to physical and substance use health. An estimated 35% of people living in Ottawa aged 12 and older said they engaged in binge drinking at least once in the past year and 15% said they binge drank at least once a month in the past year. Further, 5% said they engaged in binge drinking 2 to 3 times per month, with an additional 4%* stating they did so once a week or more. ⁸⁰

In Ottawa, 5% of drivers said they had operated a motor vehicle within 2 hours of ingesting alcohol and 5% of those aged 12 and older said they were a passenger in a vehicle where the operator had consumed alcohol in the past 2 hours.⁸¹

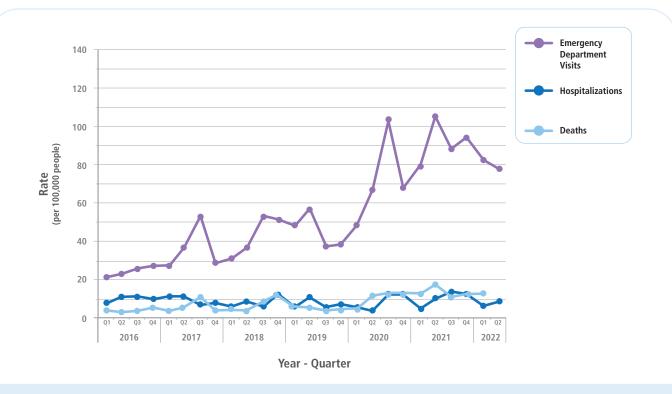


Figure 15. Opioid-related Morbidity and Mortality Rates in Ottawa by Year and Quarter, 2017 to 2022.

Source: PHO Interactive Opioid Tool, data extracted March 9, 2023

Note: Rates by quarter are adjusted to an annual rate to allow comparison between different time periods. Death data for 2021 and 2022 are preliminary and subject to change.

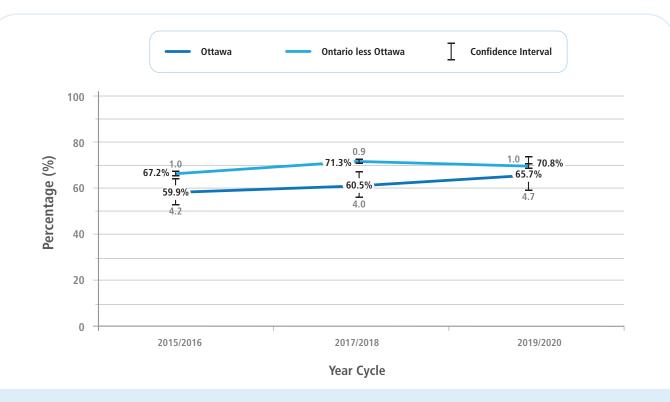


Figure 16. Percent of population aged 19 and older who are at low or no risk from alcohol related harms in Ottawa and Ontario-less-Ottawa by year, 2015-2020.

Source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health

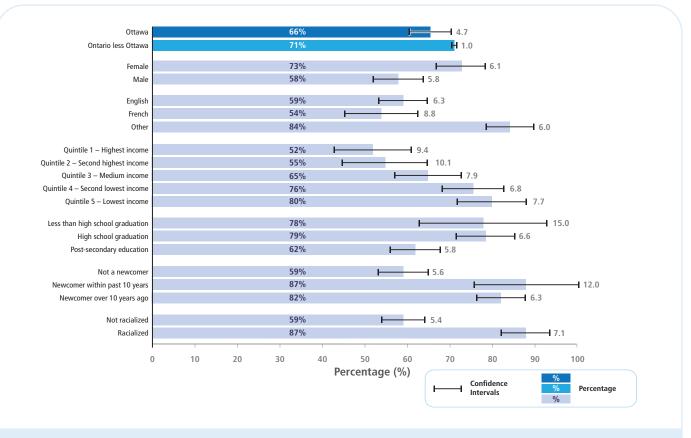


Figure 17. Percent of population aged 19 years and older who are at low or no risk from alcohol by subgroup, 2019-2020. Source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health

Cannabis

In October of 2018, cannabis became legal to consume and possess for Canadians of legal age. In 2019/2020, an estimated 22% of people living in Ottawa aged 19 and older used cannabis more than once in the past year. This is not different than the estimate for the rest of Ontario (21%). In Ottawa, such use is higher among males, people aged 19 to 44, people with English as a mother tongue and people who are not immigrants (Figure 18). In terms of frequency of use, 7% of residents of Ottawa used cannabis more than once per week. Of those who have used cannabis in the past 12 months, an estimated 7% were considered "dependent" using the Severity of Dependence Scale for cannabis. This is not different compared to the rest of Ontario.

Smoking

In 2019/2020, 9% of Ottawa residents aged 19 and older identified as a current smoker,^{xv} either smoking daily or occasionally, down from 15% in 2017/2018.⁸³ ⁸⁴ This continues the decreasing trend in smoking over time and is significantly less than the estimate of 13% for Ontario-less-Ottawa (Figure 19). Smoking rates tend to be higher in males, those living alone, those with lowest educational achievement, those living in low income, and people who are renters versus owners (Figure 20).

Daily smoking continued to decrease in 2019/2020 with an estimated 7% of people living in Ottawa reporting they were daily smokers, lower than 10% in the rest of Ontario (Figure 21). These rates have declined consistently since 2013/2014 in Ottawa. Daily smoking rates are highest among males, those living in lowest income, those living alone and those who are renting (Figure 22).

People who have smoked less than 100 cigarettes in their lifetime are excluded.

ΧV

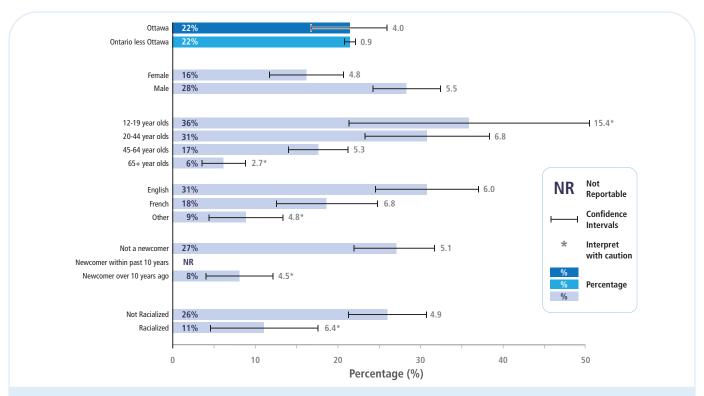


Figure 18. Percent of population aged 19 years and older who have used cannabis more than once in the past year by subgroup, 2019-2020.

Source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health NR: Not reportable due to high sampling variability

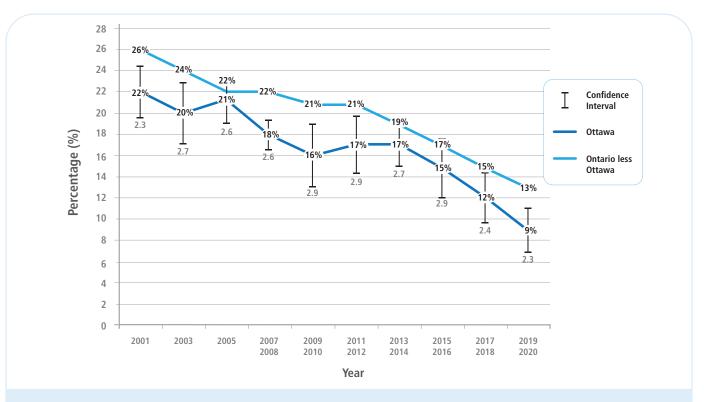


Figure 19. Percent of the population aged 19 and older who reported currently smoking by year, 2001-2020.

Source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health

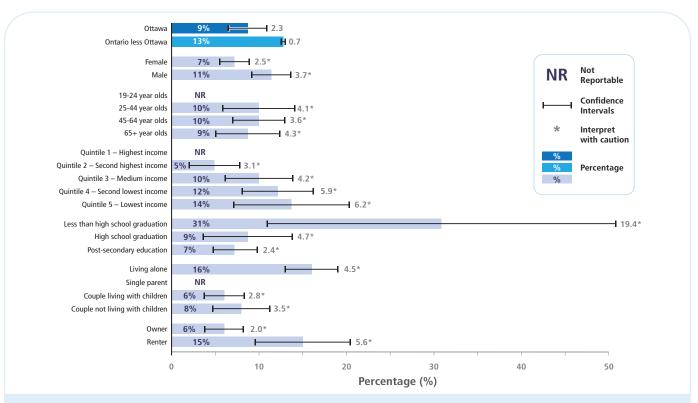


Figure 20. Percent of the population aged 19 and older who reported currently smoking by subgroup, 2019-2020.

Source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health NR: Not reportable due to high sampling variability

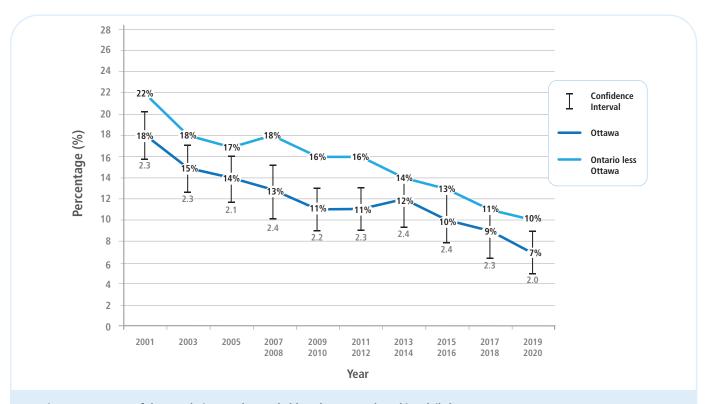


Figure 21. Percent of the population aged 19 and older who reported smoking daily by year, 2001-2020.

Source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health

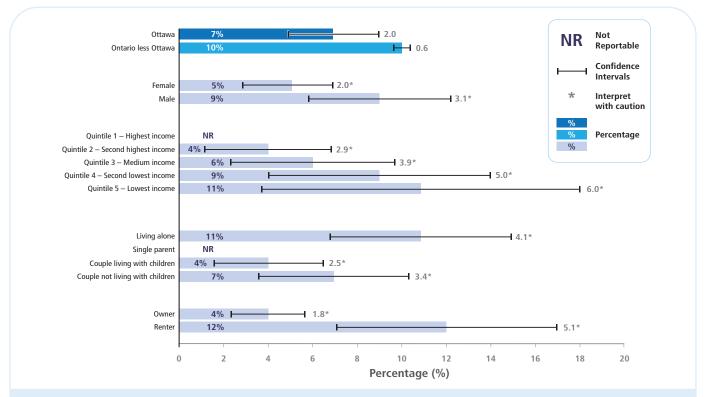


Figure 22. Daily smoking rates among those aged 19 and older, by subgroup, by subgroup, 2019-2020.

Source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health NR: Not reportable due to high sampling variability

Despite the promise of reduced rates of smoking from these estimates, the effects of tobacco use continue to result in an important health burden. There are an estimated 1,004 deaths, 3,573 hospitalizations and 6,234 emergency department visits in residents of Ottawa residents annually due to tobacco use in those aged 35 and older.⁸⁵

Substance Use Among StudentsPast Year Substance Use

In 2021, past year use of alcohol (32%), cannabis (15%), opioids (non-medical) (10%), vapes/e-cigarettes (9%*) and tobacco cigarettes (3%*) by Ottawa students in grades 7 to 12 was similar both to the rest of Ontario, as well as to 2019, with the exception of vape/e-cigarette use which was significantly lower for Ottawa students relative to those in the rest of Ontario (16%) (Figure 23).^{86, 87}

Overall, use of these substances in the past year was significantly higher among grade 9 to 12 students compared to those in grades 7 and 8; except for non-medical opioid use, which was reported equally between these grade categories. Other subgroups also showed significant differences in substance use, for example, the use of vapes/e-cigarettes was higher among males (12%) compared to females (7%), and both alcohol and vape/e-cigarette use was reported by more students who identified as non-racialized (37% and 11%,* respectively) compared to people who identified as racialized (18% vs. 5%*).

In 2021, only 6%* of Ottawa students in grades 9 to 12 reported binge drinking^{xvi} in the past month, which was a significant decrease compared to 2019 (19%*). However, this difference may likely be a result of restrictions to social gatherings due to the COVID-19 pandemic throughout much of 2021.

ii Binge drinking is defined as consuming 4+ drinks on one occasion for females or 5+ drinks on one occasion for males.

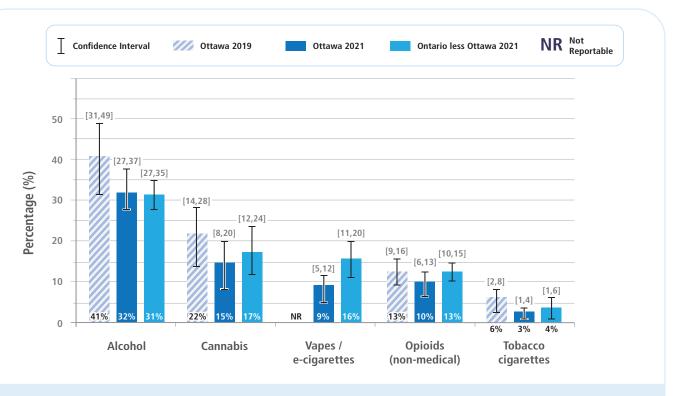


Figure 23. Percentage of students in grades 7 to 12 who reported using substances in the past year in Ottawa, 2019 and 2021, and Ontario-less-Ottawa, 2021.

Sources: Ottawa Public Health. Public Health Monitoring of Risk Factors in Ontario – Ontario Student Drug Use and Health Survey (2021), Centre for Addiction and Mental Health; Ottawa Public Health. Public Health Monitoring of Risk Factors in Ontario –Ontario Student Drug Use and Health Survey (2019), Centre for Addiction and Mental Health.

For further details on substance use health among Ottawa students, please see OPH's OSDUHS 2021 report.88

Perceived Availability of Substances

Perceived availability of substances in 2021, were relatively unchanged from 2019 and not different from students in the rest of Ontario. About half (52%) of students in grades 7 to 12 reported that it would be fairly or very easy to obtain a vaping device if they wanted one (Figure 24).^{89, 90}

Impaired Driving

In 2021, 7% of Ottawa students in grades 7 to 12 reported that in the past year they had been a passenger in a vehicle driven by someone who had consumed alcohol, which was a significant decrease from 2019 (21%). About one in 10 (12%) of students reported they had been a passenger with someone who had consumed drugs (excluding alcohol) in 2019 (estimate not reportable for 2021). 91, 92

Estimates for the proportion of Ottawa students who drove a vehicle within an hour of consuming either alcohol or cannabis were not reportable for 2021 or 2019. In 2019, 2% and 3% of Ontario students reported driving after consuming alcohol and cannabis, respectively.

Alcohol, Smoking and Cannabis Use During Pregnancy

One in forty (2.5%, 242) residents of Ottawa who gave birth in 2021 reported drinking alcohol during their pregnancy, representing a small decline in consumption compared to recent years (e.g., 4.6% in 2014; 4.6% in 2017; 3.7% in 2019).⁹³

Approximately one in thirty (3.5%, 329) residents of Ottawa women who gave birth in 2018 reported smoking close to the time of their child's birth.⁹⁴

Approximately one in forty (2.7%, 260) residents of Ottawa women who gave birth in 2021 reported exposure to cannabis (e.g., consuming and/or smoking cannabis) during their pregnancy.⁹⁵

Stigma

Stigma is defined as a set of negative beliefs and prejudices about a group of people, as well as negative behaviors towards groups of people. Many people face stigma because of their race, religion, gender, sexuality, economic situation, and a variety of other factors including their substance use health or mental health. ⁹⁶ Unfortunately, stigma is one of the biggest barriers preventing people experiencing challenges with mental health, addictions and substance use health from seeking and receiving appropriate health care and support.

In November 2021, the results of an OPH survey to gain a better understanding of the stigma that exists in the community around mental health and substance use health indicated that 90% or more of residents understood that mental health conditions and substance use health conditions can affect anyone, and that people living with these conditions need the right treatment and support and are deserving of health care. 97 However, there were some indications that stigma continues to be a barrier. For example, less than half (46%) of residents reported they would hire someone with a substance use disorder, and one in six (17%) reported they would not feel comfortable working with someone with a substance use disorder. For more detailed results, please see the Status of Mental Health, Addictions, and Substance Use Health in Ottawa During the COVID-19 Pandemic, Fall of 2021 report.

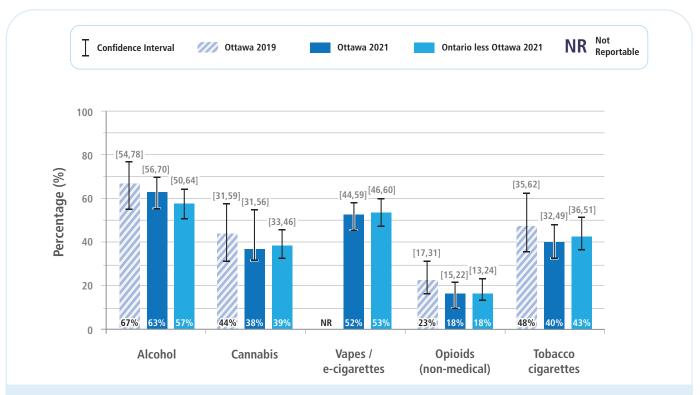


Figure 24. Percentage of students in grades 7 to 12 who reported that it would be fairly or very easy to obtain substances in Ottawa, 2019 and 2021, and Ontario-less-Ottawa, 2021.

Sources: Ottawa Public Health. Public Health Monitoring of Risk Factors in Ontario – Ontario Student Drug Use and Health Survey (2021), Centre for Addiction and Mental Health; Ottawa Public Health. Public Health Monitoring of Risk Factors in Ontario –Ontario Student Drug Use and Health Survey (2019), Centre for Addiction and Mental Health.

*Notes: Interpret with caution, high sampling variability; Data not available for 2019 as question was not asked.

Chapter 3

What is the health status of residents of Ottawa?



This section of the report highlights the different measures available including measures of general health, and mental health, leading causes of emergency department visits and hospitalizations and provides a summary of infectious diseases in Ottawa.

PERCEIVED HEALTH

Approximately 65% of Ottawa residents aged 12 and older rated their general health as very good to excellent, similarly to the rest of Ontario. ⁹⁸ An estimated 9% or (78,000 people) rate their health as fair to poor. Self-rated general health tends to be lower among those aged 65 and older, those living alone, and those living in the lowest income quintile (Figure 25).

In 2019, 93% of parents/caregivers of children aged 2 to 5 years living in Ottawa reported their child's health as excellent or very good and 93% of parents/caregivers of children aged 5 to 11 yearsreported their child's health as excellent or very good.⁹⁹

In 2021, less than half (48%) of Ottawa students in grades 7 to 12 reported their physical health as very good or excellent; this was similar to the rest of Ontario, but significantly lower than in 2019 (61%) prior to the pandemic. 100, 101

CHRONIC CONDITIONS

Self-reported chronic conditions for people in Ottawa aged 18 and older and aged 65 and older are shown in Table 4. Chronic disease prevalence tends to be higher in those aged 65 and older, which is not surprising, however for both age groups, arthritis and high blood pressure are the most prevalent chronic condition. Of note, anxiety and mood disorders are reported at similar proportions as asthma or diabetes in those aged 18 and older.

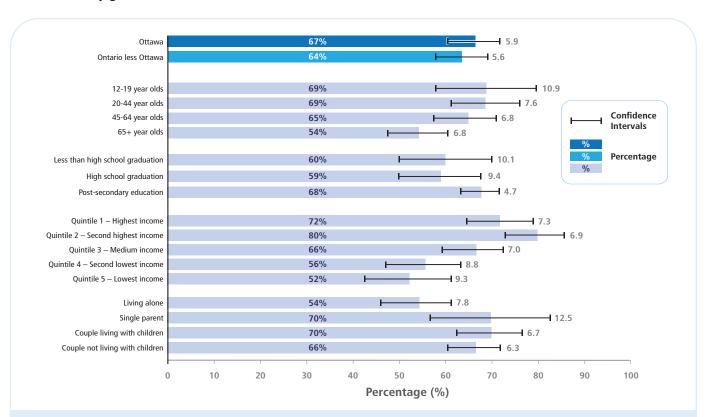


Figure 25. Percent of Ottawa residents aged 12 years and older who rated their general health as very good or excellent, 2019-2020..

Source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health.

Table 4. Percent and count of Ottawa residents self-reporting chronic condition by adult age group, 2019-2020. Estimates are rounded to the nearest percent or 100 people.

Chronic Condition	Percent Aged 18 and older	Count aged 18 and older	Percent Aged 65 and older	Count aged 65 and older
Arthritis	16%	135,300	43%	67,900
High blood pressure	16%	135,200	41%	65,500
Anxiety disorders	10%	84,000	*8%	*12,100
Mood disorders	10%	80,900	*6%	*8,700
Asthma	8%	62,800	*8%	*12,000
Diabetes	6%	51,700	16%	25,400
Heart disease	5%	43,900	20%	31,500
COPD	*2%	*16,200	*6%	*8,900
Cancer	*2%	*14,400	*5%	*7,700
Stroke	*1%	*8,200	*4%	*6,700

Source: source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health

Cancer Incidence

Table 5 presents a summary of the leading types of cancer in Ottawa in 2018, including counts of diagnoses of cancer by cancer type, sex, and comparison to Ontario-less-Ottawa. Cancer rates estimates are adjusted for differences in age structure between Ottawa and the rest of Ontario. The incidence rate due to all cancers combined was similar in Ottawa compared to the rest of Ontario (499.5 per 100,000 vs. 506.4 per 100,000). The top five cancers with the highest incidence rates in Ottawa were prostate, breast, lung, colorectal, and uterine cancer.

Incidence of melanoma was significantly higher in Ottawa compared to the rest of Ontario (27.1 per 100,000 vs. 22.7 per 100,000). Incidence was significantly lower in Ottawa compared to the rest of Ontario for cancers of the thyroid (14.7 per 100,000 vs. 21.7 per 100,000) and kidney (12.5 per 100,000 vs. 16.4 per 100,000).

Cancer Mortality

Table 6 presents a summary of the leading cancer deaths in Ottawa in 2018, including counts of deaths by cancer type, sex and comparison to Ontario-less-Ottawa. The cancer mortality rates are adjusted for differences in age structure

between Ottawa and the rest of Ontario. The mortality rate from all cancers combined was similar in Ottawa compared to Ontario-less-Ottawa in 2018 (180 per 100,000 vs. 185.4 per 100,000). The most common cancer deaths were attributable to lung, colorectal, breast, pancreatic, and prostate cancer.

Mortality rates for breast cancer were significantly higher in Ottawa compared to the rest of Ontario (16.0 per 100,000 vs. 12.6 per 100,000).

LEADING CAUSES OF EMERGENCY DEPART-MENT VISITS

In 2021, Ottawa residents made 327,086 visits to the emergency department (ED). ¹⁰² The top ten leading causes of these visits are shown in Figure 26. Injuries (e.g., falls, self-harm, collisions, overdose and poisoning, burns, cuts, overexertion) were the leading cause of ED visits in all age groups.

^{*}Note: Interpret with caution due to high sampling variability.

Table 5. Summary of leading cancer diagnoses in Ottawa, 2018.

Cancer type	Ottawa males (count)	Ottawa females (count	Ottawa age- standardized rate	Ottawa 95% confidence interval	Ontario-less- Ottawa age- standardized rate	Ontario-less- Ottawa 95% confidence interval
All cancers, combined	2591	2570	499.5	485.9, 513.4	506.4	502.8, 510.1
Prostate*	659	NA	134.0	123.9, 144.7	124.9	122.2, 127.6
Breast**	NA	714	133.5	123.8, 143.8	130.8	128.2, 133.5
Lung	306	334	60.6	56.0, 65.5	32.1	60.9, 63.4
Colorectal	276	246	51.0	46.7, 55.6	51.9	50.8, 53.1
Body of uterus**	NA	193	36.1	31.1, 41.6	36.5	35.1, 37.9
Melanoma	161	116	§27.1	24.0, 30.5	22.7	21.9, 23.5
Non-Hodgkin lymphoma	148	114	25.1	22.1, 28.3	26.7	25.9, 27.6
Ovary**	NA	90	16.7	13.4, 20.6	15.7	14.8, 16.6
Leukemia	83	73	15.2	12.9, 17.8	15.5	14.9, 16.2
Thyroid	54	94	§14.7	12.4, 17.3	21.7	20.9, 22.5
Oral cavity	102	47	14.7	12.4, 17.2	13.5	12.9, 14.1
Pancreas	77	75	14.5	12.2, 17.0	12.6	12.1, 13.2
Bladder	109	37	13.9	11.7, 16.4	13.2	12.7, 13.8
Kidney	82	46	§12.5	10.5, 14.9	16.4	15.8, 17.1

Source: Ontario Cancer Registry SEER*Stat Package - Release 12 - OCR (Mar. 2021). Pop Est Summary [Ministry of Health and Long-Term Care: IntelliHEALTH ONTARIO, extracted March 2012 (1986-2000); Statistics Canada. Table 17-10-0086-01 Estimates of population (2011 Census and administrative data), by age group and sex for July 1st, Canada, provinces, territories, health regions (2017 boundaries) and peer groups, inactive (2001-2005); Statistics Canada. Table 17-10-0134-01 Estimates of population (2016 Census and administrative data), by age group and sex for July 1st, Canada, provinces, territories, health regions (2018 boundaries) and peer groups (2006-2018).]

Notes: * Includes males only. ** Includes females only. § Statistically significantly different from the Ontario-less-Ottawa rate at a 95% confidence interval. NA = not applicable. Rates are per 100,000 population.

Table 6. Summary of leading cancer deaths in Ottawa, 2018.

Cancer type	Ottawa males (count)	Ottawa females (count	Ottawa age- standardized rate	Ottawa 95% confidence interval	Ontario-less- Ottawa age- standardized rate	Ontario-less- Ottawa 95% confidence interval
All cancers, combined	980	905	180.0	171.9, 188.3	185.4	183.2, 187.6
Lung	226	202	40.6	36.8, 44.6	43.3	42.2, 44.4
Colorectal	113	87	19.2	16.7, 22.1	19.6	18.9, 20.3
Breast**	NA	165	§16.0	13.7, 18.7	12.6	12.1, 13.2
Pancreas	72	56	12.2	10.2, 14.6	11.7	11.2, 12.3
Prostate*	100	NA	9.4	7.6, 11.4	10.1	9.6, 10.6
Miscellaneous malignant	36	46	7.7	6.1, 9.6	9.9	9.4, 10.4
Non-Hodgkin lymphoma	49	23	6.8	5.3, 8.6	7.1	6.7, 7.5
Leukemia	31	28	5.6	4.3, 7.2	6.8	6.4, 7.2
Brain	33	23	5.4	4.1, 7.0	5.4	5.1, 5.8
Oral cavity	32	16	4.7	3.5, 6.3	3.9	3.6, 4.2
Bladder	29	21	4.7	3.5, 6.2	5.3	4.9, 5.6
Myeloma	27	18	4.3	3.2, 5.8	3.6	3.3, 3.9
Liver	36	8	4.2	3.0, 5.6	4.2	3.9, 4.6
Ovary**	NA	42	4.1	2.9, 5.5	4.3	4.0, 4.6
Body of uterus**	NA	37	3.5	2.5, 4.9	3.0	2.8, 3.3

Source: Ontario Cancer Registry SEER*Stat Package - Release 12 - OCR (Mar. 2021). Pop Est Summary [Ministry of Health and Long-Term Care: IntelliHEALTH ONTARIO, extracted March 2012 (1986-2000); Statistics Canada. Table 17-10-0086-01 Estimates of population (2011 Census and administrative data), by age group and sex for July 1st, Canada, provinces, territories, health regions (2017 boundaries) and peer groups, inactive (2001-2005); Statistics Canada. Table 17-10-0134-01 Estimates of population (2016 Census and administrative data), by age group and sex for July 1st, Canada, provinces, territories, health regions (2018 boundaries) and peer groups (2006-2018).]

Notes: * Includes males only. ** Includes females only. § Statistically significantly different from the Ontario-less-Ottawa rate at a 95% confidence interval. NA = not applicable. Rates are per 100,000 population.

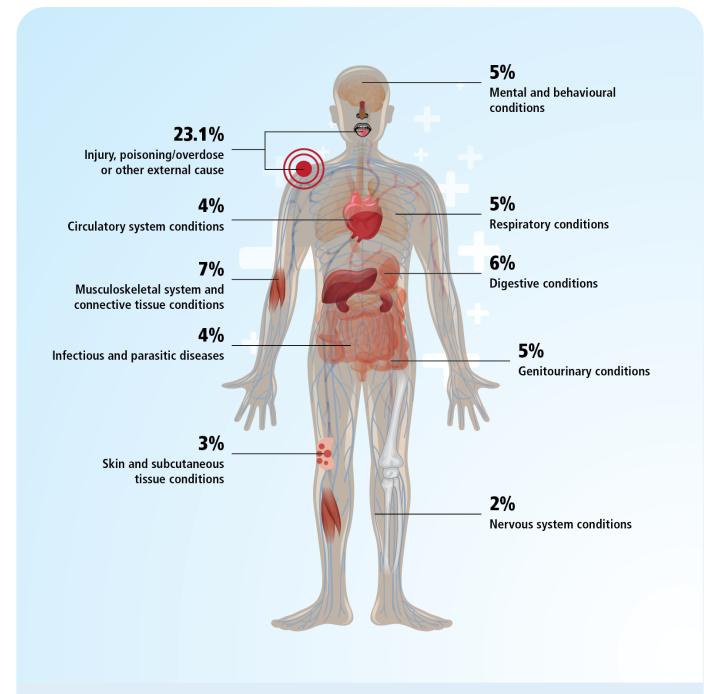


Figure 26. Top ten leading causes of emergency department (ED) visits by Ottawa residents, 2021.

Sources: Ottawa Public Health. Emergency Department Visits. National Ambulatory Care Reporting System 2021. Ontario Ministry of Health, IntelliHEALTH Ontario. Extracted December 16, 2022.

LEADING CAUSES OF HOSPITALIZATIONS

Leading causes of hospitalizations are from diseases of the circulatory system such as hypertension, heart disease or stroke; endocrine, nutritional, and metabolic disease such as diabetes; genitourinary disease such as renal failure or pelvic inflammatory disease; digestive system disease such as noninfecitive enteritis or appendicitis and injuries. While these conditions are leading causes of disease regardless of socioeconomic advantage, the rates of hospitalization vary. Neighbourhoods with the lowest socioeconomic advantage have the highest rates of hospitalization for all five causes when compared to the most advantaged neighbourhoods (Figure 27).

LEADING CAUSES OF DEATHS

At the time this report was prepared, data on deaths beyond 2015 was not available. Information beyond what is already published on the OPH website is not currently available. More recent mortality data will be analysed and published at a future date. For more information about deaths in Ottawa, please refer to the Morbidity, Mortality, and Quality of Life — Ottawa Public Health section of the Ottawa Public Health website.

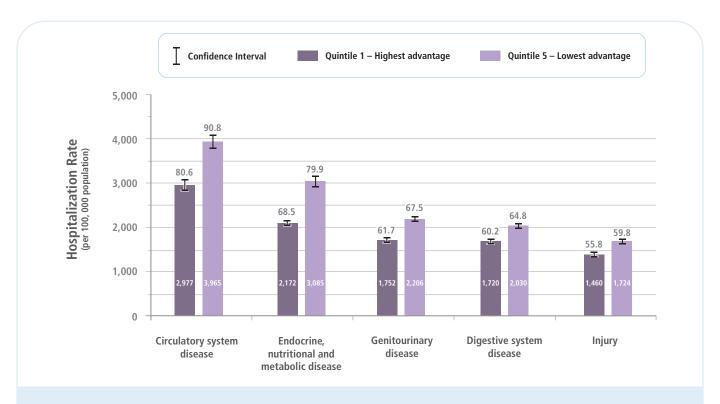


Figure 27. Age standardized hospitalization rates by cause and Ottawa Neighbourhood Study socioeconomic quintiles 1 and 5, 2021

Source: Unscheduled hospitalizations, Discharge Abstract Database (2021). IntelliHealth Ontario, Ontario Ministry of Health. Extracted Dec 2022

LEADING CAUSES OF INJURIES

Injuries are the leading cause of emergency department (ED) visits and are among the leading cause of hospitalizations for residents of Ottawa. Figure 28 shows the causes of injury by percent of injury-related ED visits and hospitalizations as a percent of injuries in 2021.¹⁰⁴ Only causes that represent 5% or more of either ED visits or hospitalizations are shown. Falls contributed most to the burden of injury for both injury-related ED visits (39%) and hospitalizations (70%). Sport and recreation injuries contributed the second highest burden of injury-related ED visits (12%) and self-harm contributing the second highest burden of injury-related hospitalizations (13%). This is similar to patterns seen in previous reports.

Across the lifespan, falls were the leading cause of injury-related ED visits. For those aged under 25 years, sport and recreation related injuries were the second highest contributor. Among those aged 25 to 64, cuts were the second most common, and for those 65 and older, being struck against or by something was second most common reason for injury-related ED visits.

Falls were the leading cause of injury-related hospitalizations in all age groups except in those aged 15 to 44 where self-harm is the leading cause. Both leading cause and second most common cause of hospitalization by age group is shown in Table 7. These rankings are similar to those reported in previous health status reports.

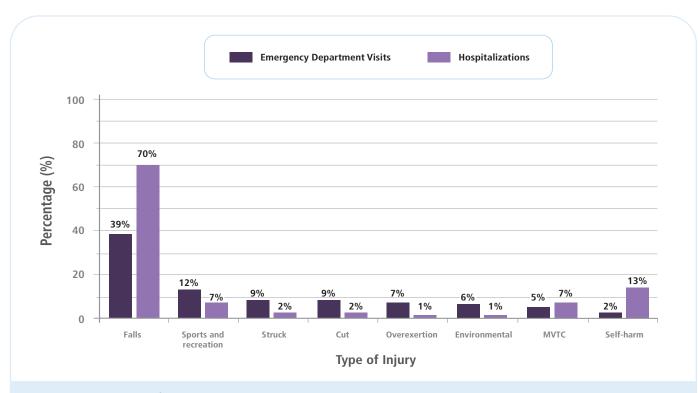


Figure 28. Percentage of injury related emergency department visit and hospitalizations by cause in Ottawa, 2021.

Source: External cause. National Ambulatory Care Reporting System 2021, IntelliHEALTH ONTARIO, Ontario Ministry of Health. Date Extracted: March 2023.

Notes: MVTC = Motor vehicle traffic collision. Data is filtered by patient disposition to create estimates of hospitalization resulting from injuries. Categories are not mutually exclusive.

Table 7. Leading cause of hospitalization among resident of Ottawa by age group 2021.

	Less than 15 years	15 to 24 years	25 to 44 years	45 to 64 years	65 years and older
Leading cause of hospitalizations	Falls	Self-harm	Self-harm and falls	Falls	Falls
Second most common cause of hospitalizations	Sport injuries	Motor vehicle traffic collisions	Motor vehicle traffic collisions	Self-harm	Suffocation or choking

Source: External cause. National Ambulatory Care Reporting System 2021, IntelliHEALTH ONTARIO, Ontario Ministry of Health. Date Extracted: March 2023.

Notes: Data is filtered by patient disposition to create estimates of hospitalization resulting from injuries.

MENTAL HEALTH

Mental health is the ability to feel, think and act in ways that help us enjoy life and cope with challenges. As life experiences and circumstances change, so can moods, thoughts, and sense of well-being, both positive and negative.

Mental Health in the Community

Sixty percent of residents of Ottawa aged 12 and older rated their mental health as very good or excellent in 2019/2020, an approximate 8 to 10% decrease from previous years. ¹⁰⁵ An estimated 12% (100,600 people) rated their mental health as fair to poor. Self-rated mental health tends to be lowest among females, those aged 20 to 44, those in the lowest two income quintiles, those living in an urban setting, renters and those living alone (Figure 29).

The COVID-19 pandemic has had a significant and negative impact on mental health, disruption of social networks, decreasing access to much-needed services or support as well as the effects of worry or fear associated with the pandemic. To assess the impact of the pandemic on mental health, OPH undertook a series of population surveys in June and October 2020, and November 2021. ¹⁰⁶ ¹⁰⁷ ¹⁰⁸ In June and October of 2020, only 28% of Ottawa residents rated their mental health as excellent or very good. While this improved to 43% in November of 2021, it is still well below the 2019/2020 population estimate of 60%. This latter estimate would include data

from prior to the pandemic. During the pandemic, people living in Ottawa who tended to fair worse with regards to their mental health included people with disabilities, young adults, people who identify as racialized, those with lower household income and people who identify as 2SLGBTQQIA+. About a quarter (24%) of people living in Ottawa also reported that in the past two weeks they wanted to reach out for mental health support but did not know where to turn (Figure 30) highlighting an ongoing need for mental health resource promotion exists.

Mental Health Among Students

Ottawa students in grades 7 to 12 reported significantly poorer mental health and emotional wellness in 2021 compared to 2019 (pre-pandemic)^{109, 110} (see the OSDUHS 2021 report for detailed results). Almost half (44%) of students reported fair or poor mental health, 42% reported wanting to talk to someone in the past year but not knowing where to turn, and 33% reported that their ability to handle an unexpected crisis or difficult family or friend problem was fair or poor (Figure 31). Further, 16%* of Ottawa students reported seriously considering suicide in the past year (not different from the rest of Ontario or from 2019). In particular, high school students (grades 9 to 12), students of socioeconomic disadvantage, or those identifying as 2SLGBTQQIA+ reported poorer mental and emotional well-being compared to their counterparts. 111

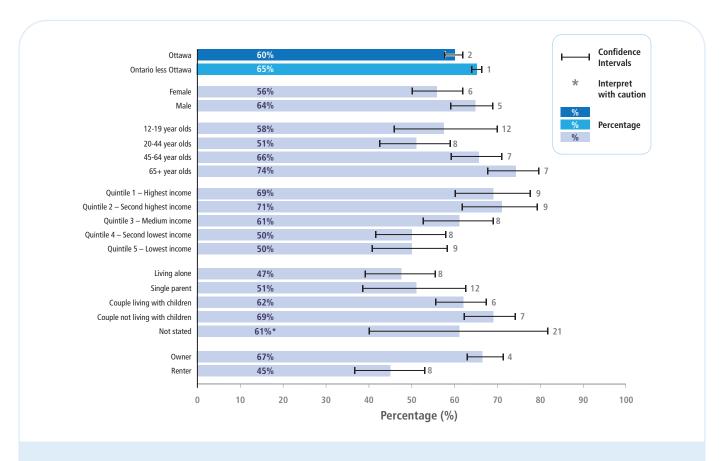


Figure 29. Self-rated mental health among Ottawa residents aged 12 years and older by subgroup, 2019-2020.

Source: Canadian Community Health Survey 2019-2020, Statistics Canada, Share File, Ontario Ministry of Health.

* Note: Interpret with caution due to high sampling variability.

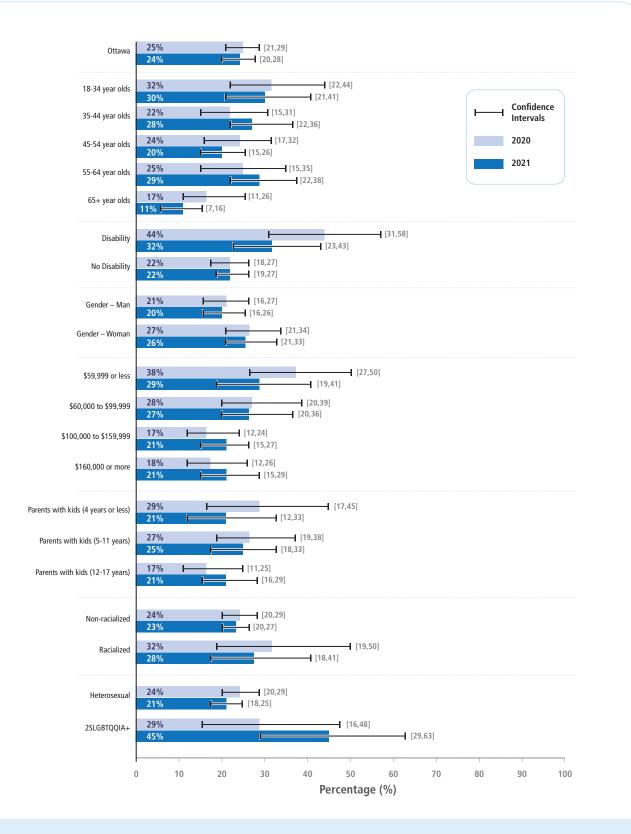


Figure 30. Percentage of Ottawa residents (18+ years) who wanted to reach out for mental health support but did not know where to turn.

Source: Ottawa Public Health. Impact of COVID-19 online survey of Ottawa adults. June, October 2020, November 2021, 2020, 2021.

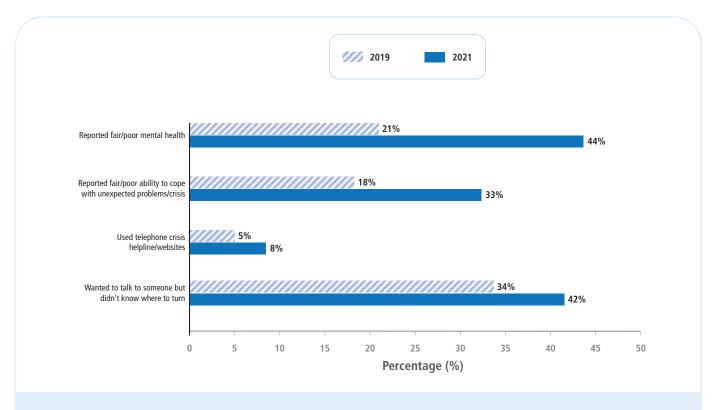


Figure 31. Percentage of Ottawa students in grades 7 to 12 reporting mental health and emotional well-being, in 2021 compared to 2019.

Source: Better Outcomes Registry & Network (BORN) Ontario, 2013-2022. Extracted March 13, 2023.

Mental Health Among Pregnant Individuals

During pregnancy or after childbirth, some parents develop mental health concerns such as anxiety and depression, and these conditions can cause additional challenges for parents and their families. Among Ottawa residents who gave birth in 2022, close to a quarter (23%) reported a mental health concern during their pregnancy, up from 14% in 2014, and increasing year over year (Figure 32).¹¹²

XVII

INFECTIOUS DISEASES

The Ontario Health Protection and Promotion Act^{xvii} requires that certain diseases of public health significance be reported when they are diagnosed, to help public health officials identify disease trends, and track and manage disease outbreaks.

These communicable diseases are generally underreported. This can be due to people being diagnosed based on symptoms rather than a laboratory test. People may not be severely ill and, as a result, do not seek testing or health care or that the disease agent can't be detected in the laboratory specimen.

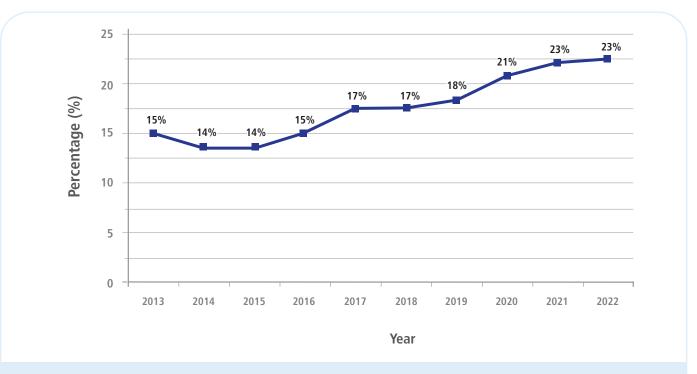


Figure 32. Percentage of Ottawa residents with a mental health concern during their pregnancy, 2013 to 2022. Source: Better Outcomes Registry & Network (BORN) Ontario, 2013-2022. Extracted March 13, 2023.

Reportable infectious diseases in Ottawa are organized into five major groups: 1) direct contact and respiratory infections including tuberculosis, 2) sexually transmitted and blood-borne infections, 3) vaccine preventable diseases, 4) enteric, food and water-borne infections and 5) vector-borne and other zoonotic infections.

Direct Contact and Respiratory Infections, Including Tuberculosis

Respiratory infections and diseases transmitted by direct contact are spread from person to person through droplets in the air (e.g., from a person coughing or sneezing) or through direct contact with an infected person. The epidemiology and symptoms of each disease vary depending on the infectious agent.

Ontario has an annual universal influenza immunization program to offer vaccination against seasonal influenza.

In addition, vaccines against common serogroups of invasive meningococcal disease, invasive Streptococcus pneumoniae and Haemophilis influenza are part of the publicly funded immunization schedule.

Overall Trends

There was a decrease in incidence of some direct contact and respiratory diseases reported to OPH during the COVID-19 pandemic that persisted into 2022 (e.g. invasive group A streptococcal disease), while others increased (e.g. tuberculosis, carbapenemase-producing enterobacteriaceae, legionellosis, blastomycosis) compared to the pre-pandemic average (Figure 33).

Legionellosis^{xviii} appears to have increased over time, likely due to the increased use of less invasive diagnostic methods. Incidence of legionellosis was lower in Ottawa (1.6 per 100,000) than the average of Ontario-less-Ottawa (2.2 per 100,000). Blastomycosis^{xix} has increased from 4 people

xviii Legionellosis is a disease caused by the Legionella bacteria that can result in serious pneumonia (Legionnaires' disease).

xix Blastomycosis is caused by the inhalation of Blastomyces fungal spores. It primarily affects the lungs but can be systemic. Symptoms can include fever and cough, and can be serious if not treated.

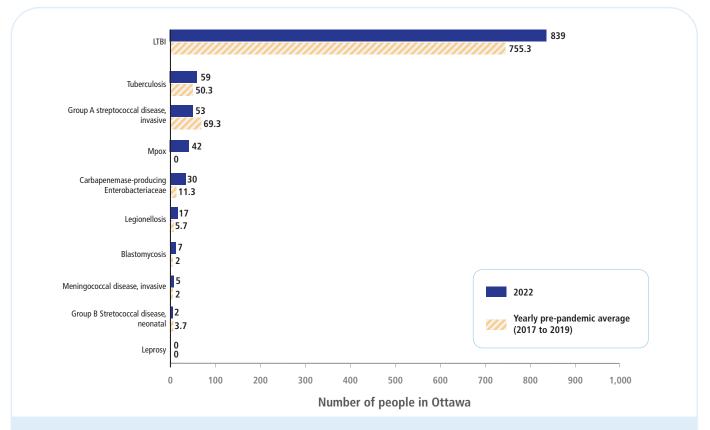


Figure 33. Number of Ottawa residents with an infection from a direct contact or respiratory disease of public health significance, 2022 vs pre-pandemic (2017 to 2019) average.

Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 13, 2023.

Notes: Three (3) additional people reported with confirmed blastomycosis from 2022 were pending confirmation in iPHIS and are not represented above. Blastomycosis counts may include people meeting the probable case definition in addition to people meeting the laboratory confirmed case definition.

reported with infections a year in each of 2019 to 2021 to 10 people reported in 2022. Incidence of blastomycosis was higher in Ottawa (0.93 per 100,000) than the average of Ontario-less-Ottawa (0.69 per 100,000), although still many times lower than hyperendemic areas in Northwestern Ontario (50 per 100,000). The incidences of Carbapenamase-producing enterobacteriaceae (CPE)^{xx} and group B streptococcal disease^{xxi} were similar to the average incidences in Ontario-less-Ottawa during 2022.

In June 2022, mpox (formerly known as monkeypox) became reportable as a Disease of Public Health Significance. The disease was not previously circulating in Canada. Please refer to the mpox section for more details.

Invasive group A streptococcus (iGAS)

The incidence of invasive group A streptococcus (iGAS), xxii caused by Streptococcus pyogenes, reported to OPH was

xx CPE are a group of bacteria that have become resistant to many antibiotics. Infections caused by CPE can be difficult to treat.

xxi Group B streptococcus bacteria are usually harmless in healthy adults but can cause serious disease in newborns.

xxii Most Group A strep infections are mild illnesses like strep throat or impetigo. Sometimes the bacteria can invade the lungs, blood or tissues around the muscle causing very serious, sometimes life-threatening disease.

stable from 2017 through to 2019 (Figure 34). The rates of iGAS dropped in 2020, likely due to COVID-19-related public health measures such as handwashing and the absence of seasonal respiratory viruses which make people more susceptible to secondary bacterial infections. Rates rose in 2021 and 2022 following the decrease in COVID-19 prevention measures together with increases in respiratory viral infections.

The incidence of iGAS in Ottawa (4.9 per 100,000) was lower than the average of Ontario-less-Ottawa (which had 5.7 cases diagnosed per 100,000) in 2022. People diagnosed with iGAS in 2022 were predominantly male (66%) and were over age 40 years (75%). Chronic skin conditions, and drug and alcohol use were the most common risk factors identified, but those most at risk for severe infections and fatalities were those with immune deficiencies. The proportion of people with iGAS who were underhoused more than doubled from 18% in 2017 to 45% in 2022.

Invasive Meningococcal Disease (IMD)

In the past 10 years, there have been five or fewer annual cases of invasive meningococcal disease (IMD)^{xxiii} reported in Ottawa due to routine immunization in Ontario during infancy and at 12 years of age beginning in 2009. In the school year 2020-21, approximately 96% of 17-year-olds in Ottawa had been vaccinated against meningococcal disease (see Childhood Immunization).¹¹³

In 2022, the incidence of IMD (0.5 per 100,000) was the highest it has been in the last ten years and higher than the average of Ontario-less-Ottawa (0.1 per 100,000).¹¹⁴ This increase was likely due to loosening of COVID-19 public health measures that resulted in close, unmasked contact with a larger number of people and higher rates of viral respiratory disease which makes people susceptible to secondary bacterial infections.¹¹⁵

Tuberculosis

Tuberculosis (TB) is an infection caused by a group of Mycobacterium bacteria species, which primarily infects the lungs but can also infect other parts of the body. In 2022, 59 cases of active TB, or 5.5 per 100,000, were reported among Ottawa residents.** The rate of activeTB in Ottawa has increased over the last six years (Figure 35) and it is higher than the average for Ontario-less-Ottawa (4.6 per 100,000).** Indigenous peoples in Canada are disproportionally affected by TB due to ongoing impacts of colonization and health inequities.**

The average age at diagnosis was 46 years. Roughly half (52%) of people diagnosed with TB had pulmonary disease. The major risk factor for TB was living in or travelling to an endemic area. 118 Of residents of Ottawa diagnosed with TB in 2022, most (73%) were born outside Canada, similar to previous years. Among Canadian-born individuals in Ottawa, Inuit are disproportionately affected by TB. In 2022, 8% of the cases of TB in Ottawa were in individuals who identify as Inuk. This disproportionate burden of TB illness is also seen elsewhere in Canada. Among Inuit living within Inuit Nunangat, the rate of TB was 40 times the rate for Canada as a whole (189/100,00 vs. 4.7/100,000) and more than 400 times the rate for the Canadian-born, non-Indigenous population (189/100,000 vs. 0.4/100,000) in 2019. 119

Case fatality rates, the proportion of people infected who die from TB, have fluctuated slightly over the last 10 years, with an average of 6%, compared with the Canadian case fatality rate of 5% from 2010 – 2019. At the time of this report, no deaths from TB have been recorded for people diagnosed in 2022. 120 Ottawa Public Health works closely with individuals as they are treated for TB and were able to support 93% through successful treatment according to the Canadian guidelines.

xxiv Reports of active TB and LTBI are all recorded by date of diagnosis. For example, if a person was diagnosed in 2020 and successfully treated the successful treatment date would be 2020, rather than in year in which treatment was actually completed. The same applies to all other outcomes including fatalities.



xxiii A serious illness that results when *Neisseria meningitidis* bacteria invade the blood or tissues around the brain and cause serious disease like meningitis or septicemia.

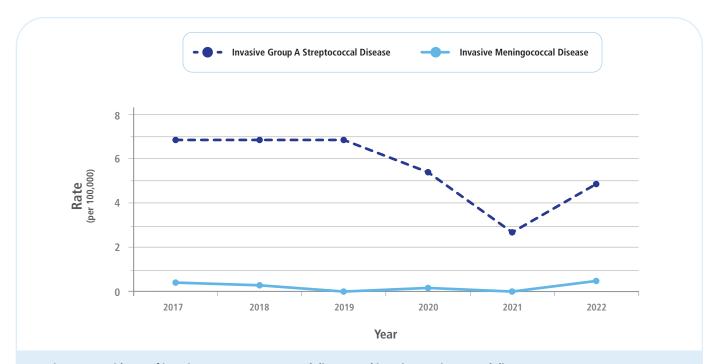


Figure 34. Incidence of invasive group A streptococcal disease and invasive meningococcal disease, Ottawa, 2017 to 2022. Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 13, 2023.

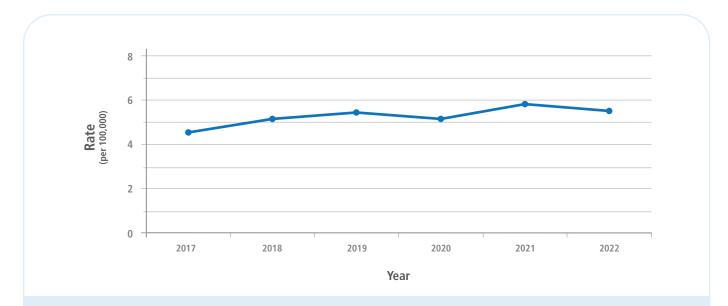


Figure 35. Incidence of active tuberculosis, Ottawa, 2017 to 2022.

Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 13, 2023.

Latent Tuberculosis Infection

Latent tuberculosis infection (LTBI) occurs when the TB bacteria is dormant in a person for months to years with no symptoms. It is estimated that about 5 to 10% of people with LTBI will have an active TB infection over their lifetime. The primary prevention strategy is screening for LTBI in people born outside of Canada, Indigenous people, and others who may be at high risk (e.g., immune compromised, unstable housing). The rates of LTBI in Ottawa dropped to 39 per 100,000 in 2020, likely due to decreased screening during the COVID-19 pandemic. By 2022, rates returned to 78 per 100,000, which is similar to what was observed pre-pandemic. 121 The rates of LTBI in Ottawa have been higher than the Ontario-less-Ottawa rates for the last 10 years. 122 Of the people diagnosed in 2022, $^{\scriptscriptstyle XXV}$ 55% were in females, and the average age at diagnoses was 39 years. 123

Influenza

Influenza, commonly known as the "flu", is a respiratory infection caused by the influenza virus. Influenza can easily spread from person to person and influenza virus circulation follows a seasonal pattern with most infections reported between fall and spring. Annual influenza immunization is the most effective way to protect against influenza.

Please refer to the OPH Respiratory and Enteric Surveillance Report dashboard for up-to-date influenza data presented alongside data on COVID-19, respiratory syncytial virus (RSV), outbreaks and all-cause and respiratory-related emergency department visits to Ottawa hospitals.xxvi Influenza activity in spring of 2020 declined suddenly and dramatically due to the introduction of COVID-19-related public health measures. Activity remained very low for two years until a slight increase was noted in the spring of 2022 (31 lab-confirmed cases in April and May) associated with the lifting of public health measures.

Influenza activity during the 2022-2023 influenza season (the period from September 2022 to August 2023) began^{xxvii} the week of October 30, 2022, five weeks earlier than the pre-COVID-19 average (Figure 36). 124 The influenza season rapidly peaked in early December and declined to levels typically seen in late spring or summer by mid-January, resulting in a shorter season. As of mid-March 2023, 870 Ottawa residents tested positive for influenza (99% influenza A and 1% influenza B), slightly above the pre-pandemic average of 833. Children and youth were disproportionately impacted with 40% of people who tested positive being under the age of 20 years, resulting in a median age of 34 years, which is significantly younger than pre-pandemic seasons where the median age was typically 60 years or older. The influenza rate among children aged 1 to 4 years this season (322 per 100,000) was more than triple the pre-pandemic average (105 per 100,000). Co-circulation of influenza, RSV, COVID-19 and other respiratory viruses in fall 2022 resulted in an unprecedented surge in emergency department visits and admissions to CHEO.xxviii

As of March 13, 2023, there were still 478 cases requiring entry into the provincial case reporting system, iPHIS. Counts, averages, and rates for 2022 have been manually adjusted to include these missing cases for the purposes of the report. However, sex and age information are not reflective of the 478 cases pending entry into iPHIS. Please interpret with caution.

xxvi Testing for influenza and RSV is limited to patients hospitalized due to respiratory illness and symptomatic individuals in health care institutions (i.e. long-term care homes, retirement homes, public hospitals), while COVID-19 testing is currently more widely available additionally to health care workers and high risk individuals. Testing does not capture the majority of people who become ill with reportable diseases in Ottawa. Prior to November 14, 2022, testing for influenza and RSV in health care institutions was limited to the first four symptomatic individuals in a suspect outbreak.

xxvii Based on the influenza percent positivity for Eastern Ontario exceeding 5%.

xxviii CHEO. Viral season and you: How you can help. Updated December 12, 2022 at https://www.cheo.on.ca/en/news/viral-season-and-you-how-you-can-help.aspx. Accessed March 14, 2023

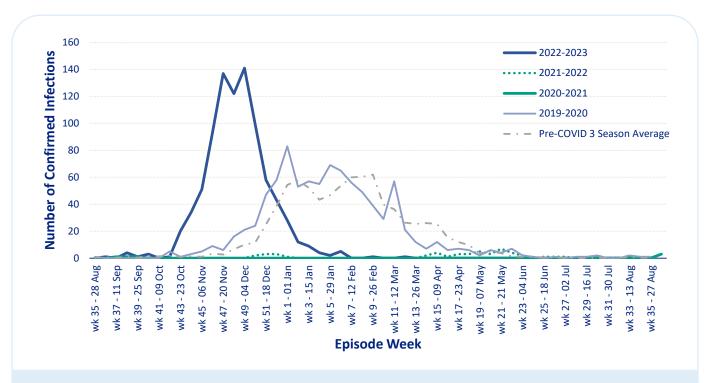


Figure 36. Number of reported laboratory-confirmed influenza cases by type and reported week in Ottawa, September 2022 (week 35) to March 2023 (week 11), and historical trends.

Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 23, 2023.

Note: Pre-COVID 3 season average includes 2016-2017, 2017-2018, and 2018-2019 seasons.

Influenza Vaccination

Each fall, the Universal Influenza Immunization Program makes influenza vaccination available to all residents 6 months of age or older. During the 2020-21 influenza season, half (50%) of Ottawa residents aged 18 years and older reported receiving an influenza vaccination while 74% of residents aged 65 years and older received an influenza vaccination. Influenza vaccination was lower for older adults in the 2020-21 season than in previous seasons (Figure 37). 125

COVID-19

Cases, hospitalizations, and deaths

COVID-19 is caused by a novel coronavirus, SARS-CoV-2. SARS-CoV-2 spreads from an infected person to others through respiratory droplets of varying size, including aerosols, and through contact with contaminated surfaces or objects without proper hand hygiene.

The first laboratory confirmation COVID-19 infection was reported to Ottawa Public Health on March 9, 2020. Since the beginning of the pandemic through December 2022, there have been 88,012 confirmed cases of COVID-19 infection among the people living in Ottawa, 3,464 hospitalizations, and 1,001 deaths due to COVID-19 or as a contributing cause of death. 126 In 2022, there were 39,671 cases of COVID-19 infections, 1,702 hospitalizations, and 381 deaths. However, the number of COVID-19 infections reported after December 2021 are significantly underestimated due to restrictions placed on testing eligibility.

There were six distinct waves of infection between March 2020 and April 2022. The first wave saw the highest rates among those 65 years of age and older, with many outbreaks in long-term care and retirement homes. Further community spread led to the implementation of public health restrictions to control the rising number of cases. These included the closing of schools and non-essential businesses, limited

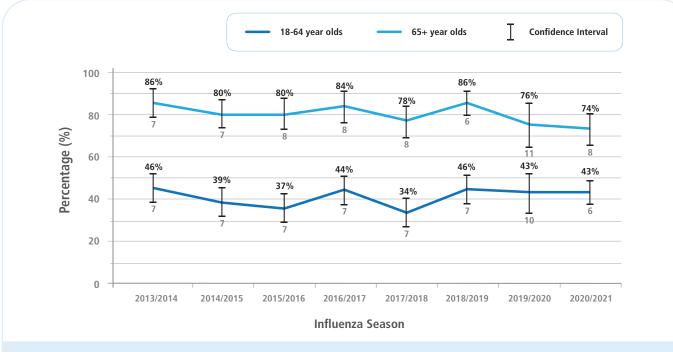


Figure 37. Percentage of Ottawa adults reporting influenza immunization by age group and influenza season, 2013/14 to 2020/21.

Source: Ottawa Public Health. Rapid Risk Factor Surveillance System, 2013-2021.

social gatherings, travel restrictions, capacity limits, closure of indoor dining, and the requirement to wear masks in indoor public spaces. The provincial measures introduced over the course of the pandemic are shown in Figure 38.

COVID-19 Vaccination

A COVID-19 vaccine became available in December 2020. When the vaccine was first introduced, eligibility was limited to populations at highest risk, including long-term care home and retirement home residents, and health-care workers required for the pandemic response. Within 3 months, 90% of retirement and long-term care home residents were fully vaccinated (with two doses), and within 9 months and as eligibility expended, 80% of all eligible residents of Ottawa were fully vaccinated. 127

As of March 2023, 85% of the Ottawa population has had at least one dose of COVID-19 vaccine, 82% at least two doses, 56% at least three doses and 31% at least four doses. Vaccination rates increase with age and have been very low among those age 6 months to 4 years and 5 to 11 years. Ottawa has the third highest COVID-19 vaccination coverage in the province. For more up-to-date statistics

on COVID-19 vaccination coverage, please visit <u>Ottawa</u> <u>Public Health's COVID-19 Vaccination Dashboard</u>.

Health disparities in COVID-19 epidemiology and vaccination

The structural and systemic inequities and barriers that pre-existed the COVID-19 pandemic influenced its epidemiology and vaccine uptake. The rate of COVID-19 infection was higher among residents of less-advantaged communities (Figure 39). These communities are not inherently more susceptible to COVID-19, but underlying social realities, such as systemic racism, barriers to health information and services, and/or participation in occupations without access to paid sick leave, contributed to people's exposure to COVID-19. COVID-19 case rates are shown in three different time periods throughout the pandemic:

- (A) pre COVID-19 vaccination;
- (B) when 60% of Ottawa residents are protected by COVID-19 and before the arrival of Omicron; and
- (C) after the arrival of Omicron.

Disparities are less evident during the latter two time periods.

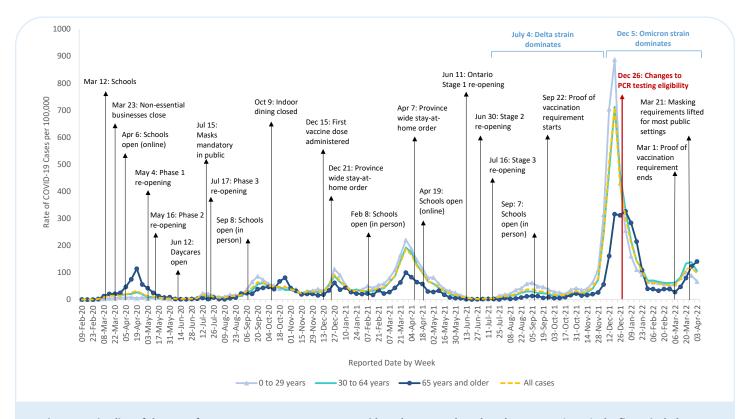


Figure 38. Timeline of the rate of COVID-19 cases among Ottawa residents by reported week and age group (years). The figure includes labels for select pandemic milestones (e.g., school closures, stages of re-opening).

Source: Data extracted April 21, 2022, from the Case and Contact Management Solution (CCM) by the Epidemiology team at Ottawa Public Health, Ottawa, ON. Population data provided by ICES.

The population rate of COVID-19 hospitalizations and deaths was also higher in communities with less socioeconomic advantage as described by the Ottawa Neighbourhood Study SES index. Population hospitalization and death rates were almost three times higher in quintile 5 neighborhoods (lowest socioeconomic status) compared to those in quintile 1 neighbourhoods (highest socioeconomic status). While the latter two time periods showed less disparity in infection rates (Figure 40), 128 hospitalization and death rates remained higher in less advantaged neighborhoods compared to most advantaged neighborhoods across all time periods (Figure 41). Similar findings have been seen across Ontario.

Despite efforts to prioritize lower income neighbourhoods, COVID-19 vaccination was also unevenly distributed across socioeconomic levels in Ottawa. Neighbourhoods that are more socioeconomically advantaged generally experienced higher levels of vaccination compared with neighbourhoods with lower socioeconomic advantage The disparity is greater among younger populations. For more information on socioeconomic disparities in COVID-19 vaccination in Ottawa, refer to the COVID-19 Vaccination Coverage in Ottawa Neighbourhoods dashboard, developed in partnership with the ONS.

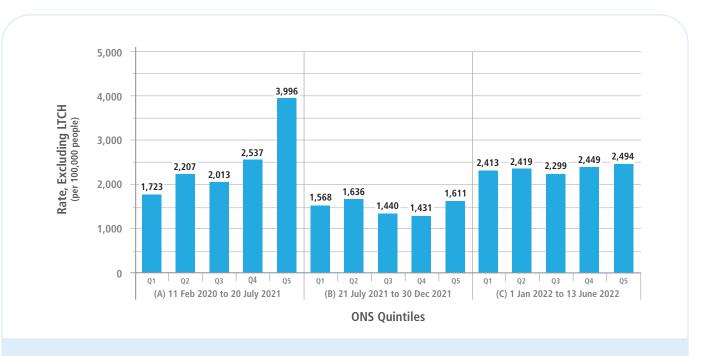


Figure 39. COVID-19 infection rates, per 100,000 population excluding LTCH residents, across quintiles in Ottawa based on case reported date by neighbourhood SES quintile: (A) prior to most Ottawa residents being protected by COVID-19 vaccination, (B) more than 60% of Ottawa residents protected by COVID-19 vaccination and before the arrival of the Omicron variant, and (C) after the arrival of the Omicron variant in Ottawa.

Source: Data extracted June 13, 2022, from the Case and Contact Management Solution (CCM) by the Epidemiology team at Ottawa Public Health, Ottawa, ON. Population data provided by ICES.

Note: Neighbourhood socioeconomic status (SES) quintiles are as defined by the Ottawa Neighbourhood Study (ONS) Quintile 1 has the most SES advantage, Quintile 5, the least.

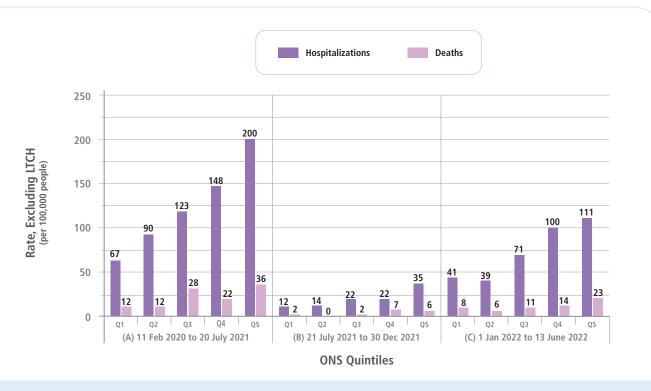


Figure 40. Population COVID-19 hospitalization and death rates, per 100,000 population excluding LTCH, based on case reported date by neighbourhood SES quintile: (A) prior to most Ottawa residents being protected by COVID-19 vaccination, (B) more than 60% of Ottawa residents protected by COVID-19 vaccination and before the arrival of the Omicron variant, and (C) after the arrival of the Omicron variant in Ottawa.

Source: Data extracted June 13, 2022, from the Case and Contact Management Solution (CCM) by the Epidemiology team at Ottawa Public Health, Ottawa, ON. Population data provided by ICES.

Note: Neighbourhood socioeconomic status (SES) quintiles as defined by the Ottawa Neighbourhood Study (ONS)122



Figure 41. COVID-19 vaccination coverage in Ottawa neighbourhoods by SES quintile.

Source: Ontario Ministry of Health's COVaxON application, through intellihealth Ontario. Extracted March 22, 2023.

Mpox

During 2022, a global outbreak of mpoxxxix (pronounced "em-pox" and formerly known as "monkeypox") occurred and included countries that have not historically reported mpox cases. The first person with of mpox was reported in Ottawa in May 2022. In total, 42 cases were diagnosed in Ottawa residents between May and September 2022 (Figure 42). The incidence of mpox in Ottawa was lower than the average of Ontario-less-Ottawa in 2022, which was driven by a high percentage of cases in Toronto.

Almost all cases of mpox were in gay, bisexual and other men who reported sex with other men (GBOMSM), most of whom recently had a new sexual partner, more than one sexual partner, or anonymous sex.

Imvamune, a two-dose vaccine approved for the prevention of mpox, became available in June 2022. Over 4,600 Ottawa residents were vaccinated with one dose of Imvamune between June 2022 and February 2023; a little over a third (37%) of those receiving a first dose, have also received a second dose. A second dose of the mpox vaccine is recommended to provide the best protection.

Sexually Transmitted and Blood-Borne Infections (STBBIs)

Sexually transmitted and blood-borne infections (STBBIs) are spread through body fluids (e.g., blood, vaginal fluid, semen) or skin-to-skin contact during sexual contact, while others are spread through non-sexual activities such as sharing needles used for injecting drugs. Certain infections can be transmitted both through blood and sexual contact, such as hepatitis B, HIV, and rarely, hepatitis C. Reportable sexually transmitted infections include chlamydia, gonorrhea, hepatitis B, human immunodeficiency virus (HIV), syphilis, and rarely, hepatitis C. Reportable bloodborne infections include hepatitis B, hepatitis C, and HIV.

Overall Trends

Trends in sexually transmitted and blood-borne infections are associated with factors such as age, ethnicity, income, gender, and sexual orientation. Populations most affected by STBBIs in Ottawa include: youth; gay, bisexual, and other men who have sex with men (GBOMSM); people who use drugs; and people who come from a country where infection is common.

The incidence of STBBIs decreased during the pandemic, most likely due to decreased testing and/or decreased sexual contacts (Figure 43). Recently, rates have begun to rebound to pre-pandemic (2017-19) levels (Figures 44 and 45).

Chlamydia

Chlamydia^{xxx} was the most frequently reported of all reportable infections, after COVID-19. The incidence in 2022 was 284 infections per 100,000 population, corresponding to 3,084 cases (Figure 43). The rate of chlamydia in Ottawa was higher than the average of Ontario-less-Ottawa, which had 237 cases diagnosed per 100,000 in 2022. 129 Most cases were in young adults ages 20 to 24 years who recently had, condomless sex with a partner of the opposite sex, a new sexual partner, or more than one sexual partner.

Gonorrhea

The incidence of gonorrhea^{xxxi} in 2022 was 76 infections per 100,000 population, corresponding to 819 cases (Figure 43). The rate of gonorrhea in Ottawa was slightly higher than the average of Ontario-less-Ottawa, which had 72 cases diagnosed per 100,000 in 2022. Most cases are in people who recently had condomless sex, a new sexual partner, or more than one sexual partner.

Almost half of cases are among GBOMSM.

xxxi Gonorrhea is a bacterial infection caused by Neisseria gonorrhoeae bacterium, which can be symptomatic or asymptomatic. If untreated, it can cause serious health problems.



xxix Mpox is viral disease that cause a variety of symptoms including a rash, skin lesions, and flu-like symptoms including fever, headache, swollen lymph nodes and fatique.

chlamydia is a bacterial sexually transmitted infection that can occur in both men and women. Infections can be symptomatic or asymptomatic. Infertility can be a complication of infection in women.

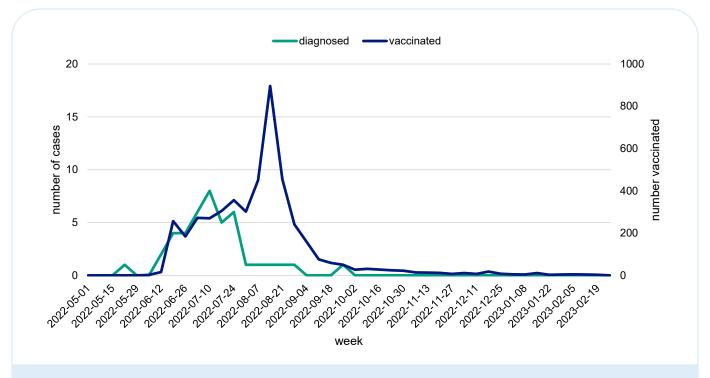


Figure 42. Ottawa residents diagnosed with, or vaccinated with at least one dose against, mpox by week, May 1, 2022 to Feb 19, 2023.

Sources: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 6, 2023; Ottawa Public Health. Panorama, Ontario Ministry of Health. Extracted March 3, 2023.

Syphilis

The incidence of syphilis xxxiii in 2022 was 23 infections per 100,000 population, corresponding to 248 cases (Figure 43). Syphilis has an infectious (earlier infection) and a late latent (later infection) stage. Approximately 40% of 2022 cases were infectious; most of the remainder were latent infections. The rate of infectious syphilis in males was 22 per 100,000 population and 2 per 100,000 in females. The rate of syphilis in Ottawa was lower than the average of Ontario-less-Ottawa, which had 33 cases diagnosed per 100,000 in 2022. 131 Approximately three-quarters of infectious cases were in adult GBOMSM. The most common risk factor was recent anonymous sex. Among those diagnosed with a late latent infection for whom origin is known, 85% were born outside Canada. Congenital

syphilis, which can occur if a woman is infected during pregnancy, has not been reported in Ottawa since 1992.

Hepatitis C

The incidence of hepatitis C^{xxxiii} in 2022 was 22 infections per 100,000 population, corresponding to 240 cases (Figure 43). Many people with a hepatitis C infection are diagnosed later in their infection since someone can live with hepatitis C for many years (20-30 years) before developing symptoms. Approximately 60% of infections diagnosed in 2022 were older infections, a quarter were new infections, and timing for the remainder could not be determined. The rate of hepatitis C in Ottawa was higher than the average of Ontario-less-Ottawa, which had 16 cases diagnosed per 100,000 in 2022.¹³² Approximately one-quarter of people diagnosed in 2022 reported being homeless or underhoused.

xxxii Syphilis is a bacterial sexually transmitted infection (STI) that can present with a number of different symptoms, depending on stage of illness and cause serious health problems without treatment.

xxxiii Hepatitis C is an infection by the hepatitis C virus that can result in liver inflammation and damage. For some it's a short-term illness but it can become a chronic infection that can result in serious, even life threatening health problems like cirrhosis or liver cancer.

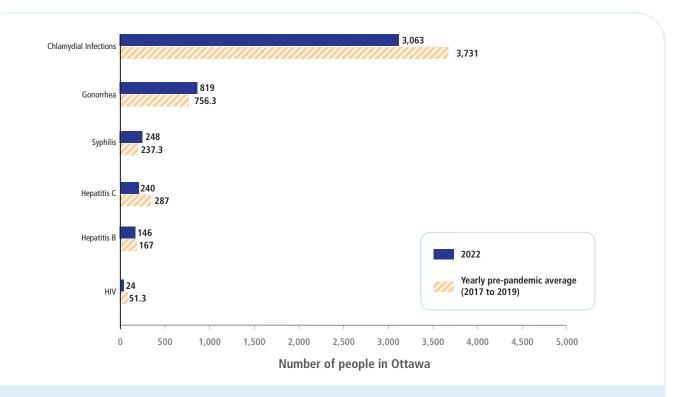


Figure 43. Number of residents of Ottawa with a laboratory-confirmed infection from a sexually transmitted or blood-borne disease of public health significance, 2022 vs pre-pandemic (2017 to 2019) average.

Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 6, 2023.

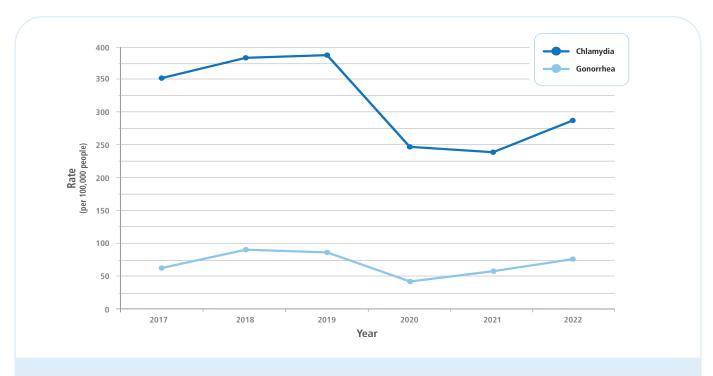


Figure 44. Incidence rate of chlamydia and gonorrhea by year in Ottawa, 2017 to 2022

Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 6, 2023.

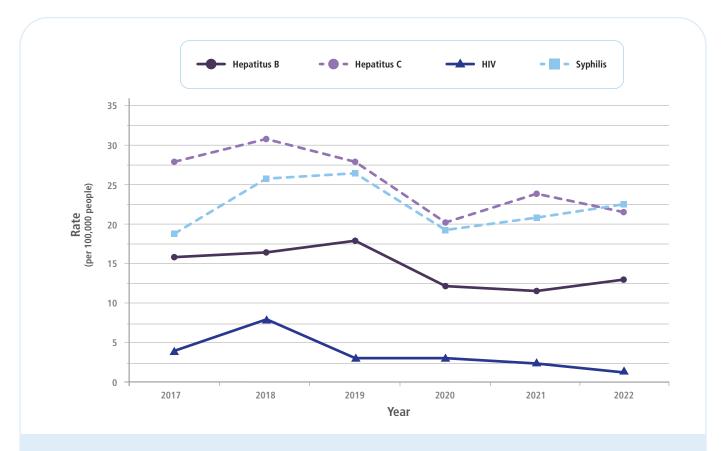


Figure 45. Incidence of hepatitis B, hepatitis C, HIV, syphilis by year in Ottawa, 2017 to 2022.

Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 6, 2023.

Injection and non-injection drug use and sharing of equipment were among the top reported risk factors by people diagnosed with hepatitis C. Approximately 10% of cases were born in a country where hepatitis C is more common.

Hepatitis B

The incidence of hepatitis B^{xxxiv} in 2022 was 14 infections per 100,000 population, corresponding to 146 cases (Figure 43). Like hepatitis C, many people with a hepatitis B infection are diagnosed later in their infection since someone can live with hepatitis B for many years (20 to 30 years) before

developing symptoms. Ninety-eight percent of hepatitis B infections were not recently acquired; approximately 70% of these diagnoses were among people born in a country where hepatitis B is more common. The rate of hepatitis B in Ottawa was more than twice the average of Ontario-less-Ottawa (which had 6 cases diagnosed per 100,000 in 2022). There were only two cases of recently acquired infection in 2022, owing in large part to a provincial school-based vaccination program that began in 1994. In 2020-2021, approximately 80% of 17-year-olds in Ottawa had been vaccinated against hepatitis B. The rate of hepatitis B.

xxxiv Hepatitis B is a vaccine-preventable disease caused by the hepatitis B virus. For many it is a short term illness but can become a chronic infection that can lead to serious, even life-threatening issues like cirrhosis or liver cancer.

HIV

The incidence of HIV^{XXXV} in 2022 was 2 infections per 100,000 population, corresponding to 24 cases (Figure 43). Many people with an HIV infection are diagnosed later in their infection, as someone can live with HIV for a long time before developing symptoms. Approximately 50% of infections diagnosed in 2022 were older infections, approximately 12% were new infections, and timing for the remainder could not be determined. The rate of HIV in Ottawa was lower than the average of Ontarioless-Ottawa, which had 5 cases diagnosed per 100,000 in 2022. ¹³⁶ Populations most represented among people with HIV infection were those born in, or with a sexual partner from, a country where HIV is common; and GBOMSM.

Vaccine Preventable Diseases

Vaccine preventable diseases (e.g., measles, mumps, rubella, diphtheria, tetanus, polio) are an area of considerable focus for public health programs because they are highly contagious and can cause severe disease, particularly in un-vaccinated or under-vaccinated infants and young children. In general, reports of vaccine-preventable diseases to OPH have been uncommon because of effective immunization programs and high immunization coverage. Ensuring vaccination rates remain high is important in preventing the spread of vaccine preventable diseases.

Overall Trends

The most frequently reported routine vaccine-preventable diseases in 2022 were invasive pneumococcal disease (77 cases), chickenpox (varicella) (21 cases) and invasive Haemophilus influenzae disease (11 cases). There were more people reported with invasive pneumococcal disease (IPD) and chickenpox in 2022 than the average during pre-pandemic years (2017 to 2019). For the first time in over 10 years, a person in Ottawa was diagnosed with tetanus in 2022. Finally, there were no people reported with the other vaccine-preventable diseases of public health significance, including measles, pertussis, polio, rubella, and smallpox, in Ottawa in 2022.

The Ottawa rate of IPD (7.1 per 100,000) and invasive Haemophilus influenza disease (1.0 per 100,000) are slightly lower than Ontario-less-Ottawa, but provincial data for chickenpox are not available for comparison (Figure 46).¹³⁷

Pneumococcal Disease

Invasive pneumococcal disease (IPD) is caused by the bacteria Streptococcus pneumoniae, of which there are 90 known serotypes. Invasive disease often presents as pneumonia, sepsis (blood poisoning) or meningitis, and a recent influenza infection can increase the risk of IPD.¹³⁸

Reports of Ottawa residents with IPD declined during 2020 and 2021 due to the COVID-19 related public health measures. The rates fully rebounded to pre-pandemic levels in 2022. The Ottawa incidence rate (7.1 per 100,000) was slightly lower than the average of Ontario-less-Ottawa (7.9 per 100,000) in 2022. 139 In 2022, 18% of people reported with IPD were infants and children aged 9 years and under and 42% were adults older than 60 years.

Pneumococcal vaccines are offered, as part of Ontario's publicly funded schedule, to infants, older adults, and high-risk groups. These vaccines protect against some serotypes of Streptococcus pneumoniae. The volume of Pneumococcal Conjugate 13 (Pneu-C-13) vaccines, routinely administered to infants, distributed to health care providers in OPH's catchment was relatively stable over the course of the pandemic. Distribution volumes in 2020-2022 were 3% to 5% lower than the pre-pandemic 2-year average doses distributed (2018-2019), indicating some backlog in children requiring immunization. The volume of Pneumococcal Polysaccharide 23 (Pneu-P-23) vaccines, typically administered to older adults 65 years and older and those with certain immunosuppressive conditions, dropped dramatically in 2020 and 2021 (by 27% and 35%, respectively) compared to pre-pandemic. These volumes made a marked recovery in 2022, back to within 5% of pre-pandemic volumes; however, it is likely that many who became eligible during the pandemic have not yet been vaccinated.

xxxv HIV is a virus that attacks the body's immune system. There is no cure for HIV, but medication can control infection and prevent progression to acquired immunodeficiency syndrome (AIDS).



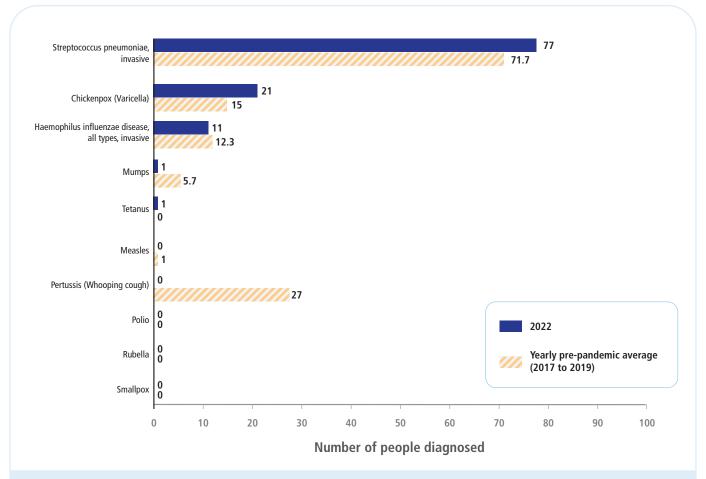


Figure 46. Number of Ottawa residents reported with an infection from a vaccine preventable disease of public health significance, 2022 vs pre-pandemic (2017 to 2019) average.

Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 13, 2023.

Note: Mumps and pertussis counts include people meeting the probable case definition in addition to people meeting the laboratory confirmed case definition.

Measles

Outbreaks of measles^{xxxvi} are occurring in every region of the world. As a result of successful vaccination programs, measles has been eliminated in Canada since 1998. In Ottawa, almost all cases of measles are in visitors or returning travelers from countries where measles is more common. While there were no cases of measles in Ottawa in 2020 through 2022, likely due to reduced travel during

the COVID-19 pandemic, the risk of local outbreaks has increased due to COVID-19 related delays in routine immunization (see Childhood Immunization). Other jurisdictions in Ontario have reported cases of measles related to international travel by under-immunized residents in 2023. OPH is monitoring measles activity, preparing for potential measles cases, and encouraging routine vaccinations.

xxxvi Measles is a highly contagious viral disease that can result in mild disease with fever, runny nose, red eyes cough, and rash, to much more serious disease or death.

xxxvii Measles in Canada. Government of Canada. Updated April 1, 2019. Accessed March 21, 2023. https://www.canada.ca/en/public-health/services/diseases/measles/measles-in-canada.html

Enteric, Food and Water-borne Infections

Enteric or gastrointestinal (GI) illnesses are often acquired through the ingestion of contaminated food or water. They can also be transmitted from person-to-person through fecal-oral contact, and transmission among sexual partners is being increasingly recognized.

Overall Trends

Enteric illnesses most frequently reported in Ottawa in 2022, which make up 65% of all enteric illnesses reported, were salmonellosis (99 cases), campylobacter enteritis (96 cases), and giardiasis (87 cases) (Figure 47). While there were fewer people reported with most enteric infections in 2022 than the average during pre-pandemic years, there were more people reported with infections with listeriosis and typhoid fever. The increase in listeriosis and typhoid fever is partially owing to a listeriosis outbreak in a long-term care home (4 residents confirmed infected) and a locally-acquired typhoid fever outbreak (3 people confirmed infected in 2022) in the community. For the first time since 2017, one person was reported with cholera, related to travel outside Canada.

The rates of salmonellosis (9.2 per 100,000) and Campylobacter enteritis (8.9 per 100,000) in Ottawa were lower than the equivalent averages of Ontario-less-Ottawa in 2022. ¹⁴¹ The incidences of cryptosporidiosis (1.4 per 100,000), paratyphoid fever (0.2 per 100,000), and yersiniosis (0.7 per 100,000) were slightly lower than in the rest of Ontario in 2022.

The incidences of giardiasis (8.1 per 100,000) and amebiasis (2.5 per 100,000) in Ottawa were higher than in the rest of Ontario in 2022.

The incidence of hepatitis A (0.6 per 100,000) was similar to the rest of Ontario in 2022.

Salmonellosis, campylobacter enteritis and giardiasis^{xxxviii} decreased during the COVID-19 pandemic and continued to remain lower in 2022 than pre-pandemic years (Figure 48). This is most likely due to fewer social gatherings involving food, decreased travel and/or decreased testing, and rates are expected to rise in 2023.

The most common risk factor for salmonella and Campylobacter enteritis was consumption of poultry in a private home (52% of cases) and travel outside of Canada during the incubation period (36% of cases). Recreational water (e.g., swimming in a lake or river) is typically the most common cause of giardiasis. 142

Although enteric illnesses are reported throughout the year, a higher number of cases are reported during summer months (Figure 49). Seasonal patterns in enteric illnesses are often linked to increases in travel, warmer temperatures, outdoor activities, and social gatherings.

Cyclosporiasis

An increase in people reported with locally acquired cyclosporiasis**xxxix* has been noted across Canada in recent years, associated with consumption of imported produce. In 2022, 54 cases of cyclosporiasis were reported in Ottawa, compared with 32 cases in 2018. 143 Reports of people infected in 2022 increased in May, peaked in June, and declined by August. The incidence of cyclosporiasis in Ottawa (5.0 per 100,000) was higher than the average of Ontario-less-Ottawa (2.9 per 100,000) in 2022. 144

Shigellosis

Shigellosis is a bacterial infection transmitted via the fecal-oral route from contaminated food or water and, increasingly, through sexual contact.^{xl} Risk of spread increases for individuals engaging in anal-oral sex, and in settings where personal hygiene is limited such as in childcare centres. The incidence of shigellosis in Ottawa (1.8 per 100,000) was slightly higher than the average

xxxviii These diseases cause gastrointestinal/diarrheal illness and can cause severe dehydration or more serious complications.

xxxix Cyclosporiasis is a parasitic disease that can cause diarrhea and other symptoms and may last weeks to a month or more if not treated.

xl Shigellosis can result in watery or bloody diarrhoea and can cause serious complications like severe dehydration or septicemia in those with weakened immune systems.



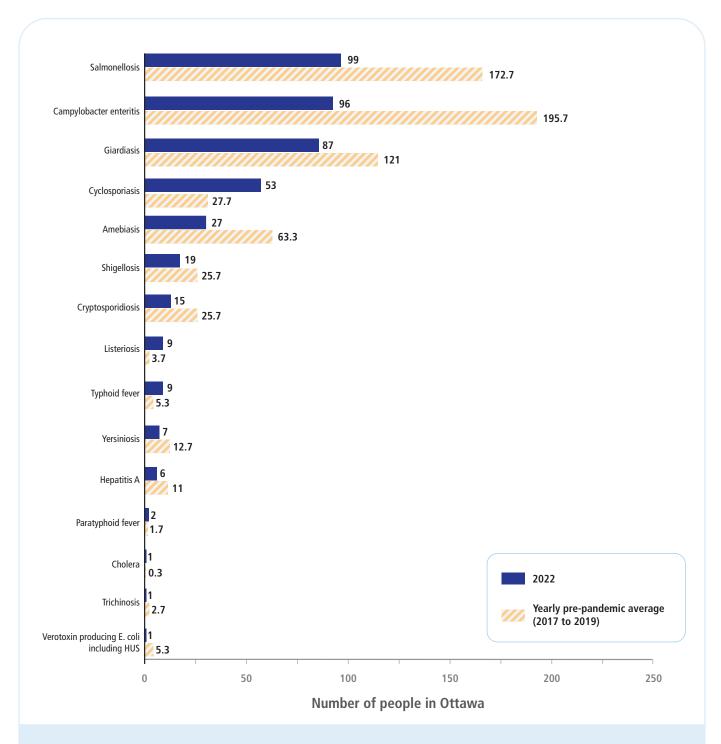


Figure 47. Number of Ottawa residents reported with an enteric disease of public health significance, 2022 vs pre-pandemic (2017 to 2019) average.

Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 13, 2023.

Note: For Amebiasis and Giardiasis, probable as well as confirmed infections in Ottawa residents are included.

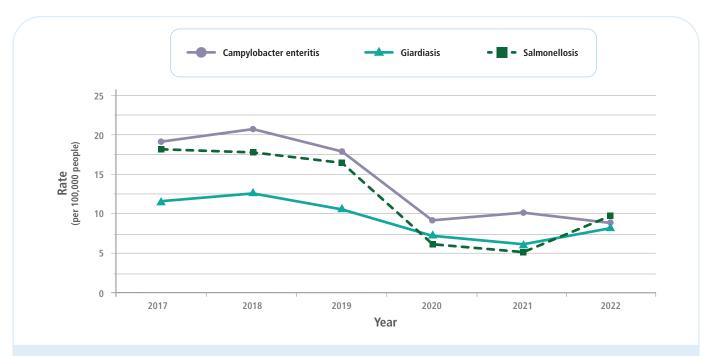


Figure 48. Incidence rate of campylobacter enteritis, giardiasis and salmonellosis by year in Ottawa, 2017 to 2022.

Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 13, 2023.

Note: For Giardiasis, probable as well as confirmed infections in Ottawa residents are included.

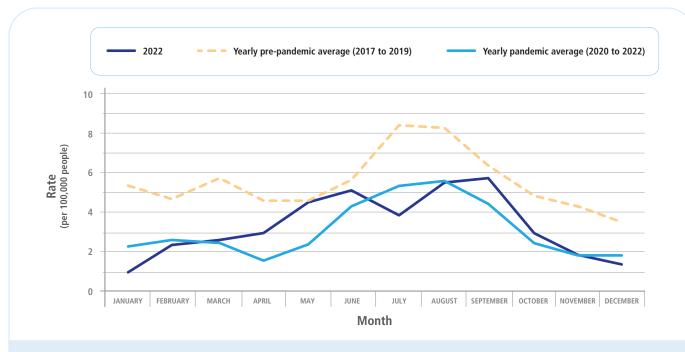


Figure 49. Incidence rate of all enteric diseases of public health significance combined by month, Ottawa, pre-pandemic average (2017 to 2019) vs pandemic average (2020 to 2022) vs 2022.

Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 13, 2023.

Note: For Amebiasis and Giardiasis, probable as well as confirmed infections in Ottawa residents are included.

of Ontario-less-Ottawa (1.5 per 100,000) in 2022.¹⁵¹ Of the 19 Ottawa residents with confirmed shigellosis reported in 2022, 58% reported travel outside the province during the incubation period, 16% reported anal-oral sexual contact, and 11% were part of an outbreak related to a restaurant in Québec.¹⁵²

Extensively drug resistant (XDR) Shigella strains (i.e. strains that are resistant to all commonly recommended antibiotics) emerged in Ontario in 2022 and antibiotic resistance is being monitored locally. To date, no people in Ottawa have been diagnosed with XDR shigellosis.

Vector-borne and Other Zoonotic Infections

Vector-borne diseases are transmitted by an insect or other living organisms carrying a pathogen that can infect a person who comes into contact with the vector. Examples include Lyme disease, the bacterial agent of which is carried by the blacklegged tick, and West Nile virus (WNV), which is carried by certain mosquito species. Due to climate change, the presence of blacklegged ticks continues to increase in Ottawa.

Overall Trends

Lyme disease, WNV infection and Q fever were the only vector-borne diseases of public health significance reported among Ottawa residents in 2022 (Figure 50), with only one person with Q fever and WNV each reported in 2022.

There were no people reported with the other vector-borne diseases of public health significance in Ottawa in 2022. These include anthrax, brucellosis, hantavirus pulmonary syndrome, plague, rabies, and tularemia.

Lyme Disease

The City of Ottawa is an established Lyme diseaseⁱ risk area. Tick surveillance work conducted by the University of Ottawa estimated that 32% of black-legged ticks in

2019 tested positive for the disease-causing bacterium, Borrelia burgdorferi. Adult ticks were more likely than nymphal ticks to test positive, and ticks collected from the sites located within the Greenbelt zone, in the suburban/rural areas of the western portion of Ottawa and along the Ottawa river were more likely to test positive than ticks in the suburban/urban core.ⁱⁱ

In 2022, 215 people infected with Lyme disease were reported in Ottawa, compared with 50 reported in 2013 (Figure 51). Of the people reported in 2022 with Lyme disease, 31% reported exposure within Ottawa and 61% reported exposure outside of Ottawa within Ontario. Exposure was commonly associated with spending time outdoors at a private home or camping in neighbouring regions.

When comparing the incidence rate of Lyme disease in 2022 to the three health units neighbouring Ottawa, the rate in Ottawa was the lowest (range of 20.2/100,000 to 163.3/100,000). However, the incidence of Lyme disease in Ottawa (20.2 per 100,000) was higher than the average of Ontario-less-Ottawa (8.2 per 100,000) in 2022. 153

Rabies

Although there have been no human cases of rabies in Ontario since 1967, the risk continues to exist. Bats have been found to be infected with rabies in Ottawa. Elsewhere in Ontario, raccoons, foxes, and skunks have been found to be infected with rabies. Importation of infected animals can be a source of rabies for local pet and domestic animals. Foreign travel also presents risk scenarios for Ottawa residents.

All potential rabies exposures are risk assessed by OPH and rabies post-exposure prophylaxis (RPEP) is provided when indicated for the prevention of rabies in humans. In 2022, OPH, working alongside local health care providers, coordinated the distribution of RPEP doses to 195 individuals.

Early symptoms of Lyme disease symptoms can include fever, headache, fatigue, and a characteristic skin rash called erythema migrans. If left untreated, infection can spread to joints, the heart, and the nervous system.

Burrows H, Talbot B, McKay R, Slatculescu A, Logan J, et al. (2021) A multi-year assessment of blacklegged tick (Ixodes scapularis) population establishment and Lyme disease risk areas in Ottawa, Canada, 2017-2019. PLOS ONE 16(2): e0246484. https://doi.org/10.1371/journal.pone.0246484

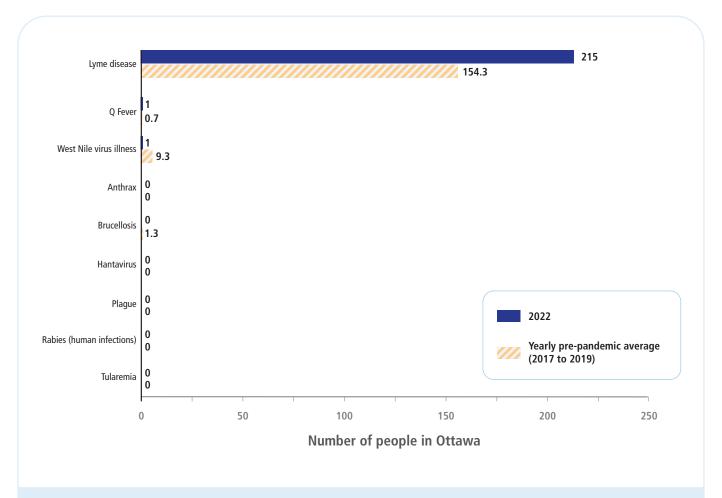


Figure 50. Number of Ottawa residents reported with an infection from a vector-borne or zoonotic disease of public health significance, 2022 vs pre-pandemic (2017 to 2019) average.

Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 13, 2023.

Note: For Brucellosis, Lyme disease, and West Nile virus, probable as well as confirmed infections in Ottawa residents are included.

of Ontario-less-Ottawa (1.5 per 100,000) in 2022.¹⁴⁵ Of the 19 Ottawa residents with confirmed shigellosis reported in 2022, 58% reported travel outside the province during the incubation period, 16% reported anal-oral sexual contact, and 11% were part of an outbreak related to a restaurant in Québec.¹⁴⁶

Extensively drug resistant (XDR) Shigella strains (i.e. strains that are resistant to all commonly recommended antibiotics) emerged in Ontario in 2022 and antibiotic resistance is being monitored locally. To date, no people in Ottawa have been diagnosed with XDR shigellosis.

Vector-borne and Other Zoonotic Infections

Vector-borne diseases are transmitted by an insect or other living organisms carrying a pathogen that can infect a person who comes into contact with the vector. Examples include Lyme disease, the bacterial agent of which is carried by the blacklegged tick, and West Nile virus (WNV), which is carried by certain mosquito species. Due to climate change, the presence of blacklegged ticks continues to increase in Ottawa.

Overall Trends

Lyme disease, WNV infection and Q fever were the only vector-borne diseases of public health significance reported among Ottawa residents in 2022 (Figure 50), with only one person with Q fever and WNV each reported in 2022.

There were no people reported with the other vector-borne diseases of public health significance in Ottawa in 2022. These include anthrax, brucellosis, hantavirus pulmonary syndrome, plague, rabies, and tularemia.

Lyme Disease

The City of Ottawa is an established Lyme disease^{xli} risk area. Tick surveillance work conducted by the University of Ottawa estimated that 32% of black-legged ticks in

2019 tested positive for the disease-causing bacterium, Borrelia burgdorferi. Adult ticks were more likely than nymphal ticks to test positive, and ticks collected from the sites located within the Greenbelt zone, in the suburban/rural areas of the western portion of Ottawa and along the Ottawa river were more likely to test positive than ticks in the suburban/urban core.xlii

In 2022, 215 people infected with Lyme disease were reported in Ottawa, compared with 50 reported in 2013 (Figure 51). Of the people reported in 2022 with Lyme disease, 31% reported exposure within Ottawa and 61% reported exposure outside of Ottawa within Ontario. Exposure was commonly associated with spending time outdoors at a private home or camping in neighbouring regions.

When comparing the incidence rate of Lyme disease in 2022 to the three health units neighbouring Ottawa, the rate in Ottawa was the lowest (range of 20.2/100,000 to 163.3/100,000). However, the incidence of Lyme disease in Ottawa (20.2 per 100,000) was higher than the average of Ontario-less-Ottawa (8.2 per 100,000) in 2022.¹⁴⁷

Rabies

Although there have been no human cases of rabies in Ontario since 1967, the risk continues to exist. Bats have been found to be infected with rabies in Ottawa. Elsewhere in Ontario, raccoons, foxes, and skunks have been found to be infected with rabies. Importation of infected animals can be a source of rabies for local pet and domestic animals. Foreign travel also presents risk scenarios for Ottawa residents.

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xlii Burrows H, Talbot B, McKay R, Slatculescu A, Logan J, et al. (2021) A multi-year assessment of blacklegged tick (Ixodes scapularis) population establishment and Lyme disease risk areas in Ottawa, Canada, 2017-2019. PLOS ONE 16(2): e0246484. https://doi.org/10.1371/journal.pone.0246484



xli Early symptoms of Lyme disease symptoms can include fever, headache, fatigue, and a characteristic skin rash called erythema migrans. If left untreated, infection can spread to joints, the heart, and the nervous system.

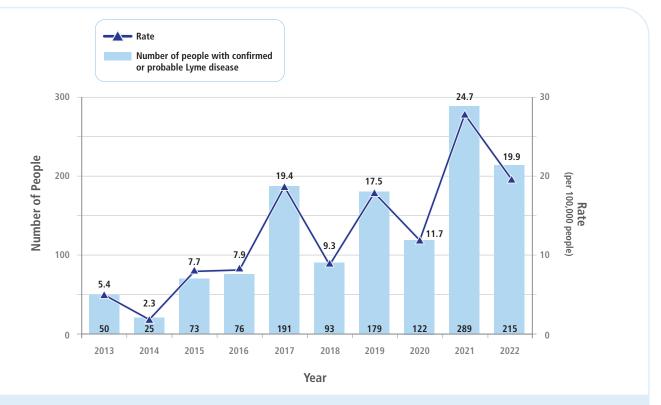


Figure 51 Incidence and number of Ottawa residents with confirmed or probable Lyme disease by episode year, 2013 to 2022. Source: Ottawa Public Health. Integrated Public Health Information System (iPHIS), Ontario Ministry of Health. Extracted March 13, 2023.

Long-Term Care, Retirement Home, and Hospital Outbreaks

Respiratory and gastroenteritis infection outbreaks in institutions are reportable to local public health authorities. This report summarizes outbreaks in hospitals, retirement homes and long term care homes: institutions where outbreak reporting is most reliable. As of March 20, 2023, the 2022-2023 outbreak season (the period from September 2022 to August 2023) has been predominated by COVID-19 outbreaks, while influenza, other respiratory outbreaks and enteric outbreaks partially rebounded after dropping during the previous two seasons.

There have been 284 COVID-19 outbreaks in institutions since September 1st of 2022, the start of the current respiratory season, which is a greater number of outbreaks than were reported in the entire first respiratory season of the pandemic (231 outbreaks between September 2020 and August 2021) and more than season-to-date in the second season of the pandemic (187 outbreaks between September 2021 and March 2022).¹⁴⁸

There have been 19 influenza A outbreaks and 46 other non-COVID respiratory outbreaks in Ottawa institutions (i.e., hospitals, long-term care homes, and retirement homes) during the 2022-2023 season-to-date. This is lower than the average of 100 respiratory outbreaks (including 46 influenza and 54 other respiratory outbreaks) seen in pre-pandemic seasons (2016-2017 through 2018-2019 weeks 35 through 11).¹⁴⁹

Finally, there have been 14 gastroenteritis outbreaks in institutions for the season-to-date, which is lower than the average of 42 gastroenteritis outbreaks seen in pre-pandemic seasons (2016-2017 through 2018-2019 weeks 35 through 11).¹⁵⁰

Please refer to the <u>OPH Respiratory and Enteric Surveillance</u> Report <u>Dashboard</u> for additional up-to-date summaries, to the <u>OPH Outbreak Status Dashboard</u> for a list of ongoing and recently closed confirmed respiratory and enteric outbreaks, and to the <u>OPH COVID-19 Dashboard</u> for details on COVID-19 outbreaks.

Appendix and References



APPENDIX

Data Tables

Data table for Figure 1. Population distribution as counts, for males and females, City of Ottawa, 2023, 2030 and 2040

Age	2023 Males	2023 Females	2030 Males	2030 Females	2040 Males	2040 Females
0-4	26,094	25,237	31,167	29,602	36,575	34,742
5-9	27,893	27,503	30,267	29,039	36,855	35,176
10-14	29,585	28,919	30,009	29,394	36,375	34,748
15-19	31,506	30,736	33,846	32,901	37,101	35,383
20-24	41,941	39,111	46,689	43,333	50,238	46,240
25-29	45,132	44,251	47,645	46,068	52,933	51,027
30-34	43,081	42,395	48,646	48,785	53,679	53,813
35-39	40,126	39,689	50,808	49,276	55,309	54,801
40-44	35,460	37,005	44,953	44,139	55,261	54,914
45-49	32,537	35,253	38,572	39,587	52,950	51,857
50-54	32,705	34,014	32,586	35,336	44,446	44,195
55-59	34,553	34,668	31,389	33,695	36,983	38,615
60-64	34,289	35,332	31,394	32,866	30,946	34,648
65-69	27,641	30,075	34,020	35,598	29,570	33,126
70-74	21,582	24,926	28,143	31,082	29,069	31,915
75-79	16,656	19,861	20,799	24,785	29,857	32,899
80-84	9,966	12,846	15,386	19,210	22,309	26,310
85+	8,619	14,388	12,219	18,653	22,003	31,559
Total	539,366	556,209	608,538	623,349	712,459	725,968

Data table for Figure 2. Number of live births and fertility rates in Ottawa from 2013 to 2022

Year	# of Live Female Population Births Age 15-49y		Fertility Rate (per 1,000 females)
2013	9,978	232,765	42.9
2014	9,815	231,407	42.4
2015	9,655	230,487	41.9
2016	9,649	232,638	41.5
2017	9,553	237,524	40.2
2018	9,534	243,064	39.2
2019	9,798	248,414	39.4
2020	9,457	254,655	37.1
2021	9,865	256,184	38.5
*2022	9,510	262,155	36.3

Data table for Figure 3. Age-specific fertility rates in Ottawa from 2013 to 2022

Year	Birth Rate Age 15-19 (per 1,000 females)	Birth Rate Age 20-24 (per 1,000 females)	Birth Rate Age 25-29 (per 1,000 females)	Birth Rate Age 30-34 (per 1,000 females)	Birth Rate Age 35-39 (per 1,000 females)	Birth Rate Age 40-44 (per 1,000 females)
2013	5.4	22.6	72.4	120.4	66.5	12.8
2014	5.1	22.1	71.3	117.0	65.8	13.8
2015	4.9	21.9	70.8	112.6	66.6	13.1
2016	4.0	19.4	66.8	115.6	67.0	14.4
2017	3.6	18.2	62.5	110.7	66.6	14.3
2018	2.4	15.5	57.9	109.5	66.9	14.7
2019	2.7	16.3	54.6	109.6	67.9	15.0
2020	2.1	12.4	47.7	105.1	65.7	14.4
2021	1.9	12.8	49.2	106.1	67.9	14.8
*2022	2.0	12.9	44.9	96.0	64.5	15.5

Data table for Figure 5. Percentage of students in grades 7 to 12 who reported school connectedness in the past year in Ottawa, 2019 and 2021, and Ontario-less-Ottawa, 2021. CI = Confidence Interval

School Connectedness	Ottawa 2019	Ottawa 2021	Ontario- less- Ottawa 2021	Upper CI Ottawa 2019	Lower Cl Ottawa 2019	Upper CI Ottawa 2021	Lower CI Ottawa 2021	Upper CI Ontario- less- Ottawa 2021	Lower CI Ontario- less- Ottawa 2021
Like school	70%	74%	75%	6%	5%	5%	4%	6%	5%
Feel part of school	81%	71%	73%	4%	4%	4%	4%	5%	4%
Feel close to people at school	80%	65%	74%	3%	3%	6%	5%	6%	5%
Feel safe at school	87%	88%	90%	2%	2%	6%	4%	4%	3%

Data table for Figure 6. Percent of population aged 12 and older who stated they had access to a regular health care provider by subgroup, 2019-2020.

Category	Percentage of population aged 12 and over (%)	Confidence Interval (%)
Ottawa	86%	3%
Ontario less Ottawa	91%	1%
12-19	89%	8%
20-44	76%	7%
45-64	93%	4%
65+	96%	2%
Q1 - Highest income	90%	7%
Q2	89%	8%
Q3	89%	6%
Q4	82%	8%
Q5 - Lowest income	80%	6%
Urban	86%	3%
Rural	99%	2%
Not an immigrant	86%	4%
Immigrant within past 10 years	62%	16%
Immigrant over 10 years ago	96%	4%
Owner	92%	3%
Renter	71%	9%

Data table for Figure 7. Immunization coverage rates for school year 2018-19 among 7- and 17-year-olds in Ottawa, and national coverage goals, by disease.

Diseases	7-year- olds	17-year-olds	National Coverage Goal 7-year-olds	National Coverage Goal 17-year-olds
Measles	87%	97%	95%	95%
Mumps	87%	97%	95%	95%
Rubella	99%	99%	95%	95%
Diphtheria	86%	76%	95%	90%
Tetanus	86%	76%	95%	90%
Polio	86%	95%	95%	95%
Pertussis	85%	72%	95%	90%
Haemophilus influenza B	86%	N/A	95%	N/A
Pneumococcal disease	80%	N/A	95%	N/A
Meningococcal disease	98%	N/A	95%	N/A
Varicella	83%	N/A	N/A	N/A

Data table for Figure 8: Total annual volume of vaccine doses distributed by OPH by vaccine product, 2018-2022.

Vaccine Product	Diseases Covered by Vaccine	2018	2019	2020	2021	2022
DTap-IPV-Hib	Diphtheria, tetanus, per- tussis, polio, Haemophilus influenza B	43,440	41,825	42,060	42,245	42,275
Men-C-C	Meningococcal disease	14,991	14,230	12,800	11,950	13,418
MMR	Measles, mumps, rubella	24,426	31,910	18,482	17,890	21,707
MMR-Var	Measles, mumps, rubella, varicella		18,000	12,150	14,080	15,962
Pneu-C-13	Pneumococcal disease	35,300	34,610	33,430	33,070	33,881
Tdap	Diphtheria, tetanus, pertussis	62,450	62,445	33,126	38,395	50,080
Diphtheria, tet- anus, pertussis, polio		20,916	21,885	15,615	15,635	21,147
Var	Varicella	18,072	15,830	13,910	14,850	16,781

Data table for Figure 9: Immunization coverage rates for hepatitis B, HPV, and MCV4, among 12- and 17-year-olds in Ottawa by school year, 2018-19 to 2021-22.

School Year	Population	Hepatitis B	HPV	MCV4
2018-19	12-year-olds	75%	67%	88%
2019-20 (with catch-up)	12-year-olds	48%	30%	89%
2020-21 (with catch-up)	12-year-olds	63%	54%	78%
2021-22	12-year-olds	58%	47%	78%
2018-19	17-year-olds	80%	67%	96%
2019-20 (with catch-up)	17-year-olds	80%	66%	96%
2020-21 (with catch-up)	17-year-olds	80%	67%	96%
2021-22	17-year-olds	76%	63%	93%

Data table for Figure 10: Percent of the population aged 18 years and older that met the Canadian Physical Activities guidelines by subgroup, 2017-2018.

Category	Percentage of the population aged 18 and older (%)	Confidence Interval (%)
Ottawa	67%	3%
Ontario less Ottawa	55%	1%
Female	61%	5%
Male	72%	5%
18-44	73%	5%
45-64	68%	5%
65+	47%	7%
English	72%	4%
French	59%	7%
Other	59%	9%
Less than high school graduation	36%*	18%
High school graduation	68%	8%
Post-secondary education	68%	4%

Data table for Figure 11: Breast cancer and cervical screening participation as a percent of screen-eligible residents of Ottawa 2018-2020

Cancer Screening	Year	Percent of screen-eligible people
Breast cancer screening participation	2018	65%
Breast cancer screening participation	2019	64%
Breast cancer screening participation	2020	58%
Cervical screening participation	2018	61%
Cervical screening participation	2019	60%
Cervical screening participation	2020	56%

Data table for Figure 12: Percent of those screen-eligible people in Ottawa overdue for colorectal cancer screening 2018-2020

Cancer Screening	Year	Percent of screen-eligible people
Overdue for colorrectal cancer screening	2018	37%
Overdue for colorrectal cancer screening	2019	38%
Overdue for colorrectal cancer screening	2020	43%

Category	Percent of population aged 18 and older (%)	Confidence Interval (%)
Ottawa	58%	4%
Ontario less Ottawa	65%	1%
Male	64%	5%
Female	56%	6%
18-44	50%	7%
45-64	69%	6%
65 and older	60%	6%

Data table for Figure 14. Percent of population aged 18 and older with a BMI estimate of overweight or obese in 2019-2020 by region, sex and age.

Year	Percent of population aged 18 and older (%)	Confidence Interval (%)
2005	44%	3%
2007/2008	48%	3%
2009/2010	52%	3%
2011/2012	47%	3%
2013/2014	49%	4%
2015-2016	57%	4%
2017-2018	61%	4%
2019/2020	58%	4%

Data table for Figure 15: Opioid-related Morbidity and Mortality Rates in Ottawa by Year and Quarter, 2017 to 2022.

Year	Quarter	Population	ED visits	Hospitalizations	Deaths
2016	Q1	966,584	21.5	9.5	4.6
2016	Q2	970,722	23.5	11.1	2.9
2016	Q3	975,412	26.2	11.9	3.3
2016	Q4	981,204	28.5	10.6	6.1
2017	Q1	986,997	28.8	11.8	3.6
2017	Q2	992,789	37.5	11.7	6.4
2017	Q3	998,267	52.9	8.4	11.2
2017	Q4	1,003,114	29.5	9.2	5.2
2018	Q1	1,007,961	32.9	6	5.6
2018	Q2	1,012,808	37.9	9.9	5.5
2018	Q3	1,017,509	52.7	7.5	9
2018	Q4	1,021,919	51.3	11.7	12.1

Year	Quarter	Population	ED visits	Hospitalizations	Deaths
2019	Q1	1,026,329	38.2	7	7.8
2019	Q2	1,030,739	58.6	10.9	7.4
2019	Q3	1,034,996	37.5	7	4.3
2019	Q4	1,038,948	39.3	8.5	5.8
2020	Q1	1,042,900	49.9	7.3	6.9
2020	Q2	1,046,852	68	4.2	12.2
2020	Q3	1,050,647	103.6	12.6	14.5
2020	Q4	1,054,131	68.3	12.5	14.4
2021	Q1	1,057,615	80.6	6.4	14
2021	Q2	1,061,099	105.2	10.6	17
2021	Q3	1,064,587	89	13.2	11.6
2021	Q4	1,068,083	94.7	12	13.1
2022	Q1	1,071,578	72	7.8	13.8
2022	Q2	1,075,074	69.6	9.3	N/A

Data table for Figure 16: Percent of population aged 19 and older who are at low or no risk from alcohol related harms in Ottawa and Ontario-less-Ottawa by year, 2015-2020.

Cycle	Percent Ottawa	Confidence Interval Ottawa	Percent Ontario— less—Ottawa	Confidence Interval Ontario—less—Ottawa
2015/2016	59.9%	4.2%	67.2%	1.0%
2017/2018	60.5%	4.0%	71.3%	0.9%
2019/2020	65.7%	4.7%	70.8%	1.0%

Data table for Figure 17: Percent of population aged 19 years and older who are at low or no risk from alcohol by subgroup, 2019-2020.

Category	Percent of population aged 19 and older (%)	Confidence Interval (%)
Ottawa	66%	4.7%
Ontario less Ottawa	71%	1.0%
Male	58%	5.8%
Female	73%	6.1%
English	59%	6.3%
French	54%	8.8%
Other	84%	6.0%
Quintile 1 – Highest income	52%	9.4%
Quintile 2 – Second highest income	55%	10.1%
Quintile 3 – Medium income	65%	7.9%
Quintile 4 – Second lowest income	76%	6.8%

Category	Percent of population aged 19 and older (%)	Confidence Interval (%)
Quintile 5 – Lowest income	80%	7.7%
Less than high school	78%	15.0%
High school	79%	6.6%
Post secondary	62%	5.8%
Not an immigrant	59%	5.6%
Immigrated past 10 years	87%	12.0%
Immigrated more than 10 years	82%	6.3%
Not racialized	59%	5.4%
Racialized	87%	7.1%

Data table for Figure 18: Percent of population aged 19 years and older who have used cannabis more than once in the past year by subgroup, 2019-2020. NR = Not Reportable

Category	Percentage of population aged 19 and older (%)	Confidence Interval (%)
Ottawa	22%	4.0%
Ontario less Ottawa	22%	0.9%
Men	28%	5.5%
Women	16%	4.8%
12 to 19	36%	15.4%
20 to 44	31%	6.8%
45 to 64	17%	5.3%
65 and older	6%	2.7%
English	31%	6.0%
French	18%	6.8%
Other	9%	4.8%
Not an immigrant	27%	5.1%
Immigrated in past 10 years	NR	NR
Immigrated over 10 years ago	8%	4.5%
Not racialized	26%	4.9%
Racialized	11%	6.4%

Data table for Figure 19: Percent of the population aged 19 and older who reported currently smoking by year, 2001-2020.

Years	Ottawa Percentage (%)	Ottawa Confidence Interval (%)	Ontario-less- Ottawa Percentage (%)	Ontario-less-Ottawa Confidence Interval (%)
2001	22%	2.3%	26%	0.8%
2003	20%	2.7%	24%	0.7%
2005	21%	2.6%	22%	0.7%
2007/2008	18%	2.6%	22%	0.7%
2009/2010	16%	2.9%	21%	0.8%
2011/2012	17%	2.9%	21%	0.8%
2013/2014	17%	2.7%	19%	0.7%
2015/2016	15%	2.9%	17%	0.8%
2017/2018	12%	2.4%	15%	0.8%
2019/2020	9%	2.3%	13%	0.7%

Data table for Figure 20: Percent of the population aged 19 and older who reported currently smoking by subgroup, 2019-2020. NR = Not Reportable

Category	Percentage of population aged 19 and older (%)	Confidence Interval (%)
Ottawa	9%	2.3%
Ontario-less-Ottawa	13%	0.7%
Male	11%*	3.7%
Female	7%*	2.5%
19-24	NR	NR%
25-44	10%*	4.1%
45-64	10%*	3.6%
65+	9%*	4.3%
Quintile 1 – Highest income	NR	NR
Quintile 2 – Second highest income	5%*	3.1%
Quintile 3 – Medium income	10%*	4.2%
Quintile 4 – Second lowest income	12%*	5.9%
Quintile 5 – Lowest income	14%*	6.2%
Less than high school	31%*	19.4%
High school	9%*	4.7%
Post secondary	7%*	2.4%
Living alone	16%*	4.5%
Single parent	NR	NR
Parents and children	6%*	2.8%
Couple	8%*	3.5%
Owner	6%*	2.0%
Renter	15%*	5.6%

Data table for Figure 21: Daily smoking rates among the population 19 and older in Ottawa and Ontario less Ottawa by year, 2001-2020.

Year	Percent Ottawa	Confidence Interval Ottawa	Percent Ontario– less–Ottawa	Confidence Interval Ontario–less–Ottawa
2001	18%	2.3%	22%	0.7%
2003	15%	2.3%	18%	0.6%
2005	14%	2.1%	17%	0.6%
2007/2008	13%	2.4%	18%	0.7%
2009/2010	11%	2.2%	16%	0.6%
2011/2012	11%	2.3%	16%	0.7%
2013/2014	12%	2.4%	14%	0.7%
2015/2016	10%	2.4%	13%	0.6%
2017/2018	9%	2.3%	11%	0.6%
2019/2020	7%	2.0%	10%	0.6%

Data table for Figure 22: Daily smoking rates among those aged 19 and older, by subgroup, by subgroup, 2019-2020. NR = Not Reportable

Category	Percentage of population aged 19 and older (%)	Confidence Interval (%)
Ottawa	7%	2.0%
Ontario less Ottawa	10%	0.6%
Male	9%*	3.1%
Female	5%*	2.0%
Quintile 1 – Highest income	NR	NR
Quintile 2 – Second highest income	4%*	2.9%
Quintile 3 – Medium income	6%*	3.9%
Quintile 4 – Second lowest income	9%*	5.0%
Quintile 5 – Lowest income	11%*	6.0%
Living alone	11%*	4.1%
Single parent	NR	NR
Couple living with children	4%*	2.5%
Couple not living with children	7%*	3.4%
Owner	4%*	1.8%
Renter	12%*	5.1%

Data table for Figure 23: Percentage of students in grades 7 to 12 who reported using substances in the past year in Ottawa, 2019 and 2021, and Ontario-less-Ottawa, 2021. NR = Not Reportable

Indicator	Population	Percent	Lower Confidence Interval	Upper Confidence Interval
Alcohol	Ottawa 2019	41%	10%	9%
Cannabis	Ottawa 2019	22%*	8%	6%
Vapes/e-cigarettes	Ottawa 2019	NR	NR	NR
Opioids (non-medical)	Ottawa 2019	13%	4%	3%
Tobacco cigarettes	Ottawa 2019	6%*	4%	2%
Alcohol	Ottawa 2021	32%	5%	5%
Cannabis	Ottawa 2021	15%*	7%	5%
Vapes/e-cigarettes	Ottawa 2021	9%*	4%	3%
Opioid (non-medical)	Ottawa 2021	10%	4%	3%
Tobacco cigarettes	Ottawa 2021	3%*	2%	1%
Alcohol	Ontario-less-Ottawa 2021	31%	4%	4%
Cannabis	Ontario-less-Ottawa 2021	17%	5%	4%
Vapes/e-cigarettes	Ontario-less-Ottawa 2021	16%	5%	4%
Opioid (non-medical)	Ontario-less-Ottawa 2021	13%	3%	2%
Tobacco cigarettes	Ontario-less-Ottawa 2021	4%*	3%	2%

Data table for Figure 24: Percentage of students in grades 7 to 12 who reported that it would be fairly or very easy to obtain substances in Ottawa, 2019 and 2021, and Ontario-less-Ottawa, 2021. CI = Confidence Interval; NR = Not Reportable

Substance	Percent Ottawa 2021	Lower CI Ottawa 2021	Upper CI Ottawa 2021	Percent Ottawa 2019	Lower CI Ottawa 2019	Upper CI Ottawa 2019	Percent Ontario- less- Ottawa 2021	Lower CI Ontario- less- Ottawa 2021	Upper CI Ontario- less- Ottawa 2021
Alcohol	63%	7%	7%	67%	13%	11%	57%	7%	7%
Cannabis	38%	7%	8%	44%	13%	15%	39%	6%	7%
Tobacco cigarettes	40%	8%	9%	48%	13%	14%	43%	7%	8%
Vaping device	52%	8%	7%	NR	NR	NR	53%	7%	7%
Opioids (non-medical)	18%	3%	4%	23%	6%	7%	18%	5%	6%

Category	Percent of population 12 years and older (%)	Confidence Interval (%)
Ottawa	67%	5.9%
Ontario less Ottawa	64%	5.6%
12-19	69%	10.9%
20-44	69%	7.6%
45-64	65%	6.8%
65+	54%	6.8%
Less than high school graduation	60%	10.1%
High school graduation	59%	9.4%
Post-secondary education	68%	4.7%
Quintile 1 - highest income	72%	7.3%
Quintile 2	80%	6.9%
Quintile 3	66%	7.0%
Quintile 4	56%	8.8%
Quintile 5 - lowest income	52%	9.3%
Living alone	54%	7.8%
Single parent	70%	12.5%
Couple living with children	70%	6.7%
Couple not living with children	66%	6.3%
Not stated	56%*	22.0%

Data table for Figure 26: Top ten leading causes of Emergency Department (ED) visits by Ottawa residents, 2021.

Leading Causes of ED Visit	Number of Visits	Percent of Total Visits
Injury, poisoning/overdose or other external cause	75,652	23%
Musculoskeletal system and connective tissue conditions	21,310	7%
Digestive conditions	19,482	6%
Genitourinary conditions	16,964	5%
Mental and behavioural conditions	16,418	5%
Respiratory conditions	15,122	5%
Circulatory system conditions	12,771	4%
Infectious and parasitic diseases	11,799	4%
Skin and subcutaneous tissue conditions	10,863	3%
Nervous system conditions	6,120	2%

Data table for Figure 27: Age standardized hospitalization rates by cause and Ottawa Neighbourhood Study socioeconomic quintiles 1 and 5, 2021.

Hospitalizations	Quintile 1 — Highest advantage	Quintile 1 — Confidence Interval	Quintile 5 – Lowest Advantage	Quintile 5 – Confidence Interval
Circulatory system disease	2977	80.6	3965	90.8
Endocrine, nutritional and metabolic disease	2172	68.5	3085	79.9
Genitourinary disease	1752	61.7	2206	67.5
Digestive system disease	1720	60.2	2030	64.8
Injury	1460	55.8	1724	59.8

Data table for Figure 28: Percentage of injury related emergency department visit and hospitalizations by cause in Ottawa, 2021.

Injury type	Emergency department visits	Hospitalizations
Falls	39%	70%
Sport and recreation	12%	7%
Struck	9%	2%
Cut	9%	2%
Overexertion	7%	1%
Environmental	6%	1%
MVTC	5%	7%
Selfharm	2%	13%

Data table for Figure 29: Self-rated mental health among Ottawa residents aged 12 years and older by subgroup, 2019-2020.

Category	Category Percent of population aged 12 and older (%)	
Ottawa	60%	2%
Ontario less Ottawa	65%	1%
Male	64%	5%
Female	56%	6%
12-19	58%	12%
20-44	51%	8%
45-64	66%	7%
65+	74%	7%

Category	Percent of population aged 12 and older (%)	Confidence Interval (%)
Quintile 1 – Highest income	69%	9%
Quintile 2 – Second highest income	71%	9%
Quintile 3 – Medium income	61%	8%
Quintile 4 – Second lowest income	50%	8%
Quintile 5 – Lowest income	50%	9%
Own	67%	4%
Rent	45%	8%
Living alone	47%	8%
Single parent	51%	12%
Couple living with children	62%	6%
Couple not living with children	69%	7%
Not stated	61%*	21%

Data table for Figure 30: Percentage of Ottawa residents (18+ years) who wanted to reach out for mental health support but did not know where to turn.

Category	Precent	Year	Lower Confidence Limit	Upper Confidence Limit
Ottawa	25%	2020	21%	29%
Ottawa	24%	2021	20%	28%
18-34 years	32%	2020	22%	44%
18-34 years	30%	2021	21%	41%
35-44 years	22%	2020	15%	31%
35-44 years	28%	2021	22%	36%
45-54 years	24%	2020	17%	32%
45-54 years	20%	2021	15%	26%
55-64 years	25%	2020	17%	35%
55-64 years	29%	2021	22%	38%
65 years or older	17%	2020	11%	26%
65 years or older	11%	2021	7%	16%
Disability	44%	2020	31%	58%
Disability	32%	2021	23%	43%
No disability	22%	2020	18%	27%
No disability	22%	2021	19%	27%
Gender - Man	21%	2020	16%	27%
Gender - Man	20%	2021	16%	26%

Category	Precent	Year	Lower Confidence Limit	Upper Confidence Limit
Gender - Woman	27%	2020	21%	34%
Gender - Woman	26%	2021	21%	33%
\$59,999 or less	38%	2020	27%	50%
\$59,999 or less	29%	2021	19%	41%
\$60,000 to \$99,999	28%	2020	20%	39%
\$60,000 to \$99,999	27%	2021	20%	36%
\$100,000 to \$159,999	17%	2020	12%	24%
\$100,000 to \$159,999	21%	2021	15%	27%
\$160,000 or more	18%	2020	12%	26%
\$160,000 or more	21%	2021	15%	29%
Parents with kids (4 years or less)	29%	2020	17%	45%
Parents with kids (4 years or less)	21%	2021	12%	33%
Parents with kids (5-11 years)	27%	2020	19%	38%
Parents with kids (5-11 years)	25%	2021	18%	33%
Parents with kids (12-17 years)	17%	2020	11%	25%
Parents with kids (12-17 years)	21%	2021	16%	29%
Non-racialized	24%	2020	20%	29%
Non-racialized	23%	2021	20%	27%
Racialized	32%	2020	19%	50%
Racialized	28%	2021	18%	41%
Heterosexual	24%	2020	20%	29%
Heterosexual	21%	2021	18%	25%
2SLGBTQQIA+	29%	2020	16%	48%
2SLGBTQQIA+	45%	2021	29%	63%

Data table for Figure 31: Percentage of Ottawa students in grades 7 to 12 reporting mental health and emotional well-being, in 2021 compared to 2019.

Indicator	2019	2021
Reported fair/poor mental health	21%	44%
Reported fair/poor ability to cope with unexpected problems/crisis	18%	33%
Used telephone crisis helpline / websites	5%	8%
Wanted to talk to someone but didn't know where to turn	34%	42%

Data table for Figure 32: Percentage of Ottawa residents with a mental health concern during their pregnancy, 2013 to 2022.

Year	Percentage of women with a mental health concern
2013	15%
2014	14%
2015	14%
2016	15%
2017	17%
2018	17%
2019	18%
2020	21%
2021	23%
2022	23%

Data table for Figure 33. Number of Ottawa residents with an infection from a direct contact or respiratory disease of public health significance, 2022 vs pre-pandemic (2017 to 2019) average.

Disease	Ottawa residents with laboratory-confirmed infections in 2022	Yearly pre-pandemic average of Ottawa residents with lab- oratory-confirmed infections (2017 to 2019)	
LTBI	839	755.3	
Tuberculosis	59	50.3	
Group A Streptococcal Disease, Invasive	53	69.3	
Мрох	42	0	
Carbapenemase-Producing Enterobacteriaceae	30	11.3	
Legionellosis	17	5.7	

Disease	Ottawa residents with laboratory-confirmed infections in 2022	Yearly pre-pandemic average of Ottawa residents with lab- oratory-confirmed infections (2017 to 2019)
Blastomycosis	7	2
Meningococcal Disease, Inva- sive	5	2
Group B Streptococcal Disease, Neonatal	2	3.7
Leprosy	0	0

Data table for Figure 34: Incidence of invasive group A streptococcal disease and invasive meningococcal disease, Ottawa, 2017 to 2022.

Disease	Year	Rate per 100,000 population
Group A Streptococcal Disease, Invasive	2019	6.9
Group A Streptococcal Disease, Invasive	2017	6.9
Group A Streptococcal Disease, Invasive	2018	6.9
Group A Streptococcal Disease, Invasive	2020	5.4
Group A Streptococcal Disease, Invasive	2022	4.9
Group A Streptococcal Disease, Invasive	2021	2.8
Meningococcal Disease, Invasive	2022	0.5
Meningococcal Disease, Invasive	2017	0.4
Meningococcal Disease, Invasive	2018	0.2
Meningococcal Disease, Invasive	2020	0.1
Meningococcal Disease, Invasive	2019	0
Meningococcal Disease, Invasive	2021	0

Data table for Figure 35: Incidence of active tuberculosis, Ottawa, 2017 to 2022.

Diagnosis Year	Incidence Rate
2017	4.6
2018	5.1
2019	5.4
2020	5.1
2021	5.9
2022	5.5

Data table for Figure 36: Number of reported laboratory-confirmed influenza cases by type and reported week in Ottawa, September 2022 (week 35) to March 2023 (week 11), and historical trends.

Episode Week	2022-2023	2021-2022	2020-2021	2019-2020	Pre-COVID 3 Season Average
wk 35 - 28 Aug	0	0	0	1	0.3
wk 36 - 04 Sep	1	0	0	0	0.7
wk 37 - 11 Sep	0	1	1	0	0.3
wk 38 - 18 Sep	4	0	1	0	1.0
wk 39 - 25 Sep	1	0	1	0	0.3
wk 40 - 02 Oct	3	0	0	0	1.7
wk 41 - 09 Oct	0	0	0	0	1.3
wk 42 - 16 Oct	1	0	0	5	1.7
wk 43 - 23 Oct	20	0	0	1	1.0
wk 44 - 30 Oct	34	0	0	3	1.3
wk 45 - 06 Nov	51	0	0	5	1.0
wk 46 - 13 Nov	93	0	0	9	3.3
wk 47 - 20 Nov	137	0	0	6	2.7
wk 48 - 27 Nov	122	0	0	16	6.7
wk 49 - 04 Dec	141	0	0	21	10.0
wk 50 - 11 Dec	99	2	0	24	11.7
wk 51 - 18 Dec	58	3	0	47	25.0
wk 52 - 25 Dec	43	3	0	58	38.7
wk 1 - 01 Jan	28	1	0	83	54.3

Episode Week	2022-2023	2021-2022	2020-2021	2019-2020	Pre-COVID 3 Season Average
wk 2 - 08 Jan	12	0	0	53	57.7
wk 3 - 15 Jan	9	0	0	57	52.3
wk 4 - 22 Jan	4	0	0	55	43.3
wk 5 - 29 Jan	2	0	0	69	46.7
wk 6 - 05 Feb	5	0	0	65	53.7
wk 7 - 12 Feb	0	0	0	56	60.0
wk 8 - 19 Feb	0	0	0	49	60.3
wk 9 - 26 Feb	1	0	0	39	62.0
wk 10 - 05 Mar	0	0	0	29	39.7
wk 11 - 12 Mar	0	0	0	57	36.3
wk 12 - 19 Mar	1	0	0	21	26.3
wk 13 - 26 Mar	0	0	0	12	25.3
wk 14 - 02 Apr	0	2	0	7	26.0
wk 15 - 09 Apr	0	4	0	12	25.3
wk 16 - 16 Apr	0	1	0	6	15.3
wk 17 - 23 Apr	0	3	0	7	12.0
wk 18 - 30 Apr	0	3	0	6	9.7
wk 19 - 07 May	0	5	0	2	3.7
wk 20 - 14 May	0	3	0	6	5.0
wk 21 - 21 May	0	7	0	4	3.7
wk 22 - 28 May	0	4	0	7	1.3
wk 23 - 04 Jun	0	2	0	2	1.0
wk 24 - 11 Jun	0	0	0	1	0.7
wk 25 - 18 Jun	0	1	0	0	0.7
wk 26 - 25 Jun	0	1	0	1	0.3
wk 27 - 02 Jul	0	1	0	0	0.3
wk 28 - 09 Jul	0	0	0	1	0.0
wk 29 - 16 Jul	0	0	0	1	0.0
wk 30 - 23 Jul	0	0	0	2	0.3
wk 31 - 30 Jul	0	0	0	0	0.0
wk 32 - 06 Aug	0	0	0	0	0.3
wk 33 - 13 Aug	0	1	0	2	0.7
wk 34 - 20 Aug	0	0	0	1	0.3
wk 35 - 27 Aug	0	0	0	1	0.3

Data table for Figure 37: Percentage of Ottawa adults reporting influenza immunization by age group and influenza season, 2013/14 to 2020/21.

Influenza Season	Age 18 to 64 Years (%)	Age 18 to 64 Years (95% Confidence Intervals)	Age 65+ Years (%)	Age 65+ Years (95% Confidence Intervals)
2013/14	45.8%	38.8% - 52.8%	86%	78.5% – 93.4%
2014/15	38.6%	32.2% – 45.1%	79.9%	72.8% – 87.0%
2015/16	36.6%	30.0% - 43.1%	79.6%	71.7% – 87.6%
2016/17	43.7%	36.9% - 50.4%	83.7%	75.7% – 91.7%
2017/18	33.5%	27.0% - 40.0%	77.9%	70.0% – 85.8%
2018/19	45.8%	39.0% - 52.6%	85.8%	78.4% – 91.0%
2019/20	43.0%	33.4% - 53.3%	76.1%	63.1% - 85.6%
2020/21	43.2%	37.8% – 48.9%	73.9%	65.3% - 81.0%

Data Table for Figure 38: Timeline of the rate of COVID-19 cases among Ottawa residents by reported week and age group (years).

Wools		Co	unt			Ra	Rate			
Week Start	0 to 29 years	30 to 64 years	65 years and older	All cases	0 to 29 years	30 to 64 years	65 years and older	All cases		
09-Feb-20			1	1	0.0	0.0	0.6	0.1		
16-Feb-20		2		2	0.0	0.4	0.0	0.2		
23-Feb-20		2		2	0.0	0.4	0.0	0.2		
01-Mar-20	2	16	4	22	0.5	3.3	2.4	2.1		
08-Mar-20	10	57	21	88	2.6	11.6	12.5	8.4		
15-Mar-20	17	95	35	147	4.4	19.3	20.8	14.1		
22-Mar-20	21	88	36	145	5.4	17.9	21.4	13.9		
29-Mar-20	27	80	42	149	7.0	16.3	25.0	14.2		
05-Apr-20	29	94	79	202	7.5	19.1	47.0	19.3		
12-Apr-20	33	102	126	261	8.5	20.8	74.9	24.9		
19-Apr-20	18	132	192	342	4.7	26.9	114.2	32.7		
26-Apr-20	31	98	94	223	8.0	20.0	55.9	21.3		
03-May-20	16	44	71	131	4.1	9.0	42.2	12.5		
10-May-20	32	52	42	126	8.3	10.6	25.0	12.0		
17-May-20	25	30	22	77	6.5	6.1	13.1	7.4		
24-May-20	16	21	13	50	4.1	4.3	7.7	4.8		

Wools	Count			Rate				
Week Start	0 to 29 years	30 to 64 years	65 years and older	All cases	0 to 29 years	30 to 64 years	65 years and older	All cases
31-May-20	9	18	15	42	2.3	3.7	8.9	4.0
07-Jun-20	10	24	4	38	2.6	4.9	2.4	3.6
14-Jun-20	12	12	2	26	3.1	2.4	1.2	2.5
21-Jun-20	13	17	2	32	3.4	3.5	1.2	3.1
28-Jun-20	12	13	4	29	3.1	2.6	2.4	2.8
05-Jul-20	22	32	5	59	5.7	6.5	3.0	5.6
12-Jul-20	89	65	10	164	23.0	13.2	5.9	15.7
19-Jul-20	84	66	3	153	21.7	13.4	1.8	14.6
26-Jul-20	53	40	13	106	13.7	8.1	7.7	10.1
02-Aug-20	36	27	3	66	9.3	5.5	1.8	6.3
09-Aug-20	40	29	2	71	10.3	5.9	1.2	6.8
16-Aug-20	68	59	8	135	17.6	12.0	4.8	12.9
23-Aug-20	62	56	12	130	16.0	11.4	7.1	12.4
30-Aug-20	71	63	37	171	18.3	12.8	22.0	16.3
06-Sep-20	139	136	40	315	35.9	27.7	23.8	30.1
13-Sep-20	254	169	36	459	65.6	34.4	21.4	43.9
20-Sep-20	333	276	65	674	86.0	56.2	38.7	64.4
27-Sep-20	282	301	73	656	72.9	61.3	43.4	62.7
04-Oct-20	225	234	79	538	58.1	47.6	47.0	51.4
11-Oct-20	200	220	65	485	51.7	44.8	38.7	46.4
18-Oct-20	159	224	113	496	41.1	45.6	67.2	47.4
25-Oct-20	178	172	136	486	46.0	35.0	80.9	46.5
01-Nov-20	160	174	72	406	41.3	35.4	42.8	38.8
08-Nov-20	146	133	54	333	37.7	27.1	32.1	31.8
15-Nov-20	85	114	32	231	22.0	23.2	19.0	22.1
22-Nov-20	119	148	35	302	30.7	30.1	20.8	28.9
29-Nov-20	125	140	35	300	32.3	28.5	20.8	28.7
06-Dec-20	151	133	26	310	39.0	27.1	15.5	29.6
13-Dec-20	124	145	31	300	32.0	29.5	18.4	28.7
20-Dec-20	211	269	57	537	54.5	54.8	33.9	51.3
27-Dec-20	436	428	104	968	112.7	87.2	61.9	92.5
03-Jan-21	346	322	64	732	89.9	64.9	36.9	69.4
10-Jan-21	209	250	77	536	54.3	50.4	44.4	50.8
17-Jan-21	122	167	48	337	31.7	33.6	27.7	31.9
24-Jan-21	130	185	38	353	33.8	37.3	21.9	33.5

Week	Count				Rate			
Start	0 to 29 years	30 to 64 years	65 years and older	All cases	0 to 29 years	30 to 64 years	65 years and older	All cases
31-Jan-21	141	150	36	327	36.6	30.2	20.7	31.0
07-Feb-21	191	156	39	386	49.6	31.4	22.5	36.6
14-Feb-21	163	159	30	352	42.3	32.0	17.3	33.4
21-Feb-21	207	183	60	450	53.8	36.9	34.6	42.7
28-Feb-21	224	208	39	471	58.2	41.9	22.5	44.7
07-Mar-21	306	317	48	671	79.5	63.9	27.7	63.6
14-Mar-21	423	428	75	926	109.9	86.2	43.2	87.8
21-Mar-21	633	706	110	1449	164.5	142.2	63.4	137.4
28-Mar-21	849	954	173	1976	220.6	192.2	99.7	187.3
04-Apr-21	723	865	144	1732	187.8	174.3	83.0	164.2
11-Apr-21	562	639	112	1313	146.0	128.7	64.5	124.5
18-Apr-21	445	496	100	1041	115.6	99.9	57.6	98.7
25-Apr-21	311	335	52	698	80.8	67.5	30.0	66.2
02-May-21	315	291	49	655	81.8	58.6	28.2	62.1
09-May-21	223	213	57	493	57.9	42.9	32.8	46.7
16-May-21	150	158	31	339	39.0	31.8	17.9	32.1
23-May-21	122	105	14	241	31.7	21.2	8.1	22.8
30-May-21	94	70	9	173	24.4	14.1	5.2	16.4
06-Jun-21	59	51	8	118	15.3	10.3	4.6	11.2
13-Jun-21	35	22	2	59	9.1	4.4	1.2	5.6
20-Jun-21	16	15	1	32	4.2	3.0	0.6	3.0
27-Jun-21	13	9	2	24	3.4	1.8	1.2	2.3
04-Jul-21	11	17	3	31	2.9	3.4	1.7	2.9
11-Jul-21	18	24	4	46	4.7	4.8	2.3	4.4
18-Jul-21	21	20	3	44	5.5	4.0	1.7	4.2
25-Jul-21	56	39	1	96	14.5	7.9	0.6	9.1
01-Aug-21	69	44	9	122	17.9	8.9	5.2	11.6
08-Aug-21	81	67	4	152	21.0	13.5	2.3	14.4
15-Aug-21	136	81	7	224	35.3	16.3	4.0	21.2
22-Aug-21	159	125	13	297	41.3	25.2	7.5	28.2
29-Aug-21	225	147	21	393	58.5	29.6	12.1	37.3
05-Sep-21	238	147	23	408	61.8	29.6	13.3	38.7
12-Sep-21	188	119	22	329	48.8	24.0	12.7	31.2
19-Sep-21	179	116	11	306	46.5	23.4	6.3	29.0
26-Sep-21	141	100	15	256	36.6	20.1	8.6	24.3
03-Oct-21	109	64	9	182	28.3	12.9	5.2	17.3

Wook	Week			Rate				
Start	0 to 29 years	30 to 64 years	65 years and older	All cases	0 to 29 years	30 to 64 years	65 years and older	All cases
10-Oct-21	98	70	9	177	25.5	14.1	5.2	16.8
17-Oct-21	77	70	16	163	20.0	14.1	9.2	15.5
24-Oct-21	137	105	28	270	35.6	21.2	16.1	25.6
31-Oct-21	161	127	39	327	41.8	25.6	22.5	31.0
07-Nov-21	134	99	26	259	34.8	19.9	15.0	24.6
14-Nov-21	152	131	29	312	39.5	26.4	16.7	29.6
21-Nov-21	242	203	35	480	62.9	40.9	20.2	45.5
28-Nov-21	422	362	46	830	109.6	72.9	26.5	78.7
05-Dec-21	1209	1210	97	2516	314.1	243.8	55.9	238.5
12-Dec-21	2711	2367	280	5358	704.3	476.9	161.4	508.0
19-Dec-21	3417	3539	548	7504	887.7	713.0	315.8	711.4
26-Dec-21	1655	2301	541	4497	430.0	463.6	311.8	426.3
02-Jan-22	1001	1666	587	3254	255.8	330.9	326.3	302.8
09-Jan-22	628	1093	510	2231	160.5	217.1	283.5	207.6
16-Jan-22	432	721	386	1539	110.4	143.2	214.6	143.2
23-Jan-22	360	572	196	1128	92.0	113.6	108.9	105.0
30-Jan-22	260	353	72	685	66.4	70.1	40.0	63.7
06-Feb-22	249	357	70	676	63.6	70.9	38.9	62.9
13-Feb-22	242	330	59	631	61.8	65.5	32.8	58.7
20-Feb-22	231	310	70	611	59.0	61.6	38.9	56.9
27-Feb-22	195	310	70	575	49.8	61.6	38.9	53.5
06-Mar-22	224	317	50	591	57.2	63.0	27.8	55.0
13-Mar-22	317	415	85	817	81.0	82.4	47.2	76.0
20-Mar-22	397	673	144	1214	101.4	133.7	80.0	113.0
27-Mar-22	347	696	221	1264	88.7	138.2	122.8	117.6
03-Apr-22	262	532	253	1047	66.9	105.7	140.6	97.4

Data Table for Figure 39: COVID-19 infection rates, per 100,000 population excluding LTCH residents, across quintiles in Ottawa based on case reported date: (A) prior to most Ottawa residents being protected by COVID-19 vaccination, (B) more than 60% of Ottawa residents protected by COVID-19 vaccination and before the arrival of the Omicron variant, and (C) after the arrival of the Omicron variant in Ottawa.

Reported Date	ONS SES Quintile	Rate per 100,000 (Excl. LTCH)
(A) 11 Feb 2020 to 20 July 2021	1	1723
(A) 11 Feb 2020 to 20 July 2021	2	2207
(A) 11 Feb 2020 to 20 July 2021	3	2013
(A) 11 Feb 2020 to 20 July 2021	4	2537

Reported Date	ONS SES Quintile	Rate per 100,000 (Excl. LTCH)
(A) 11 Feb 2020 to 20 July 2021	5	3996
(B) 21 July 2021 to 30 Dec 2021	1	1568
(B) 21 July 2021 to 30 Dec 2021	2	1636
(B) 21 July 2021 to 30 Dec 2021	3	1440
(B) 21 July 2021 to 30 Dec 2021	4	1431
(B) 21 July 2021 to 30 Dec 2021	5	1611
(C) 1 Jan 2022 to 13 June 2022	1	2413
(C) 1 Jan 2022 to 13 June 2022	2	2419
(C) 1 Jan 2022 to 13 June 2022	3	2299
(C) 1 Jan 2022 to 13 June 2022	4	2449
(C) 1 Jan 2022 to 13 June 2022	5	2494

Data table for Figure 40: Population COVID-19 hospitalization and death rates, per 100,000 population excluding LTCH, based on case reported date: (A) prior to most Ottawa residents being protected by COVID-19 vaccination, (B) more than 60% of Ottawa residents protected by COVID-19 vaccination and before the arrival of the Omicron variant, and (C) after the arrival of the Omicron variant in Ottawa.

Reported Date	ONS SES Quintile	Hospitalizations (Excl. LTCH)	Deaths (Excl. LTCH)
(A) 11 Feb 2020 to 20 July 2021	1	67	12
(A) 11 Feb 2020 to 20 July 2021	2	90	12
(A) 11 Feb 2020 to 20 July 2021	3	123	28
(A) 11 Feb 2020 to 20 July 2021	4	148	22
(A) 11 Feb 2020 to 20 July 2021	5	200	36
(B) 21 July 2021 to 30 Dec 2021	1	12	2
(B) 21 July 2021 to 30 Dec 2021	2	14	0
(B) 21 July 2021 to 30 Dec 2021	3	22	2
(B) 21 July 2021 to 30 Dec 2021	4	22	7
(B) 21 July 2021 to 30 Dec 2021	5	35	6
(C) 1 Jan 2022 to 13 June 2022	1	41	8
(C) 1 Jan 2022 to 13 June 2022	2	39	6
(C) 1 Jan 2022 to 13 June 2022	3	71	11
(C) 1 Jan 2022 to 13 June 2022	4	100	14
(C) 1 Jan 2022 to 13 June 2022	5	111	23

Data table for Figure 41: COVID-19 vaccination coverage in Ottawa neighbourhoods by SES quintile.

SES Quintile	Percent Coverage – At Least 1 Dose	Percent Coverage – At Least 2 Doses	Percent Coverage – At Least 3 Doses	Percent Coverage – At Least 4 Doses
1	88%	86%	63%	38%
2	87%	85%	62%	37%
3	90%	87%	67%	43%
4	88%	86%	62%	38%
5	85%	81%	53%	30%

Data table for Figure 42: Ottawa residents diagnosed with, or vaccinated against, mpox by week, May 1, 2022 to Feb 19, 2023.

Start of week	Number diagnosed with mpox	Number vaccinated with at least one dose of Imvamune
2022-05-01	0	0
2022-05-08	0	0
2022-05-15	0	0
2022-05-22	1	0
2022-05-29	0	0
2022-06-05	0	2
2022-06-12	2	16
2022-06-19	4	257
2022-06-26	4	184
2022-07-03	6	272
2022-07-10	8	270
2022-07-17	5	305
2022-07-24	6	356
2022-07-31	1	302
2022-08-07	1	451
2022-08-14	1	896
2022-08-21	1	455
2022-08-28	1	241
2022-09-04	0	159
2022-09-11	0	76
2022-09-18	0	59
2022-09-25	1	50
2022-10-02	0	27
2022-10-09	0	31
2022-10-16	0	28

Start of week	Number diagnosed with mpox	Number vaccinated with at least one dose of Imvamune
2022-10-23	0	24
2022-10-30	0	22
2022-11-06	0	14
2022-11-13	0	13
2022-11-20	0	12
2022-11-27	0	7
2022-12-04	0	11
2022-12-11	0	7
2022-12-18	0	18
2022-12-25	0	8
2023-01-01	0	5
2023-01-08	0	4
2023-01-15	0	11
2023-01-22	0	3
2023-01-29	0	4
2023-02-05	0	5
2023-02-12	0	4
2023-02-19	0	3
2023-02-26	0	0

Data table for Figure 43: Number of residents of Ottawa with a laboratory-confirmed infection from a sexually transmitted or blood-borne disease of public health significance, 2022 vs pre-pandemic (2017 to 2019) average.

Disease	Ottawa Residents with a confirmed infection in 2022 (Previous Year)	Yearly pre-pandemic average of Ottawa residents with a confirmed infection (2017 to 2019)
Chlamydial Infections	3063	3731.0
Gonorrhea	819	756.3
Syphilis	248	237.3
Hepatitis C	240	287.0
Hepatitis B	146	167.0
HIV	24	51.3

Data table for Figure 44: Incidence rate of chlamydia and gonorrhea by year in Ottawa, 2017 to 2022

Disease	Year	Rate per 100,000 population
Chlamydial Infections	2017	350.9
Chlamydial Infections	2018	378.9
Chlamydial Infections	2019	383.6
Chlamydial Infections	2020	249.8
Chlamydial Infections	2021	239.4
Chlamydial Infections	2022	284.1
Gonorrhea	2017	65.0
Gonorrhea	2018	89.5
Gonorrhea	2019	71.3
Gonorrhea	2020	46.9
Gonorrhea	2021	56.5
Gonorrhea	2022	76.0

Data table for Figure 45: Incidence of hepatitis B, hepatitis C, HIV, syphilis by year in Ottawa, 2017 to 2022.

Disease	Year	Rate per 100,000 population
Hepatitis B	2017	15.5
Hepatitis B	2018	16.4
Hepatitis B	2019	17.9
Hepatitis B	2020	12.9
Hepatitis B	2021	12.2
Hepatitis B	2022	13.5
Hepatitis C	2017	27.4
Hepatitis C	2018	31.2
Hepatitis C	2019	27.1
Hepatitis C	2020	20.3
Hepatitis C	2021	24.2
Hepatitis C	2022	22.3
HIV	2017	4.4
HIV	2018	7.5
HIV	2019	3.5
HIV	2020	3.5
HIV	2021	3.0
HIV	2022	2.2
Syphilis	2017	18.3
Syphilis	2018	25.7
Syphilis	2019	26.7

Disease	Year	Rate per 100,000 population
Syphilis	2020	19.7
Syphilis	2021	21.0
Syphilis	2022	23.0

Data table for Figure 46: Number of Ottawa residents reported with an infection from a vaccine preventable disease of public health significance, 2022 vs pre-pandemic (2017 to 2019) average.

Disease	Ottawa residents with a reported infection in 2022	Yearly pre-pandemic average of Ottawa residents with a reported infection (2017 to 2019)
Streptococcus Pneumoniae, Invasive	77	71.7
Chickenpox (Varicella)	21	15
Haemophilus Influenzae Disease, All Types, Invasive	11	12.3
Mumps	1	5.7
Tetanus	1	0
Measles	0	1
Pertussis (Whooping Cough)	0	27
Polio	0	0
Rubella	0	0
Smallpox	0	0

Data table for Figure 47: Number of Ottawa residents reported with an enteric disease of public health significance, 2022 vs pre-pandemic (2017 to 2019) average.

Disease	Ottawa residents with a reported infection in 2022	Yearly pre-pandemic average of Ottawa residents with a reported infection (2017 to 2019)
Salmonellosis	99	172.7
Campylobacter Enteritis	96	195.7
Giardiasis	87	121
Cyclosporiasis	53s	27.7
Amebiasis	27	63.3
Shigellosis	19	25.7
Cryptosporidiosis	15	25.7
Listeriosis	9	3.7
Typhoid Fever	9	5.3
Yersiniosis	7	12.7
Hepatitis A	6	11

Disease	Ottawa residents with a reported infection in 2022	Yearly pre-pandemic average of Ottawa residents with a reported infection (2017 to 2019)
Paratyphoid Fever	2	1.7
Cholera	1	0.3
Trichinosis	1	2.7
Verotoxin Producing E. Coli	1	5.3

Data table for Figure 48: Incidence rate of campylobacter enteritis, giardiasis and salmonellosis by year in Ottawa, 2017 to 2022.

Year	Disease	Rate per 100,000 population
2017	Campylobacter Enteritis	19.4
2018	Campylobacter Enteritis	21.3
2019	Campylobacter Enteritis	17.7
2020	Campylobacter Enteritis	9.4
2021	Campylobacter Enteritis	10.2
2022	Campylobacter Enteritis	8.9
2017	Giardiasis	12.2
2018	Giardiasis	13.1
2019	Giardiasis	10.8
2020	Giardiasis	7.1
2021	Giardiasis	6.4
2022	Giardiasis	8.1
2017	Salmonellosis	17.6
2018	Salmonellosis	17.8
2019	Salmonellosis	16.2
2020	Salmonellosis	6.3
2021	Salmonellosis	5.5
2022	Salmonellosis	9.2

Data table for Figure 49: Incidence rate of all enteric diseases of public health significance combined by month, Ottawa, pre-pandemic average (2017 to 2019) vs pandemic average (2020 to 2022) vs 2022.

Month	Rate in 2022	Average Yearly Rate from 2017 to 2019 (Prior to COVID)	Average Yearly Rate from 2020 to 2022 (During COVID)
January	1	5.4	2.2
February	2.4	4.8	2.8
March	2.8	5.9	2.5
April	3	4.7	1.6
May	4.5	4.7	2.4
June	5	5.8	4.2
July	3.9	8.4	5.2
August	5.4	8.2	5.7
September	5.8	6.4	4.4
October	3	4.9	2.7
November	1.9	4.2	1.9
December	1.5	3.7	1.9

Data table for Figure 50: Number of Ottawa residents reported with an infection from a vector-borne or zoonotic disease of public health significance, 2022 vs pre-pandemic (2017 to 2019) average.

Disease	Ottawa residents with a reported infection in 2022	Yearly pre-pandemic average of Ottawa residents with a reported infection (2017 to 2019)
Lyme Disease	215	154.3
Q Fever	1	0.7
West Nile Virus Illness	1	9.3
Anthrax	0	0
Brucellosis	0	1.3
Hantavirus	0	0
Plague	0	0
Rabies (Human Cases)	0	0
Tularemia	0	0

Data table for Figure 51: Incidence and number of Ottawa residents with confirmed or probable Lyme disease by episode year, 2013 to 2022.

Year	Ottawa residents reported with probable or confirmed Lyme disease	Rate per 100,000 population
2013	50	5.4
2014	22	2.3
2015	73	7.7
2016	76	7.9
2017	191	19.4
2018	93	9.3
2019	179	17.5
2020	122	11.7
2021	289	27.4
2022	215	19.9

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EQUITY PREVENTION IMPACT

OTTAWA PUBLIC HEALTH'S 2023-2027 STRATEGIC PLAN







Land Acknowledgement

Odàwàng kì ombàkonigàde ega wìkàd kà mìgiwàniwang Màmìwininì Aishinàbe-wakì.

Pimàdizìg Màmìwininì Anishinàbeg kàgigekamig kì abig ondaje akìng. Odanishinàbewiziwiniwà obimàdjiwowiniwà ogì nanegàdjichigàdànàwà nanàj ako nongom iyo abinàs.

Kichi Odenaw Odàwàng okikàdjìyàwàn pimàdizìn Màmìwininì Anishinàben kaye okikàdjitònàwà iyo akì. Ottawa is built on unceded Algonquin Anishinabe territory.

The peoples of the Algonquin Anishinabe Nation have lived on this territory for millennia. Their culture and presence have nurtured and continue to nurture this place.

The City of Ottawa honours the peoples and the land of the Algonquin Anishinabe Nation.

A message from the Board of Health Chair and Medical Officer of Health for Ottawa Public Health

Together, we are pleased to release the new, four-year strategic plan: **Equity, Prevention, Impact: Ottawa Public Health's 2023-2027 Strategy.**

The Ottawa Public Health 2023-2027 Strategic Plan continues work advanced during the pandemic. This includes prioritizing the needs of Ottawa's diverse communities, eliminating barriers to achieving health and wellbeing, and recognizing the importance of building genuine and lasting relationships with partners and residents to shape relevant and effective approaches.

A range of diverse inputs were gathered and analyzed to support the strategic planning process. Consultations with employees, community members and partners, as well as a review of the State of Ottawa's Health 2023 report and grey literature were carried out to gain insight about the strategic areas and public health issues to focus on in 2023-2027.

The Strategy demonstrates Ottawa Public Health's dedication to equity, prevention, and impact which guides our efforts as we work in partnership to achieve our Strategic Goals.

 Equity-driven: Being equity-driven means bringing public health services and interventions closer to communities facing the greatest barriers. It means building trust with communities to be a part of the solution in influencing the conditions and environments around them to support the health and wellbeing of all.

- Prevention-focused: Being preventionfocused means leveraging all available opportunities to shift our work to address root causes of poor health, to create the conditions that support a healthy community and individual decisions. This work must be done in collaboration with partners and policy decision-makers.
- Impact-maximizing: Being impact-maximizing means strategically allocating public health resources effectively to reach a broader audience and effect the greatest amount of change. This also means having the right people, skills, and resources to do the work.

This Strategy provides a framework to collaboratively examine and influence the systemic barriers to health and wellbeing in Ottawa and addresses key public health challenges.

We are excited to work in partnership over the next four years to make real inroads towards achieving health and wellbeing within the vibrant, diverse, and resilient communities of Ottawa.

Catherine Kitts, Chair Ottawa Board of Health

Dr. Vera Etches, Medical Officer of Health for Ottawa Public Health

Who We Are

For over 125 years, Ottawa Public Health (OPH) has worked in service of individuals and communities in Ottawa with the overall mission of protecting and promoting health. OPH is made up of a diverse team of professionals including public health nurses, dental hygienists, public health inspectors, dietitians, health promoters & communicators and epidemiologists.

Our Mandate

Public health works to prevent illnesses, injuries and poor health. OPH delivers a range of mandated core programs and services that are outlined in the **Ontario Public Health Standards**. The programs and services are designed to meet the health needs of the communities in Ottawa. We work with local communities and partners to create equitable opportunities for all residents to be healthy and thrive, regardless of any social or economic reasons.

Ottawa Public Health's Impact

The OPH 2019-2022 Strategic Plan provided a framework to focus on the most important and pressing work to drive positive health outcomes in the community. Examples of OPH's impact through this Strategy include:

 Completed a research study to assess the views and experiences of Ottawa's African, Caribbean and Black (ACB) communities with respect to mental health as well as identified gaps and strategies for improving and advocating for mental health services, leading to the development and implementation an action plan.

- Provided education on the administration of naloxone as well as the distribution of naloxone kits to help prevent opioid overdose deaths through partnerships and the Ontario Naloxone Program.
- Provided epidemiology and surveillance data on COVID-19 people testing positive, hospitalizations and outbreaks, as well as vaccinations and vaccine coverage for Ottawa residents.
- Informed residents, healthcare partners, community organizations and businesses of emerging information throughout the pandemic through our webpages, social media feeds, media requests and prevention-based campaigns.
- Created Neighbourhood Health and Wellness Hubs to deliver public health programs, such as Parenting in Ottawa, dental screenings and mental health resources, in addition to employment and social services.
- Embedded a health lens in the City of Ottawa Official Plan through our co-location with the City Planning, Real Estate, and Economic Development department to ensure the city's development will promote health.
- Completed a diversity, equity and inclusion (DEI) audit of OPH, which is informing changes to hiring and human resource processes and led to the development of an employeebased DEI community of practice.
- Led a working group to make recommendations to the Ministry of Health for standardized

- socio-demographic data (SDD) collection to be able to orient services to areas of greatest need.
- Delivered case and contact management and infection prevention and control investigations to address the spread of COVID-19 in Ottawa.
- Managed 2784 outbreaks with a total of 32,311 cases attributed; investigated

1,212 suspect outbreaks in facilities where early intervention helped to break the chain of transmission and prevent the further spread of infectious disease in our high-risk congregate facilities and supported over 4,700 outbreak related calls as part of initial outbreak investigations.

Strategic Planning

Aligned with the appointment of the new Board of Health, OPH initiates its strategic planning cycle every four years. This cycle provides an opportunity to evaluate areas where OPH can enhance our focus and drive innovation in order to create the conditions for all people and places in Ottawa to be healthy and thriving. Strategic planning encompasses a comprehensive review and refresh of the existing strategy to adjust to evolving community needs and changes in our environment. The Strategy is also reviewed annually to respond to emerging public health challenges.

OPH is committed to ensuring strategic priority setting is informed by a range of inputs.

Over the past year, OPH has undertaken a situational analysis and partner engagement to guide the development of its 2023-2027 Strategy. This involved soliciting input from a range of perspectives, including employees, community members, partners and Board Members, as well as considering findings from the State of Ottawa's Health 2023 Report and key sources of grey literature.

Equity, Prevention, Impact.

Through a common understanding of the vision, mission, commitments and strategic goals, the OPH 2023-2027 Strategic Plan provides a framework for informed decision-making to drive progress towards improved health and wellbeing of all people and places in Ottawa.

Ottawa Public Health's strategy demonstrates that we are driven by equity, focused on prevention, and measured by our impact.

Equity-driven: Being equity-driven means bringing public health services and interventions closer to communities facing the greatest barriers. It means building trust with communities to be part of the solution in influencing the conditions and environments around them to support the health and wellbeing of all.

Prevention-focused: Being prevention-focused means leveraging all available opportunities to shift our work to address root causes of poor health to create the conditions that support a healthy community and individual decisions. This work must be done in collaboration with partners and policy decision-makers.

Impact-maximizing: Being impact-maximizing means strategically allocating public health resources effectively to reach a broader audience and effect the greatest amount of change. This also means having the right people, skills and resources to do the work.

Our Vision and Mission

Vision: All people and places in Ottawa are healthy and thriving

Mission: We work together with the community to promote and protect the health and wellbeing of all people in Ottawa

Our Commitments

Our commitments are embedded in everything we do and are required to advance the OPH 2023-2027 Strategy. Our commitments influence all aspects of program and service delivery.

Reconciliation: We are guided by the principles of respect, relationship, reciprocity and reflection as we work in partnership with Urban Indigenous Peoples – including First Nations, Inuit, Métis peoples and communities – to promote social justice and advance Indigenous rights and wellbeing.

Health equity: We identify and address systemic barriers to increase health equity in urban, suburban and rural communities in Ottawa.

Healthy and inclusive workplace: We foster an equitable, diverse, and inclusive workforce in service to the community and promote a psychologically healthy and safe workplace culture.

Meaningful engagement and relationships:

We build genuine and lasting relationships with partners and residents to collaboratively foster a healthy community.

Evidence-informed: We apply best available evidence, including community voice and local data, to identify issues impacting the community and continuously improve and innovate our work.

Impactful: We aim to strengthen our organizational performance and optimize our resources to better serve the community, while tracking our progress through measurable outcomes.

Our Strategic Goals

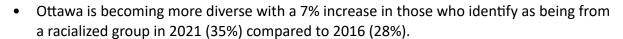
Our strategic goals address key public health challenges and work to build our organizational capacity in service to the community.

Equity-Driven

In working to improve population health outcomes and opportunities, we collaborate to eliminate health inequities, systemic racism, discrimination and oppression.

Why it matters?

Findings from the State of Ottawa's Health Report 2023ⁱ demonstrate:



- Self-rated health and mental health is approximately 20% lower in neighbourhoods with the lowest compared to those with the highest income.
- The percentage of children vulnerable in at least one Early Development Instrument domain ranged from 4% to 52% across Ottawa neighbourhoods, with the prevalence of vulnerability generally increasing in neighbourhoods with lower socioeconomic status.
- During the pandemic, residents of Ottawa who tended to fair worse with regards to their mental health included people with disabilities, young adults, people who identify as racialized, those with lower household income and those who identify as LGBTQ2S+.
- High school students (grades 9 to 12) of socioeconomic disadvantage or those identifying as 2SLGBTQQIA+ reported poorer mental and emotional wellbeing compared to their counterparts.
- The rate of active tuberculosis disease (TB) in Ottawa has increased over the last six years and it is higher than the average for Ontario-less-Ottawa (4.6 per 100,000). Among Canadian-born individuals in Ottawa, Inuit people are disproportionately affected by TB. In 2022, 8% of the cases of TB in Ottawa were in individuals who identify as Inuk. Indigenous peoples in Canada are disproportionally affected by TB due to ongoing impacts of colonization and health inequities.
- The structural and systemic inequities and barriers that pre-existed the COVID-19 pandemic influenced its epidemiology and vaccine uptake. The rate of COVID-19 infection was higher among residents of less-advantaged communities. These communities are not inherently more susceptible to COVID-19, but underlying social realities, such as systemic racism, barriers to health information and services, and/or



- participation in occupations without access to paid sick leave contributed to people's exposure to COVID-19.
- The population rate of COVID-19 hospitalizations and deaths was also higher in communities with less socioeconomic advantage, as described by the Ottawa Neighbourhood Study socioeconomic status (SES) index. Population hospitalization and death rates were almost three times higher in quintile 5 neighborhoods (lowest socioeconomic status) compared to those in quintile 1 neighbourhoods (highest socioeconomic status).

Create Conditions to Live Well and Thrive

Influence changes in the built, natural and social environments that promote health and wellbeing, and address the impacts of climate change. Essential to this is the interconnection between health and nature.

Why it matters?

Findings from the State of Ottawa's Health Report 2023 demonstrate:

 In the most recent estimates from 2017/2018, 67% of adults over the age of 18 identified that they met the Canadian Physical Activity Guidelines.

In 2019, 21% of children aged 5 to 11 were active at least 5 days in the past week. In 2021, only 18 % of students in grades 7 to 12 reported being active every day in the past week.

- In Ottawa, 58% of residents aged 18 and older report a height and weight that would classify them as being overweight or obese. This is relatively unchanged over the past 5 years but the percentage of the population that is overweight and obese has increased over the past 15 years. This percentage is higher among men and those aged 45 and older.
- In Ottawa, 42% of renter households paid 30% or more of their household income on shelter costs compared to 14% of owner households.
- Three-year estimates from the 2018, 2019, and 2020 Canadian Income Survey indicate
 that 13% of Ottawa households face food insecurity, with approximately 4% being
 marginally food insecure, 6% being moderately food insecure and 3% being severely
 food insecure.
- In Ottawa, 69% of people had a somewhat to very strong sense of community belonging in 2019 to 2020, which is similar to past years.
- In 2019, 13% of children in Ottawa aged 5 to 11 years and 11% youth aged 12 to 17 years used active forms of transportation to travel to school.



¹ Interpret with caution due to high variability in response.

Additional data sources demonstrate:

- In Ottawa (from 2017-2021) there was a median of 106 emergency room visits per year directly related to exposure to extreme heat, such as dehydration, heat exhaustion and heat stroke.
- The built environment impacts people's physical activity and health, through factors such as the types of local services and amenities and the layout and design of transportation networks. ••
- Safety and well-being is impacted through injuries and deaths from vehicular traffic and street characteristics. In Ottawa, from 2017 − 2020, there were an average of five pedestrian deaths; two cyclists deaths; 11 motor vehicle deaths and 3,314 injuries each year.^{iv}

Promote Wellbeing and Reduce Harms

Advance innovative and comprehensive approaches to promote mental health and substance use health while reducing stigma; and decreasing harms associated with substance use and addiction across the lifespan.

Why it matters?

Findings from the State of Ottawa's Health Report 2023 demonstrate:

- An estimated 60% of residents of Ottawa rated their mental health as very good or excellent in 2019/2020, an approximate 8 to 10% decrease from previous years.
- An estimated 12% (100,600 people) rated their mental health as fair to poor. Self-rated mental health tends to be lowest among females, those aged 20 to 44, those in the lowest two income quintiles, those living in an urban setting, renters, and those living alone.
- Self-harm is among the leading causes of injury-related hospitalizations among those aged 15 to 44. This is similar to what has been seen in previous reports.
- The COVID-19 pandemic created additional strains on mental health and substance use health. In November 2021, only 43% of residents of Ottawa rated their mental health as very good or excellent. This is lower than the estimates prior to the pandemic. In November of 2021, about a quarter (24%) of residents of Ottawa also reported that in the past two weeks they wanted to reach out for mental health support but did not know where to turn.



- Emergency department visits for opioid-related overdoses among residents of Ottawa more than doubled from 443 in 2019 to 982 in 2021, highlighting the impact of COVID-19 on opioid use. Similarly, deaths more than doubled from 65 in 2019 to 148 in 2021, exacerbating an increase in opioid-related harms that began in 2017.
- An estimated 69% of the population aged 19 and older in Ottawa are at no or low risk of alcohol related harms, 15% are at moderate risk and 16% are at high risk.

Focus on Prevention

Gather, analyze and share evidence on local health needs and inequities with the healthcare system to strengthen clinical prevention. We will engage with healthcare system partners to help inform decision-making.

Why it matters?

Findings from the State of Ottawa's Health Report 2023 demonstrate:

- By 2030, it is estimated that older adults, aged 65 and over, will account for 20% of the population. This shift in demographics has significant implications for health resource planning to support an aging population.
- 14% of the people living in Ottawa, or approximately 122,000 people, do not have access to a regular health care provider. This proportion is higher among those who have immigrated in the past 10 years with 38% not having access to a regular health care provider.
- Hospitalization rates are between 15 to 30% higher in the neighbourhoods with lowest socioeconomic advantage compared to those with the highest advantage.
- Routine childhood immunization rates among 7-year-olds in 2018-2019 surpassed national coverage goals of 95% for rubella and meningococcal C conjugate (MenCC) and were below the goals for diphtheria, tetanus, polio, pertussis, measles, mumps, Haemophilius influenza type B (Hib), pneumococcal disease, and Varicella. Among 17-year-olds living in Ottawa, pre-pandemic immunization coverage rates were below national goals of 90% for diphtheria, tetanus, and pertussis. These coverage estimates are limited to immunizations reported to public health.



Enrich our Workplaces

Foster a diverse, inclusive, equitable and healthy workforce grounded in a culture of learning and growth. We will support and develop employees and optimize and innovate our processes to better serve the community.

Why it matters?

In 2021, 35% of the population living in Ottawa identified as racialized, a 7% increase compared to 2016 (28%). Black, Middle Eastern, and South Asian were the most frequently reported racialized groups. According to the 2021 Census, 3% of the population



in Ottawa identified as Indigenous, including First Nations, Inuk (Inuit) and Métis. It is important that our workforce is representative of the communities we serve and that we can represent multiple ways of knowing.^v

- OPH's Diversity Audit^{vi} identified the following key findings:
 - O Overall culture at OPH is interested and engaged in improving diversity, equity and inclusion (DEI), which provides an enabling context for change.
 - O OPH's Senior Leadership Team (SLT), Board of Health members and leaders who participated in the audit believe that more diversity at OPH will allow the organization to better serve the community and achieve its health equity goals.
 - O Every racialized staff member shared multiple occurrences of incidental and systemic racism and discrimination. Racialized staff also highlighted the lack of representation within leadership, challenges in being promoted due to bias and a lack of transparency, and the risks of being negatively labelled when contemplating reporting instances of racism and discrimination.
- Our workforce demonstrated unwavering dedication to the community and resiliency throughout the COVID-19 pandemic. As the community recovers, we must ensure our workforce recovers as well. What we want to achieve for the communities of Ottawa is also what we want to achieve for the community that is OPH.
- OPH innovated programs and services throughout the pandemic to continue to provide essential public health interventions. Effective public health practice must continue beyond the pandemic to support employees to do their job efficiently and effectively in order to best serve the community.

Measuring our Impact

OPH is committed to making meaningful changes over the next four years. These strategic efforts aim to address complex challenges, leading to improved health and wellbeing of the people and places in Ottawa and greater health equity. Recognizing that addressing such intricate challenges requires collective effort, OPH will actively collaborate with community members and partners to maximize impact. This inclusive approach

involves engaging employees, community members and partners to build action plans identifying the specific short and long-term objectives, tactics, outcomes, and measures for each strategic goal. Our progress will be evaluated through defined measures, outputs and outcomes, which will be reported to the Board of Health twice annually, ensuring transparency and accountability.

Ottawa Public Health. State of Ottawa's Health: 2023 Report. Ottawa (ON): Ottawa Public Health; 2023.

^{II} National Ambulatory Care Reporting System 2017-2021, IntelliHEALTH ONTARIO, Ontario Ministry of Health. ICD-10CA T67 or X30 for Ottawa residents. Date Extracted: May 29, 2023.

^{III} Public Health Agency of Canada. The Chief Public Health Officer's Report on the State of Public Health in Canada 2017. Ottawa (ON): Public Health Agency of Canada; 2017.

^{iv} City of Ottawa. 2020 Ottawa Safety Report. Ottawa (ON); 2020.

V Ottawa Public Health. State of Ottawa's Health: 2023 Report. Ottawa (ON): Ottawa Public Health; 2023.

vi Dr. Ariff Kachra. Diversity Audit: Ottawa Public Health's Anti-Racism and Anti-Oppression Policy. Ottawa (ON): Strat-ology Consulting Inc; 2021.

From: <u>allhealthunits</u> on behalf of <u>Loretta Ryan</u>

To: All Health Units

Cc: board@lists.alphaweb.org

Subject: [allhealthunits] Public Health Matters – A Business Case for Local Public Health

Date: Wednesday, July 19, 2023 4:06:43 PM

Re. Public Health Matters – A Business Case for Local Public Health

Dear alPHa Members,

The Association of Local Public Health Agencies (alPHa) is pleased to provide you with our new infographic, <u>Public Health Matters - A Business Case for Local Public Health</u>, which highlights the business case for local public health being essential to the province's population health and the associated economic prosperity. This edition builds upon the first two infographics, <u>Public Health Matters (Fall Vaccine Success)</u> and <u>Public Health Matters (A Public Health Primer)</u>.

These communications tools can be used with local decision makers to ask for their support for the goals and objectives of public health. We anticipate these infographics will be useful resources in your various engagements with stakeholders and community partners, including local councillors and MPPs. alPHa encourages you, as local public health leaders, to use and share these resources widely.

Respectfully,

Dr. Charles Gardner
President

The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to the boards of health and public health units in Ontario. alPHa advises and lends expertise to members on the governance, administration, and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective, and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario's communities.

PUBLIC HEALTH MATTERS



A BUSINESS CASE FOR LOCAL PUBLIC HEALTH

Public health champions health for all. Local public health agencies provide programs and services that promote well-being, prevent disease and injury, and protect population health. Our work, often done in collaboration with local partners and within the broader public health system, results in a healthier population and avoids drawing on costly and scarce health care resources.

OUR ASK

We are asking decision makers for their support for the goals and objectives of public health, with sustained and sufficient resources to ensure stability for Ontario's locally-based network of public health agencies.

Local public health remains essential to the province's population health and the associated economic prosperity.

Local public health supports the Ontario government in its goals to be efficient, effective, and provide value for money.

INVESTMENT IN LOCAL PUBLIC HEALTH

Investment in local public health includes the following returns:



Public health measures such as vaccination, case and contact management, outbreak response, community infection control measures reduced hospitalizations by 13 times during the COVID-19 pandemic.

Local public health is also central to responding to new infectious disease risks such as MPOX, reemerging pathogens like poliomyelitis and tuberculosis, and the return of annual seasonal epidemics such as influenza and respiratory syncytial virus (RSV).



SAFE COMMUNITIES:

Local public health protects our communities by working with municipalities to provide safe water, safe food, and emergency preparedness and response.



Local public health protects children through promotion of healthy growth and development, vaccination, dental screening, and school health.



Population Health Assessment



Health Equity



Effective Public Health Practice



Emergency Management



Chronic Disease Prevention and Well-Being



Food Safety



Healthy Environments

PUBLIC HEALTH MATTERS





FUNDING

Local public health requires sufficient and sustainable base funding from the provincial government.

The end of mitigation funding (\$46.8M) from the province would egual a 14.76% (\$316.7M) municipal levy increase, or a 3.78% (\$1.24B) loss to the overall funding of local public health programs.

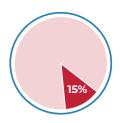
A return to the previous provincialmunicipal cost-sharing formula for all programs and services would help to offset this loss.



COVID-19 **RECOVERY**

In the wake of the COVID-19 pandemic, local public health has been working hard to put back in place its full range of programs, with progress being made on its recovery priorities (Public Health Resilience), and responding to seasonal respiratory viruses.

PUBLIC HEALTH LEADS TO HEALTH CARE SAVINGS



Health promotion and **disease prevention** are mandated roles for local public health agencies. In doing this, they also who work with the Ministry of Health and key stakeholders in addressing chronic diseases such as diabetes, heart disease and cancer.

HEALTH INEQUITIES DUE TO SOCIOECONOMIC POSITION CONTRIBUTED \$60.7B = 15% OF ALL HEALTH CARE COSTS.

Smoking, alcohol, diet and physical activity improvements could prevent \$89B in health care costs = 22% of all health care costs over 10 years.





Alcohol use is another major contributor to health care and societal cost. It is estimated that alcohol use costs the Ontario economy \$5.3B in health care, law enforcement, corrections, prevention, lost productivity and premature mortality.

It is estimated that diabetes in Canada cost the health care system \$15.36 billion over a 10 year period, affecting nearly 10% of the population.





Promotion of tobacco cessation and tobacco control reduced health care costs by 1.7% overall = \$4.2B saved over 10 years.



Healthy Growth and Development





Infectious and Immunization Communicable Diseases Prevention and Control



Oral Health



Safe Water



School Health



Substance Use and Injury Prevention



CITY OF HAMILTON PUBLIC HEALTH SERVICES Healthy Families Division

то:	Mayor and Members Public Health Committee
COMMITTEE DATE:	August 16, 2023
SUBJECT/REPORT NO:	Public Health Services Indigenous Health Strategy (BOH23026) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Sue Connell (905) 546-2424 Ext. 3798 Terry Ramirez (905) 546-2424 Ext. 3820
SUBMITTED BY:	Dr. Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services
SIGNATURE:	

RECOMMENDATION

That the Public Health Services Indigenous Health Strategy, attached as Appendix "A" to Public Health Committee Report BOH23026, be approved.

EXECUTIVE SUMMARY

Public Health Services worked with the Indigenous leaders and community in Hamilton to help inform a strategy to improve the health of Indigenous people in the City of Hamilton. Public Health Services conducted interviews with leaders of Indigenous organizations in Hamilton and nearby reserves. A survey was available to community members to share their insights. This report used responses from the interviews and surveys to provide recommendations for the Public Health Services Indigenous Health Strategy.

The recommendations have been categorized into the following themes:

- 1. Relationship Building;
- 2. Communication;
- 3. Staffing and Governance;
- Collaboration and Co-Development;
- 5. Equitable and Safe Services;
- 6. Resources;
- 7. Advocacy; and,

SUBJECT: Public Health Services Indigenous Health Strategy (BOH23026) (City Wide) - Page 2 of 4

8. Access to Indigenous Traditional Knowledge and Practices.

The findings from the survey and interviews provide the groundwork for Public Health Services to implement a strategy that honours the principles of friendship, mutual respect, and peace, as the Two Row Wampum agreement teaches. It is important to note that some recommendations are outside of the mandate of Public Health Services, while others are applicable to other health and social service organizations. This reinforces the need for a collaborative response across sectors to improve health outcomes for the Indigenous community.

Alternatives for Consideration – Not Applicable

FINANCIAL - STAFFING - LEGAL IMPLICATIONS

Financial: Not Applicable.

Staffing: Not Applicable.

Legal: Not Applicable.

HISTORICAL BACKGROUND

Public Health Services recognizes the inequities in the health of Indigenous people, and in 2019 an Indigenous Health Strategy Specialist position was created to support the integral work of improving health outcomes for Indigenous people.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

The goal of public health is to improve and protect the health and well-being of the population and reduce health inequities (Ministry of Health, 2021). The Ontario Public Health Standards provide the legislated mandate for Public Health in Ontario. Within the Ontario Public Health Standards' "Working with Indigenous Communities Guideline", principles for engagement of Public Health with Indigenous communities are provided. These principles are: relationship building; recognition, respect and mutuality; self-determination; timely communication and knowledge exchange; and, coordination. These principles are key for reconciliation and must be a part of any work done with Indigenous communities.

In addition, the latest report from Ontario's Chief Medical Officer ("Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics", 2023) identifies additional action for the public health sector to address Indigenous Health. The Public Health Services Indigenous Health Strategy aligns with these actions.

RELEVANT CONSULTATION

Public Health Services worked with the Indigenous leaders and community in Hamilton to help inform a strategy to improve the health of Indigenous people in the City of Hamilton. Public Health Services conducted interviews with leaders of Indigenous organizations in Hamilton and nearby reserves. A survey was available to community members to share their insights. This report used responses from the interviews and surveys to provide recommendations for the Public Health Services Indigenous Health Strategy.

Indigenous leaders have approved this report and a release to the broader Indigenous community will take place later in 2023. The first step in this work is to establish an Indigenous health governance Circle to create an action-oriented plan. Such a plan can only be developed by engaging with Indigenous leaders and community from the very beginning. This plan will be co-developed and is expected to be completed by the end of 2024 to allow for fulsome engagement, consultation, and collaboration.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

The findings from the survey and interviews provide the groundwork for Public Health Services to implement a strategy that honours the principles of friendship, mutual respect, and peace, as the Two Row Wampum agreement teaches. The Indigenous view of health and healing is wholistic and extends beyond physical health and the body to include the mind and spirit, and this view is reflected in the recommendations. It is important to note that some recommendations are outside of the mandate of Public Health Services, while others are applicable to other health and social service organizations. This reinforces the need for a collaborative response across sectors to improve health outcomes for the Indigenous community. The recommendations in the report are useful for other organizations and will be shared broadly.

The recommendations have been categorized into the following themes:

- 1. Relationship Building;
- 2. Communication;
- 3. Staffing and Governance;
- 4. Collaboration and Co-Development;
- 5. Equitable and Safe Services;
- 6. Resources;
- 7. Advocacy; and,
- 8. Access to Indigenous Traditional Knowledge and Practices.

Many of the recommendations align with key local, national, and international recommendations and calls to action. Appendix "B" to Report BOH23026 shows where there is alignment with the Hamilton Urban Indigenous Strategy, the Truth and

SUBJECT: Public Health Services Indigenous Health Strategy (BOH23026) (City Wide) - Page 4 of 4

Reconciliation Commission Calls to Action, and the United Nations Declaration on the Rights of Indigenous People. The recommendations also reflect many of the action areas identified in the Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls.

ALTERNATIVES FOR CONSIDERATION

Not Applicable.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to Report BOH23026 Public Health Services Indigenous Health Strategy Report June 2023

Appendix "B" to Report BOH23026 Public Health Services Indigenous

Health Strategy Recommendations





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The photo on the title page is of two Cornhusk Dolls on a bench by Kanien'kehá:ka (Mohawk) artist Angel Doxdator. The Corn Husk Doll is one of the core teachings of the Haudenosaunee. I understand that she was very beautiful, so beautiful that she would spend hours gazing at her reflection in the river. She spent so much time admiring herself that she would skip her responsibilities to the community. She felt entitled. As a result, The Creator took away the Corn Husk Doll's beautiful face.

It was a lesson in humility. Everyone is equal; no one part is greater than the whole.

These Corn Husk Dolls make me think of learning from each other. Everyone has knowledge or gifts to share. Everyone is essential and has a role in the community. It is like the Haudenosaunee teaching of the Five Arrows bundled together. An individual arrow can easily snap but bundle them all together; they are unbreakable. We are stronger together, working together to benefit the whole community.

It is vital that Indigenous Cultural Safety training is available for non-Indigenous community members to provide them with the tools they need to create a safe space for Indigenous clientele and ensure a strong bond of trust within the community.

It is essential to have equitable resources, services, and access.

It is essential to respect each other, work together and share ideas to keep things moving forward.

Terry Ramirez
Tuscarora, Six Nations of the Grand River
Indigenous Health Strategy Specialist
Public Health Services
City of Hamilton

^{*} The corn husk dolls were made by Angel Doxtater.

TRADITIONAL LAND ACKNOWLEDGEMENT FOR THE CITY OF HAMILTON

The City of Hamilton is situated upon the traditional territories of the Erie, Neutral, Huron-Wendat, Haudenosaunee and Mississaugas. This land is covered by the Dish With One Spoon Wampum Belt Covenant, which was an agreement between the Haudenosaunee and Anishinaabek to share and care for the resources around the Great Lakes. We further acknowledge that this land is covered by the Between the Lakes Purchase, 1792, between the Crown and the Mississaugas of the Credit First Nation.

Today, the City of Hamilton is home to many Indigenous people from across Turtle Island (North America) and we recognize that we must do more to learn about the rich history of this land so that we can better understand our roles as residents, neighbours, partners and caretakers.



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GRATITUDE AND ACKNOWLEDGMENT

This report would not have been possible without the support of:

- Coalition of Hamilton Indigenous Leaders (CHIL), Donna Gerber, Program Manager (Previous)
- De dwa da dehs nye>s Aboriginal Health Centre, Constance McKnight, Chief Executive Officer (Previous)
- Hamilton Regional Indian Centre, Audrey Davis, Executive Director
- McMaster University, Shylo Elmayan, Director Indigenous Student Services
- Mohawk College, Amy Kelaidis, Director and Special Advisor, Indigenous Initiatives
- NPAAMB Indigenous Youth Employment and Training, Shari St. Peter, Executive Director (Previous)
- Niwasa Kendaaswin Teg, Monique Lavelle, Executive Director
- Native Women's Centre, Paula Whitlow, Executive Director (Previous)
- Ontario Aboriginal Housing Services, Justin Marchand, Executive Director
- Sacajawea Non-Profit Housing, Melanie McAuley, Executive Director
- Six Nations of The Grand River Territory
- Mississaugas of the Credit First Nation
- Indigenous Community members of Hamilton, Six Nations of the Grand River Territory, and Mississaugas of the Credit First Nation who participated in the interviews and the survey.

Thank you for your time, patience and wonderful insights.



EXECUTIVE SUMMARY

Hamilton Public Health Services (HPHS) recognizes the inequities in the health of Indigenous people. The goal of public health is to improve and protect the health and well-being of the population and reduce health inequities (Ministry of Health, 2021). HPHS worked with the Indigenous leaders and community in Hamilton to help inform a strategy to improve the health of Indigenous people in the City of Hamilton. HPHS conducted interviews with leaders of Indigenous organizations in Hamilton and Health leaders from Six Nations of the Grand River and Mississaugas of the Credit First Nation. A survey was available to community members to share their insights. This report uses responses from the interviews and surveys to provide recommendations for the HPHS Indigenous Health Strategy.

The recommendations have been categorized into the following themes:

- 1. Relationship Building
- 2. Communication
- 3. Staffing and Governance
- 4. Collaboration and Co-development
- 5. Equitable and Safe Services
- 6. Resources
- 7. Advocacy
- 8. Access to Indigenous Traditional Knowledge and Practices

The findings from the survey and interviews provide the groundwork for HPHS to implement a strategy that honours the principles of friendship, mutual respect, and peace, as the Two Row Wampum agreement teaches. The Indigenous view of health and healing is wholistic and extends beyond physical health and the body to include the mind and spirit and this view is reflected in the recommendations.

Leaders from Indigenous community organizations have approved this report and a release to the broader Indigenous community will take place later in 2023. An implementation plan will be co-developed and will include goals, timelines and deliverables. An action-oriented plan can only be completed by engaging with Indigenous leaders and community from its inception. It is expected that a detailed implementation plan will be completed by the end of 2024 to allow for fulsome engagement, consultation and collaboration.

INTRODUCTION

The Ontario Public Health Standards (OPHS) provide the legislated mandate for the provision of public health services for all Public Health Units in Ontario. The goal of Public Health is to improve and protect the health and well-being of the population and reduce health inequities (Ministry of Health, 2021).

Within the OPHS, the Health Equity Guideline (2018) describes health inequities as "health differences that are:

- Systematic, meaning that health differences are patterned, where health generally improves as socioeconomic status improves;
- Socially produced, and therefore could be avoided by ensuring that all people have the social and economic conditions that are needed for good health and well-being; and
- Unfair and/or unjust because opportunities for health and well-being are limited" (Ministry of Health and Long-Term Care, 2018a, p. 5).

For Indigenous communities in Ontario, the historic and ongoing impacts of colonialism have contributed to health inequities that are systematic, socially produced, unfair, and unjust. Colonialism, through colonial strategies such as the Indian Act and residential schools, aimed to control and assimilate Indigenous Peoples by severing relationships between children and their families, families and their land and territory, and Indigenous nations from their cultures, values, and belief systems (Greenwood & Lindsay, 2019).

To understand the link between colonialism and health, the determinants of Indigenous health have often been reframed as proximal, intermediate, and distal determinants. Proximal determinants are the factors that directly influence health, such as an individual's health behaviours, physical environment (e.g., housing quality), employment status, income, and education (Reading & Wien, 2009). Intermediate determinants are described as the roots of these proximal determinants, such as the quality and funding levels of healthcare, education, and social support systems, as well as community cohesion and environmental stewardship. Distal determinants such as colonialism, racism, and self-determination, shape proximal and intermediate determinants and have the most significant impact on health. Within these determinants, self-determination is seen as the most important, since Indigenous health outcomes are most optimal when Indigenous people determine and control the programs, services, and systems designed to improve their health (Reading & Wien, 2009).

The "Working with Indigenous Communities Guideline" (2018) of the OPHS provides guiding relationship principles for engagement of Public Health with Indigenous communities.



These principles are: relationship building; recognition, respect and mutuality; self-determination; timely communication and knowledge exchange; and coordination.

The Truth and Reconciliation Commission of Canada describes reconciliation as an ongoing process of establishing and maintaining respectful relationships. Hamilton Public Health Services (HPHS) is committed to effective engagement with Indigenous communities to ensure equity-focused public health practice and to reduce health inequities. In May 2019, HPHS hired an Indigenous Health Strategy Specialist to develop an Indigenous Health Strategy to guide this work.

This Strategy focuses on strengthening relationships with Indigenous communities and improving HPHS' capacity to support Indigenous communities. In keeping with the principles described above, HPHS engaged with Indigenous leaders and community members through:

- interviews conducted with leaders of Indigenous organizations between August 2019 and February 2020
- a survey available to Indigenous community members from Hamilton, Six Nations of the Grand River Territory, and Mississaugas of the Credit First Nation from June to December 2022.

This report builds upon findings from the Indigenous Health Strategy Interim Report (2022) which gathered information from Indigenous leaders; it includes survey feedback from Indigenous community members that reinforces and strengthens the voices of the Indigenous leaders.



METHODS

Interviews with leaders of Indigenous organizations and a survey for Indigenous community members were conducted to help inform the Indigenous Health Strategy. Interview participants included leaders of Indigenous health, youth, legal, and housing organizations and Indigenous-partnered organizations (e.g., school boards, universities, colleges, and provincial health organizations). The interview guide included questions about the participant's vision for a healthy community, their organization's current successes, challenges, and priorities, and how HPHS could help to create a healthier community for Indigenous people.

From August 2019 to February 2020, 28 leaders participated in interviews. Most interviews were conducted one-on-one; however, several two-on-one or small group interviews were held with members from the same organization. All participants were provided the opportunity to review their interview notes (i.e., transcripts) before they were included in the analysis. In total, 21 transcripts from 28 participants were analyzed. In September 2020, previous interviewees were invited to review their responses and comment further. In particular, they were asked to consider how COVID-19 had impacted their communities, given that initial interviews were completed prior to the onset of COVID-19. Additional comments were received from two individuals.





A survey was available for community members from June 2022 to December 2022. The survey included questions about participants' vision for a healthy community, what made them feel healthy, if they had ever used services offered by HPHS, and what services or supports they needed. Participants were invited to complete the survey at Indigenous community events, such as powwows and the Mino Biimadziwin Wakya'ta'shatse Social held at Gage Park, and through flyers about the survey posted at Indigenous community organizations. Only Indigenous respondents aged 18 and older living in Hamilton, Six Nations of the Grand River Territory, or Mississaugas of the Credit First Nation could participate in the survey. Responses were primarily received online, however some paper and telephone surveys were completed. The survey was reviewed and approved by the Mississaugas of the Credit First Nation, Pillar 2: Nation Well-Being & Wellness, and the Research Ethics Committees of the Ontario Federation of Indigenous Friendship Centres and the Six Nations of the Grand River Elected Council.

In total, 52 completed survey responses were received. Most survey respondents described themselves as female (85%), and the survey was also completed by people who described themselves as male, two-spirited, and non-binary. Responses were received from a variety of age ranges, with people 40 to 64 years old making up the largest proportion of respondents (42%), followed by people aged 25 to 39 years (27%), 65 years and older (17%), and 18 to 24 years (13%). Three quarters of participants lived in Hamilton (75%), and the remainder in Six Nations of the Grand River (23%) or Mississaugas of the Credit First Nation (2%). Survey respondents were also from a variety of nations. About half of respondents indicated they were a member of Six Nations of the Grand River Territory (52%). As a result, Haudenosaunee nations (e.g., Cayuga, Mohawk, Tuscarora, Seneca) were most commonly represented. Participants also identified as Mi'kmaw, Ojibway/Ojibwe, Cree, and as members of specific First Nations, among other identities.

Findings from the 21 transcripts and the 52 completed surveys are summarized below. Qualitative data from interviews and survey responses were analyzed thematically, using codes informed by the data and generated from the determinants of Indigenous health. Quantitative survey data was analyzed using frequencies and cross-tabulations.

RESULTS

What is a healthy community?

In both the survey for community members and the interviews with leaders in the Indigenous community, respondents were asked to share their opinions about what a healthy community is. A healthy community was often described as having a feeling of connectedness and strong relationships between individuals, families, communities, culture, and land. A healthy community was also seen as a community with resources, such as access to wholistic healthcare, affordable housing, recreation, education, mental health supports, cultural events, ceremonies, and community events. In interviews, leaders specifically highlighted that

We would see happy families that are resilient, demonstrating healthy, strong parenting, strong coping strategies for issues related to trauma, mental unwellness, stress, racism, addictions, poverty, social justice issues and have adequate culturally safe networks of support when it is needed. A healthy community is vibrant, self sustaining, has solid leadership, has good policies with respect for environment, water, etc. A healthy community...has access to culturally relevant health services and has a sense of community that fits their worldview.

the availability of high quality and barrier-free services is essential to ensure people have the opportunity to attain good health. Other features of a healthy community included teachings and values, such as respect, compassion, and equity. Lastly, safety was another important component; both leaders and community members described safety as an absence of violence and crime. Leaders added that cultural safety in services and having safe spaces for people to go were important.

As
one participant
shared, a healthy
community is a
"community helping to lift
each other up...Because of
colonization it has moved to
'I' and 'me', we need to
move back to
community.

What makes community members feel healthy?

Community members were asked to share what helps make them feel healthy, and there were many similarities with the described components of a healthy community. Eating nutritious food was the most commonly identified aspect of what made respondents feel healthy, mentioned by just under half of respondents (44%). Being connected to community, culture, and kin (40%) and being physically active (35%) were also identified by several respondents. The availability of resources such as Indigenous services and culturally safe health care providers, having Community events and programs, being in nature, and access to clean water were all identified as making participants feel healthy.

What programs, services, or supports are needed?

In both the surveys and interviews, participants were asked to describe health needs and about specific supports or services that were needed. They were asked to think about their own needs and identify what programs or services they would most like to have in their community. The most commonly identified need was access to traditional healing and wellness, which was shared by two-thirds of respondents (67%), and access to housing was similarly high (62%).

Other commonly identified needs included:

- access to primary healthcare (38%),
- adult dental services (25%),
- exercise and physical activity opportunities (23%),
- adult mental health (23%),
- nutrition and healthy eating supports (21%),
- diabetes management (19%),
- access to on-the-land ceremonial space (17%),
- alcohol and substance use programs (17%)
- family based programs (15%).
- services for children and youth (e.g., youth programs, childcare, child, and youth dental) were reported by 10% or less of respondents. In part, this may be a result of survey participation limited to those aged 18 and older.

Leaders most commonly reported programs and services that addressed the determinants of Indigenous health as needs; this was similar to what was shared by survey respondents. Community needs identified by leaders included programs and services focused on:

- housing
- mental health
- health promotion
- diabetes
- substance use
- culture
- land-based healing
- programs specific to Indigenous men, two-spirited people, Elders, youth and families

As one participant shared,

"[What is working well is] collaboration with services within the community – [we] have a good working relationship, respond to what is needed, and if we can't, we try to find someone that can."

Beyond specific program gaps, interview participants identified more general needs within the community, such as increasing the coordination of supports available within the City of Hamilton. Participants proposed this could be done through increased Indigenous systems navigation support, increased communication between the City and Indigenous organizations about new opportunities, and a centralized support system. This system would enable organizations to better track someone across services, reduce duplication, and avoid retraumatizing community members when information disclosure is required to access services.

The last need identified by leaders was to improve transportation supports. While participants did provide some examples of transportation being provided for community members, the desire was for more transportation "without limits." In other words, transportation that would be available without restriction on age, distance, or ability, and a broader, more wholistic understanding of the importance of transportation to promote health. For example, transportation could be provided for Hamilton residents to travel to Six Nations of the Grand River Territory to attend ceremonies, or for Elders to travel to Hamilton from other nations to share their teachings.

How has COVID-19 impacted the health needs of the Indigenous community in Hamilton?

Research has shown that Indigenous communities have experienced differential impacts of COVID-19, including an increased risk of acquiring and becoming more seriously ill from COVID-19 (Statistics Canada, 2022). The Indigenous Peoples and COVID-19 in Canada report by Mashford-Pringle et al. (2021) highlights that while COVID-19 has advanced Indigenous sovereignty and relationships with government, public health, and other health organizations, other issues such as racism in healthcare, funding disparities, and mistrust persist. These challenges, combined with other impacts of COVID-19 such as decreased access to culture, community, and housing, have the potential to further existing Indigenous and non-Indigenous health gaps (Mashford-Pringle et al., 2021). In Hamilton, similar gaps have previously been documented through the Our Health Counts project (2011), which showed that Indigenous people have a higher burden of chronic diseases, as well as inequities in the determinants of Indigenous health such as access to quality housing and healthcare (Smylie et al., 2011).

Impact of COVID-19 on overall health

While some additional comments were received from leaders in Indigenous organizations about COVID-19, the survey also asked community members about the impacts of COVID-19 on themselves, their families, and their communities. Respondents were asked if their overall health was better, about the same, or worse for themselves and their families when compared to the time period before COVID-19; about three quarters reported (73%) it was about the



same or better. Similarly, about two-thirds (67%) reported that their family's overall health was the same or better when compared to before the COVID-19 pandemic. The leaders of the Hamilton Indigenous organizations believe that the enhanced supports provided to the Indigenous community members during the pandemic helped them get through the pandemic. The Indigenous organizations provided: weekly check in calls with clients; home drop off for food, medications, and activity projects (e.g. beading kits); provided food banks and increased access to food; online health services and supports; and online activities. The Indigenous organizations worked with HPHS to provide Indigenous vaccine clinics and information about COVID-19 and vaccines in a culturally sensitive way. This is a good example of how HPHS and Indigenous organizations working together is vital to support the health of the Indigenous community.

• Impact of COVID-19 on mental, spiritual, physical and emotional health

When asked about changes in mental, spiritual, physical, and emotional health when compared to before the COVID-19 pandemic, survey respondents reported differences between their self-reported health for these three elements versus how they perceived COVID-19 had impacted their families.

Respondents indicated that spiritual health was maintained the most; about two-thirds reported that it remained the same or improved for themselves (71%) and their families (65%). However, when asked about physical and mental health for themselves and their families, a significant proportion of respondents reported that these had both worsened:

- physical health: self-reported-54%, family-38%
- mental / emotional health: self-reported-46%, family-31%

To understand how to support these changes in health as a result of the COVID-19 pandemic, respondents were asked to share what services, supports, or resources they anticipated they would require over the next year. The most common theme in the responses was the importance of bringing the community back together to heal from the impacts of the COVID-19 pandemic, especially isolation. Other identified needs included mental health counselling, affordable housing, community and cultural programming, healthy foods, opportunities for physical activity, and supports for Elders.

Have survey respondents accessed public health services before? If so, which programs and services?

The survey asked respondents about their use of HPHS programs and services. Many had not accessed (54%) or were unsure if they had accessed (27%) HPHS before. For those who had previously accessed HPHS, the programs and services they attended varied. The most common programs or services accessed were public health clinics (25%), food handler training (13%), early years or Healthy Babies Healthy Children programming (8%), harm reduction supports (4%) and prenatal and pregnancy supports (4%). Respondents who had accessed HPHS programs were asked to provide suggestions for improvement. Four responses were received, and most were positive comments about their experience with HPHS programs and services. One suggestion to provide on-site naloxone kits and training in CityHousing properties was made.

From the perspective of survey respondents, how can HPHS improve programs and services provided?

Many respondents indicated they had not previously accessed HPHS services. However, nearly two-thirds of respondents (62%) would consider using programs or services offered by HPHS, and just over half of survey respondents (52%) would feel safe using HPHS (about one third reported feeling unsure for each of these questions).

To help inform how HPHS could better support Indigenous communities, respondents were asked to identify any barriers to accessing HPHS. A majority (75%) answered, although almost half (49%) of these respondents identified no barriers. Among the few responses that were received, the most common barriers identified included being unsure

if the program or service was safe for Indigenous people (n=5), concerns about either the program location or hours (n=5), lack of transportation to and from programs (n=4), and lack of knowledge of available programs and services (n=3).

When asked about suggestions to help make HPHS safer for themselves and their families, most (63%) respondents provided an answer. Nine responses focused on the need for HPHS to build the community's awareness about available programs and services. For example, respondents suggested having information days at Indigenous organizations or having a newsletter distributed in CityHousing properties.

As one participant
expressed, we need to
"change the perspective of
the assumption that other
people must do the healing on
Indigenous people, that we need
to be saved or helped, rather
than empower our own
abilities that we can
heal ourselves."

Nine responses focused on increasing the cultural safety of programs and services. To increase safety and trust, respondents suggested having cultural safety training on a regular basis for staff, having cultural supports in programs (e.g., traditional medicines), making HPHS spaces more welcoming (e.g., through welcoming posters or pictures of Indigenous people), hiring more Indigenous staff in HPHS, and hearing testimonials from community members who have accessed HPHS. Nine responses focused on increasing accessibility and reducing barriers in other ways, such as the use of different communication strategies (e.g., chat options over text), having varied locations and times for programs, providing transportation, or having more services (e.g., resources, vaccination buses, cancer screening buses).

Discussion: How can HPHS better support Indigenous communities?

In interviews, leaders were asked about how HPHS could help create a healthy community for Indigenous people. Responses from leaders ranged, but focused on:

- the importance of meaningful engagement between HPHS, Indigenous organizations, and Indigenous communities;
- opportunities for HPHS to collaborate with Indigenous organizations to provide programs, services, or training; and
- the importance of HPHS acting as an ally to Indigenous communities through advocacy.

Through interviews and surveys, many needs and opportunities were identified, and suggestions were made to enhance HPHS' capacity to support Indigenous communities. All leaders acknowledged the importance of meaningful engagement and relationship building when asked about how HPHS can help create a healthy community for Indigenous people. To build relationships and meaningfully engage, interview participants shared that cultural safety training was critical for HPHS staff. Further, several survey respondents also identified training as a strategy to increase the safety of HPHS as a service setting for both themselves and their families. Interview participants described several necessary components for cultural safety training, including that the training should:

- be locally designed and delivered, purchased from Indigenous organizations, and vetted by the Indigenous community;
- centre Indigenous understandings of health and wellbeing which is wholistic (balancing physical, mental, emotional, and spiritual aspects of being);
- include content on trauma-informed practice, the history and enduring impacts of colonialism, challenging racist stereotypes, allyship, and responding to anti-Indigenous racism;

- include content about the history of medical experimentation and its impact on vaccine confidence;
- provide an overview of the Indigenous community in Hamilton, including Indigenous community organizations and their programs and services; and
- · be comprehensive, ongoing, and mandatory for all staff.

The components of a cultural safety training program described above are consistent with the Truth and Reconciliation Commission of Canada's (2015) Call to Action #23, to provide cultural competency training for all healthcare professionals, and Call to Action #57, to provide education to public servants on "the history of Aboriginal peoples, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous law, and Aboriginal–Crown relations." Further, these components are consistent with the Wise Practices for Indigenous-specific Cultural Safety Training Programs as described by Smylie et al. (2017). Smylie et al. (2017) also emphasize that cultural safety training needs to be part of an ongoing process that includes support at both system and organizational levels; such support is required for transformation and reconciliation.

In addition to cultural safety training for staff, leaders identified specific areas where public health staff could strengthen their knowledge of Indigenous wellness to ensure programs and services are culturally safe. Collaborative work by HPHS and Indigenous organizations to offer traditional birth practices, food and tobacco use were identified.

Relationship building and meaningful engagement can also be facilitated through outreach. The participation of public health leadership at community events such as powwows and feasts were mentioned as one way to build relationships. Other suggested strategies related to staffing, including a role funded by HPHS to work within the Indigenous community (e.g., at a community organization), increasing the number of HPHS staff who are Indigenous, and having a larger team to support Indigenous health equity.

In addition to training and relationship building strategies, several mechanisms for meaningful engagement were proposed. Leaders emphasized the critical importance of including Indigenous people in governance and decision-making. Any engagement needs to be collaborative and ensure that Indigenous communities and organizations have a valued voice at the table with autonomy over programs and services that aim to improve their health. Establishing an Indigenous health governance circle was suggested by leaders. This circle could guide Indigenous health initiatives, programs, and services in Hamilton. Leaders shared that this circle should include broad representation from the



healthcare system to ensure the health sector is accountable to Indigenous people. For HPHS specifically, a suggestion was made that HPHS could conduct focus groups with Indigenous community members to help inform current programs. Another suggestion was that HPHS could consult with existing Indigenous organizations and tables about their programs and services.

Beyond cultural safety training and further engagement with the Indigenous community and leaders, suggestions were made to help strengthen existing HPHS programs. These opportunities focus on increasing the Indigenous community's awareness of HPHS programs and services and to make them more welcoming and accessible. Suggestions include:

- review current spaces where HPHS programs and services are held and consider how they could be more welcoming and safer for Indigenous clients;
- explore opportunities to improve transportation supports (e.g., through bus passes or changing clinic locations) for programs and services;
- review existing programs and services to ensure they are culturally safe (e.g., food safety, health promotion messaging, school programming, tobacco use messaging); and
- develop a tailored communication plan about existing programs and services for Indigenous organizations and community members

In addition to improving existing programs and services, leaders provided some examples of opportunities for collaboration between HPHS and Indigenous organizations on new or existing initiatives. Most suggestions related to partnering with Indigenous organizations to provide specific services at their sites. Requested services included:

- mental health counselling
- Dental Health Bus
- seniors dental programming
- flu vaccine clinics
- · sexual health clinics
- The Van Needle Syringe program

Other opportunities for collaboration and co-development of programs identified by leaders were:

- prenatal, postnatal, breastfeeding, and parenting programs
- health promotion and harm reduction messaging to ensure it is culturally appropriate
- pilot collaborative service delivery models or new programs.

Lastly, leaders suggested opportunities to work together in other ways outside of improving existing or developing new programs and services. These included:

- provide or extend invitations to professional development workshops to staff in Indigenous organizations (e.g. mental health and harm reduction);
- explore how HPHS resources could help support Indigenous organizations (e.g., data or epidemiology support, librarian support);
- share educational opportunities (e.g., Infection Prevention and Control events) with Indigenous community organizations;
- connect Native Youth Advancement With Education Hamilton (NYA:WEH) and HPHS School Programs to build relationships;
- ensure Public Health Nurses (PHNs) working in schools are aware of Indigenous community organizations, and identify other opportunities for PHNs to support students;
- increase outreach to Indigenous organizations about HPHS programs and services;
- collaborate on conferences, symposiums, or forums; and
- explore opportunities for HPHS to support Indigenous students, including through internships/ practicums or offering specific programs on campus (e.g., food safety training).

I would like to see
them [Indigenous
organizations] be equitable,
funded in the same way so they can
provide benefits, pensions and job
security that they often do not get because
the funding is different – it is less than...
Turn over for Indigenous practitioners is high
because the pay is way less (75%) and the
benefits are not as appealing, less job
security. This affects the relationship with
clients – need the consistency and
relationship for the clients to make
any steps forward. It is difficult
to build trust for people.



Results from interviews and surveys identified many health needs, including traditional healing and wellness, mental health supports, access to housing, exercise and physical activity opportunities, diabetes management, and community and cultural programming. Increased access to land-based healing such as gardening, harvesting, medicine picking, and land based ceremonial space was identified as an important need for the community. Many of these needs would be best met by Indigenous community organizations that will centre Indigenous knowledge in their programs and services. In this way, leaders shared that HPHS has a role as an ally to Indigenous service providers. This is particularly important as while one of Hamilton's strengths is the quality of Indigenous services available, leaders emphasized that these services are underfunded relative to the needs of the community. Leaders shared that HPHS can be an ally in the following ways:

- Advocate for funding for Indigenous services, including health and housing.
- Leverage the success of events such as the Mino Biimadziwin Wakya'ta'shatse Social, to continue to invest in and partner to hold events that support Indigenous community health and wellbeing.
- Explore opportunities for HPHS to fund additional roles to focus on Indigenous health within the community, including roles where staff could work for and with community organizations.
- Continue to increase staff knowledge and awareness of Indigenous programs, services, histories, and worldviews in order to advocate effectively.
- Support the designation of land within Hamilton specifically set aside for Indigenous on the Land Healing and Ceremonial space, this includes the building of structures and a sacred fire site for ceremony.



RECOMMENDATIONS

Indigenous health needs to be in Indigenous hands; equitable and adequate resources and funding must also be in place to support Indigenous health. The Indigenous view of health and healing is wholistic and extends beyond physical health and the body to include the mind and spirit and this view is reflected in these recommendations.

1. Relationship Building

- Build relationships with local Indigenous organizations and nearby reserves to work together, following their direction for the Indigenous community.
- · Provide ongoing Indigenous cultural safety education for HPHS staff.
- Ensure active and visible participation from HPHS Leaders at Indigenous community and cultural events.
- Increase communication between the City and Indigenous organizations about new opportunities.
- Increase awareness of the services and opportunities provided by HPHS and the City. Examine the time and locations of services to see if changes to these would better serve the community.

2. Communication

- Participate in information events hosted by, or for Indigenous communities to provide information about HPHS and City of Hamilton services.
- Develop a newsletter listing services and events to share with the community (CityHousing buildings were identified as target sites),
- Expand methods of community outreach- e.g. Chat over text.

3. Staffing and Governance

- Increase the number of Indigenous staff in HPHS and the City of Hamilton and include a role that is funded by HPHS to work within the Indigenous community (e.g. at a community organization).
- Create a team of HPHS staff who are Indigenous to support Indigenous health equity.
- Establish an Indigenous health governance circle, to guide Indigenous health initiatives, programs, and services in Hamilton. This circle should include broad representation from the healthcare system to ensure the health sector is accountable to Indigenous people.

4. Collaboration & Co-development

- Indigenous community to lead and guide HPHS work based on their selfidentified needs.
- Co-develop prenatal, postnatal, breastfeeding, and parenting programs.

- Co-develop health promotion and harm reduction messaging to ensure it is culturally appropriate.
- Pilot collaborative service delivery models or new programs.
- Collaborate on activities such as conferences, symposiums, or forums.
- Leverage the success of events such as the Mino Biimadziwin Wakya'ta'shatse Social and continue to invest in and partner for events that support Indigenous community health and wellbeing.
- Partner with Indigenous organizations to provide specific services at their sites.
 For example:
 - mental health counselling
 - Dental Health Bus
 - · seniors dental programming
 - Flu vaccine clinics
 - sexual health clinics
 - The Van Needle Syringe program

5. Equitable and Safe Services

- · Create a sense of belonging, safety and inclusivity with Indigenous communities
- Ensure all services are culturally safe and provided in a welcoming physical space.
- Increase access to adult dental services that is equitable with other services provided to non-Indigenous community members.
- Increase access to diabetes management services including opportunities for traditional management.
- Increase access to and availability of affordable safe housing
- Increase safe adult mental health services including counselling.
- Increase safe mental health services to provide continuity of care.
- Provide mental health services available at the time when they are needed and without a waiting list.
- Increase the awareness of and access to opportunities to participate in local programming for exercise and physical activity. Ensure these services are safe for Indigenous people.
- Improve coordination of supports available within the city.
- Grow and support Indigenous system navigation.

- Create a centralized support system. This system should enable organizations to have improved ability to track someone across services, reduce duplication, and avoid retraumatizing community members when it is required that they disclose information to access services.
- Grow and support family-based programs.
- Increase programs that support men and two-spirit people.
- Expand and grow supports for children and youth including mental health.
- Increase supports for Indigenous older adults in the community.
- Provide Naloxone kits and training at CityHousing properties.
- Ensure services are available across all parts of the City and at varied locations.

6. Resources

- Provide professional development activities to staff in Indigenous organizations or include them in professional development activities provided for HPHS staff (e.g. mental health and harm reduction).
- Explore how HPHS resources could help support Indigenous organizations (e.g., data or epidemiology support, librarian support).
- Share educational opportunities external to HPHS (e.g., Infection Prevention and Control events) with Indigenous community organizations.
- · Connect the NYA:WEH and HPHS School Programs to build relationships,
- Ensure Public Health Nurses (PHNs) working in schools are aware of Indigenous community organizations and identify other opportunities for PHNs to support students.
- Increase outreach to Indigenous organizations about HPHS programs and services.
- Explore opportunities for HPHS to support Indigenous students, including through internships/practicums, provide specific programs on campus (e.g., food safety training)

7. Advocacy

- Advocate for funding for Indigenous services, including health and housing services.
- Advocate for an equitable wage for mental health workers at Indigenous organizations.
- Advocate for clean water.



8. Access to Indigenous Traditional Knowledge and Practices

- Preserve, strengthen and increase access to Indigenous Traditional Knowledge and practices.
- Support access to traditional food (e.g. access to wild game and lyed corn, support community gardens that include traditional medicines).
- Provide support for and access to nutrition and healthy eating supports that include traditional knowledge and diets.
- Provide land based ceremonial space.
- Support events that allow for development of a strong connection to community, culture, and family. This is especially important after reported isolation and negative impacts to mental and spiritual health from the pandemic.
- Increase transportation services without restrictions to allow for attendance at cultural events and to visit family and elders to increase access to traditional healing at Six Nations or Mississaugas of the Credit.



DISCUSSION & NEXT STEPS

Many of the recommendations align with key local, national and international recommendations and calls to action. The chart below shows where there is alignment with the HUIS, the Truth and Reconciliation Commission (TRC) Calls to Action and the United Nations Declaration on the Rights of Indigenous People (UNDRIP). The recommendations also reflect many of the action areas identified in the Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls.

		HUIS			
HPHS Indigenous Health Strategy Recommendation	Land	Spirit	People	TRC	UNDRIP
Relationship Building		<u>'</u>	•		
Provide ongoing Indigenous cultural safety education for HPHS staff			#24	18, 23 iii)	
Staffing and Governance					
Increase the number of Indigenous staff in HPHS and the City of Hamilton and include a role that is funded by HPHS to work within the Indigenous community (e.g. at a community organization)			#36	23 i)	
Create a team of HPHS staff who are Indigenous to support Indigenous health equity			#36	23 i)	
Establish an Indigenous health governance circle, to guide Indigenous health initiatives, programs, and services in Hamilton. This circle should include broad representation from the healthcare system to ensure the health sector is accountable to Indigenous people					Article 23
Collaboration & Co-development					
Indigenous community to lead and guide HPHS work based on their self-identified needs					Article 19
Co-develop prenatal, postnatal, breastfeeding, and parenting programs				34	
Leverage the success of events such as the Mino Biimadziwin Wakya'ta'shatse Social and continue to invest in and partner for events that support Indigenous community health and well-being		#21			
Resources					
Explore opportunities for HPHS to support Indigenous students, including through internships/practicums, provide specific programs on campus (e.g., food safety training)			#25		
Advocacy					
Advocate for an equitable wage for mental health workers at Indigenous organizations				23 ii)	
Access to Indigenous Traditional Knowledge and Practices	;				
Preserve, strengthen and increase access to Indigenous Traditional Knowledge and practices					Article 24 1, Article 31
Support access to traditional food (e.g. access to wild game and lyed corn, support community gardens that include traditional medicines)	#9				Article 24 1
Provide support for and access to nutrition and healthy eating supports that include traditional knowledge and diets	#9				Article 24 1
Provide land based ceremonial space	#6				Article 24 1

The next step for HPHS is to work collaboratively with Indigenous leaders and community to create an implementation plan to address these recommendations. This Strategy report will be shared with community partners and the broader health care sector in Hamilton, as the findings and recommendations are not limited to HPHS and are valuable for other organizations, as they also play a critical role in reconciliation and improving health outcomes for Indigenous communities. It is also important to note that although some of the recommendations are directed solely at HPHS, others cannot be directly influenced or controlled by HPHS. As mandated by the OPHS, Public Health is responsible for health equity analysis, policy development and the advancement of healthy public policies to decrease health inequity. This requires participation from and support of other partners. HPHS is committed to continuing to work with Indigenous communities and other partners to advocate for improved health outcomes for Indigenous Peoples.

Lastly, work aligned with some of the recommendations has already begun. Some examples are:

- Mandatory Indigenous Cultural Competency Training for all HPHS staff. This training
 is part of the HPHS Departmental Learning & Development Plan and began in 2019.
 The training includes all the components identified through the interviews and focus
 groups. This training was suspended due to the pandemic and has recently resumed.
- Work with Indigenous organizations in Hamilton to increase COVID-19 vaccine confidence and uptake, including Indigenous specific vaccine clinics.
- Collaborative planning and support for an annual Indigenous Social event. The
 inaugural event was held in 2021 and was held to bring the Indigenous community
 together to support and foster connection which was lost over the due to the
 pandemic. This event is open to all Hamilton residents and aims to bring Indigenous
 and non-Indigenous communities together to celebrate and experience Indigenous
 culture.
- Assessment of the HPHS Dental Program physical clinic to create a safe and welcoming space for clients. This has also been done, along with an Indigenous community leader, at several Hamilton Health Sciences locations.

The findings from the survey and interviews provide the groundwork for HPHS to implement a strategy that honours the principles of friendship, mutual respect, and peace, as the Two Row Wampum agreement teaches. HPHS must continue to work as an ally and respect the self-determination of Indigenous Peoples. Indigenous leaders have reviewed and approved this report and a release to the broader Indigenous community will take place later in 2023. An implementation report will be co-developed and will include goals, timelines and deliverables. An action-oriented plan can only be completed by engaging with Indigenous leaders and community from its inception. It is expected that a detailed implementation plan will be completed by the end of 2024 to allow for fulsome engagement, consultation and collaboration.

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Hamilton Public Health Services Indigenous Health Strategy Recommendations in Alignment with

Hamilton Urban Indigenous Strategy, the Truth and Reconciliation Commission Calls to Action, and the United Nations Declaration on the Rights of Indigenous People

	Hamilton Urban Indigenous Strategy			Truth and Reconciliation	United Nations
Hamilton Public Health Services Indigenous Health Strategy Recommendation	Land	Spirit	People	Commission	Declaration on the Rights of Indigenous People
Relationship Building Provide ongoing Indigenous cultural safety education for Hamilton Public Health Services staff.			#24	18, 23 iii)	
3. Staffing and Governance Increase the number of Indigenous staff in Hamilton Public Health Services and the City of Hamilton and include a role that is funded by Hamilton Public Health Services to work within the Indigenous community (e.g. at a community organization).			#36	23 i)	
Create a team of Hamilton Public Health Services staff who are Indigenous to support Indigenous health equity.			#36	23 i)	

	Hamilton Urban Indigenous Strategy			Truth and Reconciliation	United Nations
Hamilton Public Health Services Indigenous Health Strategy Recommendation	Land	Spirit	People	Commission	Declaration on the Rights of Indigenous People
Establish an Indigenous health governance circle, to guide Indigenous health initiatives, programs, and services in Hamilton. This circle should include broad representation from the healthcare system to ensure the health sector is accountable to Indigenous people.					Article 23
4. Collaboration & Co-development • Indigenous community to lead and guide Hamilton Public Health Services work based on their self-identified needs.					Article 19
 Co-develop prenatal, postnatal, breastfeeding, and parenting programs. 				34	
Leverage the success of events such as the Mino Biimadziwin Wakya'ta'shatse Social and continue to invest in and partner for events that support Indigenous community health and wellbeing.		#21			

		ton Urba		Truth and Reconciliation	United Nations
Hamilton Public Health Services Indigenous Health Strategy Recommendation	Land	Spirit	People	Commission	Declaration on the Rights of Indigenous People
Explore opportunities for Hamilton Public Health Services to support Indigenous students, including through internships/practicums, provide specific programs on campus (e.g., food safety training).			#25		
 Advocacy Advocate for an equitable wage for mental health workers at Indigenous organizations. 				23 ii)	
8. Access to Indigenous Traditional Knowledge and Practices • Preserve, strengthen, and increase access to Indigenous Traditional Knowledge and practices.					Article 24 1, Article 31
Support access to traditional food (e.g. access to wild game and lyed corn, support community gardens that include traditional medicines).	#9				Article 24 1

Appendix "B" to Report BOH23026 Page 4 of 4

Hamilton Public Health Services Indigenous Health Strategy Recommendation	Hamilton Urban Indigenous Strategy Land Spirit People		Truth and Reconciliation Commission	United Nations Declaration on the Rights of Indigenous People	
Provide support for and access to nutrition and healthy eating supports that include traditional knowledge and diets.	#9				Article 24 1
Provide land based ceremonial space.	#6				Article 24 1



PUBLIC HEALTH SERVICES INDIGENOUS HEALTH STRATEGY

August 16, 2023

Background

- The Ontario Public Health Standards (2018) introduced the "Relationships with Indigenous Communities Guideline"
- The intent of the Guideline is to assist boards of health to:
 - Implement the requirements established in the Ontario Public Health Standards' Health Equity Standard; and,
 - Engage in multi-sectoral collaboration with relevant stakeholders to decrease health inequities.
- The guideline provides boards of health with the fundamentals to begin forming meaningful relationships with Indigenous communities that come from a place of trust, mutual respect, understanding, and reciprocity



Background

- Hamilton Public Health Services is committed to effective engagement with the Indigenous Community in Hamilton.
- To provide guidance and direction for Public Health Services to meet the Ontario Public Health Standards through its programs and service delivery, an Indigenous Health Strategy Specialist position was created in 2018.



Background

The role of this position is to:

- Engage and build relationships with local Indigenous leaders, health system and community partners; and,
- Plan, coordinate and lead strategic projects related to Indigenous health inalignment with Hamilton's Urban Indigenous Strategy and the Ontario Public Health Standards to improve health outcomes and increase health equity for the Indigenous community

Work began to engage with the Indigenous Community to develop an Indigenous Health Strategy in 2019. This work was suspended due to COVID-19 and resumed in 2022.



Public Health Services Indigenous Health Strategy

Recognizing the importance of Self Determination, we looked to the Indigenous community for their direction for the strategy. Interviews were conducted with:

- Coalition of Hamilton Indigenous Leaders, Donna Gerber, Program Manager (Previous)
- De dwa da dehs nye>s Aboriginal Health Centre, Constance McKnight, Chief Executive Officer (Previous)
- Hamilton Regional Indian Centre, Audrey Davis, Executive Director
- McMaster University, Shylo Elmayan, Director Indigenous Student Services
- Mohawk College, Amy Kelaidis, Director and Special Advisor, Indigenous Initiatives
- NPAAMB Indigenous Youth Employment and Training, Shari St. Peter, Executive Director (Previous)
- Niwasa Kendaaswin Teg, Monique Lavelle, Executive Director
- Native Women's Centre, Paula Whitlow, Executive Director (Previous)
- Ontario Aboriginal Housing Services, Justin Marchand, Executive Director
- Sacajawea Non-Profit Housing, Melanie McAuley, Executive Director
- Six Nations of The Grand River Territory
- Mississaugas of the Credit First Nation
- Many other people who also participated in the interviews
- Indigenous Community members of Hamilton, Six Nations of the Grand River Territory, and Mississaugas of the Credit First Nation that participated in the Interviews and the survey.

At the request of the leaders of the Indigenous organizations, a survey was also distributed to the Indigenous community to verify what the leaders were stating.



Public Health Services Indigenous Health Strategy Themes

The recommendations have been categorized into the following themes:

- 1. Relationship Building;
- 2. Communication;
- 3. Staffing and Governance;
- 4. Collaboration and Co-development;
- 5. Equitable and Safe Services;
- 6. Resources;
- Advocacy; and,
- 8. Access to Indigenous Traditional Knowledge and Practices



Healthy Community



A healthy community is a "community helping to lift each other up…Because of colonization it has moved to 'l' and 'me', we need to move back to community."



Relationship Building



Two Row Wampum Belt



Communication



Picture Source: https://ehvi.org/joining-roots-sustaining-strength



Staffing & Governance





GAGE PARK OCTOBER I, 2022 IOAM - 5PM KYA'TA'SHATSE SOC OJIHGWAGA:YO **OLD MUSH SINGERS** FREE ADMISSION FOOD, VENDORS, RAIN OR SHINE

Collaboration & Co-development

As one participant shared, "[What is working well is] collaboration with services within the community – [we] have a good working relationship, respond to what is needed, and if we can't, we try to find someone that can."



Equitable & Safe Services



A healthy community has a holistic approach to mental, physical, emotional and spiritual wellbeing for everyone. It is an equitable community, with safe spaces and freedom. The community is prosperous and has safe environmental spaces where people can gather. Full access to a range of resources. Culturally safe environments.

Image by Kevin Allaby



Resources





I would like to see them [Indigenous organizations] be equitable, funded in the same way so they can provide benefits, pensions and job security that they often do not get because the funding is different – it is less than... Turn over for Indigenous practitioners is high because the pay is way less (75%) and the benefits are not as appealing, less job security. This affects the relationship with clients – need the consistency and relationship for the clients to make any steps forward. It is difficult to build trust for people.

Advocacy





Equitable access to resources is essential – basics like unpolluted water, fresh air, healthy nutrition, connection to land base, feeling respected, secure, safe and valued.

Access to Indigenous Traditional Knowledge & Practices

As one participant expressed, we need to "change the perspective of the assumption that other people must do the healing on Indigenous people, that we need to be saved or helped, rather than empower our own abilities that we can heal ourselves."





Reflections







Meeting #: 20-001 Date: January 14, 2020 Time: 7:00 pm

Location: Room 192, 1st Floor 71 Main Street West

Heather Harvey, Health Promotional Specialist (905) 546-2424 ext. 3635

Present: Vivien Underdown (Chair), Kyle Swain, Mary Ellen Scanlon, Frank Stinellis, Drew Johnston, Elly Bowen (Co-Chair), Brian Tammi (Secretary), Maria Biasutti, Laurie Nielson, Barbara Stares, Andrew Sweetnam, Vicky Hachey, Krista D'aoust, Heather Harvey (Staff Liaison)

Absent with regrets: Jennifer Silversmith, Jordan Geertsma, Councillor Merulla, Biniam Mehretab

1. CEREMONIAL ACTIVITIES

None

2. APPROVAL OF AGENDA

(Bowen/Sweetnam)

That the agenda for Jan 14, 2020 meeting of the Food Advisory Committee be approved a presented.

CARRIED

3. DECLARATIONS OF INTEREST

None

4. APPROVAL OF MINUTES OF PREVIOUS MEETING

4.1 November 12, 2019

(Stinellis/ Nielson)

That the minutes of the November 12, 2019 meeting of the Food Advisory Committee be approved as presented.

CARRIED

5. COMMUNICATIONS

5.1 Correspondence from Dina Honig, Hamilton Immigration Partnership Council (HIPC), respecting a Request for Study/Research Ideas for HIPC's Research and Evaluation Committee

(Tammi/Nielson)

That the correspondence from Dina Honig, Hamilton Immigration Partnership Council (HIPC), respecting a Request for Study/Research Ideas for HIPC's Research and Evaluation Committee, be received.

CARRIED

6. DELEGATION REQUESTS

None

7. CONSENT ITEMS

None

8. PUBLIC HEARINGS / DELEGATIONS

None

9. STAFF PRESENTATIONS

9.1 Update on Food Strategy Status

Presentation by H. Harvey was received. Discussed actions that are underway, planned, or completed that are action items identified by, and pertaining to, the Food Strategy (FS).

10 DISCUSSION ITEMS

10.1 Discussion About Food Policy Examples or Case Studies

Members shared examples of food security / sovereignty initiatives from Hamilton and other regions.

10.2 Planning Future Committee Actions

Members discussed and decided to focus on 4 main issues for the next four meetings (one issue per meeting): climate change, education/accessibility, food sovereignty/food hub, evaluating success of Food Strategy.

10.3 Member Updates and Sharing of Food Related Issues

Discussion of local procurement policy.

11. MOTIONS

None

12. NOTICES OF MOTION

None

13 GENERAL INFORMATION/ OTHER BUSINESS

None

14. PRIVATE AND CONFIDENTIAL

None

15. ADJOURNMENT

(Sweetnam/Hachey)

That there be no further business, the Food Advisory Committee be adjourned at 9:00 PM.

CARRIED

0,

Respectfully submitted,

V. Underdown, Chair Food Advisory Committee

Heather Harvey Staff Liaison Public Health Services



Meeting #: 20-002
Date: February 11, 2020
Time: 7:00 pm

Location: Room 192, 1st Floor 71 Main Street West

Heather Harvey, Health Promotional Specialist (905) 546-2424 ext. 3635

Present:

Vivien Underdown (Chair), Elly Bowen (Co-Chair), Brian Tammi (Secretary), Maria Biasutti, Krista D'Aoust, Heather Harvey (Staff Liaison), Drew Johnston, Binamin Mehretab, Laurie Nielson, Mary Ellen Scanlon, Jennifer Silversmith, Barbara Stares, Kyle Swain, Andrew Sweetnam

Absent with regrets:

Councillor Merulla, Jordan Geertsma, Vicky Hachey, Frank Stinellis

1. CEREMONIAL ACTIVITIES

None

2. APPROVAL OF AGENDA

(Stares/ Nielson)

That the agenda for the February 11, 2020 meeting of the Food Advisory Committee be approved as presented.

CARRIED

3. DECLARATIONS OF INTEREST

None

4. APPROVAL OF MINUTES OF PREVIOUS MEETING

4.1 January 14, 2020

(Tammi/Scanlon)

That the Minutes of the January 14, 2020 meeting of the Food Advisory Committee be approved as presented.

CARRIED

5. COMMUNICATIONS

None

6. DELEGATION REQUESTS

7. CONSENT ITEMS

7.1 Nutritious Food Basket Infographic "how much does healthy eating cost in Hamilton?"

(Biasutti/D'Aoust)

That the Nutritious Food Basket Infographic be received.

CARRIED

8. PUBLIC HEARINGS / DELEGATIONS

None

9. STAFF PRESENTATIONS

9.1 Climate Change and Food Systems - Trevor Imhoff, Senior Project Manager, Air Quality and Climate Change

Presentation received by T. Imhoff was received. Discussed climate change initiatives in Hamilton that aim to reduce GHG emissions in line with IPCC targets. FAC members questioned presenter regarding presentation and discussed local climate change issues.

10. DISCUSSION ITEMS

10.1 Work plan

Members discussed food systems and climate change. Members outlined desire to receive climate change adaptation plan and advise on the working group terms of reference. FAC members discussed need to look for opportunity to advise on upcoming food issues as per our mandate. Staff Liaison will attempt to stay informed of upcoming city initiatives related to the Food Strategy and bring them forward to FAC proactively for comment.

10.2 Staff Update

FAC budget of \$2500 has been referred to budget process.

An updated committee handbook is available online and attendance rules have changed.

Food Strategy Forum notes are being processed and a report is forthcoming.

10.3 Member Updates and Food Related Issues

- D. Johnston, M. Scanlon discussed multilingual signage for guidelines regarding consuming fish from Hamilton watershed.
- B. Mehretab has been involved in discussions with private parties regarding investment into the creation of a regional Food Hub and has received lots of interest.

E. Bowen requested presentation about waste management study for a future FAC meeting.

11. MOTIONS

None

12. NOTICES OF MOTION

None

13 GENERAL INFORMATION/ OTHER BUSINESS

13.1 City of Hamilton Waste Management Survey

Community consultation complete but we may be able to submit comments. If items for comment are time sensitive FAC members can be emailed.

13.2 National Farmers Union of Ontario Conference

Committee members are invited to attend a public talk "Planning for Climate Resilience" with Lynda Lukasik of Environment Hamilton that is part of the National Farmer Union of Ontario Conference on April 25, 2020.

14. PRIVATE AND CONFIDENTIAL

None

15. ADJOURNMENT

(Johnston/Nielson)

That there be no further business, the Food Advisory Committee be adjourned at 9:00 PM.

CARRIED

Respectfully submitted,

V. Underdown, Chair Food Advisory Committee

Heather Harvey Staff Liaison Public Health Services



Meeting #: 20-003 Date: March 10, 2020

Time: 7:00 pm

Location: Room 192, 1st Floor 71 Main Street West

Heather Harvey Health Promotional Specialist (905) 546-2424 ext. 3635

Present:

Heather Harvey (Staff Liaison), Brian Tammi (Secretary), Maria Biasutti, Kyle Swain, Mary Ellen Scanlon, Vivien Underdown (Chair), Barbara Stares, Krista D'Aoust, Binamin Mehretab, Frank Stinellis

public guests: Luc Peters

Absent with regrets:

Councillor Merulla, Jennifer Silversmith, Elly Bowen (Co-Chair), Drew Johnston, Laurie Nielson

1. Ceremonial Activities Land Acknowledgement

2. Approval of Agenda

That the agenda for March 10, 2020 meeting of the Food Advisory Committee be approved a presented. (Scanlon / Stares)

3.Declarations of Interest

None

4. Approval of Minutes of Previous Meeting

4.1 February 11, 2020 (Mehretab / D'Aoust)

Carried

5. Communications

Citizen Resignation: Jordan Geertsma

6. Delegation Requests

None

7. Consent Items

None

8. Public Hearings / Delegations

None

9. Staff Presentations

None

10 Discussion Items

10.1 Food Hub Presentations

B Tammi delivers presentation to FAC

10.2 Food Sovereignty Presentation

V. Underdown delivers presentation to FAC

10.21,10.2 – Full Group discussion regarding food sovereignty / food hubs

Where does Hamilton fit into food sovereignty?

What does food sovereignty mean for Hamilton?

What are the priorities for local food sovereignty?

10.3 Letter to Ag-rural affairs committee

10.4.

Staff Update (Update on Food Strategy Steering Committee, Food Waste Update, GRIDS 2 going to GIC in April)

H. Harvey – update FAC on CoVid19 from Public Health. 55 staff have been pulled into response team as of Today. Will keep FAC updated. Updates at www.hamilton.ca/coronavirus

Internal Food Strategy: committee haven't met in a year but are meeting next Thursday. FAC will receive report from that meeting and have option for input.

H. Harvey met with waste management staff. Survey results are going to waste management advisory committee, trying to align waste management actions with Hamilton Food Strategy. Opportunity to engage around solid waste masterplan with a food waste perspective.

GRIDS2 – growth strategy. Happening in tandem with municipal review. Draft lands need assessment going to GIC.

10.5 Member Updates and Food Related Issues

FAC members discussed groups in other municipalities: Halton Food For Thought, Food and Farming Coops

11. Motions

To draft a letter to correspond with the Hamilton Aboriginal Advisory committee (D'aoust/ Stares)

To send letter on behalf of FAC to rural and agri- affairs committee

(Tammi/ Biasutti)

12. Notices of Motion

None

13 General Information/ Other Business

Free event Friday March 13 – Food Is Political 6pm – 8pm speaker is new farmer at Downsview park in Toronto

LGBTQ advisory committee delegation request- hosting all committee meeting

14. Private and Confidential

None

15. Adjournment (D'aoust /Mehretab)

CARRIED

Respectfully submitted,

V. Underdown, Chair Food Advisory Committee

Heather Harvey Staff Liaison Public Health Services



Meeting #: 21-001 Date: May 11, 2021 Time: 7:00 pm Location: Online

Richard MacDonand Manager: Food and Water Safety Healthy and Safe Communities Public Health Services- Healthy Environments, City of Hamilton (905) 546 2424 Ext. 5818

Present:

Brian Tammi (Secretary), Kyle Swain, Mary Ellen Scanlon,, Vivien Underdown (Chair), Krista D' Aoust, Frank Stinellis, Jennifer Silversmith, Elly Bowen (Co-Chair), Laurie Nielson, Drew Johnston,

Also Present: Richard MacDonald(Staff Liaison)

Absent with regrets:

Councillor S. Merulla, Barbara Stares, Binamin Mehretab, Maria Biasutti

1. Appointment of Co Chairs (Underdown, Bowen)

CARRIED

2. Approval of Agenda (Underdown, Bowen)

That the agenda for May 11, 2021 meeting of the Food Advisory Committee be approved a presented.

CARRIED

3.Declarations of Interest None

4. Approval of Minutes of Previous Meeting (Item 4)

4.1 March 10, 2020 (Scanlon / Bowen)

CARRIED

5. Discussion Items (Item 10)

- 10.1. Staff Update respecting the Status of Food Security in Hamilton During the COVID-19 Pandemic maintaining business continuity in dept. Very limited resources
- 10.2. Stop Sprawl Hamilton Update Laurie Nielsen
- 10.3. Nourish Anchor Collaborative Cohort Andrew Sweetnam
- 10.4. Roadmap to Transition from Emergency Food to Food Sovereignty (post pandemic) Brian Tammi
- 10.5. Food Advisory Committee Member Updates
- 10.6. Future Projects of the Food Advisory Committee Food Strategy approved in 2015

FAC obliged to do annual reporting: no indicators of progress / success

10.7. Budget

\$2500 in budget 2021

6. Motions (Item 11)

11.1. All Advisory Committee Event

(Scanlon/ Bowen)

That the Food Advisory Committee approves the date of proposed event being September 27, 2021 - 4:00pm to 6:00 p.m., livestreamed to YouTube.

CARRIED

11.2. All Advisory Committee Event Presenter
Motion to identify a Food Advisory Committee member to present their
mandate on behalf of the Committee for 5 minutes.

Presenter: co chairs
(Nielson / Sweetnam)

Carried

7. Notices of Motion (Item 12)
12.1 Motion for planing dept to update (Nielson / Scanlon)

Carried

8. Adjournment (Item 15) (Underdown / Tammi)

CARRIED

Respectfully submitted,

Mary Ellen Scanlon, Co-Chair Krista D-Aoust, Co-Chair Food Advisory Committee

Richard MacDonald Staff Liaison Public Health Services



Meeting #: 21-002 Date: June 8, 2021 Time: 7:00 pm Location: Online

Richard MacDonand Manager: Food and Water Safety Healthy and Safe Communities Public Health Services- Healthy Environments, City of Hamilton (905) 546 2424 Ext. 5818

Present:

Richard MacDonald (Staff Liaison), Brian Tammi (Secretary), Kyle Swain, Mary Ellen Scanlon (Co-Chair), Vivien Underdown, Krista D'Aoust (Co-Chair), Frank Stinellis, Jennifer Silversmith, Elly Bowen, Laurie Nielson, Vicky Hachey

Absent with regrets:

Councillor Merulla, Barbara Stares, Binamin Mehretab, Maria Biasutti, Andrew Sweetnam, Drew Johnston

1. CEREMONIAL ACTIVITIES

Land Acknowledment

2. Approval of Agenda

That the agenda for June 8, 2021 meeting of the Food Advisory Committee be approved a presented. (**Underdown, Bowen**)

Carried

3.Declarations of Interest None

4. Approval of Minutes of Previous Meeting

4.1 May 11, 2021 (Stinellis / Hachey)

Carried

4.2 Business arising from minutes

None

5. Communications

None

6. Delegation Requests

None

7. Consent Items

None

8. Public Hearings / Delegations

None

9. Staff Presentations

None

10 Discussion Items

10.1 Update from Planning Deptartment regarding urban sprawl and use or agricultural land presentation. At fall FAC meeting a representative from Planing Dept will deliver presentation to FAC – Richard MacDonald

- 10.2 FAC discusses formation a working group to perform an analysis of the implementation of the Food Strategy as per our mandate to report annually. Working Group to develop terms of reference and report back to FAC at August meeting Krista D'Aoust
- 10.3 Feeding the City Report: Visions of the food system to come- Mary Ellen Scanlon
- 10.4 Update about the Hamilton Community Garden Network Krista D'Aoust
- 10.5 Budget discussion for future research projects. Richard MacDonald
- 10.6 Member updates Frank Stinellis, Brian Tammi, Krista D'Aoust, Elly Bowen, Vivien Underdown

11. Motions

11.1. Form working group

Motion to create a working group to develop terms of reference for analyzing implementation progress of Food Strategy.

(D'Aoust / Scanlon)

Carried

12. Notices of Motion

None

13 General Information/ Other Business

None

14. Private and Confidential None

15. Adjournment (Hachey / Bowen)

CARRIED

Respectfully submitted,

Mary Ellen Scanlon, Co-Chair Krista D-Aoust, Co-Chair Food Advisory Committee

Richard MacDonald Staff Liaison Public Health Services



Meeting #: 21-003 Date: August 10, 2021 Time: 7:00 pm Location: Online

Richard MacDonald Manager: Food and Water Safety Healthy and Safe Communities Public Health Services- Healthy Environments, City of Hamilton (905) 546 2424 Ext. 5818

Present:

Richard MacDonald (Staff Liaison), Brian Tammi (Secretary), Mary Ellen Scanlon (Co-Chair), Vivien Underdown, Krista D'Aoust (Co-Chair), Laurie Nielson, Kyle Swain, Vicky Hachey

Absent with regrets:

Councillor Merulla, Barbara Stares, Binamin Mehretab, Maria Biasutti, Frank Stinellis, Jennifer Silversmith, Elly Bowen, Drew Johnston

1. CEREMONIAL ACTIVITIES

Land Acknowledment (Scanlon)

Roll Call (D'Aoust)

2. Approval of Agenda

That the agenda for August 10, 2021 meeting of the Food Advisory Committee be approved as presented.

(Scanlon, Hachey)

Carried

3.Declarations of Interest

None

4. Approval of Minutes of Previous Meeting

4.1 June 8, 2021 (Tammi / D'Aoust)

Carried

4.2 Business arising from minutes

None

5. Communications

None

6. Delegation Requests

None

7. Consent Items

None

8. Public Hearings / Delegations

None

9. Staff Presentations

None

10 Discussion Items

- 10.1 New Food Strategy working group present terms of reference and analysis framework for review by FAC Krista D'Aoust / Brian Tammi
- 10.2 Community Food Pantries Mary Ellen Scanlon
- 10.3 Member Updates Vicky Hachey, Krista D'Aoust, Mary Ellen Scanlon
- 10.4 All advisory committee meeting Sept 27, 2021 4pm-6pm- Richard MacDonald
- 10.5 Budget Updates and Questions Vicky Hachey, Richard Macdonald

scanlon – FAC was not allowed to meet when other committees were allowed to meet

11. Motions

11.1 Approve the terms of reference for working group (underdown/ nielson)

Carried

12. Notices of Motion

None

13 General Information/ Other Business

None

14. Private and Confidential

None

15. Adjournment

(Hachey/ Underdown)

Respectfully submitted,

Mary Ellen Scanlon, Co-Chair Krista D-Aoust, Co-Chair Food Advisory Committee

Richard MacDonald Staff Liaison Public Health Services



Meeting #: 21-001

Date: September 14, 2021

Time: 7:00 pm

Location: Online

Richard MacDonand Manager: Food and Water Safety Healthy and Safe Communities Public Health Services- Healthy Environments, City of Hamilton (905) 546 2424 Ext. 5818

Present:

Richard MacDonald(Staff Liaison), Brian Tammi (Secretary), Krista D'Aoust(Co-Chair), Frank Stinellis, Jennifer Silversmith, Vivien Underdown, Maria Biasutti, Drew Johnston, Elly Bowen, Vicky Hachey, Kyle Swain, Mary Ellen Scanlon, (Co-Chair), Kyle Swain

Absent with regrets:

Councillor Merulla, Barbara Stares, Laurie Nielson, Binamin Mehretab, Andrew Sweetnam,

1 Ceremonial Activities

Land acknowledgement - Vivien Underdown

Roll call- Krista D'Aoust

2 Approval of agenda (Bowen / Scanlon)

Carried

3 Declarations of interest

None

4 Approval of Meeting

4.1. Approval of FAC August 10, 2021 Minutes (**Tammi / Scanlon**)

Carried

4.2. Business arising from minutes

5 Communications

None

6. Delegation Requests

None

7. Consent Items

None

8. Staff presentations

None

9. Public hearings/ delegations

None

10 Discussion Items

- 10.1. Working Group to do an update /report on Food Strategy Krista D'Aoust, Vivien Underdown, Mary Ellen Scanlon, Brian tammi
- 10.2. Budget revision and review Krista D'Aoust (Budget options), Vivien Underdown (SPRC),
- 10.3. September 27th All Advisory Committee Meeting Richard MacDonald, Krista D-aoust
- 10.4. Member Updates Richard MacDonald, Maria Biasutti, Mary Ellen Scanlon, Vivien Underdown, Krista D'Aoust, Brian Tammi
- 10.5 Members who didn't sign acknowledgment of participation (from city clerks)- Krista D'Aoust, Richard MacDonald, Elly Bowen, Drew Johnston, Mary Ellen Scanlon, Maria Biasutti
- 10.6 Food Literacy Month Krista D'Aoust, Maria Biasutti, Elly Bowen, Vivien Underdown

11. Motions

11.1 Re-allocate funds from "parking, printing" to "event"

(Underdown / Stinellis)

Carried

11.2 Keep budget request the same as previous year (\$1500)

(Underdown / Scanlon)

Carried

12. Notices of Motion

None

13. General Information

None

14. Private and confidential

None

15. Adjournment

(Tammi / Underdown)

Carried

Respectfully submitted,

Mary Ellen Scanlon, Co-Chair Krista D-Aoust, Co-Chair Food Advisory Committee Richard MacDonald Staff Liaison Public Health Services



Meeting #: 21-005 Date: Oct 12, 2021 Time: 7:00 pm

Location: Due to the COVID-19 and the Closure of City Hall All electronic meetings can

be viewed at the Citys YouTube Channel

Richard MacDonald Manager: Food and Water Safety Healthy and Safe Communities (905) 546 2424 Ext. 5818

Present:

Richard MacDonald(Staff Liaison), Brian Tammi (Secretary), Krista D'Aoust(Co-Chair), Vicky Hachey, Kyle Swain, Laurie Nielson, Mary Ellen Scanlon,, (Co-Chair), Frank Stinellis, Maria Biasutti, Elly Bowen, Vivien Underdown, Adam Watson (city presenter)

Absent with regrets:

Councillor Merulla, Barbara Stares, Binamin Mehretab, Andrew Sweetnam, Jennifer Silversmith, Drew Johnston,

1 Ceremonial Activities

Land acknowledgement – Krista D'Aoust

Roll call- Krista D'Aoust

2 Approval of agenda (Scanlon /Bowen)

CARRIED

3 Declarations of interest

None

4 Approval of Meeting

4.1. Approval of FAC Sept 14, 2021 Minutes (Bowen / Underdown)

CARRIED

4.2. Business arising from minutes None

8. Staff presentations

8.1 Adam Watson - Neighbourhood Action Strategy Update

10 Discussion Items

- 10.1. All Advisory Committee meeting brief Mary Ellen Scanlon, Vicky Hachey, Vivien Underdown
- 10.2. Working Group update Krista D'Aoust -bring full plan to November meeting
- 10.3. Information Report –Social Determinants of Health in COVID-19 tabled until November meeting (information not sent to all FAC members)
- 10.4. Member Updates Mary Ellen Scanlon, Vicky Hachey, Vivien Underdown
- 10.5. Food Advisory Budget Update Richard MacDonald, Krista D'Aoust

14. Private and confidential

None

15. Adjournment (Stinellis / Bowen) Carried

Respectfully submitted,

Mary Ellen Scanlon, Co-Chair Krista D'Aoust, Co-Chair Food Advisory Committee



Meeting #: 21-006 Date: Nov 09, 2021 Time: 7:00 pm Location:

Due to the COVID-19 and the Closure of City Hall All electronic meetings can be viewed at: City's YouTube Channel: https://www.youtube.com/user/InsideCityofHamilton

Richard MacDonald Manager: Food and Water Safety Healthy and Safe Communities Public Health Services- Healthy Environments, City of Hamilton (905) 546 2424 Ext. 5818

Present: Richard MacDonald (Staff Liaison), Brian Tammi (Secretary), Krista D'

Aoust (Co-Chair), Andrew Sweetnam, Laurie Nielson, Elly Bowen, Vivien Underdown, Mary Ellen Scanlon (Co-Chair), Frank Stinellis, Drew Johnston,

Elly Bowen, Vicky Hachey, Cindy Mutch

Absent with

regrets: Councilor Merulla, Barbara Stares, Maria Biasutti, Kyle Swain, Binamin

Mehretab, Jennifer Silversmith

1. Ceremonial Activities (Item 1)

Land acknowledgment - Vivien Underdown

Roll call- Krista D' Aoust

2. Approval of agenda (Item 2)

(Nielson / Scanlon)

That the Food Advisory Committee approve the Agenda, as presented.

CARRIED

3. Declarations of interest (Item 3)

None

4. Approval of Meeting (Item 4)

(i) October 12, 2021 Minutes

(Underdown / Tammi)

That the Food Advisory Committee approve the Agenda for today's meeting, as distributed.

CARRIED

5. Staff presentations (Item 8)

(i) Presentation from Cindy Mutch - Senior Project Manager, Community Engagement to discuss the City's online public engagement platform – Engage Hamilton (live on June 15, 2020) (Item 8.1)

(Nielson / Bowen)

That the Food Advisory Committee receive the presentation from Cindy Mutch – Community Engagement - Engage Hamilton

CARRIED

6. Discussion Items (Item 10)

(i) Information Report - Social Determinants of Health in COVID-19 - Krista D' Aoust, Mary Ellen Scanlon (Item 10.?)

(Bowen / Hachey)

That the Food Advisory Committee receive the "Social determinates of Health in CoVid-19" report.

CARRIED

(Underdown / Scanlon)

That the Food Advisory Committee to request follow-up regarding "Social Determinates of Health in CoVid-19" report.

CARRIED

(ii) Code of Conduct for Boards and Committees - Integrity Commissioner Work Plan (FCS21081) (City Wide) (Item 10.3)

An Email was circulated by Staff Liaison to Committee members regarding Code of Conduct for Citizen members of committees. Review and feedback is being sought from Committee members and can be forwarded to Integrity Commissioner through the email provided by November 30, 2021.

(Hachey / Underdown)

That All Food Advisory Committee members have received the communication and members can forward feedback to the Integrity Commissioner through the information provided by November 30, 2021.

CARRIED

(Hachey / Underdown)

That Richard MacDonald, Staff Liaison, send all "Code of conduct" documents to Food Advisory Committee members as links in the forwarded email did not work.

CARRIED

(iv) Mandatory COVID-19 Vaccination Verification Policy - Richard MacDonald (Item 10.4)

Food Advisory Committee members informed of the Council-approved <u>Mandatory</u> <u>COVID-19 Vaccination Verification Policy</u> and how it affects a Council appointed representative on a city committee, where you are a member.

(Bowen/ Stinellis)

That the "Mandatory COVID-19 Vaccination Verification Policy" be received.

CARRIED

(v) Member Updates - Mary Ellen Scanlon (Item 10.5)

(Tammi / Hachey)

That the Food Advisory Committee to have FAC meeting on December 14, 2021 **CARRIED**

15. Adjournment (Item 15)

(Stinellis / Scanlon)

That, there being no further business, the Food Advisory Committee meeting for November 09, 2021 be Adjourned.

CARRIED

Respectfully submitted,

Mary Ellen Scanlon, Co-Chair Krista D' Aoust, Co-Chair Food Advisory Committee



Minutes

Meeting #: 21-007

Date: Dec 14, 2021

Time: 7:00 pm

Location:

Due to the COVID-19 and the Closure of City Hall All electronic meetings can be viewed at: City's YouTube Channel: https://www.youtube.com/user/InsideCityofHamilton

Richard MacDonald Manager: Food and Water Safety, Healthy and Safe Communities Public Health Services- Healthy Environments, City of Hamilton (905) 546 2424 Ext. 5818

Present: Richard MacDonald (Staff Liaison), Brian Tammi (Secretary), Krista D'Aoust (Co-Chair), Vicky Hachey, Kyle Swain, Andrew Sweetnam, Frank Stinellis, Drew Johnston, Elly Bowen, Vivien Underdown, Maria Biasutti, Laurie Nielson

Absent with regrets: Councillor Merulla, Barbara Stares, Binamin Mehretab, Jennifer Silversmith, Mary Ellen Scanlon (Co-Chair)

1. Ceremonial Activities (Item 1)

Land acknowledgement -Krista D'Aoust

Roll call- Krista D' Aoust

2. Approval of agenda (Item 2)

(Nielson / Stinellis)

That the Food Advisory Committee approve the Agenda, as presented.

CARRIED

3. Declarations of interest (Item 3)

None

4. Approval of Meeting (Item 4)

(i) November 9, 2021 Minutes

(Nielson / Underdown)

That the minutes from the November 9 2021 be deferred to January 2022 Food Advisory Committee meeting.

CARRIED

5. Discussion Items (Item 10)

(i) Social Planning and Research Council of Hamilton – Purchase of Service Agreement (Item 10.1)

Food Advisory Committee members discussed "SPRC - PURCHASE OF SERVICE AGREEMENT" including scopeof work, timelines, focus of review, dates of deliverables, research outcomes, process of public engagement.

(Bowen/ Sweetnam)

That the Social Planning and Research Council of Hamilton – Purchase of Service Agreement, be received.

CARRIED

(Hachey/ Underdown)

- (a) That the FAC approves the Social Planning and Research Council of Hamilton – Purchase of Service Agreement, and enters into a workplan with the SPRC; and
- (b) That the funding to the Social Planning and Research Council of Hamilton, be approved

CARRIED

(ii) Member Updates – Vivien Underdown (Item 10.4)

V. Underdown advised the Committee that the United Way Niagara is seeking to perform some coordinated advocacy during the provincial election in 2022 and to identify common interests with FAC. The first meeting is scheduled for mid-January 2022.

(Hachey/ Underdown)

That the Member Update, be received.

CARRIED

6. Adjournment (Item 15)

(Underdown/ Bowen)

That, there being no further business, the Food Advisory Committee meeting for December 14, 2021 be adjourned at 7:35 pm.

CARRIED

Respectfully submitted,

Krista D'Aoust, Chair Mary Ellen Scanlon, Co-Chair Food Advisory Committee



Meeting #: 22-001 Date: Jan 11, 2022 Time: 7:00 pm

Location: Online Due to the COVID-19 and the Closure of City Hall

Due to the COVID-19 and the Closure of City Hall All electronic meetings can be viewed at: City's

YouTube Channel: https://www.youtube.com/user/InsideCityofHamilton

Richard MacDonald Manager: Food and Water Safety, Healthy and Safe Communities
Public Health Services- Healthy Environments, City of Hamilton (905) 546 2424 Ext. 5818

Present: Richard MacDonald (Staff Liaison), Brian Tammi (Secretary), Krista D'Aoust (Co-Chair), Vivien Underdown, Elly Bowen, Drew Johnston, Frank Stinellis, Mary Ellen Scanlon (Co-Chair), Vicky Hachey, Laurie Nielsen,

Absent with regrets: Councillor Merulla, Barbara Stares Diniam Mehretab, Andrew Sweetnam, Maria Biasutti, Kyle Swain, Jennifer Silversmith,

1. Ceremonial Activities (Item 1)

Land acknowledgement –Krista D'Aoust

Roll call- Krista D'Aoust

2. Approval of agenda (Item 2)

(Hachey, Bowen)

That the Food Advisory Committee approve the Agenda, as presented.

3. Declarations of interest (Item 3)

None

4. Approval of Meeting (Item 4)

(i) November 9, 2021 Minutes

That the minutes from November 9 2021 be accepted (Scanlon, Bowen)

CARRIED

(ii) December 14, 2021 Minutes

That the minutes from December 14, 2021 be accepted (Underdown, Scanlon)

CARRIED

5. Communications (Item 5)

(i) Advisory Committees -Meeting during election period

Clerks email communication that Advisory Committees will not be meeting during the 2022 Municipal Election period (September 28th to November 17th).

6. Discussion Items (Item 10)

(i) Update to FAC regarding SPRC project - Krista D'Aoust/ Mary Ellen Scanlon (Item 10.1)

Motion – that the FAC receive the SPRC recommendation document **(Tammi / Underdown)**

Carried

Motion – That the FAC working group can continue to engage with the SPRC in regards to the present contract and report to the FAC membership.

(D'Aoust / Hachey)

Carried

(ii) Committee membership Update (Item 10.2) Krista D'Aoust, Laurie Nielson, Richard MacDonald

Motion – That following the election period 2022, the FAC would like to request a confirmation from City that the FAC can continue to meet until our successors are named.

Carried

(iii) Barbara Stares – Resignation (Item 10.3)

Motion -that the communication regarding Barbara Stares resignation be accepted and that the FAC accepts the resignation (Tammi/ Stinellis)

Carried

(iv) Diniam Mehretab, Jennifer Silversmith – resignation by abdication(Item 10.4) Motion - That these members have exceeded the threshold for absenteeism, Diniam and Jennifer are considered resigned from the FAC (D'Aoust / Bowen)

Carried

(v) Member Updates – Brian Tammi, Mary Ellen Scanlon

Motion – That the FAC requests the staff liaison clarifies, re: our terms of reference, 1) if 2 councillors will be appointed to the next term FAC, 2) what the process is for requesting the appointment of a new councillor representative

(Bowen/ Scanlon)

Carried

7. Motions (Item 11)

(i) That following the municipal election period of 2022, the FAC requests confirmation from City that the current FAC membership can continue to meet until our successors are named. (Bowen/Scanlon)

Carried

8. Adjournment (Item 15)

(Underdown/ Bowen)

That, there being no further business, the Food Advisory Committee meeting for January 11, 2022 be Adjourned at 7:35pm.

CARRIED

Respectfully submitted,

Mary Ellen Scanlon, Co-Chair Krista D'Aoust, Co-Chair Food Advisory Committee



Meeting #: 22-002 Date: June 14, 2022 Time: 7:00 pm

Location: Online Due to the COVID-19 and the Closure of City Hall

Due to the COVID-19 and the Closure of City Hall All electronic meetings can be viewed at: City's

YouTube Channel: https://www.youtube.com/user/InsideCityofHamilton

Richard MacDonald Manager: Food and Water Safety, Healthy and Safe Communities Public Health Services- Healthy Environments, City of Hamilton (905) 546 2424 Ext. 5818

Present: Richard MacDonald (Staff Liaison), Krista D'Aoust (Co-Chair), Elly Bowen, Drew Johnston, Frank Stinellis, Mary Ellen Scanlon (Co-Chair, minutes), Vicky Hachey, Laurie Nielsen, Andrew Sweetnam, Kyle Swain, Maria Biasutti

Absent with regrets: Councillor Merulla, Brian Tammi (Secretary), Vivien Underdown

1. CEREMONIAL ACTIVITIES (Item 1)

Land acknowledgement – Krista D'Aoust Roll call - Krista D'Aoust

2. APPROVAL OF AGENDA (Item 2)

That the following Discussion Items be added to the agenda:

- Appointment of New Food Advisory Committee Members (Added Item 10.4)
- Food Advisory Committee Terms of Reference (Added Item 10.5)
- Summer Meetings for the Food Advisory Committee (Added Item 10.6)

Food Advisory Committee Minutes June 14, 2022

(Bowen/Johnston)

That the Food Advisory Committee approve the Agenda, as amended.

CARRIED

3. DECLARATIONS OF INTEREST (Item 3)

None

4. APPROVAL OF MINUTES OF PREVIOUS MEETING (Item 4)

(i) January 11, 2022 minutes (Item 4.1)

(D' Aoust/Bowen)

That the minutes from January 11, 2022 be approved.

CARRIED

(ii) Business arising from Minutes (Item 4.2)

Item 6 (ii) – follow up – Richard confirmed that FAC members can continue to meet until new membership is determined, this will be sometime in 2023 once new Council is in place.

5. DISCUSSION ITEMS (Item 10)

(i) Code of Conduct Training (Item 10.1)

A follow up request was made regarding members being able to complete this training virtually / online rather than attend training in person. Staff to follow up to determine details. Committee members are meant to be aware of the Code of Conduct, document sent out by Richard.

(ii) Update from Working Group on SPRC Project (Item 10.2)

The Survey will go live in late June for one month

- Small poster will be distributed for posting.
- Request that all members promote this to their networks to increase the number of responses.
- The raw data report will be forwarded to SPRC for analysis and recommendations.
- The final report and recommendations will be submitted to the new council allowing several months for completion.
- When available and information report will be submitted to the Board of Health.

Food Advisory Committee Minutes June 14, 2022

(Hachey/Bowen)

That Engage Hamilton keep CE survey open until mid-August 2022.

CARRIED

(iii) Member Updates (Item 10.3)

No member updates

(iv) Appointment of New Food Advisory Committee Members (Added Item 10.4)

Interest in reviewing Terms of Reference in the fall to determine next steps and interest in supporting the Food Strategy going forward.

(v) Food Advisory Committee Terms of Reference (Added Item 10.5)

- Staff will advise whether the composition of the Committee will change. Quorum will remain as it, no appts during current term of Council.
- New appointments will be made after the election.
- Richard advised that the Department is examining links between the Strategy and the City's Climate Action initiatives and discussing synergies with Climate staff.
- Suggested that Public Health should provide clarification re its support for the FAC and the Food Strategy. Richard explained revision PH department structure and management are being made so it is timely to seek this clarification.
- The Committee was reminded that City Clerks has requested that all Advisory Committees review and update their terms of reference prior to the end of the current term

(vi) Summer Meetings for the Food Advisory Committee (Added Item 10.6)

- Suggested that there was no need for formal meetings during the summer and FAC could be updated by e-mail as needed.
- Committee would meet formally from Sept to Dec and an August meeting could be organized if there was a real need.

(Hachey/Stinellis)

That the Food Advisory Committee meet in September 2022.

CARRIED

Food Advisory Committee Minutes June 14, 2022

6. ADJOURNMENT (ITEM 15)

(Stinellis/Neilsen)

That, there being no further business, the Food Advisory Committee meeting for June 14, 2022 be adjourned at 8:12 p.m.

CARRIED

Respectfully submitted,

Mary Ellen Scanlon, Co-Chair Krista D'Aoust, Co-Chair Food Advisory Committee



FOOD ADVISORY COMMITTEE STAFF LIAISON REPORT 23-001

Tuesday, June 6, 2023 6:30 P.M. Virtually via WebEx

Present: Krista D'Aoust (Chair), Mary Ellen Scanlon (Co-Chair) and Drew

Johnston

Also

Present: Heather Harvey

Absent

with Regrets: Brian Tammi, Vivien Underdown, Elly Bowen, Andrew Sweetnam,

Vicky Hachey

Pursuant to Section 5.4(5) of the City of Hamilton's Procedural By-law 21-021 at 7:00 pm the Staff Liaison to the Committee advised those in attendance that quorum had not been achieved within 30 minutes after the time set for the Food Advisory Committee, therefore, the Staff Liaison to the Committee noted the names of those in attendance and the meeting stood adjourned.

Respectfully submitted,

Heather Harvey Manager, Chronic Disease Prevention Healthy Environments, Public Health Services



INFORMATION REPORT

TO:	Mayor and Members Public Health Committee
COMMITTEE DATE:	August 16, 2023
SUBJECT/REPORT NO:	Public Health Services 2022 Annual Performance and Accountability Report (BOH23024) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Konrad Lisnyj (905) 546-2424 Ext. 5452 Katrina Bergstrom (905) 536-2424 Ext. 6629 Rumaisa Aljied (905) 546-2424 Ext. 5398
SUBMITTED BY:	Dr. Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services
SIGNATURE:	

COUNCIL DIRECTION

In response to the previous Board of Health Self-Evaluation completed in 2020 (Board of Health Report BOH20021(a)), Public Health Services staff committed to continuing to provide regular updates on progress with the Annual Service Plan and Budget. Additionally, as per the 2021 Annual Report and Attestation (Board of Health Report BOH23001), staff committed to bringing forward a 2022 year-end performance report. This report fulfils both reporting commitments for the 2022 calendar year.

INFORMATION

The purpose of this report is to provide a streamlined update on Public Health Services' program and financial performance in 2022 to the Board of Health, the Ministry of Health, and the public, as it relates to the progress made towards addressing its key priority areas. As part of the 2022 Annual Service Plan and Budget, the Board of Health endorsed the following three key priorities (Board of Health Report BOH22003):

- Supporting staff wellness;
- The continuing COVID-19 response; and,
- Ramping up programs and services to support recovery and address the deficits
 of care and service backlogs within the Hamilton community.

Appendix "A" to Public Health Committee Report BOH23024 summarizes Public Health Services' progress in 2022 in achieving the objectives outlined in the Annual Service

SUBJECT: Public Health Services 2022 Annual Performance and Accountability Report (BOH23024) (City Wide) - Page 2 of 7

Plan and Budget as part of our day-to-day work. Appendix "B" to Public Health Committee Report BOH23024 provides a detailed overview of the provincial portion of the 2022 financial actuals for Ministry-funded programs and services under the Ontario Public Health Standards. Appendix "C" to Public Health Committee Report BOH23024 highlights key examples of the progress that Public Health Services has achieved within each of the three priorities.

As noted in Board of Health Report BOH19030, staff have worked to maximize the efficiency, transparency, and usefulness of Public Health Services' Performance Management and Monitoring System. This was done by streamlining and integrating the Performance Management and Monitoring System with the annual planning and budget cycles, better defining program objectives and performance measures, and strengthening targets for the full scope of Public Health Services' programs and services to inform program planning and drive continuous quality improvement. Due to the COVID-19 pandemic, the implementation of the Performance Management and Monitoring System was put on hold in 2020 and 2021, where the focus shifted to monitoring and reporting on performance related to COVID-19. In June 2022, Public Health Services restarted a regular performance management and monitoring cycle for all programs and continues to expand the Performance Management and Monitoring System, as public health programs and services return to full capacity. As such, this is the first performance report shared post-pandemic with the Board of Health.

Public Health Services Priorities: Progress Update

The following updates highlight Public Health Services' performance in 2022 toward addressing its priority areas of supporting staff wellness, continuing its COVID-19 response, and addressing the deficits of care and service backlogs in the Hamilton community:

1. Supporting Staff Wellness

On April 27, 2022, staff were demobilized from the COVID-19 response to their home programs with the end of *O. Reg 116/200 Work Deployment Measures for Boards of Health* that allowed for the redeployment of public health staff. At that time, Public Health Services began its transition to an interim organizational structure designed to support the continued COVID-19 response, resuming full operations, re-opening programs and services in a phased and prioritized way, and providing enhanced programming during recovery to address the deficits of care and service backlogs.

From May to August 2022, Public Health Services focused on returning, recruiting, and reorienting staff to programs and services, while supporting staff wellness. After being deployed for over two years to support the ongoing COVID-19 emergency response, significant reorientation and retraining were required for staff returning to their pre-COVID-19 roles. Additionally, the health and well-being

of the public health workforce have been disproportionately impacted due to the ongoing COVID-19 response. A comprehensive Mental Health and Well-Being Strategy was developed to promote and protect the mental health and well-being of Public Health Services staff, where implementation and supports are ongoing. Evidence from previous major emergencies suggests that mental health impacts can last up to three years post-emergency, making it critical to continue maintaining and resourcing wellness efforts effectively.

2. Continuing COVID-19 Response

After nearly two years of an ongoing COVID-19 pandemic emergency response. 2022 began with Public Health Services responding to the Omicron variant wave. The Omicron-driven wave showed exponential growth not previously seen in the pandemic, with cases peaking from January 9 to January 24, 2022. Public Health Services significantly scaled up COVID-19 vaccine operations to respond to the surge, while continuing to implement actions to prevent and control COVID-19 transmission, such as monitoring the status of COVID-19, communicating critical information to the public, the Board of Health, and key partners, and managing cases and outbreaks. This required the continued redeployment of a significant portion of the workforce for the early part of 2022. Performance related to COVID-19 response was reported throughout the pandemic in monthly COVID-19 updates to the Board of Health, and in the recently published Public Health Services COVID-19 After-Action Report (Board of Health Report BOH23012). From February to April 2022, the local COVID-19 situation began to stabilize and trend in a positive direction resulting in the easing of public health measures. coupled with the scaling back of large-scale clinic operations due to reduced COVID-19 vaccine uptake in Hamilton.

Another key focus for Public Health Services in 2022 was transitioning from its COVID-19 emergency response to sustained monitoring, prevention, and response. The Infectious Disease Program and the Vaccine Program integrated COVID-19 response functions into their existing programs, with a shifted focus on outbreak response, proactive inspections in the highest risk settings (e.g., long-term care homes and retirement homes), and increasing vaccine access for equity-deserving populations. With ongoing cases and outbreaks due to continuous waves of COVID-19, as well as expanded eligibility for the COVID-19 vaccine (e.g., fourth doses/second boosters, approval of the vaccine for ages six months to five years old, and bivalent boosters), workload related to COVID-19 response remained high throughout the year. Despite this, Public Health Services programs managed to successfully progress in addressing priority service backlogs and deficits of care, such as inspections of high-risk childcare facilities and routine immunizations for students (e.g., Hepatitis B, Human Papillomavirus, and Meningococcal).

3. Ramping Up Programs and Services to Support Recovery and Address the **Deficits of Care and Service Backlogs Within the Hamilton Community** The deployment of significant Public Health Services resources to the COVID response over two years meant less ability to focus on other important public health issues, impacting service delivery in many program areas and resulting in service backlogs or 'deficits of care' in the community. In addition, many longstanding health and social issues were worsened by the COVID-19 pandemic. with marginalized populations disproportionately impacted. In June 2022, the Vaccine Readiness Network published a report titled "Community Impact on Equitable Vaccine Delivery in Hamilton: Stories and Lessons Learned from the Vaccine Readiness Network" (https://www.hamilton.ca/sites/default/files/2022-07/CU-phs-lessons-learned-vaccine-readiness-network-jun292022.pdf) highlighting the lessons learned from community engagement in the COVID-19 vaccine rollout. An overview of the deficits of care and worsening health and social outcomes was included in a presentation at the September 20, 2021 Board of Health meeting (Item 8.2 Overview of COVID-19 Activity in the City of Hamilton 11 Mar 2020 to Present). Examples of deficits of care included, but were not limited to, child health and development, public health inspections, school immunizations, substance misuse, and mental health and well-being. These areas require intentional focus and attention in planning and resourcing to achieve significant gains at the population level.

Public Health Services leadership identified several programs and services, with the greatest impact on priority community health needs, to be prioritized for recovery and re-opening in 2022, including:

- Catching up on routine immunizations for students (i.e., Hepatitis B, Human Papillomavirus, and Meningococcal) and screenings under the Immunization of School Pupils Act;
- Catching up on dental screenings in schools and Healthy Smiles Ontario services;
- Ramping up mental health and well-being supports in schools;
- Ramping up infant and early years mental health initiatives to help address the disproportionate impact the pandemic had on toddlers and young children resulting from extremely limited opportunities for social interaction and social and emotional development;
- Ramping up supports for parents and caregivers (particularly for those with children aged 3.8 years to 6 years), including opportunities for screening, interventions, and developmental support referrals;
- Increasing capacity within the Ontario Seniors Dental Care Program in order to clear the backlog and reduce wait times that have resulted from reduced service levels during the pandemic;

SUBJECT: Public Health Services 2022 Annual Performance and Accountability Report (BOH23024) (City Wide) - Page 5 of 7

- Ramping up support for population health assessment related to other public health priorities;
- Developing and implementing a health equity strategy that incorporates and builds on lessons learned through the COVID-19 pandemic; and,
- Sustaining support for transition and recovery initiatives.

It is reiterated that Appendix "A" to Public Health Committee Report BOH23024 summarizes Public Health Services' progress in achieving the objectives outlined in the Annual Service Plan and Budget, and Appendix "C" to Public Health Committee Report BOH23024 highlights key examples of the progress that Public Health Services has achieved within each of these programs and service areas.

2022 Financial Performance

In 2022, the Ministry of Health granted the City of Hamilton Board of Health \$54,746,575 to support the delivery of programs and services under the Ontario Public Health Standards, which includes one-time funding to support the COVID-19 general and vaccine programs and various projects/initiatives and one-time mitigation funding to offset the increased costs for municipalities due to cost-sharing change from the mixed 75%/25% to the 70%/30%. As of December 31, 2022, a total of \$44,351,873 of the Provincial share was spent, with a positive variance of \$10,394,702. The City of Hamilton contributed \$12,134,213 in support of these same initiatives.

In 2022, the Ministry of Health continued to provide funding based on a 70%/30% Provincial/Municipal funding formula to support the delivery of public health programs and services under the Ontario Public Health Standards (i.e. Mandatory Programs), except the Ontario Seniors Dental Care Program, which remained 100% provincially funded. Overall, the City of Hamilton Board of Health received \$26,925,875 for Mandatory Programs, and the Ontario Seniors Dental Care Program received \$3,614,900 and spent \$2,928,279, which will result in the Ministry recovering \$686,621. The Ministry of Health also provided \$21,180,500 for COVID-19 costs above the Mandatory Programs at 100%, and, in 2022, we had expensed \$13,679,980. In addition, the Ministry of Health provided one-time 100% funding of \$3,025,300 to support the implementation of specific projects/initiatives and \$817,739 was claimed in 2022. The Ministry of Health also provided one-time mitigation funding to offset the increased costs for municipalities due to the cost-sharing change from a mixed 75%/25% and 100% funding model prior to 2020. A total of \$2,215,800 was granted, which was fully claimed.

Overall, the City of Hamilton Board of Health received \$24,205,800 in one-time funding and spent \$14,497,719 as of December 31, 2022. From January 1, 2023 to March 31, 2023, an additional \$810,957 was spent; the remaining \$8,897,124 will be recovered by the Ministry of Health.

Overview of Ministry of Health Performance Reporting Requirements

The Ontario Public Health Standards include a Public Health Accountability Framework and Organizational Requirements to ensure that boards of health have the necessary foundations within the four domains of program and service delivery, financial management, governance, and public health practice to successfully implement the Standards. These include completing monitoring and reporting requirements for boards of health to demonstrate accountability to the Ministry of Health.

Under the Ontario Public Health Standards, boards of health are required to report on the program and financial performance to the Ministry of Health for Ministry-funded programs through quarterly Standards Activity Reports and an Annual Report and Attestation. The program and financial performance information contained in Public Health Committee Report BOH23024 will be reported through the 2022 Annual Report and Attestation to the Ministry of Health by August 31, 2023.

Under the Ontario Public Health Standards, it is also an organizational requirement that all boards of health produce an annual performance and financial report to the general public. This helps to support enhanced transparency in the public sector and promote confidence in the public health system by providing an opportunity to increase awareness in the community on current public health issues and public health services offered in Hamilton. Appendix "C" to Public Health Committee Report BOH23024 satisfies this annual public reporting requirement. It is the responsibility of boards of health to ensure the annual performance and financial report is posted on the Board of Health website. To fulfil this requirement, the Annual Performance and Financial Report will be made available to the public on the City of Hamilton website at https://www.hamilton.ca/people-programs/public-health.

2022 Attestation of Compliance

As part of the Ministry of Health Annual Report and Attestation, boards of health are required to complete a certificate of attestation to demonstrate compliance with the Organizational Requirements as outlined in the Ontario Public Health Standards. In 2022, Public Health Services achieved full compliance with 59 out of the 64 organizational requirements. This is an increase from 2021 (Board of Health Report BOH23001), when Public Health Services fully complied with 55 of 64 organizational requirements. Of the five requirements that were not fully met in 2022, most (four out of five) were related to the inability to deliver the full scope of public health programs and services as required by the Ontario Public Health Standards due to capacity constraints related to the COVID-19 emergency response. As Public Health Services programs and services re-open, return to full capacity and resume full-service levels, compliance with these requirements will be restored. The remaining requirement that was not fully met is: "The board of health shall have a self-evaluation process of its governance practices and outcomes that is completed at least every other year." The last Board of Health self-evaluation was completed in November 2020. A Board of Health self-evaluation is

SUBJECT: Public Health Services 2022 Annual Performance and Accountability Report (BOH23024) (City Wide) - Page 7 of 7

underway, as part of the Restructuring the Board of Health Governance Structure project, with results and recommendations scheduled to be available in Q3 2023.

Summary and Next Steps

In 2022, Public Health Services successfully transitioned from a COVID-19 emergency response to sustained monitoring, prevention, and response. This involved integrating COVID-19 work into existing Public Health Services programs. As part of this transition, staff who were deployed to support the COVID-19 emergency response returned to their home programs at the end of April 2022. During this time, Public Health Services also focused on returning, recruiting, and reorienting staff to programs and services, in addition to supporting staff wellness as another key priority in 2022. Since then, Public Health Services has continued to resume routine programs and services in a prioritized way and enhance some service levels to address the deficits of care and the backlog of services due to COVID-19 in its community.

In parallel, Public Health Services' Performance Monitoring and Measurement System continues to be improved to provide the breadth and depth of information needed to ensure performance on the full scope of Public Health Services priorities and program objectives. The next annual performance and financial report will be provided to the Board of Health in Q1 2024.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to Report BOH23024	Program Indicator Results for 2022
Appendix "B" to Report BOH23024	2022 Financial Actuals for Ministry of Health Funded Programs Under the Standards
Appendix "C" to Report BOH23024	Public Health Services 2022 Annual Performance and Financial Report to the Public

Our Services

Day-to-day work to support a healthy and safe community

	Measure	Target	Q1-Q2 Results	Q3-Q4 Results	2022 Total	Comments
HRO	ONIC DISEASE PREVENTION AND	WELL-BEING				
BJE	ECTIVE: To increase access to den	tal care				
P1	% of eligible clients enrolled in Senior Dental Services who accessed the clinic service	80%	70.7% (1,507/2,132)	63.3% (1,979/3,125)	66.3% (3,486/5,257)	Target unmet. There are many eligible seniors for this program with high demand and limited capacity. The Senior's Dental Health Bus was partially operational in August, increasing to 4 days per week by November and utilizing both dental chairs while continuing to work through IT issues. To maximize our capacity, we have opened up time at satellite clinics, improved booking processes, and tightly monitored appointments in our booking software. The wait list for services is on the City of Hamilton's dashboard.
001	D SAFETY		1			
		spond to food-l	borne illnesses, the	ir associated risk fac	ctors, emerging tre	nds, and unsafe food offered for public
ons	umption					•
	0/ -fi-lt- it- d					
2	% of special events inspected as a result of a completed risk assessment of high	100%	100% (11/11)	100% (28/28)	100% (39/39)	Target met. All Special Event Advisory Team applications were risk assessed, necessitating an inspection of the special event.
P2 P3	a result of a completed risk	100%				Team applications were risk assessed, necessitating an inspection of the special
P3	a result of a completed risk assessment of high % of year-round high-risk and moderate-risk food premises requiring re-inspections due to food safety concerns that have		(11/11)	(28/28)	(39/39)	Team applications were risk assessed, necessitating an inspection of the special event. Target met. Re-inspections occurred
P3	a result of a completed risk assessment of high % of year-round high-risk and moderate-risk food premises requiring re-inspections due to food safety concerns that have received a re-inspection	100%	(11/11) 100% (218/218)	(28/28) 100% (345/345)	(39/39) 100% (563/563)	Team applications were risk assessed, necessitating an inspection of the special event. Target met. Re-inspections occurred according to operational standards.

#	Measure	Target	Q1-Q2 Results	Q3-Q4 Results	2022 Total	Comments
P5	% of outstanding department policies and procedures reviewed and approved by year-end	es and procedures			Target unmet. Due to staff recruitment challenges and competing operational demands impacting recovery work, this work was re-prioritized and delayed into 2023.	
HEAL	THY ENVIRONMENTS					
OBJE	CTIVE: To improve coordination i	n governance t	o address climate d	hange		
P6	% of assigned milestones completed from the Bay Area Climate Change Partnership project	100%	80.0% (4/5)	20.0% (1/5)	100% (5/5)	Target met. The Bay Area Climate Change Office has been established, and City Council approved the Climate Change Impact Adaptation Plan in August 2022.
OBJE	CTIVE: To increase awareness of	radon as a hea	lth hazard			
P7	# of radon kits distributed to the public	300	0	259	259	Target unmet. The promotion of radon awareness occurs in Q4 each year.
HEAL	THY GROWTH AND DEVELOPME	NT				
OBJE	CTIVE: To improve service delive	ry				
		<u>F2F ^a</u> 156	5	76	81	Target unmet. Staff remained deployed due to supporting ongoing COVID-19 response until mid-year. As part of Public
		<u>EP ⁵</u> 52	17	5	22	Health Services' recovery work, breastfeeding supports increased in the second half of 2022, and the program reengaged with breastfeeding service
P8	Breastfeeding Support "Significant Interactions" by interaction type	OTN ° 260	24	10	34	providers to update the breastfeeding support pathway and ensure Public Health Services' services are aligned with community needs/targeting those most
		Consult d 1,820	403	905	1,308	likely to stop breastfeeding. a face-to-face home visits b equipment provision
		Connection e 185	77	548	625	c Ontario Telemedicine Network d Phone/text/email/consult support Connection Support

#	Measure	Target	Q1-Q2 Results	Q3-Q4 Results	2022 Total	Comments	
#	Weasure	rarget	Q1-Q2 Results	Q3-Q4 Results	2022 TOTAL		
P9	% of pregnant individuals in Hamilton who accessed Public Health Services prenatal support	25%	30.5% (831/2,727)	24.6% (706/2,871)	27.5% (1,537/5,598)	Target met. Connecting with individuals who are pregnant to provide access to prenatal education, screen for risk and link with appropriate supports and interventions is a high priority for the Healthy Growth and Development program.	
P10	% of the annual total number of individuals who reside and give birth in Hamilton screened during pregnancy by the Healthy Babies Healthy Children program	18%	9.6% (463/4,846)	9.0% (437/4,846)	18.6% (900/4,846)	Target met. The prenatal Healthy Babies Healthy Children screening workgroup has collaborated effectively to identify and implement strategies to increase opportunities for individuals to be screened during pregnancy. Individuals at risk are referred to the Healthy Babies Healthy Children program for further assessment and support.	
P11	% of high-risk clients who accept home visiting	90%	100% (149/149)	97.2% (175/180)	98.5% (324/329)	Target met. Almost all individuals/families who have an in-depth assessment by a Healthy Babies Healthy Children Public Health Nurse are confirmed to have challenges which may negatively impact their baby or child's growth and development, and accept long-term home visiting supports.	
IMMU	NIZATION						
OBJE	CTIVE: To improve vaccine manag	gement practic	es				
P12	% of publicly funded vaccine doses wasted	<5%	9.1% (8,882/97,236)	0.9% (996/117,056)	4.6% (9,878/214,292)	Target met. Publicly funded vaccine doses were wasted under the following categories in 2022: 1. 0.7% due to cold chain error 2. 1.5% due to excessive quantity (products ordered by healthcare providers) 3. 2.3% due to expired products The Q1-Q2 is high due to large returns of expired vaccines from 2021, largely attributed to the ongoing COVID-19	

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#	Measure	Target	Q1-Q2 Results	Q3-Q4 Results	2022 Total	Comments
						provided by healthcare provider offices in Hamilton.
P13	% of flu vaccine doses wasted	<5%	3.8% (3,949/104,360)	12.3% (12,803/104,360)	16.1% (16,752/104,360)	Target unmet. Flu vaccine doses were wasted under the following categories in 2022: 1. 1.3% due to Cold chain Error 2. 14% due to excessive quantity (return of products not utilized) 3. 0.7% due to expired product The increase in wastage is attributed to the vaccine returns from the 2021-2022 Universal Influenza Immunization Program and a decrease in the uptake of flu vaccine in the community with ongoing booster campaigns for COVID-19. The increase from Q1-Q2 to Q3-Q4 is attributed to the return cycle for the flu vaccine scheduled in Q3 and an internal delay in processing.
P14	% of premises storing publicly funded vaccines which are >12 months since the last routine cold chain inspection	<10%	25.4% (86/339)	0% (0/339)	0% (0/339)	Target met. All healthcare providers who store publicly funded vaccines are required to be inspected once annually by the public health unit. The Cold Chain Program introduced new work districts in 2022, realigning the timing of inspections for some premises. This was done to improve efficiencies and costeffectiveness and was the reason for the increase noted for Q1 and Q2. All 339 premises did receive an annual inspection by year-end. "Cold chain" refers to all materials, equipment, and procedures used to maintain vaccines in the required temperature range from the time of

#	Measure	Target	Q1-Q2 Results	Q3-Q4 Results	2022 Total	Comments
						manufacture until the vaccines are administered to individuals.
OBJE	CTIVE: To increase community-ba	ased immuniza	tion outreach			
P15	% of grade 7 students who are up to date with Human Papillomavirus doses	80%	0% (2/5,770 ^f)	56.8% (3,496/6,151)	56.9% (3,498/6,151)	Target unmet. Fall of 2022 was the first return to school-based clinics since the COVID-19 pandemic.As such, staff were focused on providing catch-up vaccinations to grade 8 students at the same time as vaccinating grade 7 students. This resulted in a double cohort in schools and there were some instances where vaccination of grade 7 students was delayed. There was a significant increase from Q2 reports of 0% up to date to 57% at the end of 2022.
						f Data from Panorama records as of June 10, 2022. Denominator based on grade 6 enrollment at the time of data extraction. Target unmet. See comment above (P22).
P16	% of grade 7 students who are up to date with school-based Meningococcal vaccine	90%	3.4% (195/5,770 ^f)	65.7% (4,042/6,151)	68.9% (4,237/6,151)	At the end of 2022, approximately 69% of grade 7 students were up to date with the school-based Meningococcal vaccine.
P17	% of grade 7 students who are up to date with Hepatitis B doses	80%	9.1% (527/5,770 ^f)	56.0% (3,442/6,151)	64.5% (3,969/6,151)	Target unmet. See comment above (P22). At the end of 2022, approximately 65% of grade 7 students were up to date with the Hepatitis B vaccine.
P18	Hepatitis B coverage rate for students in grades 8 to 12 (as of the fall)	75%		52.9% (17,097/32,291)	52.9% (17,097/32,291)	Target unmet. Public Health Services began offering catch-up routine vaccine clinics at the Lime Ridge Mall COVID-19 vaccine clinic early in 2022. Although these clinics were successful, the largest increase in percentage from September to December 2022 was seen in grade 8 students who were being vaccinated with grade 7 students in a double cohort. The percentage of grade 8 students increased from 25% in September 2022 to 60% during the fall semester. This shows the importance of the school-based

#	Measure	Target	Q1-Q2 Results	Q3-Q4 Results	2022 Total	Comments
						vaccine program in providing a safe and convenient location for students to receive their vaccinations, also highlighting the importance of high school vaccine clinics in the catch-up of lapsed vaccinations. This measure's overall progress (inclusive of students in grades 8 to 12) increased from 48.7% to 52.9%. High school clinics were planned for February to March 2023
						to assist in further catch-up of students in grades 9 to 12.
P19	Human Papillomavirus coverage rate for students in grades 8 to 12 (as of the fall)	70%		44.4% (14,324/32,291)	44.4% (14,324/32,291)	Target unmet. See comment above (P25). The percentage of grade 8 students increased from 17% to 53% over the fall semester. See comment above (P25). This measure's overall progress (inclusive of grades 8 to 12) increased from 39.9% to 44.4%. High school clinics were planned for February to March 2023 to assist in further catch-up of grades 9 to 12.
P20	Meningococcal coverage rate for students in grades 8 to 12 (as of the fall)	90%		73.9% (23,861/32,291)	73.9% (23,861/32,291)	Target unmet. See comment above (P25). The percentage of grade 8 students increased from 23% to 70% during the fall semester. See comment above (P25). This measure's overall progress (inclusive of students in grades 8 to 12) increased from 66.2% to 73.9%. High school clinics were planned for February to March 2023 to assist in further catch-up of students in grades 9 to 12.
	TIOUS AND COMMUNICABLE DI					
OBJE	CTIVE: To increase compliance w	ith infectious a	nd communicable of	diseases prevention	and control (IPAC)	
P21	% of infection prevention and control complaints that were verified to be a lapse	N/A	0% (0/1)	0% (0/0)	0% (0/1)	Target met. 1 infection prevention and control lapse complaint investigation completed in 2022

#	Measure	Target	Q1-Q2 Results	Q3-Q4 Results	2022 Total	Comments
P22	% of high-risk childcare inspections completed (Food Safety and Infection Prevention and Control)	50%	16.3% (44/270)	50.4% (136/270)		Target met. All high-risk childcare premises are to receive three inspections annually; for 2022, this equated to 270 inspections across 90 high-risk childcare premises. The 50% target does not imply that only half of the high-risk childcare settings would be inspected; instead, the target was to complete at least 50% of the total number of required inspections during the 2022 year. This measure only provides metrics for the second and third inspection cycles (i.e., May to August and September to December, respectively). Routine inspections were not completed during the first inspection cycle (i.e., January to April) due to staff deployed to COVID-19 response and outbreak management. High-risk inspections were restarted in May 2022. 100% of high-risk inspections were completed in the second and third inspection cycles. Full resumption of inspection activity for Q1 in 2023.
P23	% of confirmed Human Immunodeficiency Virus cases where follow-up was completed within 2 months	75%	86.7% (13/15)	83.3% (20/24)	84.6% (33/39)	Target met.
P24	% of animals investigated that are current on their rabies vaccinations at the time of the bite	50%	50.7% (291/574)	50.6% (325/642)	50.7% (616/1,216)	Target met.
SCHO	OL HEALTH					
OBJE	CTIVE: To increase capacity to ad	ldress health-re	elated topics among	targeted schools		
P25	% of target schools that completed Ophea Healthy Schools Certification	60%		61.2% (63/103)	61.2% (63/103)	Target met. Target was based on the 2022-2023 school year. Anticipate full school year data for the 2023 Mid-Year Public Health Services Performance Report. Target on track in the first year of program-wide implementation of the HSC

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#	Measure	Target	Q1-Q2 Results	Q3-Q4 Results	2022 Total	Comments					
						process. This result indicates % of schools					
						registered and engaging.					
SCHO	SCHOOL HEALTH – ORAL HEALTH										
OBJE	BJECTIVE: To increase the uptake of preventive dental services										
P26	% of clients screened as Preventive Services Options at a public health clinic who received preventive services in our clinics	50%	64.0% (16/25)	96.0% (95/99)	89.5% (111/124)	Target met. Most children and youth screened and found eligible for Healthy Smiles Ontario received a preventive appointment. Preventive clinic services were limited to the Robert Thompson Building clinic until August, when preventive clinics re-opened. Low numbers until school screening resumed in October.					
SUBS	TANCE USE AND INJURY PREVE	NTION									
OBJE	CTIVE: To increase access to har	m reduction su	pplies and services								
P27	# of naloxone kits distributed	10% increase from 2021	4,013	6,785	10,798	Target met. In 2022, the Ontario Naloxone Program distributed 10798 naloxone kits, compared to 9008 in 2021. This represents an 11% increase. Note: this includes new kits only and not refills.					
P28	% of Needle Exchange Van service requests that were responded to	100%	94.6% (2,015/2,129)	96.0% (1,974/2,057)	95.3% (3,989/4,186)	Target unmet. Continue to see increased demand for needle exchange services. COVID-19 also impacted staffing, which impacted operational service delivery.					
P29	% of vapour product vendors in compliance with youth access legislation at the time of last inspection	90%		82.4% (14/17)	82.4% (14/17)	Target unmet. Vapour product vendors may be selling to minors due to a possible reduction in the number of inspections as a result of the COVID-19 pandemic response shortly after the amended Smoke-Free Ontario Act to include vapour products in 2018.					

ORAL	DRAL HEALTH - NON-MANDATED PUBLIC HEALTH SERVICES									
OBJECTIVE: To improve access to dental care among adults										
P30	% of eligible clients enrolled in adult dental services who accessed the clinic service	75%	51.7% (778/1,504)	53.3% (870/1,632)	52.6% (1,648/3,136)	Target unmet. Wait lists were impacted by the recruitment of a 0.6 FTE dentist, full FTE complement anticipated to free up clinic time and decrease the wait list.				

Monitoring Measures (Ministry of Health Q4 Standard Activity Report)

#	Measure		Year 2022						
HEALT	THY ENVIRONMENTS								
	No selected and the selection of the least of the selection of the selecti	Round 1							44,206
Q1	Number of catch basins treated with larvicide per	Round 2							44,955
	round	Round 3							44,683
Q2	Number of mosquito traps set per week		·					20 traps	
QZ	Number of mosquito traps set per week								10 weeks
	Number of rabies exposures investigated, broken down by species/category of animal and type of exposure (e.g., bite, non-bite, or bat)		Bite expos	ures	Non-k	oite exposures	Bat expo	sures	Total #
		_				0.10			investigations
		Dog		572		310			882
Q3		Cat Bat		178		149 110		17	327 127
		Livestock		3		110		17	4
		Wildlife		63		100			163
		Rodent		25		8			33
	Rabies vaccination status data for all dogs, cats,	rtodont	Vacci						00
			As per legislation O.Reg. 567		on- pliant	Un- vaccinated	Exempt from vaccination	Unknown status	Total # Investigations
Q4	ferrets, horses, cattle and sheep investigated following	Dog	386		7	126	7	358	884
	reported human exposures (i.e., vaccinated,	Cat	105		1	74	4	144	328
	unvaccinated, exempt or unknown)	Ferret							
		Horse	1					1	2
		Cattle							
		Sheep							
IMMUN	NIZATION								
		Catch up cli	nic at a scho	ol					
	Total number and type of catch-up clinical services held by the board of health for students in grades 8 to	Routine sch	ool-based cli	nic					108
Q5	12 for Hepatitis B, Meningococcal, and Human Papillomavirus vaccinations (for September 1, 2021 to	Catch up cli	nic at public l	nealth	office I	ocation			4
	August 31, 2022)	Appointmen	ts for catch-u	ıp scho	ool-bas	ed immunization	าร		300
		Doses provi	ded to health	care p	rovide	rs upon request			Yes

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		Total number of doses of Hepatitis B vaccine administered to students in grades 7 to 8 for the reporting period	1,869
Q6	Number of Hepatitis B, Meningococcal, and Human Papillomavirus vaccine doses administered to	Total number of doses of Meningococcal vaccine administered to students in grades 7 to 12 for the reporting period	1,712
	students (for September 1, 2021 to August 31, 2022)	Total number of doses of Human Papillomavirus vaccine administered to eligible students (i.e., male and female) in grades 7 to 12 for the reporting period	2,209
	Number and percentage of refrigerators that store publicly funded vaccines that received their routine annual inspection as per the vaccine storage and	Total number of refrigerators in operation in the public health unit jurisdiction as of Dec 31st, 2022 wsith completed routine cold chain inspection	506
Q7		Total number of refrigerators in operation in the public health unit jurisdiction as of Dec 31st, 2022	506
	handling requirements	Percentage of refrigerators that store publicly funded vaccines with completed cold chain inspection	100%
INFEC	TIOUS AND COMMUNICABLE DISEASES PREVENTION	ON AND CONTROL	
Q8	Number of infection prevention and control (IPAC)	Total Complaints	30
Qδ	complaints received that triggered an inspection	Triggered Inspection	18
Q9	Total number of verbal and written IPAC-related section 13 health hazard orders issued under the Health Protection and Promotion Act (HPPA) in 2022.	No verbal or written IPAC-related section 13 health hazard orders were issued under the HPPA in 2022.	
	Percentage of reported confirmed sexually transmitted and blood-borne infection (STBBI) cases where treatment and follow-up were conducted according to the Infectious Diseases Protocol, 2018 (or as current), for each of Hepatitis C, Gonorrhea, and Syphilis	Hepatitis C	82.5% (104/126)
040		Gonorrhea	94.9% (407/429)
Q10		Syphilis	91.9% (170/185)
		Total	92.0% (681/740)
Q11	Total number of cases with acquired drug resistance for tuberculosis (TB) identified in the public health unit jurisdiction		0
Q12	Board of health activities related to Tuberculosis Infection (TBI)	 Public health nurses receive reports of Tuberculosis Infection (TBI) identified through Immigration Medical Surveillance and/or other TBI screening methods. All reports received are reviewed and risk assessed to identify those at high risk of TBI activation. All high-risk individuals receive health teaching promoting the initiation of TBI Preventative Treatment (TPT) and are offered referral to the local TBI clinic. Clients who initiate treatment for TBI are monitored by public health nurses for the duration of their treatment. Clients are assessed regarding current treatment status, side effects, compliance with medications, bloodwork, and adherence to scheduled medical appointments. If applicable, public health nurses will contact the client to provide health teaching and promote the continuation and completion of treatment. 	

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		 In response to COVID-19 and provincial lockdowns, public health nurses dispensed and delivered medications to client homes to reduce barriers to medication supply. As the pandemic restrictions began to lift, public health nurses continued to facilitate medication delivery to clients on TPT who faced significant barriers to compliance, thus facilitating treatment completion. Hamilton has also worked closely with the local TBI Clinic to support 3HP therapy by delivering Directly Observed Therapy (DOT) for those identified as appropriate for the shortened regime. 3HP is the combination regimen of Isoniazid (INH) and Rifapentine (RPT) and is given as 12 weekly DOT doses As part of the World TBI Day health promotion campaign, our program used social media platforms to promote our local website to bring awareness to TBI. 		
Q13	Number of re-inspections of personal services settings		<u> </u>	6
Q14	Number of tickets issued per section number under the Provincial Offences Act from January 1, 2022 - December 31, 2022			0
Q15	Total number of summonses issued per section number under the Provincial Offences Act from January 1, 2022 to December 31, 2022			0
Q16	Number of infection prevention and control (IPAC) lapses by setting			0
FOOD	SAFETY			
Q17	Total number of all fixed year-round food premises in operation in 2022			3,007
Q18	Total number of all fixed seasonal food premises in operation in 2022			252
Q19	Total number of all fixed high-risk food premises in operation in 2022			629
Q20	Total number of moderate-risk food premises in operation in 2022			1,628
Q21	Total number of food safety complaints received for food premises that triggered an inspection			289
Q22	Total number of tickets issued per section number	Number of Tickets 1 1 1 1 Total Number of Tickets	Section Number 27 (1) (temperature abuse, haz 22 (sanitizing of work surface 7 (1) (g) (floor/wall/ceiling not clean 7 (1) (a) (ii) (health hazard condition) 4	ces) an)
Q23	Total number of written section 13 orders (protection from pests) issued under the Health Promotion and Protection Act (HPPA)			13
SAFE	WATER			
Q24	Recreational water: Total number of recreational water complaints that triggered an inspection			2

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			rage 12 or 17
Q25	Recreational water: Total number of tickets issued by section number		0
	Recreational water: Total number of Class A pools	Seasonal	12
Q26	(general public admitted) in operation in the public health unit jurisdiction	Year-round	34
		Total	46
	Recreational water: Total number of Class B pools	Seasonal	32
Q27	(apartment/hotel with 6+ units) in operation in the	Year-Round	39
	public health unit jurisdiction	Total	71
Q28	Recreational water: Total number of Class C facilities (splash pad, wading pool) in operation in the public health unit jurisdiction		65
	Recreational water: Total number of spas (seasonal and year-round) in operation in the public health unit jurisdiction	Seasonal	1
Q29		Year-Round Year-Round	15
		Total	16
		Class A (general public admitted)	2
	Recreational water: Total number of re-inspections for Class A, B, C and spas	Class B (apartment/hotel with 6+ units)	28
Q30		Class C (splash pad, wading pool)	10
		Spas	15
		Total	55
Q31	Drinking water: Percentage of adverse water quality incidents (AWQIs) that had an initial response by the board of health within 24 hours		100% (37/37)

Ministry Measures (Ministry of Health Annual Report and Attestation)

#	Measure	Year 2022	Epidemiological Interpretation	Comments
INFE	CTIOUS AND COMMUNICABLE DISEAS	ES PREVENTI	ON AND CONTROL	
A1	Number and percentage of Salmonella ar	nd E.Coli foodbo	orne outbreaks investigated for which a probable	e source was identified
	Salmonellosis	0% (0/0)	There were no Salmonella foodborne outbreaks investigated for which a probable source was identified.	Not applicable.
	Verotoxin Producing E. Coli Including HUS	0% (0/0)	There were no E. Coli foodborne outbreaks investigated for which a probable source was identified.	Not applicable.

A2	Incidence rate of reportable foodborne illness cases for each of Salmonella, Campylobacter and E. Coli per 100,000 population			
	Salmonellosis	74	Case incidence has been trending upward since 2019. In 2022 there were 74 cases reported. The lower incidence in 2020 and 2021 may be due to the COVID-19 pandemic's impacts on testing and reporting.	Health-seeking behaviours are generally low for mild to moderate gastrointestinal symptoms, leading to underestimating the true disease burden. The COVID-19 pandemic may have decreased health-seeking behaviours further due to pandemic restrictions or attributing enteric disease symptomatology to a COVID-19 infection as symptoms for these diseases overlap. Salmonellosis is commonly linked to frozen raw breaded chicken products. On April 1, 2019, the Canadian Food Inspection Agency introduced new measures. There were no reported Salmonellosis outbreaks in Hamilton in 2022.
	Campylobacter Enteritis	92	Case incidence is trending upward since 2019. In 2022 there were 92 cases reported. The lower incidence in 2020 and 2021 may be due to the COVID-19 pandemic's impacts on testing and reporting.	Not applicable.
	Verotoxin Producing E.Coli Including HUS	15	Case incidence is trending upward since 2019. In 2022 there were 15 cases reported. The 0 case count in 2020 may be due to the COVID-19 pandemic's impacts on testing and reporting and may not be a true 0.	While E. coli is trending upwards, there were no identified E. Coli outbreaks in Hamilton in 2022.
А3	Incidence rate of each of Hepatitis C, Gor	norrhea, and Sy	ohilis per 100,000 population	
	Hepatitis C	21.6	The Hepatitis C incidence rate is down from 2019 and has stabilized over the last three years.	Hepatitis C disproportionately affects persons who inject drugs. Although services for the provision of harm reduction supplies continued throughout the pandemic, access to testing for this at-risk population decreased during the pandemic. A decrease in testing could have contributed to a lower incidence rate of Hepatitis C in 2022 as programs slowly began to open. In late 2021 and early 2022, Public Health Services observed an increase in testing being offered at the local pharmacies and primary care by not-for-profit organizations, such as Hepcure. These

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			organizations have reported that some populations, such as those who are underhoused and persons who use drugs, are often difficult to follow and link to care. The City of Hamilton continued to partner with key local organizations, such as the AIDS network, the De dwa da dehs nye s Aboriginal Health Centre, and Shelter Health Network, for our annual World Hepatitis Day in 2022.
Gonorrhea	85.8	The gonorrhea incidence rate has remained relatively stable since 2019.	Although gonorrhea rates remain stable, screening for this sexually transmitted infection (STI) remains a priority due to the increasing trends in multi-drug resistant (MDR) strains emerging globally. The City of Hamilton is working closely to monitor MDR trends and support clinicians to treat this STI as to the most up-to-date treatment guidelines and via the provision of free medications. In 2022, the City of Hamilton continued to provide STI
Syphilis	49.7	The syphilis incidence rate is trending upward from 2019 to 2022; the 2022 incidence rate is approximately 2.9 times the 2019 incidence rate.	screening for high-risk populations at our sexual health and street health clinics. Rates of infectious syphilis have increased in both males and females, and are highest among individuals aged 30 to 39 years old. Males, including gay, bisexual, and men who have sex with men (MSM), continue to be disproportionately affected. Since 2017, Hamilton has seen an increase in congenital syphilis cases. Contributing factors to the increase in congenital syphilis could relate to barriers to accessing prenatal care, as syphilis screening is part of routine testing for pregnant individuals or lack of repeat screening at 28 to 32 weeks for pregnant women at ongoing risk of infection. Similar to other jurisdictions, Hamilton is seeing the vast majority of their congenital syphilis cases in children born to mothers who belong to marginalized communities, such as those who are underhoused and persons who use drugs. The general increase in syphilis rates could be attributed to many factors, such as decreased sexual health promotion campaigns during the COVID-19 response, a lack of awareness of this emerging disease by the general population, and widespread

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				uptake of HIV PrEP. As syphilis rates have sharply
				risen, Hamilton clinicians have expressed knowledge gaps with staging and treating syphilis, and Public Health Services is working with community partners to increase awareness and treatment capacity to prevent secondary cases of this sexually transmitted infection.
A4	Number and percentage of active respir	atory Tuberculosi	is (TB) cases that complete recommended trea	tment
	Ministry of Health Method	100% (7/7)	The percentage of TB cases completing treatment within the reporting year is stable.	The City of Hamilton partners with the St. Joseph's Tuberculosis (TB) Clinic to provide case and contact management for all active TB cases. Nurses highly specialized in public health management of this disease provide direct client care, including directly observed therapy to ensure treatment success. Nurses address health inequities by supporting individuals with food and housing security challenges
	Alternative Method	100% (7/7)	The percentage of TB cases completing treatment within 12 months of the treatment start date is stable.	and language and transportation barriers to ensure optimal health outcomes. Note: This indicator only includes respiratory TB, and other forms of active TB,
		,	start date is stable.	such as extrapulmonary TB, receive the same level of support.
#	Measure	2021- 2022	Epidemiological Interpretation	
# A5		2021- 2022		support. Comments
		2021- 2022	Epidemiological Interpretation	support. Comments

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			having up-to-date vaccination records compared to 66.4% in 2018-2019.	olds would have had the opportunity to have gone through a screening and suspension cycle prior to the pandemic, with the timing of the pandemic, many may not have been due for Tdap before the pandemic and did not have the opportunity to go through a screening cycle before they turned 18. The transition to virtual primary care visits may also have impacted the opportunity for in-person appointments that are required for vaccinations. This potential impact has not been fully assessed at this time.
A6	Percentage of grade 7 students whose v	vaccinations are ι	p-to-date for Hepatitis B, Meningococcal, and I	Human Papillomavirus (12 and 13 year olds)
	Hepatitis B	63.4% (3,886/6,133)	The percentage of grade 7 students with upto-date Hepatitis B vaccinations has trended upward from 14.3% in 2019-2020 to 63.4% in 2021-2022, but is still not as high as in 2018-2019.	The increase from 2019 and 2020 is due to the restart of public health school-based clinics in the fall of 2022 and routine catch-up clinics available at other public health vaccine clinic locations. Data from the previous two years was during the COVID-19 pandemic when school clinics were not running. Data remains lower than during the 2018-2019 school year, which was the last full year of school-based clinics prior to the pandemic and is the best comparator for past vs current status. Public Health Services is engaged with significant catch-up vaccine work and is in the process of vaccinating a double cohort of grade 7 and 8 students at school-based clinics. Grade 8 students were prioritized for catch-up as they soon will age out of regular school-based vaccine clinics in elementary schools. Due to limitations in health and human resources available in base funding models, some grade 7 students will be delayed for catch-up in grade 8.
	Human Papillomavirus	58.5% (3,590/6,133)	There has been a significant increase in the percentage of students with up-to-date Human Papillomavirus vaccinations from 1.2% in 2019-2020 to 58.5% in 2021-2022.	See comment above (A6: Hepatitis B).
	Meningococcal	80.7% (4,950/6,133)	There is a slight decrease in the percentage of grade 7 students with up-to-date Meningococcal vaccinations from 80.7% in 2019-2020 to 75.1% in 2021-2022.	The increase from 2020-2021 numbers is due to the restart of public health school-based clinics in the fall of 2022 and routine catch-up clinics available at other public health vaccine clinic locations; however, the percentage remains lower than at the start of the pandemic where the majority of grade 7 students would have had at least one opportunity (in fall of

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	1 ago 11 o1 11
	2019) to receive Meningococcal vaccine. Public
	Health Services remains engaged with significant
	catch-up vaccine work and is in the process of
	vaccinating a double cohort of grade 7 and 8 students
	at school-based clinics. Grade 8 students were
	prioritized for catch-up as they will soon age out of
	regular school-based vaccine clinics in elementary
	schools. Due to limitations in health and human
	resources available in base funding models, some
	grade 7 students will be delayed for catch-up when
	clinics return to elementary schools for the second
	round of Human Papillomavirus and Hepatitis B
	vaccinations or in grade 8.

2022 Financial Actuals for Ministry of Health Funded Programs Under the Ontario Public Health Standards (Provincial Portion)

As part of the Ministry of Health 2022 Annual Report and Attestation ('Annual Report'), boards of health are required to provide financial year-end actuals for each Ministry funded program delivered for the period of January 1, 2022 to December 31, 2022.

Base Funding:

- 1. Mandatory Programs Cost-Shared (70% provincially funded/30% levy funded): The Ministry granted \$26,925,875 as the 70% provincial contribution in 2022 to support the delivery of programs and services under the Ontario Public Health Standards (Mandatory Programs). Overall, mandatory programs were underspent due to staff being redeployed to COVID-19 and/or staff hiring issues. As per Ministry direction, expenditures from the COVID-19 General Program were claimed under Mandatory Programs to fully spend funding. Of the \$26,925,875 in funding, \$19,761,214 was spent on mandatory programs, and \$7,164,661 was spent on the COVID-19 General Program. The City of Hamilton contributed \$12,134,213 to support the delivery of Mandatory Programs.
- 2. Ontario Seniors Dental Care Program (100% provincially funded): This program was underspent due to staff being redeployed to COVID-19 and/or staff hiring issues, the Ministry approved a total of \$3,614,900. Actual expenditures were \$2,928,279, with \$686,621 being underspent.

One-Time Funding:

Several one-time 100% funding opportunities were approved. The timelines for these were either January 1, 2022 to December 31, 2022 or April 1, 2022 to March 31, 2023. Boards of Health are required to report actuals for both timelines up to December 31, 2022.

1. Cost-Sharing Mitigation:

For the period of January 1 to December 31, 2022, the Ministry granted **\$2,215,800** in one-time mitigation funding to offset the increased costs of municipalities as a result of the 70% (provincial)/30% (municipal) cost-sharing change for mandatory programs from a mixed 75/25% and 100% funding model prior to 2020, which was fully claimed.

2. COVID-19: General Program (Non-Vaccine):

For the period of January 1 to December 31, 2022, Public Health Services requested \$12,112,449 to reimburse extraordinary costs above the Annual Service Plan and Budget subsidized expenditures associated with COVID-19 case and contact management, outbreak management, infection prevention and control, and surveillance. The Ministry granted \$4,602,800. Of the \$9,456,426 of actual expenditures, \$9,456,426 was claimed under the Mandatory program as stipulated by the Ministry of Health. This left expenditures of \$0 to be claimed under COVID-19 General Program.

3. COVID-19: Vaccine Program:

For the period of January 1 to December 31, 2022, Public Health Services requested \$10,862,727 to reimburse extraordinary costs above the Annual Service Plan and Budget subsidized expenditures associated with the planning and implementation of the COVID-19 vaccine program. The Ministry granted \$16,577,700. Of the \$14,458,784 of actual expenditures, \$778,804 was claimed under the Mandatory program as stipulated by the Ministry of Health. This left expenditures of \$13,679,980 to be claimed under COVID-19 General Program, with \$2,118,916 being under spent.

4. Public Health Inspector Practicum Program:

\$30,000 to hire Public Health Inspector Trainees for program support and to provide future Public Health Inspectors with training and hands-on field experience. This funding has been in place for many years and must be requested annually. The Ministry granted **\$30,000**, which is fully spent.

5. Ontario Seniors Dental Care Program, Equipment and Furniture:

For the period of April 1, 2022 to March 31, 2023, Public Health Services requested \$325,300 for dental equipment and furniture. The Ministry granted \$325,300. For the Annual Report reporting period of April 1, 2022 to December 31, 2022 actual expenditures were \$0. The balance of actual expenditures in January-March 2023 was fully spent at \$325,300, with \$0 to be recovered by the Ministry after the 2023 Settlement is submitted to the Ministry sometime in June 2024.

6. Ontario Seniors Dental Care Program, IT Dental Bus:

For the period of April 1, 2022 to March 31, 2023, Public Health Services requested \$27,279 for equipment and licences for the Seniors Dental Health Bus. The Ministry granted \$27,300. For the Annual Report reporting period of April 1, 2022 to December 31, 2022 actual expenditures were \$0. The balance of actual expenditures in January-March 2023 was \$0, with \$27,300 being underspent.

7. Ontario Seniors Dental Care Program Capital: Public Health Services Seniors Dental Clinic:

For the period of April 1, 2022 to March 31, 2023, the Ministry granted \$157,700 to build two operatory Public Health Services Seniors Dental Clinics with a dedicated instrument reprocessing/sterilization area. For the Annual Report reporting period of April 1, 2022 to December 31, 2022 actual expenditures were \$597. The balance of actual expenditures in January-March 2023 was \$16,137, with \$5,268 being under spent, and \$135,700 approved by the Ministry to be carried forward to the April 1,2023 to March 31, 2024 funding year.

8. Needle Exchange Program:

For the period of April 1, 2022 to March 31, 2023, the Ministry granted **\$19,000** for extraordinary costs associated with delivering the Needle Exchange Program. For the Annual Report reporting period of April 1, 2022 to December 31, 2022 actual expenditures were **\$0.** The balance of actual expenditures in January-March 2023 was **\$19,000**, with **\$0** to be recovered by the Ministry after the 2023 Settlement is submitted to the Ministry sometime in June 2024.

9. New Purpose-Built Vaccine Refrigerators:

For the period of April 1, 2022 to March 31, 2023, Public Health Services requested \$225,350 to purchase two (2) 25 cu. ft. and seven (7) 55 cu. ft. new purpose-built vaccine refrigerators used to store publicly funded vaccines. The Ministry granted \$173,600. For the Annual Report reporting period of April 1, 2022 to December 31, 2022 actual expenditures were \$0. The balance of actual expenditures in January-March 2023 was \$0, with \$173,600 being under spent.

10. School-Focused Nurse Initiative:

For the funding period of April 1, 2022 to March 31, 2023, the Ministry granted \$2,292,400 to support additional nursing FTE capacity to provide rapid-response support to school boards and schools in facilitating Public Health and preventative measures related to the COVID-19 pandemic. For the Annual Report reporting period of April 1, 2022 to December 31, 2022, actual expenditures were \$787,142. The balance of actual expenditures in January-March 2023 was \$450,523 with \$1,054,735 being under spent.





Message from the Mayor and Medical Officer of Health:

ANDREA HORWATH MAYOR

On behalf of the Board of Health, I am proud to share the 2022 Annual Performance and Financial Report demonstrating the remarkable progress made in bridging the care gap in our community, addressing the ongoing challenges of COVID-19, and prioritizing the wellness of our staff. Through collaborative efforts with local organizations and healthcare professionals, significant steps have been taken to improve the well-being of Hamiltonians. The overall prosperity of community members remains at the forefront of achieving our vision to be the best place to raise a child and age successfully.

DR. ELIZABETH RICHARDSON MEDICAL OFFICER OF HEALTH

Public Health Services remains committed to improving community health and well-being. I am pleased to present the 2022 Public Health Services Annual Performance and Financial Report, highlighting our exceptional accomplishments in this regard. The pandemic has underscored the importance of focusing our efforts where they are most needed, and we have successfully risen to this challenge. Through bridging care gaps, facilitating program recovery, and maintaining effective COVID-19 response efforts, we have made significant strides by leveraging local strengths and fostering partnerships. Collaborations with community leaders and multi-sectoral partners have further fueled our progress, allowing us to tap into the collective power of our neighbourhood and communities. I extend sincere gratitude to our dedicated staff for their unwavering commitment, as well as to our community for their continued support and active engagement. Together, we prioritize the health and well-being of the community in Hamilton and will continue to do so.

Introduction

We are pleased to present this Annual Performance and Financial Report to the Public to highlight the achievements and initiatives of Public Health Services for 2022 in promoting the health and well-being of the community. This report showcases our commitment to reducing health inequities and ensuring access to essential public health services for all residents of Hamilton.

What does Public Health Services do?

Public Health Services offers a wide range of services and supports related to health promotion, health protection, and injury and disease prevention to enhance the health and well-being of the population. Our dedicated team of professionals, including nurses, doctors, public health inspectors, dental staff, nutritionists, social workers, specialist roles and health promoters, collaborates with community partners to address the health needs of the community. Our services encompass immunization, disease screening, education programs, family and child health services, population health assessment, sexual health services, air quality monitoring, school services, dental services, food and water safety, injury prevention, and public health inspections, among others.

Public Health Services Priority Health Issues

In 2022, the Board of Health endorsed three key priorities to address the pressing health needs of the Hamilton community:

• Ramping Up Programs and Services to Address Backlogs in the Community: Many Public Health Services staff moved from their home programs for over two years during the COVID-19 pandemic emergency response. This meant less ability to focus on other important public health issues, impacting service delivery in many non-pandemic program areas and resulting in service backlogs in the community. The most impacted areas include child health and development, dental screenings in schools, dental services for seniors, routine public health inspections, student immunizations, substance use support, and mental health and well-being initiatives. In 2022, Public Health Services focused on revitalizing these service areas and bridging care gaps to address these backlogs.

- Continuing COVID-19 Response: The COVID-19 pandemic, particularly the
 Omicron wave in early 2022, posed significant challenges to the community's
 health and well-being. Public Health Services' main goal was to continue to
 control the spread of the virus and ensure everyone had access to the COVID-19
 vaccine. As the local COVID-19 situation began to stabilize, we adapted our
 strategies and measures to prioritize the health and safety of the community by
 shifting from an emergency response to sustained monitoring, prevention, and
 response.
- Supporting Staff Wellness: We deeply value the dedication and efforts of our staff members who have tirelessly worked during the prolonged emergency response. Recognizing the impact of the pandemic on their well-being, we prioritized supporting our staff's wellness. Public Health Services developed a comprehensive wellness strategy to protect and enhance the mental health, well-being, and resilience of our staff. By prioritizing the well-being of the team, we ensured the continuity of high-quality public health services to the community with care and dedication.

By addressing these three priorities in 2022, Public Health Services worked to strengthen the overall health and well-being of Hamilton residents. These priority areas allowed us to remain committed to providing accessible, equitable, and responsive public health services to promote the health of the community – for all Hamiltonians.

Ramping Up Programs and Services to Address Backlogs in the Community

In 2022, we focused on ramping up programs and services that were most impacted by delays experienced during the COVID-19 emergency response. Our priority was to restore essential public health services and address any gaps or backlogs in care.

Programs and Services for Children, Families, and Seniors

We prioritized the health and well-being of Hamilton's children, families, and seniors. These populations require special attention and support to achieve optimal population health outcomes. Supporting children is important for ensuring a strong foundation in life in terms of educational attainment, economic productivity, and lifelong health and well-being. Families play a vital role in community well-being, and supporting their health contributes to a healthier, more resilient Hamilton. Lastly, seniors, especially those with limited resources, often face unique challenges in accessing public health services.

Key achievements completed under this priority include catching up on routine immunizations for students, catching up on dental screenings, supporting the mental health and well-being of school-aged children, expanding initiatives and supports for mental health screening in infants and young children, developing and implementing a health equity strategy that incorporates and builds on lessons learned throughout the COVID-19 pandemic, and sustaining support for transition and recovery initiatives.

Routine Immunizations for Students

In 2022, Public Health Services' Vaccine Program organized catch-up vaccine clinics across Hamilton to address the backlog of school-aged children who had not received their routine immunizations during the pandemic, including Hepatitis B, Human Papillomavirus, and Meningococcal vaccines. Starting in March 2022, Public Health Services held catch-up clinics for students in grades 7 to 12 at multiple locations, including Lime Ridge Mall (now closed), East End, and Mountain public health clinics. In September 2022, Public Health Services staff returned to schools to restart regular school-based vaccinations for grade 7 students and began catching up with the grade cohorts missed during the pandemic. Grade 8 students were prioritized because they would soon age out of regular school-based vaccine clinics. Additional catch-up clinics will run throughout 2023 to ensure school-aged students receive any missed vaccines and stay up-to-date with their immunizations.

Dental Care and Screenings

Public Health Services' Dental Program, through the Healthy Smiles Ontario program, ensures that children and youth from low-income households have access to free preventive, routine, and emergency dental services. The COVID-19 pandemic presented its own set of challenges for dental care, temporarily disrupting school screenings and Healthy Smiles Ontario services, which resulted in a backlog of students awaiting screenings and a waitlist for preventive Healthy Smiles Ontario services.

In August 2022, we successfully restarted the Healthy Smiles Ontario dental clinics, and by the end of the year, we efficiently cleared the waitlist of 278 clients. Additionally, routine dental screenings in schools resumed in October 2022. We are committed to providing comprehensive oral health assessments to all students throughout the 2022-2023 school year, especially those who missed screenings during the pandemic. Our goal is to ensure that every student receives the care they need for a healthy smile.

At Public Health Services, we are dedicated to ensuring equitable access to high-quality dental care for low-income seniors in the community as well. To bridge the gap in dental care among seniors, we launched the Seniors Dental Health Bus, as part of the provincial Ontario Seniors Dental Care Program. The Seniors Dental Health Bus increases the Dental Program's capacity to offer free preventive and restorative dental services for eligible seniors aged 65 and older. Initially operating on a limited schedule, the Seniors Dental Health Bus expanded to four days per week by November to meet the growing demand and ensure seniors receive the care they deserve.

"Many thanks for your dedication, service, and care working in Hamilton's muchneeded Public Health Dental Program. My parents have been so kindly treated over the past year and a half. I always appreciate the professionalism and high level of care that they receive. My parents are very grateful to all!" – **Daughter of Dental Clinic Clients**

School-Based Mental Health Supports

Public Health Services recognizes that mental health is crucial to students' well-being, academic success, and overall development. This resulted in action to improve mental health support in schools. In the 2022-2023 school year, the School Program resumed full operations with the continuation of funding for an additional 23 public health nurses through the Ontario Ministry of Health's School-Focused Nurses Initiative. While the initiative was initially launched during the 2020-2021 school year to assist with COVID-19 management in schools, the funding also enabled our nurses to address broader health needs outlined in the School Health Program Standard and related guidelines and protocols. The funding extension until June 2023 allowed us to scale up mental health promotion support and provide direct services in 103 priority schools in Hamilton, which is double the usual number of schools we serve. Public health nurses worked closely with these schools, collaborating with students, teachers, parents and caregivers, and community partners to create comprehensive plans that support students' mental health and well-being.

To promote good mental health, we organized activities, provided social-emotional support sessions, and worked to create safe and welcoming school environments for all students. We are proud to announce that 63 out of the 103 priority schools were certified as "Healthy Schools" by the national healthy schools certification program. This certification ensures schools have the appropriate tools to promote and enhance the health and well-being of students, school staff, and the broader school community.

"[Healthy Schools Certification] is a testament to the hard work and commitment that each school has shown as well as the collaboration of many partnerships. Most notable is the strong partnership that the HWCDSB [Hamilton-Wentworth Catholic District School Board] has with Public Health and the amazing group of public health nurses that work at our schools." – https://example.com/hwcdstate/

Expanded Healthy Growth and Development Services

The Healthy Growth and Development Program played a crucial role in supporting families during pregnancy, postpartum, and the early years, particularly during the challenging times of the pandemic. Throughout this period, essential services such as Healthy Babies Healthy Children Home Visiting Programs, Health Connections, breastfeeding support, and virtual groups for the Canadian Prenatal Nutrition Program were offered, as well as engagement through social media. In 2022, our Healthy Growth and Development Program fully resumed its operations, ensuring that families continued to receive the support they needed.

The Healthy Growth and Development Program recognizes the unique impact of the pandemic on toddlers and young children, who faced limited opportunities for social interaction and emotional development. To address this, interventions were prioritized that focused on education, early identification of developmental and social-emotional

issues, confidence and skill building, and connecting families to community supports. The aim is to support children aged 0 to 6 years old who are at risk of poor social and emotional development, providing them with the necessary tools for healthy growth.

Another important aspect of our Healthy Growth and Development Program was optimizing health during the perinatal period, which encompasses pregnancy to 12 months after birth. We offered prenatal education, identified individuals at risk for poor mental health during pregnancy and postpartum, provided breastfeeding support, and connected families with community resources. We transitioned from virtual and phone-based interventions to in-person sessions for programs such as the Canadian Prenatal Nutrition Program and parenting education groups, allowing for more direct and personal support. By focusing on this critical period, we aimed to ensure the well-being of both parents and their babies.

The impacts of the COVID-19 pandemic were addressed through collaboration with community coalitions, planning tables, and key partnerships. This involved identifying the effects of the pandemic, establishing priorities, and expanding screening, assessment, and intervention during pregnancy, infancy, and the early years. We used geospatial mapping to identify neighbourhoods with high needs to ensure that our resources were allocated where most necessary.

Another noteworthy program implemented by Public Health Services, fully funded by the Ministry of Health, is the low-barrier, quick-access mental health clinic established through a sustained partnership with the Good Shepherd Centre and the Hamilton Family Health Team. This collaborative effort has played a crucial role in providing onsite support for families experiencing homelessness, ensuring they receive comprehensive care during challenging times. One significant outcome of this partnership is the introduction of Theraplay group programming for caregivers and their young children.

"Theraplay, a play-based therapy approach, has fostered stronger bonds between caregivers and children during this trying period. The benefits of this partnership are evident, as it contributes to greater social stability and lasting support for those in need." – **Grace Baldwin, Director of the Good Shepherd Family Centre**

For more information on Public Health Services' Healthy Growth and Development Program, please visit this <u>link</u> for pregnancy and prenatal health and this <u>link</u> for parenting supports.

Health Equity

The COVID-19 pandemic exacerbated existing health and social issues, disproportionately affecting marginalized populations. To address some of these challenges, Public Health Services established the Vaccine Readiness Network in December 2020. The Vaccine Readiness Network consisted of community organizations and representatives in Hamilton, working together to improve COVID-19

vaccine planning, distribution, and access for priority populations.

In June 2022, the Vaccine Readiness Network published a report titled "Community Impact on Equitable Vaccine Delivery in Hamilton: Stories and Lessons Learned from the Vaccine Readiness Network." This report highlighted the valuable lessons learned from various health, education, social service, and community organizations across Hamilton to strengthen community engagement and equitable vaccine rollout during the COVID-19 pandemic. The Vaccine Readiness Network demonstrated that community outcomes are improved when community and institutional partners work together to plan policies and programs to address health inequities at the local level.

Building upon the lessons learned from the Vaccine Readiness Network, in 2022, Public Health Services' Health Equity Program developed a comprehensive plan across various program areas to enhance public health capacity for health equity and antiracism action. The plan, with four components - Competency Development, Data for Health Equity, Community Collaboration and Awareness, and Communication - aims to equip Public Health Services to meet health equity outcomes outlined in the Ontario Public Health Standards.

The plan will be implemented in stages over several years, with a focus on achieving tangible progress. It includes comprehensive training and competency development for Public Health Services staff to deepen their understanding of health equity principles and empower them with effective tools to address health disparities. The plan also involves establishing health equity key performance indicators for each program within Public Health Services, allowing for monitoring progress toward health equity goals by the end of 2024. Data collection on the social determinants of health will be enhanced to inform evidence-based decision-making, and a co-design approach will be employed, working closely with community organizations, to gather insights and shape strategies that effectively address social determinants of health.

Through these collective efforts, Public Health Services aims to foster a healthier and more inclusive community in Hamilton, ensuring that everyone, regardless of their background or circumstances, can thrive.

Sustaining Support for Transition and Recovery Initiatives

In addition to the other programs and services mentioned, Public Health Services took specific actions to prioritize various public health needs in the Hamilton community. Here are some more key initiatives achieved in 2022:

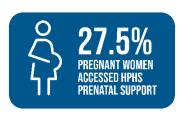
Safeguarding Food and Water: In 2022, our dedicated team conducted
thorough inspections of 3,007 food inspections and 198 water sources, including
various recreational water facilities, in Hamilton. These inspections allowed us to
proactively identify and address potential risks that could lead to foodborne
illnesses, compromised water quality, or safety concerns in recreational water
areas. Our commitment is to protect the community by enforcing food safety

regulations, monitoring water quality, and promoting safe recreational water activities. We strive to create a healthy and enjoyable environment for everyone in Hamilton, where they can have confidence in the safety of their food, water, and recreational experiences.

- Restoring Essential Programs: In response to the pandemic's impact, we
 resumed essential programs at Public Health Services, such as the Chronic
 Disease Prevention Program and the Tobacco Control Program. These programs
 play a crucial role in promoting healthier lifestyles, preventing chronic diseases,
 and reducing the harmful effects of tobacco use, directly benefiting the residents
 of the community.
- Addressing Climate Change: Recognizing the interplay between human health and climate change, our Health Hazards and Vector Borne Disease Program provided leadership to the City of Hamilton's Climate Change Impact Adaptation Plan, which is now being implemented corporately. This collaborative effort involves multiple stakeholders across the community, working together to address the specific climate change impacts affecting Hamilton and to develop strategies for adaptation and resilience-building.
- Workforce Development for Local Expertise: We are committed to nurturing a skilled workforce within the community. Training opportunities for individuals aspiring to become certified public health inspectors continued to be provided. This investment in local expertise ensures that our public health services are delivered by qualified professionals who deeply understand the specific needs and challenges faced by the Hamilton community.

Through these initiatives, Public Health Services demonstrated its firm dedication to protecting and promoting the health and well-being of the community. By focusing on local food and water safety, restoring essential programs, addressing climate change, and investing in our local workforce, we strive to create a healthier and more resilient future for the residents of Hamilton.

Programs and Services Data Highlights for 2022























Continued COVID-19 Response

In 2022, Public Health Services faced significant challenges in responding to the COVID-19 pandemic, particularly with the emergence of the Omicron variant end of December 2021. To address the rapid increase in cases, we scaled up our vaccine operations by redeploying over 276 staff members.

In February, efforts were made to increase COVID-19 vaccine coverage in Hamilton. Notably, over 90% of residents aged 12 and above received their first dose, with second dose coverage approaching 90%. School-based and mobile clinics were established to target younger age groups and areas with lower vaccine coverage, resulting in the administration of 3,234 doses at 159 school clinics.

Throughout the year, Public Health Services closely monitored the status of the virus, communicated up-to-date information, and managed cases and outbreaks. We responded to and managed 1,249 outbreaks and completed 537,019 tests to detect and control the spread of the virus. Through our dedicated efforts, we have administered 1,432,325 COVID-19 vaccine doses to protect the community. Additionally, we have been a reliable source of information and assistance, handling over 750,000 phone calls to address public concerns.

Throughout the year, Public Health Services collaborated with community partners to ensure the success of the COVID-19 vaccine rollout. We led the planning and coordination of a booster campaign, working closely with local healthcare partners to provide additional vaccine doses.

To address vaccine hesitancy and build trust, as proposed by the Black Health Leaders Forum and the Vaccine Readiness Network, Public Health Services implemented the Vaccine Ambassador Program. These ambassadors, representing communities disproportionately impacted by the pandemic, played a crucial role in engaging priority populations. They provided information, addressed concerns, and built confidence in COVID-19 vaccination. Working at vaccine clinics, they offered translation services, assisted with appointment booking, and built relationships with community groups and organizations. They played an important part in closing the gap in vaccine uptake gap for first and second doses of COVID-19 vaccination between Hamilton's most and least racialized neighbourhoods. One example of the valuable contribution of our vaccine ambassadors was shown through this anecdote shared by a vaccine ambassador.

"I actually had a teenage boy say to me, 'Hey, I'm really sorry I lied about already having my shots. I've seen you guys around and finally decided to get it.' [This story underscores the fact that people lead busy lives and have their own priorities]. Our approach aims to avoid overwhelming them with constant promotion. The consistency of our presence and being easily accessible made a significant difference in building trust and encouraging vaccination." – **Public Health Services Vaccine Ambassador**

As the year progressed, positive trends in the local COVID-19 situation emerged, leading to a stabilization in the spread and severity of COVID-19 transmission. Therefore, public health measures transitioned from being mandatory to recommended, allowing for a gradual easing of restrictions while still maintaining vigilance to protect the community's health and well-being.

To ensure a coordinated response, COVID-19 functions were successfully integrated into existing programs, such as the Infectious Disease Program and Vaccine Program. The Infectious Disease Program proactively responded to outbreaks and conducted inspections in high-risk settings. Simultaneously, the Vaccine Program collaborated closely with health and social care partners to ensure equitable access to vaccines and reduce barriers that may hinder vaccination efforts. This has led to significant efficiencies and building capacity within Public Health Services to support future pandemic responses.

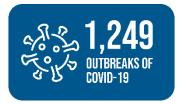
Throughout these transitions and challenges, Public Health Services remained dedicated to striking a balance between managing the impacts of the pandemic and implementing appropriate measures to safeguard the health and well-being of the community. The collective efforts of our staff, the engagement of community vaccine ambassadors, and collaboration with partners have been instrumental in achieving remarkable progress in COVID-19 vaccination coverage and addressing vaccine hesitancy in Hamilton.

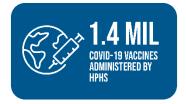
COVID-19 Data Highlights:

Some key data related to COVID-19. Please note that the following data is up until the

end of December 2022:







For a more comprehensive overview of COVID-19 timelines and vaccination numbers, please read our <u>COVID-19 After-Action Report.</u>

Supporting Staff Wellness

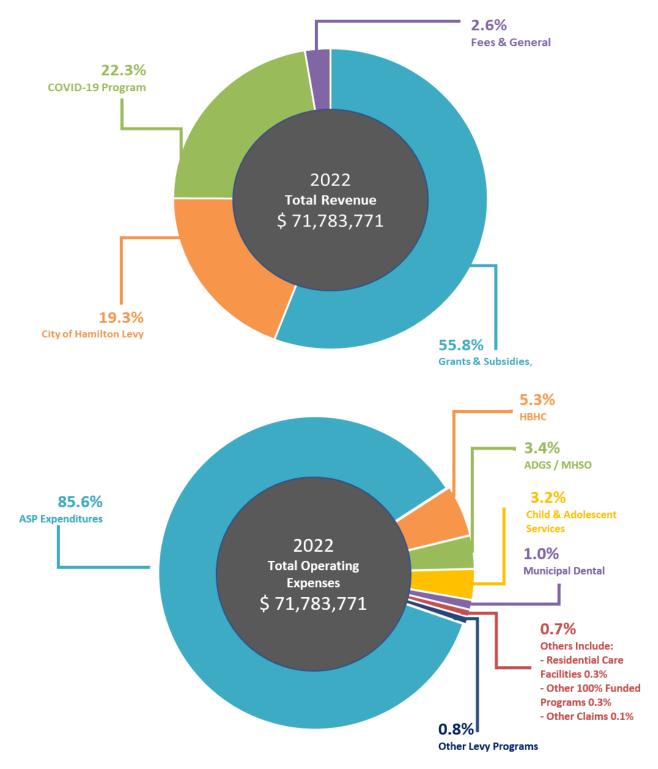
We recognize the significant impact the past few years have had on the mental health and well-being of our Public Health Services staff due to the challenges brought about by the pandemic. As an organization serving the community, we understand that the well-being of our staff directly influences the quality of care and support we can provide to the residents of Hamilton. Public Health Services is committed to cultivating staff well-being as they continue to serve and positively impact the community.

During the months of May to August, Public Health Services focused on redeploying our staff, recruiting new staff, onboarding, and familiarizing them with our programs and services. We placed special emphasis on prioritizing their well-being throughout this process, particularly considering that many team members had been deployed for over two years and required comprehensive reorientation and training as they returned to their pre-COVID-19 roles.

Public Health Services remains committed to a measured and realistic recovery transition, mindful of the health and well-being of our people, and confident in the ability of our entire workforce to rise to emerge better equipped and positioned to continue our vital work in promoting and protecting the health and well-being of those who live, work, and visit the City of Hamilton. To effectively support our staff, we continue to implement a comprehensive strategy to protect and strengthen staff mental health and well-being. We understand that the effects on mental health can persist for an extended period after a major emergency, which is why we continue to work on implementing and refining this strategy. This is especially important as we observed a high, stable trend in staff unplanned absences compared to pre-COVID-19 absenteeism levels.

As part of our commitment to staff wellness, Public Health Services has organized various initiatives across different programs. Investing in the wellness of staff is not only a reflection of our commitment to their personal well-being but also a recognition of their integral role in the betterment of Hamilton. Their resilience and dedication are essential in enabling us to make a lasting positive impact on the lives of those who we serve in the community.

Public Health Services Funding:



^{*}Legend: HBHC: Healthy Babies Healthy Children, ADGS/MHSO: Alcohol, Drugs & Gambling Services/ Mental Health & Street Outreach, ASP: Annual Service Plan



CITY OF HAMILTON

PUBLIC HEALTH SERVICES Epidemiology and Wellness Division

ТО:	Mayor and Members Public Health Committee
COMMITTEE DATE:	August 16, 2023
SUBJECT/REPORT NO:	Mental Health Street Outreach Program and Hamilton Public Library Partnership (BOH23027) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Susan Boyd (905) 546-2424 Ext. 2888
SUBMITTED BY:	Julie Prieto Director, Epidemiology and Wellness Division Public Health Services
SIGNATURE:	

RECOMMENDATION

That the Board of Health authorize and direct the Medical Officer of Health to enter into an amendment of the current Collaboration Agreement between the City of Hamilton Public Health Services' Alcohol Drug and Gambling Services and Mental Health Street Outreach Program (Mental Health Street Outreach Program) and the Hamilton Public Library, satisfactory in form to the City Solicitor, including:

- (i) The temporary increase of a 0.4 FTE Social Worker, in the Mental Health Street Outreach Program, to increase service delivery to the Hamilton Public Library for up to an approximate four-month period to be fully funded by the Hamilton Public Library; and,
- (ii) Upon request and written agreement, that the complement in the Mental Health Street Outreach Program may at any time during the term of the Collaboration Agreement have the City provide an additional Social Worker, for up to 14 hours per week at the expense of the Hamilton Public Library.

EXECUTIVE SUMMARY

The Hamilton Public Library approached Public Health Services in 2022 to discuss the possibility of working collaboratively to address the needs of community members who were experiencing complex social and health needs and to build capacity within the library to provide enhanced services. The Hamilton Public Library identified that a social

SUBJECT: Mental Health Street Outreach Program and Hamilton Public Library Partnership (BOH23027) (City Wide) - Page 2 of 3

work position could effectively work within the library system and enhance their ability to respond to the needs of the vulnerable population described above.

Board of Health Report BOH22009 established a partnership between Public Health Services' Alcohol, Drug, and Gambling Services and Mental Health and Street Outreach Program (Mental Health Street Outreach Program), and the Hamilton Public Library to support a full-time social work position to address the above needs. The Central Library location was identified as the library site to implement enhanced services and these services have been provided for the past eight months.

The Hamilton Public Library has approached Public Health Services, Mental Health Street Outreach Program, to pilot an approximate four-month pilot of 0.4 FTE social work position at the Barton Street Branch. This enhancement would provide the opportunity to determine the needs at this Branch, provide direct service to members, and to build capacity with Library staff.

Alternatives for Consideration – Not Applicable

FINANCIAL - STAFFING - LEGAL IMPLICATIONS

Financial: Hamilton Public Library agrees to cover the full cost of 0.4 FTE social

worker including salary and benefits, for an approximate four-month period. Based on current staffing the approximate cost will be \$13,110.

Staffing: The Mental Health Street Outreach Program will extend hours of existing

staff to fill this request.

Legal: An amendment to the original collaborative agreement will be signed

between the Hamilton Public Library and Public Health Services for the current request. The amendment will also include an option, upon request and written agreement, to increase the complement in the Mental Health Street Outreach Program at any time during the term of the collaborative agreement to provide an additional Social Worker (Bachelor of Social

Work) for up to 14 hours per week during the length of the term.

HISTORICAL BACKGROUND

The Hamilton Public Library has a membership base of over 130,000 and regularly sees an average of 70,000 visits per week system-wide. Libraries are community spaces where individuals experiencing issues such as, housing and income insecurity, physical health, mental health and addiction issues visit to have a place to rest, access resources (e.g., knowledge resources, technical resources, basic needs, etc.), and find a place of community.

SUBJECT: Mental Health Street Outreach Program and Hamilton Public Library Partnership (BOH23027) (City Wide) - Page 3 of 3

A partnership between Public Health Services and the Hamilton Public Library was implemented in the fall of 2022 to provide social work services to library members at the Central Library site. The social work services have been well utilized by library members. The social work and library staff have been building relationships and capacity through consultations around resource needs, harm reduction work and referrals. The successful uptake of services at the Central Library site and needs identified at different branches has resulted in the request to pilot similar services at the Barton Street site.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

This agreement will be implemented in accordance to City of Hamilton Finance and Administration policies.

RELEVANT CONSULTATION

Consultations have taken place with members of the Hamilton Public Library Senior Leadership Team, Legal Services, and Finance and Administration staff, who support the recommendation in Public Health Committee Report BOH23027.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

The current program offering services at the Central Library site has been well utilized by library members and has resulted in capacity building for staff in both programs. The Hamilton Public Library has identified that similar services offered at the Barton Street site could benefit community members accessing that site.

The implementation of a short-term pilot would assist the library to determine the needs and service uptake at the Barton Street site. This work would also benefit individuals using the site to address needs related to health and social services.

ALTERNATIVES FOR CONSIDERATION

Not Applicable.

APPENDICES AND SCHEDULES ATTACHED

Not Applicable.



CITY OF HAMILTON **PUBLIC HEALTH SERVICES**

Epidemiology and Wellness Division

то:	Mayor and Members Public Health Committee	
COMMITTEE DATE:	August 16, 2023	
SUBJECT/REPORT NO:	Supervised Consumption Site Evaluation Framework (BOH23025) (City Wide)	
WARD(S) AFFECTED:	City Wide	
PREPARED BY:	Melissa Biksa (905) 546-2424 Ext. 6709 Rachel Goodland (905) 546-2424 Ext. 4149 Mark A. Cachia (905) 546-2424 Ext. 1391	
SUBMITTED BY:	Dr. Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services	
SIGNATURE:		

RECOMMENDATION

- That the Supervised Consumption Site Evaluation Framework, attached as (a) Appendix "A" to Public Health Committee Report BOH23025, be approved; and,
- (b) That the Public Health Services budgeted complement be increased by 1.0 FTE in order to hire a Program Evaluation Coordinator at anticipated annualized cost of \$127,630 to be referred to the 2024 Tax Operating Budget for Council approval.

EXECUTIVE SUMMARY

Hamilton continues to experience a significant public health burden related to an increasingly toxic and unpredictable drug supply. As outlined in the Hamilton Opioid Action Plan (Pubic Health Committee Report BOH23021), continued local coordination of interventions aimed to reduce the harms and increase access to treatment are needed in the community. One evidence-based intervention is the provision of supervised consumption sites which operate to allow individuals to use substances in the presence of trained staff. Hamilton currently has two operating sites; however, the 2023 Opioid Action Plan has prioritized increasing the availability of these services in Hamilton. To understand the local impact, Council directed Public Health Services in February 2023 to develop an evaluative framework to demonstrate the community impact of supervised consumption sites.

SUBJECT: Supervised Consumption Site Evaluation Framework (BOH23025) (City Wide) - Page 2 of 6

After a review of surrounding municipal evaluations and other projects completed across Canada, an evaluative framework has been developed for local consideration. The proposed framework would evaluate site usage, community safety, community health and well-being and economic impact through qualitative and quantitative site data and ongoing engagement with community members, persons who use substances, and site operators.

Alternatives for Consideration – Not Applicable

FINANCIAL - STAFFING - LEGAL IMPLICATIONS

Financial: Recommendation (b) to Report BOH23025 is requesting the approval of a

1.0 FTE Program Evaluation Co-ordinator to support the operationalization and execution of the evaluative framework, at an anticipated annualized

cost of \$127,630, to be referred for consideration in the 2024 Tax

Operation Budget.

Staffing: Recommendation (b) to Report BOH23025 is requesting the Public Health

Services budgeted complement be increased by 1.0 FTE Program

Evaluation Co-ordinator to support the operationalization of the evaluative framework and support the evaluation of the Hamilton Opioid Action Plan to be referred to the 2024 Tax Operation Budget for Council approval.

Legal: Not Applicable.

HISTORICAL BACKGROUND

Previous reports related to supervised consumption sites include:

- BOH217004(a) December 2017
 Hamilton Supervised Injection Site Needs Assessment & Feasibility Study;
- BOH19017 March 18, 2019
 Consumption and Treatment Services in Hamilton;
- BOH23007 February 13, 2023
 Consumption and Treatment Services Site Application; and,
- BOH23021 June 12, 2023
 Hamilton Opioid Action Plan

At its meeting on February 22, 2023 Council provided Public Health Services with the following direction:

SUBJECT: Supervised Consumption Site Evaluation Framework (BOH23025) (City Wide) - Page 3 of 6

"(b)(iii) That staff be directed to provide an evaluative framework with open data that demonstrates the community impact of Consumption and Treatment Services operations in Hamilton and make it publicly accessible on the City's website."

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

Development of a supervised consumption site evaluation framework aligns with the Substance Use and Injury Prevention standard as outlined in the Ontario Public Health Standards. The standard outlines that Public Health Units are required to collaborate with local agencies and assess programs and services in order to build upon community assets. Of note, Public Health Services does not currently operate any supervised consumption sites and evaluation of these services in the community would require additional resource support.

RELEVANT CONSULTATION

Current site operators of supervised consumption sites were consulted during the development of the evaluative framework.

Finance and Administration provided consultation on the staffing costs and budgetary recommendations, and supports the proposed recommendations.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

Responding to the ongoing drug toxicity crisis requires several coordinated interventions that are aimed at prevention, social justice, harm reduction and treatment. One evidence-based intervention is supervised consumption sites where individuals can use substances in the presence of trained staff. Supervised consumption sites also provide access to sterile drug-use equipment and facilitate access to healthcare and social services. Supervised consumption sites require an exemption from the federal *Controlled Drugs and Substances Act* to permit the use of illegal substances.

To develop the evaluative framework a review of the local municipalities was completed and found that three local public health units in Ontario have conducted evaluations of supervised consumption sites including, Region of Waterloo Public Health & Emergency

SUBJECT: Supervised Consumption Site Evaluation Framework (BOH23025) (City Wide) - Page 4 of 6

Services,¹ Middlesex-London Health Unit,² and Ottawa Public Health.³ In addition to local site evaluations, some health units also report supervised consumption site data via a public facing dashboard. These health units include Ottawa Public Health, Region of Waterloo, and Toronto Public Health. Locally, Hamilton Urban Core Community Health Centre currently posts Consumption and Treatment Services Fact Sheets on their website, which communicates select Consumption and Treatment Services metrics such as visits and demographic data.

Elsewhere across Canada, evaluations have been done and published in both British Columbia^{4,5} and Alberta,^{6,7} although in the case of the Alberta Health evaluation, criticism has been raised with respect to methodology and subsequent conclusions.⁸

¹ Region of Waterloo Public Health and Emergency Services & Sanguen. (2021, July). Consumption and Treatment Services (CTS) Review (January to December 2020). Retrieved from https://www.regionofwaterloo.ca/en/regional-government/resources/Reports-Plans--Data/Public-Health-and-Emergency-Services/CTS-2020-Review-Infographic.PDF

² Middlesex-London Health Unit. (2019, March). Comprehensive Report Findings from an Evaluation of London's Temporary Overdose Prevention Site. Retrieved from https://www.healthunit.com/uploads/saving-lives-changing-lives-evaluation-of-londons-temporary-overdose-prevention-site-comprehensive-report.pdf

³ Ottawa Public Health. (2018, February 5). Interim OPH SIS Evaluation Results. Retrieved from https://pub-

ottawa.escribemeetings.com/filestream.ashx?documentid=40073

⁴ Island Health. (2018, August). Evaluation of Overdose Prevention Sites: Campbell River, Courtenay, Cowichan Valley, and Port Alberni - Final Report. Retrieved from https://www.islandhealth.ca/sites/default/files/2018-10/evaluation-OPS-report.pdf

⁵ Mema, S. C., Frosst, G., Bridgeman, J., Drake, H., Dolman, C., Lappalainen, L., & Corneil, T. (2019, January 10). Mobile supervised consumption services in Rural British Columbia: lessons learned. Harm Reduction Journal, 16(4). doi:https://doi.org/10.1186/s12954-018-0273-3

⁶ Alberta Community Council on HIV. (2019, August). A Community Based Report on Alberta's Supervised Consumption Service Effectiveness. Retrieved from https://crismprairies.ca/wp-content/uploads/2019/08/A-Community-Based-Report-on-Alberta%E2%80%99s-SCS-Effectiveness-2019-08-16.pdf

⁷ Alberta Health, Government of Alberta. (2020, March). Impact: A socio-economic review of supervised consumption sites in Alberta. Retrieved from https://open.alberta.ca/dataset/dfd35cf7-9955-4d6b-a9c6-60d353ea87c3/resource/11815009-5243-4fe4-8884-11ffa1123631/download/health-socio-economic-review-supervised-consumption-sites.pdf

⁸ Livingston, J. D. (2021). Supervised consumption sites and crime: scrutinizing the methodological weaknesses and aberrant results of a government report in Alberta, Canada. Harm Reduction Journal, 18(4). doi:https://doi.org/10.1186/s12954-020-00456-2

SUBJECT: Supervised Consumption Site Evaluation Framework (BOH23025) (City Wide) - Page 5 of 6

Public Health Services is proposing a framework to demonstrate the impact of sites in reducing the harms associated with the increasingly toxic drug supply in the community. The framework is built upon the community consultations completed during the 2017 Hamilton Supervised Injection Site: Needs Assessment and Feasibility Study. As part of this study, the consultations focused on the perceived benefits and consequences of establishing a supervised consumption site in Hamilton. The four overarching domains proposed for the evaluation have been based upon the synthesized findings and are:

- 1. Site Usage;
- 2. Community Safety;
- 3. Community Health & Well-Being; and,
- 4. Economic Impact.

The proposed framework would incorporate data from all operating sites providing supervised consumption services. Currently this includes the Consumption and Treatment Services site at the Hamilton Urban Core Community Health Centre and the Urgent Public Health Needs site at YWCA Hamilton's Carole Anne's Place. This framework would also support the evaluation of the proposed Urgent Public Health need site housed at a men's shelter site as outlined in the Hamilton Opioid Action Plan (Public Health Committee Report BOH23021). Due to the few supervised consumption sites currently in existence, aggregating the data will evaluate the intervention and not compare or evaluate individual sites.

Each of the domains above are associated with indicators and metrics to capture community impact. An overview of these indicators is available in Appendix "A" to Public Health Committee Report BOH23025. The indicators are primarily quantitative and have been mapped to existing metrics that sites are already collecting and/or required to report monthly to the Ministry of Health. The economic impact would be evaluated using previously published methodology used in Calgary. 10 Understanding the community impact would be done through engagement with community partners, individuals who use supervised consumption sites, and any working groups associated with supervised consumption sites via a survey and site operators (e.g. impact on community outside of operational hours).

⁹ City of Hamilton Public Health Services & McMaster University. (2017, December). Hamilton Supervised Injection Site: Needs Assessment & Feasibility Study. Retrieved from https://www.hamilton.ca/sites/default/files/2023-03/hamilton-supervised-injection-site-study.pdf

¹⁰ Khair, S., Eastwood, C. A., Lu, M., & Jackson, J. (2022). Supervised consumption site enables cost savings by avoiding emergency services: a cost analysis study. Harm Reduction Journal, 19(32). doi:https://doi.org/10.1186/s12954-022-00609-5

SUBJECT: Supervised Consumption Site Evaluation Framework (BOH23025) (City Wide) - Page 6 of 6

The findings of the evaluation will be published on the Hamilton Opioid Information System and are anticipated to be updated on a routine basis (e.g. quarterly). The community survey is proposed to be completed on a bi-annual basis.

While the above outlines the high-level direction of the framework, operational details will be determined through engagement with people who use substances, the supervised consumption site operators, community members and any emerging best practices or guidelines from other local jurisdictions engaged in this work. An ongoing collaborative relationship is important to also proactively minimize any risk of stigma associated with substance use through the introduction of an evaluative framework. As such, the indicators and metrics are subject to change depending on feasibility, utility, or other identified community needs. Additionally, data sharing agreements will need to be entered into with the supervised consumption site operators which will require coordination with the City's Legal Services Division.

To operationalize the framework and support this new portfolio of work, a 1.0 FTE Program Evaluation Co-ordinator position is recommended. This position will support operationalizing the framework (e.g. survey design, validation of metrics, etc.), engagement with community partners and site operators, production of reports and recommendations, and any knowledge translation products and support the evaluation of the Hamilton Opioid Action plan. If the recommendations are approved as part of the 2024 Tax Operation budget, the evaluative framework will be operationalized in Q4 2024.

ALTERNATIVES FOR CONSIDERATION

Should Council determine that the work be initiated in 2023, Council could approve funding of \$26,767 in 2023 and an increase to the Public Health Services budgeted complement in 2023 by 1.0 FTE to hire a Program Evaluation Co-ordinator, to be funded first from any Public Health surplus, then from any Healthy and Safe Communities departmental surplus, then from any Corporate surplus or any other source as deemed appropriate by General Manager of Corporate Services. The anticipated annualized cost of \$127,630 would be included in the 2024 Tax Operated Budget.

If the alternative is approved, the evaluative framework will be operationalized by Q2 2024.

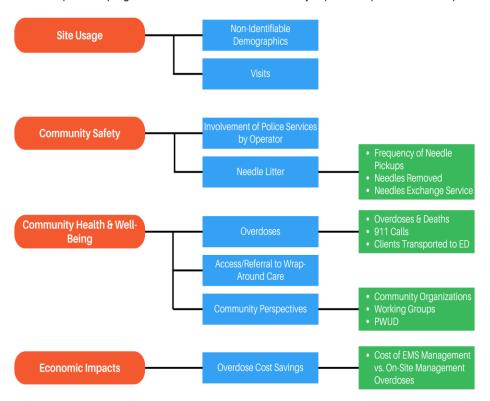
APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to Report BOH23025 Supervise

Supervised Consumption Site Evaluative Framework

Supervised Consumption Site Evaluative Framework

Goal: An open data program that demonstrates the community impact of supervised consumption sites in Hamilton



Notes:

- Assumes monthly reporting with the exception of the community survey
- Data sharing agreements would need to be put in place
- Final metrics subject to change



CITY OF HAMILTON PUBLIC HEALTH SERVICES Office of the Medical Officer of Health

TO:	Mayor and Members Public Health Committee	
COMMITTEE DATE:	August 16, 2023	
SUBJECT/REPORT NO:	2023 Public Health Services Organizational Risk Management Plan (BOH23022) (City Wide)	
WARD(S) AFFECTED:	City Wide	
PREPARED BY:	Konrad Lisnyj (905) 546-2424 Ext. 5452 Nancy Sullivan (905) 546-2424 Ext. 5752	
SUBMITTED BY:	Dr. Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services	
SIGNATURE:		

RECOMMENDATION

That Appendix "A" to Public Health Committee Report BOH23022, the 2023 Public Health Services Organizational Risk Management Matrix and Action Plan, be approved.

EXECUTIVE SUMMARY

As part of the Ontario Public Health Standards' Public Health Accountability Framework and Organizational Requirements, boards of health are required to develop an organizational risk management framework, create action plans to mitigate risks, and submit an annual risk management report to the Ministry of Health.

There are two types of risk that boards of health regularly encounter:

- 1. Issues that may be creating a risk to the public's health; and,
- 2. Issues that place the organization at risk of not meeting established business objectives.

Public Health Services addresses risks to the public's health by delivering effective public health programs and services that are informed by population health assessment, evidence, and ongoing surveillance and monitoring strategies. The contents of this plan relate to organizational risk.

The Public Health Leadership Team reassessed existing risks and identified new risks to inform the 2023 Public Health Services Organizational Risk Management Matrix and

SUBJECT: 2023 Public Health Services Organizational Risk Management Plan (BOH23022) (City Wide) - Page 2 of 4

Action Plan (Appendix "A" to Public Health Committee Report BOH23022). The plan includes a total of 26 risks; 24 were carried over from 2022 and two are new. Of these, five are classified as high risk, as they have the highest likelihood of occurring and the greatest potential impact on operations.

Action plans for mitigating and monitoring the high risks are developed and will be implemented by staff in 2023 (Appendix "A" to Public Health Committee Report BOH23022). The Public Health Leadership Team will continue to review and update the action plans on a semi-annual basis.

Alternatives for Consideration – See Page 4

FINANCIAL - STAFFING - LEGAL IMPLICATIONS

Financial: The risk assessment outlines financial risks/concerns. These concerns

inform the annual service plan and budget planning process; this report

does not ask for new financial investments.

Staffing: The risk assessment outlines staffing risks/concerns. These concerns

inform the annual service plan and budget process; this report does not

ask for new staffing.

Legal: Board of Health approval and subsequent submission to the Ministry of

Health of the 2023 Public Health Services Organizational Risk Management Plan will ensure compliance with the Public Health Accountability Framework and Organizational Requirements. It also supports the Board of Health in practicing good governance and due

diligence by mitigating potential organizational risks.

HISTORICAL BACKGROUND

In 2018, the Ministry of Health introduced the Public Health Accountability Framework and Organizational Requirements to ensure that boards of health have the necessary foundations within the four domains of program and service delivery, financial management, governance, and public health practice to successfully implement the Ontario Public Health Standards. As part of Public Health Accountability Framework and Organizational Requirements, public health units must have a formal risk management framework in place to identify, assess, and address organizational risks. To demonstrate compliance with this requirement, boards of health must submit a risk management report annually to the Ministry of Health as part of the Q3 Standard Activity Report.

Accordingly, in 2018, the Public Health Leadership Team developed the first Public Health Services Risk Management Plan that identified organizational risks across 14

SUBJECT: 2023 Public Health Services Organizational Risk Management Plan (BOH23022) (City Wide) - Page 3 of 4

risk categories. This plan was based on the Ontario Public Service Risk Management Framework (Appendix "B" to Public Health Committee Report BOH23022).

Each year, the Public Health Leadership Team reviews and updates the Risk Management Plan. Action plans to mitigate the risks that have the greatest likelihood of occurring and the greatest potential impact on operations are monitored and updated on a semi-annual basis. Progress on implementing these action plans and risk reduction strategies is reported to the Board of Health on an annual basis.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

Developing a risk management plan and submitting an annual risk management report to the Ministry of Health is a requirement within the Public Health Accountability Framework and Organizational Requirements. The Board of Health is held accountable to these requirements through the Public Health Funding and Accountability Agreement.

RELEVANT CONSULTATION

Finance and Administration has been consulted regarding the development of the 2023 Public Health Services Organizational Risk Management Plan, and supports the proposed recommendation.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

The Public Health Services Organizational Risk Management Plan focuses on organizational risk and supports the Board of Health in identifying and mitigating issues that place Public Health Services at risk of not meeting established business objectives. To inform the 2023 Public Health Services Organizational Risk Management Plan, the Public Health Leadership Team reassessed risks from the 2022 plan (Board of Health Report BOH22014) and identified new risks. A total of 24 risks were carried over from 2022, and two new risks were added.

The most significant organizational risks in the 2023 plan are listed below (Appendix "A" to Public Health Committee Report BOH23022):

Financial Risks;

 (1.1) Uncertainty related to the impact on Public Health Services programs and services due to budget pressures as a result of changing and insufficient provincial funding, as well as competing priorities at the municipal level.

Operational or Service Delivery Risks;

 (2.1) The Board of Health may not be able to fully address increased demand due to service backlogs, and worsening and emerging public health issues due to lack of capacity; and,

SUBJECT: 2023 Public Health Services Organizational Risk Management Plan (BOH23022) (City Wide) - Page 4 of 4

- (2.2) The Board of Health will need to work through the impacts of the COVID-19 pandemic on the organization and the roles and responsibilities of Public Health Services
- People / Human Resources Related Risks; and,
 - (3.1) The Board of Health may be at risk of precarious staffing due to challenges with recruitment and retention.
- Information / Knowledge Risks
 - (5.1) The Board of Health may be at risk due to unreliable information management systems and practices.

Action plans were developed for all five high-risk items listed above, as they have the highest likelihood of occurring and the greatest potential impact on operations (Appendix "A" to Public Health Committee Report BOH23022).

ALTERNATIVES FOR CONSIDERATION

The Board of Health could choose to amend the 2023 Public Health Services Organizational Risk Management Plan.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to Report BOH23022 2023 Public Health Services Organizational Risk Management Matrix and Action Plan

Appendix "B" to Report BOH23022 Ontario Public Service Risk Management

Framework

= High Risk

2023 Public Health Services Organizational Risk Management Action Plan

The chart below shows the **current ratings** for 2023 risks categorized by low, medium, and high.

	5	8.2 Space limitations in key IT applications	12.2 Active violence			
	4	8.1 Network outage	6.1 Outdated organizational policies & procedures 12.1 Network security 13.1 Health inequities 14.1 Change to provincial policies		2.1 Lack of capacity to meet growing demand 3.1 Precarious staffing 5.1 Unreliable information management practices	
IMPACT	3	12.3 Theft		1.2 Financial forecasting gaps 4.1 Environmental emergency 8.2 Use of unsupported technology 9.1 Elected officials' balancing responsibilities 9.2 Incomplete risk management 9.3 Impact of changing priorities with changed BOH membership/ structure 11.1 Negative image due to lack of understanding of PH role & services	2.2 Impacts of COVID-19 on organizations and R&Rs of PHS	1.1 Uncertainty re: impact of budget pressures on programs & services
	2		1.4 Lack of provincial funding to complete capital projects	10.1 Privacy breaches 11.2 Negative image due to reduced services 11.3 Negative image due to limits to data sharing	8.4 Lack of IT capacity to implement new and improve technologies	
	1			1.3 Financial fraud or corruption		
		1	2	3 LIKELIHOOD	4	5
					Overa	all Risk Rating = Low Risk = Medium Risk

2023 City of Hamilton Public Health Services Organizational Risk Management Action Plan

Overall Objective: PHS will use a formal risk management framework that identifies, assesses, and addresses risk.

RISK IDENTIFICATION				RISK ASSESSMENT		RISK REDUCTION		
ID#	Risk Exposure	Description of Risk	Cause/Source of Risk	Current Controls/Mitigation Strategies (what are we doing)	Rating Scale 1 (low) - 5 (high) (Likelihood x Impact)	Action Plan (what else can we do?) Only for <u>HIGH</u> risk	Person Responsible	Estimated Residual Risk once Action Plan is Fully Implemented (L x I)
1. Finan	cial Risks							
1.1		mitigation funding, the anticipated provincial subsidy will only be approximately 70% of the total costs of mandatory programs in 2023, a shortfall of \$2.3M. With the mitigation funding expected to end in 2023, PHS will have substantial cost pressures in 2024 and beyond. Currently, the shortfall is funded through the municipal levy. Additionally, COVID-19 requires dedicated resources to sustain the ongoing response, and permanent funding is required to sustain these efforts. The Ministry of Health has communicated that the one-time funding for the COVID-19 School Focused Nurses Initiative will end in June 2023, and has not committed to providing one-time funding for the reimbursement of COVID-19 general and vaccine extraordinary costs beyond December 2023.	In 2020, the Province shifted from a mixed 75%/25% and 100% funding model to a 70%/30% Provincial/Municipal funding formula for all public health programs and services under the Ontario Public Health Standards (Mandatory Programs), except the Ontario Seniors Dental Care Program (OSDCP), which remains 100% provincially funded. Since that time, the Ministry of Health has been providing one-time mitigation funding to keep levy increases below 10% of existing costs. The Province has not committed to continuing this funding beyond December 2023. The Board of Health has only received a 1% increase in base funding since 2018 from the Province. The level of provincial funding has not kept pace with inflationary costs or covered additional requirements added to the Ontario Public Health Standards since 2018. In addition, the COVID-19 response has been funded with one-time funding, and the Province has not committed to any additional COVID-19-related funding beyond December 2023.	funding through the ASPB submission and participation in various strategic provincial-level forums (e.g., AMO, alPHa, COMOH, etc.). 5. Cover Provincial funding shortfall through the municipal budget.	L5, I3	1. Track all costs related to COVID-19 for reimbursement through quarterly financial reporting processes. 2. Offset COVID-19 recovery costs through the redirection of base funding. 3. Manage uncertainty related to COVID-19 response funding beyond 2023. 4. Manage program and financial performance through the regular monitoring of key performance measures. 5. Advocate to the Province for adequate funding through the ASPB submission and participation in various strategic provincial level forums (e.g., AMO, aIPHa, COMOH, etc.). 6. Fund Provincial funding shortfall through the municipal budget.	1. Public Health Leadership Team (PHLT), Finance & Administration (F&A) 2. PHLT, F&A 3. PHLT 4. PHLT 5. PHLT 6. F&A	L5, I3
2. Opera	ntional or Service Delivery Risks							
2.1		Lack of capacity due to continued staff fatigue/burnout, high turnover of experienced staff, and challenges with recruitment and retention has resulted in resources being unavailable to address increased demand due to deficits of care/service backlogs and worsening and emerging public health issues.	Lack of capacity resulting from challenges with retention and recruitment, and lack of additional funding to support recovery activities.	Identification and utilization of gapping funding (resulting from recruitment/retention challenges) has, in some areas, allowed COVID-19-funded staff to additionally work on recovery activities, with those costs reallocated back to the base budget. Review program and financial performance data on a regular basis to ensure effective delivery of services in an efficient and fiscally responsible manner. Identify and communicate PHS priorities.	L4, 14	Determine and communicate 2023 PHS priorities. Continue to review program and financial data on a regular basis to demonstrate accountability and ensure the effective delivery of services in an efficient and fiscally responsible manner. Work with community partners to address community health priorities through collaborative tables and intersectoral action.	1. PHLT 2. PHLT 3. PHLT	L3, I3
2.2	PHS.	Uncertainties related to the changes needed to the organization, roles, and responsibilities of PHS to address the ongoing COVID-19 response, the impact of the COVID-19 pandemic on the health needs of the community, and increased demand due to the restart and change of corporate processes, while balancing re-start and catch-up of PHS programs and services.	emerging public health issues that were caused or	Gathered intelligence and monitoring system changes related to the impact of COVID-19. Developed and implemented advanced plans, including PHS Recovery Plan, Equitable Recovery Plan, and COVID-19 Vaccine and Communicable Disease Control transition plans. Provided timely updates to the Board of Health, including COVID-19 status updates, recovery plans, transition plans, etc.	L4, 13	1. Continue gathering intelligence and monitor changes related to the impact of COVID-19 on population health. 2. Complete planning to identify the staffing complement needed to continue meeting Provincial requirements related to COVID-19 and to respond to potential future COVID-19 situations. 3. Continue participating in provincial discussions on the roles and responsibilities of public health. 4. Re-establish planning, change management, and performance management systems.	Epidemiology & Evaluation Program Communicable Disease Control Division Director PHLT	L4, I2

RISK IDENTIFICATION			RISK ASSESSMENT		RISK REDUCTION			
ID#	Risk Exposure	Description of Risk	Cause/Source of Risk	Current Controls/Mitigation Strategies (what are we doing)	Rating Scale 1 (low) - 5 (high) (Likelihood x Impact)	Action Plan (what else can we do?) Only for <u>HIGH</u> risk	Person Responsible	Estimated Residual Risk once Action Plan is Fully Implemented (L x I)
3.1	staffing due to challenges with recruitment and retention.	Recruitment and retention are difficult due to more competition for certain core public health positions (e.g., public health nurses, public health inspectors, etc.). We are able to recruit staff, but the recruitment process takes longer and is more resource intensive. There have been a significant number of retirements over the last few years due to staff fatigue/burnout and decreased work satisfaction as a result of the prolonged COVID-19 emergency response, and this trend is expected to continue. The result is a loss of experienced staff and new/young staff. Impacts include increased cost of and amount of time needed to onboard, orient, and train new staff, the cost of losing knowledge/expertise when people leave, and the impacts related to depth and quality of work programs can have with new staff. A significant number of positions currently supporting the ongoing COVID-19 response and recovery are temporary positions with uncertain future funding. As a result, these temporary staff are beginning to seek other employment opportunities, and backfilling positions is challenging for the short durations to fill the outstanding contract length (end of the 2023 calendar year). Failure to retain staff to support these areas will impact the ability to continue COVID-19 response activities and/or recovery efforts. Some of these activities cannot be deprioritized and would require reallocation of staffing and impact other ASPB programs and services. Precarious staffing impacts the Public Health Committee's ability to achieve objectives, resulting in constant re-prioritization	across all settings and a high number of staff facing burnout and mental health challenges as a result of the COVID-19 emergency response. Difficult to retain staff in which we are losing a high number of experienced staff due to decreased work satisfaction, high competition for core public health positions, and the temporary nature of some positions.	1. Regularly assess current vacancies across the department to proactively identify staffing needs. Participation incorporates assessment and analysis of vacancies. 2. Complete succession planning and ensure sequencing when staff onboarding to transfer knowledge for all program areas. 3. Identify opportunities for new work allies (e.g. co-op students) to build capacity. 4. Ensure contracts are as long as possible (e.g. minimum of one year) to help retain staff. 5. Implement strategies to improve recruitment and retention. Raise key issues and participation in corporate discussions. Consult with and provide feedback to Human Resources (HR). Temporary strategies and continuous quality improvement (CQI) activities were implemented. An external consultant engaged corporately and made recommendations, and corporate recruitment and retention improvements are being rolled out. 6. Establish a Nursing Recruitment and Retention Working Group. 7. Advocate for provincial funding to build capacity in the public health system to ensure dedicated staff are available to respond to emergencies without impacting core public	L4, 14	1. Regularly assess current vacancies across the department to proactively identify staffing needs and share information corporately to inform corporate strategies. 2. Complete succession planning and ensure sequencing when staff onboarding to transfer knowledge for all program areas. 3. Continue to identify opportunities for new work allies (e.g. coop students) to build capacity. 4. Continue to raise key issues and participate in corporate discussions related to recruitment and retention. Participate in corporate recruitment and retention improvements resulting from external consultant recommendations. 5. Re-establish the Nursing Recruitment and Retention Working Group as needed. 6. Advocate for provincial funding to build capacity in the public health system to ensure dedicated staff are available to respond to emergencies without impacting core public health programs and services. 7. Request HR analysis of staff demographics to inform the development of retention strategies appropriate for the different workforce. 8. Work with HR to implement short-term CQI activities to support recruitment (e.g., periodic posting to have a staffed candidate pool) and increase job satisfaction. 9. Continue implementation of PHS health and wellness initiatives.	2. PHLT, Managers 3. Health Equity Program 4. PHLT 5. Chief Nursing Officer 6. PHLT 7. PHLT, PHS Human Resources (HR) Business Partner 8. PHLT, PHS HR Business Partner 9. Planning & Competency Development Program	14, 13
5. Inforr	5. Information / Knowledge Risks							
5.1		Varying information management practices and the absence of a formalized records management platform could lead to loss of information, privacy breaches or non-compliance with the records retention schedule, and could prevent staff from accessing information.	management platform. Lack of staff awareness, and	 Internal Privacy, Security and Information Management (PSIM) Committee at PHS was re- established in 2022 to address information management concerns. 	L4, 14	 Develop and implement approved policies to support records and information management. 	Epidemiology & Wellness Division, Data Management Program	L3, I2



RISK MANAGEMENT STRATEGY & PROCESS TOOLKIT

14 categories of risk

Step 1: Establish objectives

- Risks must be assessed and prioritized in relation to an objective
- Objectives can be at any level; operational, program, initiative, unit, branch, health system
- Each objective can be general or can include specific goals, key milestones, deliverables and commitments

Risk

The future event that may impact the achievement of established objectives. Risks can be positive or negative.

Control / Mitigation Strategy

Controls / mitigation strategies reduce negative risks or increase opportunities.

RISK Description Uncertainty around obtaining, committing, using, Financial losing economic resources; or not meeting overall financial budgets/commitments. Uncertainty regarding the activities performed in Operational or carrying out the entity's strategies or how the Service Delivery entity delivers services. Uncertainty as to the capacity of the entity to People / Human attract, develop and retain the talent needed to Resources meet the objectives. Uncertainty usually due to external risks facing an organization including air, water, earth, forests. . An Environmental example of an environmental, ecological risk would be the possible occurrence of a natural disaster and its impact on an organization's operations. Uncertainty regarding access to, or use of, Information / inaccurate, incomplete, obsolete, irrelevant or Knowledge untimely information; unreliable information systems; inaccurate or misleading reporting. Uncertainty around strategies and policies achieving required results; or that old and/or new Strategic / Policy policies, directives, guidelines, legislation, processes, systems, and procedures fail to recognize and adapt to changes Uncertainty regarding compliance with laws, Legal / regulations, standards, policies, directives, Compliance contracts, MOUs and the risk of litigation. Uncertainty regarding alignment of IT infrastructure **Technology** with technology and business requirements; availability of technological resources. Uncertainty about maintenance or development of appropriate accountability and control Governance / mechanisms such as organizational structures Organizational and systems processes; systemic issues, culture and values, organizational capacity, commitment, and learning and management systems, etc. Uncertainty with regards to exposure of personal Privacy information or data; fraud or identity theft; unauthorized data. Uncertainty around managing the expectations of the public, other governments, Ministries, or Stakeholder / other stakeholders and the media to prevent **Public Perception** disruption or criticism of the service and a

negative public image.

warehouses, labs, etc).

Security

Equity

Political

Uncertainty relating to breaches in physical or

Uncertainty that policies, programs, or services will

have a disproportionate impact on the population.

Uncertainty that events may arise from or impact

the Minister's Office/Ministry, e.g. a change in government, political priorities or policy direction.

logical access to data and locations (offices.

The risk management process



Consequences

- Identify the specific consequences of each risk
- Consider financial, non-financial, performance, etc.

Vulnerability

- Identify exposure to risk
- Vulnerability may vary with each situation and change over time

Cause/Source of Risk

- Understand the cause/source of each risk
- Use a fish-bone diagram

Step 2: Identify risks & controls Identify risks - What could go wrong?

- Consider each category of risk
- Obtain available evidence
- Brainstorm with colleagues and/or stakeholders
- Examine trends and consider past risk events
- Obtain information from similar organizations or projects
- Increase awareness of new initiatives/ agendas and regulations

Identify existing controls – What do you already have in place?

- Preventive controls
- Detective controls
- Recovery / Corrective controls



RISK MANAGEMENT STRATEGY & PROCESS TOOLKIT

Step 3: Assess Risks & Controls

Assess inherent risks

- Inherent likelihood Without any mitigation, how likely is this risk?
- Inherent impact Without any mitigation, how big will be the impact of the risk on your objective?

Assess controls

Evaluate possible preventive, detective, or corrective mitigation strategies.

Reassess residual risks

- Re-assess the impact, likelihood and proximity of the risk with mitigation strategies in place.
- Residual likelihood With mitigation strategies in place, how likely is this risk?
- Residual impact With mitigation strategies in place, how big an impact will this risk have on your objective?

Key Risk Indicators (KRI)

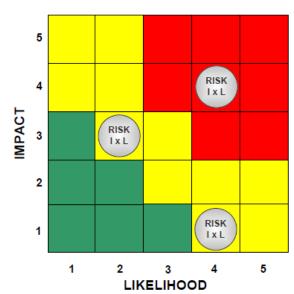
- Leading Indicators Early or leading indicators that measure sources or causes to help prevent risk occurrences
- Lagging Indicators Detection and performance indicators that help monitor risks as they occur.

Risk Tolerance

- The amount of risk that the area being assessed can manage
 Risk Appetite
- The amount of risk that the area being assessed is willing to manage

The tolerance and risk appetite values may differ e.g. Staff can afford to lose email capabilities for five hours (risk tolerance) but only be willing to lose email capabilities for one hour (risk appetite).

RISK PRIORITIZATION MATRIX



Step 4: Evaluate & Take Action

- Identify risk owners.
- Identify control owners.
- Have mitigation strategies reduced the risk rating (Impact x Likelihood) enough that the risk is below approved risk tolerance levels?
- Do you need to implement further mitigation strategies?
- Develop SMART (Specific, Measurable, Achievable, Realistic, Time-specific) actions that will either reduce the likelihood of the risks or minimise the impact.
- Develop detailed action plans with timelines, responsibilities and outline deliveries.

Step 5: Monitor & Report

- Have processes in place to review risk levels and risk mitigation strategies as appropriate.
- Monitor and update by asking:
 - Have risks changed? How?
 - · Are there new risks? Assess them
 - Do you need to report or escalate risks? To whom? When? How?
- Develop and monitor risk indicators

Definitions

VALUE	LIKELIHOOD IMPACT		PROXIMITY	SCALE
1	Unlikely to occur	Negligible Impact	More than 36 months	Very Low
2	May occur occasionally	Minor impact on time, cost or quality	12 to 24 months	Low
3	Is as likely as not to occur	Notable impact on time, cost or quality	6 to 12 months	Medium
4	Is likely to occur	Substantial impact on time, cost or quality	Less than 6 months	High
5	Is almost certain to occur	Threatens the success of the project	Now	Very High