Regional Municipality of Waterloo

Community Services Committee

Agenda

Tuesday, September 12, 2017

9:00 a.m.

Regional Council Chamber

150 Frederick Street, Kitchener, Ontario

1. Declarations of Pecuniary Interest under the “Municipal Conflict Of Interest Act”

2. Delegations

Consent Agenda Items

Items on the Consent Agenda can be approved in one motion of Committee to save time. Prior to the motion being voted on, any member of Committee may request that one or more of the items be removed from the Consent Agenda and voted on separately.

3. Request to Remove Items from Consent Agenda

4. Motion to Approve Items or Receive for Information

4.1 CSD-EIS-17-12, 2017-2018 Ontario Works Service Plan

Recommendation:

That the Regional Municipality of Waterloo approve the 2017-2018 Ontario Works Service Plan;
And that the plan be forwarded to the Ministry of Community and Social Services for approval as outlined in report CSD-EIS-17-12, dated September 12, 2017.
4.2 **CSD-DES-17-03, Grants to Community Organizations at the Region of Waterloo**

**Recommendation:**

That the Regional Municipality of Waterloo take the following actions with respect to Grants to Community Organizations as outlined in Report CSD-DES-17-03 dated September 12, 2017:

1. Continue grants to the agencies identified in Appendix 1 at the noted levels for one additional year (2018) allowing them to prepare for transition to either a new funding model or discontinuation of Region of Waterloo funding as detailed in report CSD-DES-17-03 dated September 12, 2017; and

2. Approve in principle entering into Purchase of Service Agreements, effective January 1, 2019, with those organizations identified in Appendix 2 providing programs which directly support the Region’s programs, services and role as Consolidated Municipal Service Manager (CMSM) for housing and homelessness, social assistance, or childcare.

4.3 **CSD-CHS-17-14, Journey Together Update (Information)**

4.4 **PDL-CUL-17-07, Curatorial Centre Expansion Project Deferral**

**Recommendation:**

That the Regional Municipality of Waterloo defer the existing Curatorial Centre Storage Expansion Capital Project (42046) to 2019 – 2021; and

That the Regional Municipality of Waterloo provide pre-budget approval of the $11.83 million for the project as outlined in PDL-CUL-16-10 dated September 13, 2016; and

That the Regional Municipality of Waterloo accept the Canada Cultural Spaces Fund $1.0 million grant contribution with proposed deferral to 2019-2021 and enter into any required agreements, subject to the approval of the Regional Solicitor.

4.5 **PHE-17-05, Infectious Diseases in Waterloo Region: Surveillance Report 2016 (Information)**
4.6 **PHE-CRS-17-02**, Review of Community Grants Assigned to Public Health and Emergency Services

**Recommendation**

That the Regional Municipality of Waterloo discontinue the annual grant to the Canadian Mental Health Association (Waterloo, Wellington and Dufferin Branch) Distress Centre, effective December 31, 2017, and discontinue the grant to Telecare Cambridge effective December 31, 2018, and that the respective allocations of $23,700 and $4,600 (gross and net levy) be removed from the PHE base budget in 2018 and 2019.

### Regular Agenda Resumes

5. **Reports – Community Services**

5.1 **CSD-IP-17-03**, Immigration Partnership Update (Presentation)

**Recommendation:**

That the Regional Municipality of Waterloo approve entering into agreements with agencies or consultants, as determined by the Commissioner of Community Services from time to time, to support implementation of the Waterloo Region Immigration Partnership Community Action Plan for the period 2017-2019, subject to receipt of Federal Government funding;

That the Regional Municipality of Waterloo approve the continuation of temporary staffing within the Immigration Partnership of 2.9 FTE for the period April 1, 2017 – March 31, 2020; and

That the Regional Municipality of Waterloo approve an increase in the 2017 Operating Budget for the Immigration Partnership by $141,605 gross and $0 net Regional Levy as outlined in report CSD-IP-17-03, dated September 12, 2017.

6. **Information/Correspondence**

6.1 Council Enquiries and Requests for Information Tracking List

7. **Other Business**

8. **Next Meeting – October 3, 2017**

9. **Adjourn**

2507716
Region of Waterloo
Community Services
Employment and Income Support

To: Chair Geoff Lorentz and Members of the Community Services Committee

Date: September 12, 2017  File Code: S12-40

Subject: 2017-2018 Ontario Works Service Plan

Recommendation:

That the Regional Municipality of Waterloo approve the 2017-2018 Ontario Works Service Plan;

And that the plan be forwarded to the Ministry of Community and Social Services for approval as outlined in report CSD-EIS-17-12, dated September 12, 2017.

Summary:

A full Service Plan is required and developed in the first year (2017) of a two year approval cycle, and updated in the second year (2018) as part of the budget process. A draft of the Region of Waterloo’s 2017-2018 Ontario Works Service Plan has been distributed separately.

Report:

1.0 Background

Ontario Works provides two types of assistance: employment services and basic financial assistance. The vision for the Ontario Works (OW) program is to achieve improved employment outcomes for Ontario Works participants with the goals of sustainable employment and increased financial independence. The mandate is to provide temporary financial and employment assistance to people in financial need. Eligibility for financial assistance and the amount granted are based on a financial assessment and participation in employment related activities. In order to receive financial assistance, applicants enter into a participation agreement which includes an
individualized employment plan (unless there is an approved reason to be deferred from participation).

The Region of Waterloo is one of forty-seven Consolidated Municipal Service Managers (CMSMs) in the Province of Ontario. Community Services, through Employment & Income Support, provides financial assistance under the *Ontario Works Act* to people in need to cover the cost of food, shelter and clothing. Additional financial support is provided through the discretionary benefits program for such items as vision, dental and medical services for Ontario Works and Ontario Disability Support Program participants and persons with low income. A range of services which assist people to find employment are purchased or directly delivered by Employment & Income Support. As well, staff refers to a variety of community partners which provide the services and supports required by the individual participant.

2.0 The Service Plan

The Province requires that all Consolidated Municipal Service Managers submit an Ontario Works Service Plan every two years that summarizes service delivery information including service targets and strategies for the period covered by the Service Plan. The plan contains an environmental scan, a review of the management of the Ontario Works’ program within the Region and a discussion of the strategies to achieve the program outcomes. The primary goal of service planning is to demonstrate how the range and type of services being provided will best serve Ontario Works participants. The intent is to link Provincial funding for Employment Assistance activities to employment outcomes. Once approved, the 2017-2018 Service Plan will become part of the service description schedule of the Ontario Works service contract between the Region and the Province.

3.0 Key Directions for 2013

In developing the 2017-2018 Service Plan Employment and Income Support consulted two key reports: the Workforce Planning Board of Waterloo Wellington Dufferin (WPB) Community Labour Market Analysis and SAMS Benefit Unit Summary reports. These documents provide an overview of local labour market conditions and the demographic profile of Ontario Works participants. This information helps Employment and Income Support understand the population it is serving as well as trends in local economic conditions. This information complements the service experience of the past years and the information received from community partners and collaboration initiatives such as our Employment and Income Support Community Advisory Committee.

Regional initiatives that Employment and Income Support will take part in over the course of this service plan include: improved community engagement activities such as Connectivity Table, Community Employment Linkages Committee, the Cambridge Employment Facilitation Network and the Immigration Partnership Council; follow up to
the 2017 Employee Engagement Survey; Modernization and Integration activates intended to align our services so that we are ready for provincial initiatives and provide improved employment focused experiences for clients across Employment and Income Support, Children’s Services and Housing.

At the same time, there are several Provincial initiatives that will impact the work of the division, including:

- Implementation of the Ministry of Community and Social Services culture change initiatives that are intended to create seamless access to child care, housing supports, income and employment supports and create risk based approaches to the province’s financial and employment support systems;

- Continued participation on provincial workgroups to improve the reporting and interface functions of the Social Assistance Management System (SAMS);

- Advisory participation in the Ministry of Community and Social Services Risk Based Certification of Assurance initiative;

- Collaboration with Transportation and Environmental Services, Corporate Services and the Treasury Board of Ontario Local Poverty Reduction Strategy research grant to explore the impact of reduced transit fares.

Finally, Employment and Income Support has identified a number of activities to better support its participants in the coming years. These include a restructuring of the division’s services to enhance access, ongoing support and program integrity; the integration of the Employment Ontario program within the broader Ontario Works Employment Services to establish a continuum of service; retooling of employment programs to emphasize individual employment planning; the establishment of an evidenced based measurement system to inform program gaps, successes and change requirements; and, continued partnerships with external agencies such as Conestoga College in the delivery of the General Equivalency Diploma given the requirements of the labour market and the general profile of participants.

In consultation with the Ministry of Community and Social Services regional Office Employment and Income Support has set a modest target increases (e.g., timeframe within which a person is employed, number of those who exit and return to Ontario Works) for its Employment Assistance activity.

**Corporate Strategic Plan:**

The 2017-2018 Ontario Works Service Plan supports the Region’s Corporate Strategic Focus Area 4, *Healthy and Inclusive Communities*. In addition, the proposed activities will promote Focus Area 5, *Service Excellence*.
**Financial Implications:**

The 2017 Budget approved by Regional Council provides for the delivery of Ontario Works programs. The following chart summarizes the 2017 Provincial and Regional funding for employment services and the administration of financial assistance.

<table>
<thead>
<tr>
<th>Financial Assistance</th>
<th>2017 Cost Share Ratio</th>
<th>Provincial Subsidy</th>
<th>Region Contribution</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>50.0%</td>
<td>$13,233,400</td>
<td>$13,233,400</td>
<td>$26,466,800</td>
</tr>
<tr>
<td>Employment Assistance *</td>
<td>97.2%</td>
<td>6,449,500</td>
<td>185,800</td>
<td>6,635,300</td>
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<tr>
<td>Total</td>
<td></td>
<td>$19,682,900</td>
<td>$13,419,200</td>
<td>$33,102,100</td>
</tr>
</tbody>
</table>

* Employment assistance is subject to Provincial Upload.

The Region’s contribution is funded by the property tax levy. The 2017 budget assumed $19.6 million in provincial subsidy for these programs.

The 2018 Budget currently being developed will be based on the 2017 provincial approval.

**Other Department Consultations/Concurrence:**

Finance contributed to the development of the 2017-2018 Ontario Works Service Plan.

**Attachments**

Attachment A: 2017-2018 Ontario Works Service Plan

**Prepared By:** Curt Shoemaker, Manager, Employment and Income Support

Carolyn Schoenfeldt, Director, Employment and Income Support

**Approved By:** Douglas Bartholomew-Saunders, Commissioner, Community Services
Ontario Works
Service Plan
2017-2018

Approved by Council __________
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For more information regarding Ontario Works in Waterloo Region, for additional copies of this document, or to request alternate formats, please contact:

<table>
<thead>
<tr>
<th>Carolyn Schoenfeldt, Director</th>
<th>Nina Bailey-Dick, Social Planning Associate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment &amp; Income Support</td>
<td>Employment &amp; Income Support</td>
</tr>
<tr>
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<td>Region of Waterloo Community Services</td>
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</table>

Ontario Works Service Delivery Sites

- **Waterloo Office** - 99 Regina St. S., Waterloo, ON N2J 4V3 Phone 519 575 4400 Fax 519 884 8395
- **Cambridge Office** - 150 Main St., Cambridge, ON N1R 8H6 Phone 519 575 4400 Fax 519 622 6642
- **Kitchener Office** - 235 King St. E., Kitchener, ON N2G 4N5 Phone 519 575 4400 Fax 519 883 2224
Section 1: Guiding Principles

1.1 Vision and Mission of Region of Waterloo
The vision and mission statements of the Region of Waterloo are as follows:

**Vision:**
Waterloo Region: A community where people matter and ideas grow.

**Mission:**
We serve with caring and responsible government.
We engage by listening and responding to community needs.
We inspire with new ideas and creative solutions.

1.2 Vision and Mission of Region of Waterloo Community Services
The vision and mission statements of the Region of Waterloo Community Services department are as follows:

**Vision**
We believe in the creation of a community where everyone has the opportunity to thrive and nobody is left behind.

**Mission**
To deliver essential services that removes obstacles and creates opportunities in partnership with our community.

1.3 Vision and Mission of the Employment and Income Support Division
The Employment and Income Support Division (E&IS) is engaged in a strategic planning process. The current draft vision and mission statements are as follows:

**Vision**
A community where everyone can reach their potential.

**Mission**
We provide the citizens of Waterloo Region with employment, financial, and social supports for improved well-being by:
- **Engaging** Engaging with internal partners and community
- **Inspiring** Inspiring individuals and families to reach their potential
- **Serving** Serving individuals and families through caring and responsive services.

1.4 Vision and Mandate of Ontario Works
The vision and mandate of Ontario Works are as follows:
Vision
To achieve improved employment outcomes for Ontario Works participants by increasing individual employability with the goal of sustainable employment and increased financial independence.

Mandate
The Ontario Works Program combines financial assistance and employment assistance to help persons in temporary financial need move toward sustainable employment and independence.

- recognizes individual responsibility and promotes self-reliance through employment;
- provides financial assistance to those most in need while they meet obligations to become and stay employed;
- effectively serves people needing assistance; and
- is accountable to the taxpayers of Ontario

1.5 Priorities for Employment and Income Support

The Province has identified three priorities for Ontario Works delivery partners in 2017-2018. The Region of Waterloo is addressing these priorities through a variety of projects and ongoing activities within the Employment and Income Support (E&IS) Division, as described below.

1. Improved service coordination and communication between Ontario Works and Ontario Disability Support Program (ODSP) delivery offices within the service area, including transfers between programs, business protocols, shared case management when appropriate, and expanded and strengthened access to employment services for ODSP clients and people with disabilities within the community.

- **ODSP specialized caseload** – E&IS is considering a specialized caseload for people who have made application to the Disability Adjudications Unit (DAU). The intent is to find efficiencies and streamline processes so that applications are well informed and files are transferred without delay. A decision will be made in late 2017/early 2018. In 2016, staff in OW made a total of 1,445 referrals to ODSP.

- **ODSP information sessions** – E&IS holds ODSP Information sessions for people intending to make an application to the DAU. The ODSP Information Session is available for OW recipients at all three OW offices. The session provides a comprehensive review
of the ODSP application package and process including both the mandatory portion that requires medical input and the optional self-report portion. The intent is to inform applicants about DAU requirements to avoid unnecessary appeals and delays with benefits. Should OW recipients require additional one-to-one support to complete their application, there are a number of options available both internally and in the community.

- **E&IS is working with the non-disabled ODSP spouses and dependents adults to assist them in moving towards employment.** This initiative will be moved into the Employment Ontario program. The number of non-disabled ODSP spouses/dependent adults who participated in OW programs in 2016 was a monthly average of 206.

- **Local Partners Group** – Managers and Directors from the ODSP office and E&IS discuss strategic directions related to benefits and service program. The goal is to keep one another informed of changes to programs and to strengthen service design linkages. The two programs are considering offering joint training to staff. This group meets twice each year.

- **Issue resolution protocols** – Well established protocols are now in place to resolve issues related to file transfer, discretionary benefits and employment services.

- **EISCAC** - The Employment and Income Support Community Advisory Committee (EISCAC) provides a forum for stakeholders to provide advice on the programs and services delivered by the E&IS Division of the Region of Waterloo Community Services Department. The EISCAC meets five times per year and includes up to 37 members. Members include Ontario Works/Ontario Disability Support Program participants, community agencies and partners, funders, business representatives, ODSP staff and Regional staff.

  The goal of the EISCAC is to provide advice on potential improvements to the services provided by Employment & Income Support to those residents of Waterloo Region who use these services.

2. Stronger collaboration with local economic development organizations to identify, expand and leverage provincial investments in infrastructure and resource development to provide opportunities for Ontario Works clients, youth and disadvantaged populations to access skills training, work experience, and new jobs.
Employer Engagement – The Region continues to seek out employers through Employment Ontario (EO). Job Developers engage employers in the community to source out their hiring needs and the skill set of the employers they are looking to hire. Electronic and hard copy job boards located in the E&IS Resource Centres display current job opportunities. The Region also hosted 5 job fairs for local employers and surveys employers. No numbers are available on how many participants in job fairs secured employment.

Employment Programs – The Region provides internal employment services as well as Employment Ontario supports and programs at all three of our OW locations. In 2016 the Employment Program Team had 618 participants complete a group, workshop or GED pre-test. Of those 618, 537 and/or 87% were on Ontario Works. 81 (13%) were on ODSP.

Transit Review - A review of affordable transit is underway. This is a joint review with E&IS, the Regional Transit Division and the University of Waterloo. Funding was granted from the Poverty Reduction Fund for a two-year evaluation to research the outcomes of transit subsidies for citizens living with low income and how access to subsidized transit effects an individual’s quality of life.

Employment Services redesign – The Employment Services Redesign Steering Committee was formed in December 2015 with the responsibility to engage E&IS employees and develop recommendations for a new Employment Services model. The Committee was comprised of E&IS staff from each program area (Direct Services staff from Employment and Income, management and Social Planning). The Committee presented their work to the E&IS Management Team and Commissioner, Community Services on March 24, 2016. Work is now underway to implement the redesign.

Youth Job Link – Youth employment funding ended in March 2016 with targets met (19 clients). A new program, Youth Job Link began in April 2016. This is a youth employment program for youth with minimal.

The Cambridge Employment Facilitators Network and Community Employment Literacy Committee – Region staff participate in these networks to support, coordinate and discuss employment initiatives.
• **Employment Ontario Employment Services Network** – Region staff chair this group to support, coordinate and discuss issues relating to Employment Ontario (EO). An offshoot of this Network is the Canada Ontario Job Grant network, these meetings are to look at the coordination of the EO program.

There is also a Job Developers Table that E&IS staff participate in. This group minimizes the overlap of visits to Employers and standardizes payments and incentives to minimize competition among network members and to increase cooperation and coordination with other networks.

• **Networking with Trades** – E&IS staff are working with the new Region of Waterloo Economic Development Manager and supervisor, and with the Waterloo Economic Development Corporation to network with the larger economic development community in the Region.

• **YouthForce** – E&IS is collaborating with Regional Housing to run the summer youth program YouthForce. This program began in 2016 and was highly successful. It hires youth to support maintenance and inspection duties at Waterloo Region Housing Units during the summer. As part of the programming, the youth will be provided with employment workshops & training. In 2016, 25 youth were hired.

• **Chamber of Commerce** - Memberships in the Chambers of Commerce for the cities of Waterloo, Kitchener and Cambridge allow E&IS staff to strengthen relationships with Regional employers.

3. Establishing local partnerships with community organizations to build on and strengthen supports to Ontario Works clients, including individuals with multiple barriers to employment (i.e. long-term recipients of social assistance), marginalized or disadvantaged groups across service sectors including: health, developmental services, housing, violence against women prevention, human trafficking or education and training.

• **The Counselling Collaborative Program** – A partnership between the Region of Waterloo and seven local counselling agencies. It was developed to ensure that individuals in receipt of Ontario Works or Ontario Disability Support Program benefits receive counselling services in an agency of their choice. Recipients of Ontario Works or Ontario Disability Support Program benefits are eligible for up to eight counselling sessions and include such modalities as individuals, group, couple, and family counselling supports. Counselling services allow individuals
the opportunity to maximize their well-being and assist many to engage in the workforce.

The agencies who comprise the Collaborative work closely together to provide evidence-based services. This means that individuals who receive Ontario Works or Ontario Disability Support Program benefits have access to counselling at a location of their choice across Waterloo Region. The Supervisor of the E&IS Social Work Team is a member of the Counselling Collaborative Program for enhanced coordination of counseling services. Efforts are being undertaken to improve outcome measures.

- **The Emergency Food Hamper Program** - Emergency food hampers are distributed to the residents of Waterloo Region. The Region of Waterloo contributes $719,000 to this program which is managed by the Waterloo Region Food Bank, who act as the lead agency for the coordination of the program.

- **John Howard Society** – An agreement exists with the John Howard Society to fund OW client applications for pardons of past criminal offences. This removes a barrier to employment for some people.

- **Kitchener Downtown Community Health Centre** – The Region has a financial agreement with the Health Centre to assist clients obtain birth certificates and Social Insurance Numbers. This funding removes these barriers to employment and Direct Bank deposits for Ontario Works clients.

- **The Family Outreach Program** - A region-wide program created to reduce and/or prevent the depth of child poverty in the Waterloo Region. The Region funds the Program and provides funding to the House of Friendship to act as the lead agency in the delivery of this initiative. This initiative delivered in 30 neighbourhoods and communities of interest. The Program supports children and their families by providing support to navigate various systems and access to basic needs such as food, clothing, shelter, transportation, employment/education and recreation. There is a great benefit to having Family Outreach Workers located in neighbourhoods where they connect with families who might not otherwise access the system.

- **Interpreter services** – Interpreter services in Waterloo/Kitchener are provided through a formal contracted agreement between E&IS and KW Multicultural Centre. In Cambridge, an informal agreement with the YMCA is in place. In both cases interpreters
are used for OW applications and employment related discussions with non-English speaking applicants/recipient.

- **Waterloo Region Energy Assistance Program (WREAP)** – The E&IS Intake Team delivers the Region’s Waterloo Region Energy Assistance Program (WREAP). Using a number of different funds (Union Gas Energy Assistance Program, Low-income Energy Assistance Program (LEAP), Community Homelessness Prevention Initiative (CHPI), emergency assistance, and discretionary benefits) staff assist families and individuals with low income including OW and ODSP participants who need financial assistance to pay their heating and hydro bills.

- **Community Presence Initiative**

  E&IS is moving to partner with the community to provide E&I supports in both the rural and urban community centres of the Region.

**NOTE:**

E&IS is also undergoing a major Modernization Initiative which is a key overarching priority for the Division in 2017-2018. The goal is to create more client-centred and employment outcomes-focused services for Ontario Works participants. See section 3.1 for details and Appendix A for project objectives and timeline.
Section 2: Environmental Scan

The Region has undertaken an environmental scan to identify internal and external factors that may impact program delivery and client outcomes. The scan includes information on outcomes from the previous cycle, upcoming external influences, local caseload, local labour market and community stakeholders.

2.1 Analysis of Previous Planning Cycle

The Region met or exceeded its outcome targets set in the 2015-2016 Ontario Works (OW) Service Plan (see Table 2.1.1). The estimates for 2015-16 were based on available Service Delivery Model Technology (SDMT) data. The average monthly number of applicants was 257 applicants lower than estimated for 2016. The forecast for the average monthly caseload was very close (lower by 2 applicants). The Region had 49 more ODSP participants in OW employment programs than forecasted.

Table 2.1.1 Outcome Measures and Forecasts

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<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Average monthly number of applicants</td>
<td>911</td>
<td>668</td>
<td>925</td>
<td>668</td>
</tr>
<tr>
<td>Average monthly caseload (number of singles and families including temporary care assistance recipients)</td>
<td>8,597</td>
<td>8,493</td>
<td>8,726</td>
<td>8,724</td>
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<tr>
<td>Average monthly number of ODSP participants (voluntary)</td>
<td>156</td>
<td>85</td>
<td>157</td>
<td>206</td>
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*As reported in Social Assistance Operations Performance Reports

Table 2.1.2 shows more outcome data for 2014, 2015 and 2016 as measurements of the success of the service delivery. The number of monthly applicants decreased while the caseload increased. This may be explained by fewer people leaving the OW program while other people continue to steadily join the program. It may also be that in 2014 more people left OW for short work contracts and then reapplied. Another theory is that data on applications received was recorded differently in the SDMT than SAMS.

Looking at the employment related outcomes, the number of cases with employment earnings increased slightly which is a positive change as even low earnings from employment can indicate a positive connection to the community that may lead to a better quality of life and better job opportunities. The number of exits to employment failing to increase despite a low unemployment rate in Waterloo Region is of concern and is being addressed with the modernization changes staff are implementing in 2017 and 2018.
Table 2.1.2 Outcomes

<table>
<thead>
<tr>
<th>Service Delivery Outcome Measures*</th>
<th>Waterloo 2016</th>
<th>Province 2016</th>
<th>Waterloo as % of Province</th>
</tr>
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<tr>
<td>Average Monthly Number of Applicants</td>
<td>668</td>
<td>17,418</td>
<td>3.8%</td>
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<tr>
<td>Average Monthly Employment Earnings per Case</td>
<td>$771.55</td>
<td>$772.4</td>
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<tr>
<td>Average Monthly Percentage of Caseload with Employment Earnings</td>
<td>13.6%</td>
<td>12.2%</td>
<td></td>
</tr>
<tr>
<td>Average monthly number of ODSP participants in OW programs (voluntary)</td>
<td>206</td>
<td>7,849</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

*As reported in Social Assistance Operations Performance Reports

Table 2.1.3

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<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Average monthly number of applicants</td>
<td>813</td>
<td>668</td>
<td>668</td>
<td>-145</td>
</tr>
<tr>
<td>Average monthly caseload (number of singles and families including temporary care assistance recipients)</td>
<td>8,392</td>
<td>8,493</td>
<td>8,724</td>
<td>332</td>
</tr>
</tbody>
</table>

Table 2.1.3 shows that the total caseload size has increased in each of the past two years. It increased by 1.2 per cent from 2014 to 2015, and increased by 2.7 per cent, from 2015 to 2016. The decrease in applications combined with the increased caseload shows that clients who have entered the system in the past
are staying on longer, which may reflect changes in the types of employment opportunities currently available in the local market. The increase in caseload numbers may be partly due to the new Canadians from Syria that Waterloo Region welcomed in 2016 and who then joined the OW program December 2016 – March 2017. Some newcomers need time to learn English, upgrade job skills, medical care and trauma supports before they are ready to sustain full time employment. To increase newcomers’ connections to the work force, E&IS provides job skills training and partners with the Immigration Partnership Waterloo Region to connect with local business leaders. The higher caseload numbers may also be the result of E&IS not connecting participants to employment supports as quickly as possible. E&IS staff are optimistic that the changes they are making to modernize E&IS (including integrating employment and income supports) will increase exits to employment over 2018 and beyond. The caseload numbers have increased since 2008 but the per cent of the population receiving OW assistance has only increased slightly (1.2% in 2008 compared to 1.5% in 2016).

2.2 External Influences

2.2.1 Social, Economic & Demographic Trends
Each year, Regional planners estimate the number of people living in Waterloo Region. As of year-end 2015, the population estimate was 575,000. Based on this estimate, over the past 15 years the Region's population has grown an average of 1.58 per cent per year. The Regional population estimates provide the best estimate of the total number of people and households in the Region, as they take into account the Census population, estimated to year-end, the Census undercount and full-time post-secondary students.

According to the 2011 Census, there were 111,495 residents of Waterloo Region who were born outside of Canada, which accounted for 22.3 per cent of the Region’s total population. About 50 percent of immigrants were born in Europe and about 30 percent were born in Asia and the Middle East. Other than English, the most common languages spoken in the Region are German, Portuguese, and Chinese languages.

The Region’s population is relatively young, with a median age of 37.7 which is well below the provincial median of 40.4. The working-age population is growing older, with the percentage of population in each of the 45 to 65 age categories increasing since 2006. Despite the aging of the working-age population, Waterloo Region has substantially more people of the age to be typically entering the workforce (15 to 24 years) than of the age to be typically leaving it (55 to 64 years). This is in contrast to the national trend.

2.2.2 Refugees
Approximately 1200 refugees from Syria settled in Waterloo Region in 2016. In October 2016, the Division launched a six month Pilot project to support Syrian refugees who needed employment and income support. To date, a dedicated
team has successfully provided specialized services to over 200 families, by working closely with interpreters and community partners that provide relevant resources.

2.2.3 Regional Government Initiatives
The following regional initiatives and factors will impact the ongoing work of the E&IS Division:

- Region of Waterloo 2015-2018 Strategic Plan
- Employment and Income Division Modernization Project
- Community Services Department “Destination: Integration” Project
- Fiscal constraint within the Ontario Works Discretionary Benefits program

2.2.4 Provincial Initiatives
In addition, there are several Provincial initiatives that may impact the work of the division, including:

- Social Assistance Service Delivery Modernization (including: policy simplification, social assistance reform, human services integration);
- Province’s implementation of the Social Assistance Accountability Framework, including the pilot project on a Risk Management Certificate of Assurance;
- Introduction of reloadable payment card system for social assistance recipients;
- Benefits Transformation;
- Poverty Reduction Strategy;
- Province’s interest in a pilot project on Basic Income Guarantee;
- Community Hubs Action Plan;
- Local Employment Planning Councils Pilot;
- Provincial Employment Strategy for People with Disabilities; and
- Youth Jobs Strategy.

2.3 Caseload Description
In 2016, the average monthly number of OW applicants screened in the Region was 780 and the average monthly caseload was 8,643. The average monthly number of ODSP participants (voluntary) was 206 (Social Assistance Operations Performance Reports, 2016).

Forecasts for 2017 and 2018 were calculated considering historical caseload trends, restructuring within EIS, and anticipated local demographic changes.

Table 2.3.1 summarizes additional key service delivery statistics from 2016 and provides annual forecasts to 2018. Because the E&IS modernization changes will not yet have affected service levels, staff kept forecasts for employment related outcomes in 2017. For ODSP participation in OW programs, an increase of 10% staff forecasted as a result of increased connections between the two programs. The employment earnings levels are largely beyond the control or influence of staff as employers decide what they will pay employees. With minimum wage being increased in 2017, staff predicted a modest increase in earnings for 2018.
Staff is forecasting an increase in the number of cases with earnings and the number of exits to employment for 2018 as a result of the modernization changes lowering the caseloads for Caseworkers. Lower caseloads for Caseworkers means staff will have more time to meet with clients and support them in taking steps toward a better quality of life and employment.

Table 2.3.1 Service Delivery Statistics

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Average monthly number of applicants</td>
<td>668</td>
<td>704</td>
<td>675</td>
<td>680</td>
</tr>
<tr>
<td>Average monthly caseload (number of singles and families including temporary care assistance recipients)</td>
<td>8,724</td>
<td>8,933</td>
<td>8,989</td>
<td>9,348</td>
</tr>
<tr>
<td>Average monthly number of ODSP participants (voluntary)</td>
<td>206</td>
<td>245</td>
<td>225</td>
<td>250</td>
</tr>
<tr>
<td>Average Monthly Employment Earnings per Case</td>
<td>$772</td>
<td>$764.82</td>
<td>$765</td>
<td>$775</td>
</tr>
<tr>
<td>Average monthly Number of Cases with Employment Earnings</td>
<td>1,167</td>
<td>1,235</td>
<td>1,160</td>
<td>1,215</td>
</tr>
<tr>
<td>Percentage of Terminations Exiting to Employment</td>
<td>12.9%</td>
<td>15.8%</td>
<td>13.09%</td>
<td>16.00%</td>
</tr>
<tr>
<td>Percentage of Caseload Exiting to Employment</td>
<td>.73%</td>
<td>1.0%</td>
<td>1.015%</td>
<td>1.03%</td>
</tr>
</tbody>
</table>

*Averages calculated using monthly data for the period: January to December, 2016.
**As reported in the Social Assistance Operations Performance Reports

The Region conducts a Caseload Profile annual review of the known demographic characteristics of participants who are on the Ontario Works caseload to inform service planning. The next Annual Caseload Profile will be ready in March 2018.

Table 2.3.2 provides additional details about the Ontario Works caseload from 2014-2016, based on data from the Ontario Works Caseload at a Glance report released in January 2017.
Table 2.3.2*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Cases**</td>
<td>8,423</td>
<td>8,493</td>
<td>8,724</td>
<td>2.6%</td>
</tr>
<tr>
<td>Number of dependants1</td>
<td>6,825</td>
<td>6,831</td>
<td>6,835</td>
<td>0.1%</td>
</tr>
<tr>
<td>Total beneficiaries</td>
<td>15,153</td>
<td>15,255</td>
<td>15,478</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Family Structure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Singles without Children</td>
<td>60%</td>
<td>60%</td>
<td>62%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Singles with children</td>
<td>32%</td>
<td>32%</td>
<td>30%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Couples without children</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Couples with children</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grade 1-8</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Grade 9-11</td>
<td>41%</td>
<td>39%</td>
<td>38%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Grade 12-13</td>
<td>33%</td>
<td>35%</td>
<td>36%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Post-secondary</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Months on assistance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>24%</td>
<td>19%</td>
<td>19%</td>
<td>0.0%</td>
</tr>
<tr>
<td>5-12</td>
<td>26%</td>
<td>22%</td>
<td>22%</td>
<td>0.0%</td>
</tr>
<tr>
<td>13-18</td>
<td>11%</td>
<td>12%</td>
<td>10%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>19+</td>
<td>39%</td>
<td>47%</td>
<td>49%</td>
<td>2.0%</td>
</tr>
<tr>
<td>More than 12 months</td>
<td>50%</td>
<td>59%</td>
<td>60%</td>
<td>1.0%</td>
</tr>
<tr>
<td>More than 24 months</td>
<td>30%</td>
<td>38%</td>
<td>41%</td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>Average Time on Assistance (months)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>28</td>
<td>30</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>Accommodation type</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boarders</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Owners</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Renters</td>
<td>95%</td>
<td>96%</td>
<td>96%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Renters Private Market</td>
<td>85%</td>
<td>87%</td>
<td>88%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Renters Subsidized</td>
<td>10%</td>
<td>9%</td>
<td>7%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

* As reported in the Ontario Works Caseload at a Glance report January 2017
** As reported in the Social Assistance Operations Performance Reports

1 Includes ongoing (i.e. not terminated) spouses, dependant adults and dependant children.

2 Highest level of education completed by adults.
Table 2.3.2 shows that the proportion of the caseload on assistance for longer than one year increased from 50% per cent in 2014 to 60% per cent in 2016. It also shows a slight decrease (2 per cent) in sole-support parents and a 2 per cent increase in singles without children. The total number of beneficiaries only increased by 1.5 per cent from 2015 to 2016. This reason this number is lower than the total caseload size may be the result of more smaller family units participating in OW and/or more larger families exiting OW. This would result in the total number of families (cases) increasing while the total number of beneficiaries stays relatively the same.

### 2.3.3 Ages of Participants*

<table>
<thead>
<tr>
<th>Ages of Participants</th>
<th>2014</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children aged 0-6</td>
<td>2,852</td>
<td>3,019</td>
</tr>
<tr>
<td>Average age of adults**</td>
<td>35.6</td>
<td>38.4</td>
</tr>
</tbody>
</table>

*Source: CRS100 Reports 2017
**Includes heads of household, spouses, and dependant adults

The data in Table 2.3.3 demonstrates that there was a 5.9 per cent increase in the number of children aged 0-6 on the caseload from 2014 to 2016.

### 2.4 Local Labour Market

The Region of Waterloo, Department of Planning, Development and Legislative Services publishes a Labour Force Report. The most recent report highlights labour force characteristics of the Kitchener-Cambridge-Waterloo Census Metropolitan Area (CMA) for 2016. The report indicates that the economic conditions in Waterloo Region are among the strongest in the Province.

Key characteristics of the local 2016 labour force include:

- Employment in the Kitchener-Cambridge-Waterloo CMA has risen from 250,700 to 281,600 since 2009, while unemployment has dropped from 26,900 to 16,400 for the same period (post-recession);
- The total working age population increased by 4,500 people in 2016 to 426,200. Most of the growth since 2013 has come from people who are not in the labour force. These people are typically students, retired or not seeking employment.
- Participation rates, which represent those people who are employed and unemployed, have fluctuated between 69.3 and 72.7 per cent since 2001, currently sitting at 69.9 per cent;
- Similarly, employment rates have ranged between 64.2 and 68.5 per cent, currently sitting at 66.1 per cent;
- The current unemployment rate of 5.5 per cent is the lowest reported since before the recession;
- The youth unemployment rate for 2016 was 13.2 per cent. This rate while higher than other age groups in the CMA, is consistent with what is happening across Ontario (13.1%) and slightly lower than Canada’s rate of 14 per cent;
- The number of those employed between the ages of 55 and 64 and those employed over the age of 65 have more than doubled since 2001.
- ‘Manufacturing’ is the largest industry in the CMA, representing nearly one fifth of all CMA employment, while the ‘Educational services’ industry is the fastest growing since 2001 with an average annual growth of 6.0 per cent;
- ‘Sales and services occupations’ is the largest occupation class in the CMA with 22.1 per cent of employment while ‘Health Occupations’ is the fastest growing occupation class in the CMA since 2001, with an average annual growth rate of 4.8 per cent.

The Workforce Planning Board of Waterloo Wellington Dufferin (WPB) 2014-17 Local Labour Market Plan (October 2016) highlighted similar trends. The report noted that local youth unemployment rates are high at approximately 16% and that changing demand in the labour market is creating job opportunities in a variety of local industries including, but not limited to, manufacturing, health care, finance and insurance, agriculture, accommodation/food services and transportation/logistics. The number of jobs available to individuals with secondary school education and/or occupation-specific training appears to be increasing.

2.5 Community Engagement

The Region collaborates with key stakeholder groups to improve employment outcomes for OW participants. Feedback that is received from community partners is a critical piece of service delivery evaluation and development. Forming partnerships enables E&IS to be involved in key Regional and Provincial projects, supports innovation in programming, and ensures service is responsive to the needs of the community. This section of the plan will provide a brief overview of a number of these partnerships and initiatives.

Connectivity Table

There are two Connectivity Tables, one in Cambridge and one in Waterloo. The table, which brings together professionals from police, social services, health and counselling support agencies for weekly discussions, takes a unique approach to community well-being by providing immediate care to individuals and families facing acute risk of being harmed or causing harm within 24 to 48 hours. E&IS staff sit at both tables and assist families and individuals in a way that respects confidentiality but at the same time provides supports.

Employment and Income Support Community Advisory Committee (EISCAC)
The EISCAC is comprised of key stakeholders including social assistance recipients, community agencies, Provincial representatives, and the Greater Kitchener-Waterloo Chamber of Commerce. The Committee meets six times a
year to offer advice on the delivery of services by EIS. The Committee is chaired by a member of Regional Council and reports to the Community Services Committee of Regional Council. The 2016 EISCAC Annual Report is available upon request.

**Community Employment Linkages Committee (CELC) and Cambridge Employment Facilitation Network (CEFN)**

The Region participates as a member on both the Community Employment Linkages Committee (CELC) as well as the Cambridge Employment Facilitation Network (CEFN). EIS staffs serve as Co-Chairs of the CELC and CEFN. These partnerships are developed with the goal of facilitating inter-organizational support for citizens who are job searching and collaboration of service development among member groups. The CELC has been active with the implementation of the Employment Ontario service model in Waterloo region, while EIS is a key funder and sponsor of the CEFN’s annual Employer Recognition Breakfast.

**Employment Ontario Service Providers**

As an Employment Ontario Service Provider the Region of Waterloo attends the Employment Ontario Service Provider meetings, which seek to promote, enhance and ensure collaboration with other Employment Ontario service providers.

**Immigration Partnership Council (IPC)**

Is a federally funded initiative that is a collective of community partners that come together to implement collaborative strategies to facilitate the successful settlement and integration of immigrants and refugees in Waterloo Region. The IPC sits within the Community Services Department and their role is to:

- Educate
- Inform and Facilitate
- Engage
- Communicate
- Influence and Advocate

One of the working groups within the IPC is the Immigrant Employment Awareness Group. E&IS staff are active members of this working groups. This group’s mandate is to assist immigrants find and maintain work within Waterloo Region.

**The Workforce Planning Board of Waterloo Wellington Dufferin (WPB)**

The Workforce Planning Board of Waterloo Wellington Dufferin works to engage communities and community partners in local labour market development and to develop solutions to local workforce development issues. The Region of Waterloo has formed a strong partnership with the WPB and has collaborated on a number of initiatives including the Making Cent$ of Abilities coalition of individuals, agencies and employers to promote the employment of persons with a disability. E&IS staff participate on the Board of Directors of the WPB in an advisory capacity and is a member of the Making Cent$ of Abilities steering...
committee.

**Waterloo Region Energy Assistance Program (WREAP)**

Through its Intake unit, EIS delivers the Region’s Waterloo Region Energy Assistance Program (WREAP). Using a number of different funds (Low-income Energy Assistance Program (LEAP), Community Homelessness Prevention Initiative (CHPI), emergency assistance, and discretionary benefits) staff assists families and individuals with low income including Ontario Works (OW) and Ontario Disability Support Program (ODSP) participants who need financial assistance to pay their heating and hydro bills. For the discretionary benefits portion of the energy assistance program, the Region contributes 100 per cent regional funding over and above the funding provided by the Province. Agreements with local utility companies to administer the LEAP funds have oversight from the Ontario Energy Board.

**Housing Services**

To further support and ensure housing for Ontario Works (and Ontario Disability Support Program) participants, senior E&IS staff meet regularly with colleagues in Housing Services. These relationships have resulted in enhanced internal communication protocols and a more formal divisional response to crisis support (e.g. in response to emergencies such as evacuation). In this way, housing is stabilized and secured for people who are particularly vulnerable to losing their housing.

The staff from the Employment Services Team and the Housing Services team have joined in a collaborative partnership whereby youth who live in the Housing complexes are hired as summer students to complete housing unit inspections. The youth are interviewed and trained by Employment and Housing staff. 2016 was the first year for this highly successful initiative and it has now become an annual program.

**Transit Affordability and Accessibility**

The Transit for Reduced Incomes Program (TRIP) advisory group, chaired by Grand River Transit (GRT) staff, seeks to identify strategies to increase affordable transportation opportunities for persons with low income. The advisory committee oversees the administration of the Regionally-funded program which provides a concession to the cost of a bus pass for persons with low income. Through the Transit Affordability Pass Program (TAPP), E&IS provides bus passes to Ontario Works participants who are upgrading their education (grade 12 or GED) or participating in its employment placement programs.

In 2013, a survey was conducted with OW and ODSP participants concerning their transportation needs and use of public transit, as well as the benefits of the existing programs. Wide reaching community engagement with stakeholders across the region to gather input for the Region of Waterloo 2015-18 Strategic Plan has again found the issue of affordable transportation as a high priority in the Region.
The CAO of the Region of Waterloo called together a steering group comprised of himself and the Commissioners who provide oversight to the Community Services, Finance and Grand River Transit program areas. This group struck a working group in 2016 tasked with simplifying the Region’s affordable transit systems and making recommendations for program sustainability. The Working Group was successful in its application in round two of the Treasury Board of Ontario’s Local Poverty Reduction Fund for a research grant to study affordable transportation in the Region of Waterloo. This research will explore the outcomes of reduced transit fares for low income citizens that will then support informed recommendations about future reduced transit fares.

**Ontario Municipal Social Services Association (OMSSA)**
The Region of Waterloo, and Community Services in particular, remain active members of OMSSA. Staff from the division participates on the Employment and Income Network and other relevant working groups. Staff also participate in direct service staff training, the OMSSA annual conference, and other training events.

**Provincial and Regional Partnerships**
E&IS will participate in the following initiatives in 2017:

- The Region has been approved as a full-suite Employment Ontario Service Provider which has enhanced the continuum of services and support available to OW participants;
- As an Employment Ontario service provider, the Region delivers the Youth Employment Fund. For the 2017/18 year, targets for successfully placed at-risk youth have been increased from nine to 76.
- Staff regularly meet with representatives of the MCSS and the local Ontario Disability Support Program offices to discuss issues of mutual concern and ensure effective service coordination (e.g., changes to discretionary benefits program and timely fulsome file transfers);
- Staff also participate with Ontario Works Administrators and municipal staff from the Central West Region as well as key Provincial staff from the Regional office of MCSS in the Directors Administrators Reference Group and the Social Assistance Directors Forum;
- The Region of Waterloo supports employees by providing funding for job/career related courses, as well as professional development opportunities provided by the Association of Municipal Employment Services (AMES). This organization provides learning opportunities through its yearly conference. E&IS is represented on the AMES executive committee;
- Employment Services continues to provide enhanced services through co-location opportunities in its three Employment Resource Centres. Project Read, Conestoga College, and other organizations utilize Resource Centre space for the services they provide and as a site for local employment Job Fairs; and,
- The Region continues to support its rural communities through a Rural Outreach project. The E&IS employment desktop and resources can be accessed electronically with Regional staff support available by telephone at four rural sites.
Currently, E&IS are working on two partnerships that are in developmental/research phases:

**Chiropractic Community**
This partnership is in conjunction with local Chiropractors, the Chiropractic Association and a Research institution to study how chiropractic assessments will help individuals with employment and employability. Chiropractic services will be provided to OW clients at a reduced cost to assist them with employment/physical assessments.

**Concurrent Disorders Program**
This partnership will provide supports to OW clients that suffer from concurrent disorders and will work in conjunction with our MSW Team.
Section 3: Program Management

3.0 Introduction

Employment and Income Support (E&IS) offers service out of three locations within Waterloo Region. The Waterloo office is located at 99 Regina Street and provides income support and some employment services including an Employment Resource Area to citizens living in the cities of Kitchener and Waterloo as well as the Townships of Woolwich, Wilmot and Wellesley. Employment programming and services are offered to citizens living in Kitchener-Waterloo and the surrounding Townships largely from the Kitchener office, which is located at 235 King Street. Citizens living in the City of Cambridge and the Township of North Dumfries are provided both income support and employment services at a co-located site situated at 150 Main Street in Cambridge. As an approved Employment Ontario service provider the full suite of employment services are offered at all three locations.

The number of OW FTEs as of January 1, 2017 was 265.9 FTE. The caseworker to case ratio was 1:117. The management to staff ration was 1:12. Please see Appendix B for the Organizational Chart. This section of the plan provides an overview of key organizational drivers and supports and services to participants including Intake and Emergency Assistance, Case Management, and Program Integrity.

3.1 Service Delivery Rationale

E&IS Modernization

In the winter of 2016 a staff and management group was formed to look at redesigning Employment Services with the purpose of ensuring that our employment programs were in line with the needs of the individuals utilizing our program. This Working Group developed a number of recommendations. Then in June 2016 a Process Redesign team was formed once again with staff and management on the team. This Process Redesign work was led by a trained Six Sigma LEAN facilitator. This group was tasked with coming up with recommendations on how to modernize Waterloo Region’s delivery of OW. Both these working groups mandate was to develop methods to ensure that the individuals and families on OW in Waterloo were receiving client centered - holistic services that increased their quality of life, whether it be through Employment or social inclusion. Changes to programs had to made in order to assist E&IS meet the 4 Ministry Outcomes.

The following diagrams depict the work of both these working groups.
Service Delivery Principles:

- Integration
- Quality of Life approach
- Caring and inclusive
- Risk management-focus
- Flexible and nimble service

<table>
<thead>
<tr>
<th>2016 Project Recommendations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Coordinator – primary contact with client, supportive high-value interactions, less time in administrative benefits eligibility</td>
<td>✓</td>
</tr>
<tr>
<td>Service (employability) assessment to be used throughout client's pathway, beginning at initial point of contact</td>
<td>✓ ✓</td>
</tr>
<tr>
<td>Increased job development to link clients with jobs; employment conversations at beginning; Social Workers to assist with assessments earlier</td>
<td>✓</td>
</tr>
<tr>
<td>Key performance indicators, enhanced capacity to track client progress and measure outcomes, etc.</td>
<td>✓ ✓</td>
</tr>
<tr>
<td>More integration/collaboration of service delivery within division/department</td>
<td>✓ ✓</td>
</tr>
<tr>
<td>Evaluate existing employment programs; scan for delivery gaps/overlaps in the community</td>
<td>✓</td>
</tr>
<tr>
<td>Central focus on employment/quality of life – with client at the centre of service delivery</td>
<td>✓ ✓</td>
</tr>
</tbody>
</table>
The Senior E&IS Management team using these principles and recommendations designed the New Service Delivery Model.

The new model of delivery is circular instead of linear as it is a first step towards an integrated model where any service / program can be added at any time to the circle. Our current model is a linear model which doesn’t lead well to integration.

In order achieve this model of service delivery and allow the staff the time to engage the clients in richer and employment focused conversations caseloads need to be lower. To achieve this the management team collapse two programs teams (Community Placement and Extensive case management) and made these staff caseworkers, hence lowering the caseloads.

To ensure that the customer service model is accurate, we have developed a Test Team that will test our "end state" model. This test team will run for 4 months and will run parallel with our current delivery model. Once the 4 months is completed we will analysis the data make any changes and then in February 2018 all of E&IS will shift to the new model.

The Community Services Department currently has an Integrated Pilot Team that began January 1, 2017 and will run for one year when a decision will be made about continuing, ending or expanding. This team is comprised of 2 OW
caseworkers, 1 Childcare Subsidy Worker, 1 Housing Worker and 1 MSW and is located at 235 King St. E in Kitchener. The E&IS new model clearly fits well with this integrated team.

**Supports to Participants**

In response to the capping of provincial funding, the Region contributes an additional $2 million above the provincial funding cap for discretionary benefits. The total Discretionary Benefit expenditure for 2016 was $4,660,735.54. (The province contributed $2,234,100.00 and the Region $2,426,635.54.) The Provincial portion of the total discretionary funding covered Dental costs ($1,800,000) and Funerals costs ($445,000) and a few others items paid through SAMS (adult eye glasses). All the other items were covered by the Region. The Provincial cost per case is based on the cost sharing formula is $10 per case. The Region contributed an additional $10.44 per case. The division continually monitors this budget to assess the need and spending usage. A report is going to Council in August with proposed strategies to reduce spending of the Discretionary Benefits.

The Region of Waterloo is again working to support eligible children to access the Canada Learning Bond (CLB), a federal education grant offering up to $2000 for post-secondary education. With 7 out of 10 eligible children in the region still missing out on this fund, the CLB Committee is working to expanding its promotion of grant to families accessing services in Income Support, Children’s Services and Housing. Activities include training staff in these areas, leveraging opportunities to connect with eligible families and removing barriers to accessing the funds through a supportive approach. This initiative works to support the overarching goals of integration within Regional Services, as well as to promote financial literacy and inclusion for children and families.

The Region hosts free tax clinics in its Resource Centres and offers a “drop off” service to assist persons with low income to complete their income tax returns. Tax returns are completed by Regional staff on their own time from various Regional departments.

The Region offers OW services in English and French - including applications and information handouts in both languages. When an interpreter is needed to provide quality service to a citizen, the Region calls an interpreter from the KW Multicultural Centre with whom the Region has an agreement for interpreter services.

In 2016, the Region of Waterloo’s Service First Call Centre (SFCC) supported 19,496 inquiries related to the Employment & Income Support division. SFCC provides a 24/7 contact point for residents of the Region of Waterloo, and is trained to identify available supports that can address a client’s needs. For EIS, this includes a wide variety of topics including directing to a client’s caseworker, explaining the OW application process, providing details on monthly support payment timing, addressing questions related to OW benefits, as well as many other issues.
Intake, Eligibility Determination and Emergency Assistance
Intake staff triage the needs of applicants to determine eligibility and the appropriate level of support. Available supports include: emergency assistance; assistance with utility arrears/disconnection (Waterloo Region Energy Assistance Program); discretionary benefits for Ontario Disability Support Program participants; and/or ongoing Ontario Works assistance as well as discretionary benefits for non-Social Assistance recipients. In June 2013 the Region of Waterloo implemented an Enhanced Intake where Intake staff completed the entire application process, including documentation verification appointments, through to issuance of first payment for enhanced service to participants. With this change and the introduction of the SAMS, the online application process has been promoted. In 2016, an average of 26% of applicants applied for OW online. The numbers of online applications in 2017 is lower than it was in 2016. This process is currently being realigned in an effort to improve our customer service outcomes and performance results.

In addition to the services described above, the Social Services After Hours Emergency Service provides on-call support to assist individuals outside of regular business hours. The First Response Protocol responds to individuals who have lost their housing as a result of a catastrophe. Through an agreement with the Red Cross, immediate shelter and support is provided.

Case Management
Income Support Caseworkers manage ongoing cases to enhance service and outcomes to ongoing participants. Caseworkers use the Participation Agreement to work collaboratively with participants to develop a realistic plan to assist the client move toward self-reliance and sustainable employment.

Currently, the E&IS Division has a multiple phase approach to working with clients. This approach has an Intake Team completing the initial verification appointment with the client and then referring the client to an Ongoing Caseworker. This model leads to intake service pressures to see the client in a timely manner. While committed to program integrity and ongoing case management, a current pilot initiative to ensure applicants are granted assistance in a timely manner is being undertaken. This initiative has Case Workers are completing verification appointments with applicants.

Program Integrity
The Quality Assurance Unit focuses on aspects of OW program integrity that includes employment focused outcomes supported by effective program design, accountability for funds issued through third party access oversight and evaluation, and information management to inform OW program delivery. This unit continues to partner with SAMO to create the framework for an Accountability Certification program. There are continued efforts on the development and implementation of a file audit system that will inform an overall
metrics program. As well, Quality Assurance will be involved in the formation of the resumption of the EVP program throughout 2017. A separate EVP unit allows cases to be reviewed from a third party perspective offering greater objectivity and scope for file reviews.

One of the roles of the Quality Assurance Unit is to recover sponsorship debt when a new Canadian is sponsored to come to Canada and then the Sponsor does not uphold her or his obligations. The process for recovering sponsorship debt is outlined below.

- Caseworker confirms there is a sponsorship obligation.
- The sponsor is normally notified (with some exceptions such as family violence). There are deferrals for this process where appropriate (such as Sponsor is on OW).
- The amount of sponsorship debt is calculated by our office (ER) up to the point that the referral is made to the Province.
- Referral to Province: SAMS evidence page is populated and sponsorship debt Case is created and uploaded with the amount of OW payments populated.
- The Province then validates the calculations on OW issued, and from there the Province monitors the BU and adds any additional assistance issued to the Sponsor’s debt calculations.
- The Province monitors any recoveries from the sponsor and the Province also sends the Region a quarterly report of recoveries which is reconciled only to the extent of ensuring the sponsored individual was on OW. The Province tells us when the Sponsor has fully paid the Sponsorship debt.
- Once Sponsor has repaid debt, the Region’s ER office notifies Immigration that the debt is paid.

The Region is still learning the EVP process and is developing processes around it.

- The Region is bringing staff on-board, but there have been delays, and this means that the Region will not be able to hit the monthly targets yet. Delays are due to:
  o Identifying funding for the staffing positions
  o EOI process
  o Training capacity
  o Timing with vacations
- The Region is developing office processes about how to manage files who fail to cooperate with the EVP process (do not provide the requested info).
- From a Quality Assurance perspective the EVP model is a stand-alone EVP team, this means that:
  o CW are not reviewing their own files, so the review is impartial
  o Over time the EVP workers will develop an expertise for the work that we hope results in both accurate and quicker completion of the EVP audit
- Challenges are the EVP timelines and the SAMS environment
The Region finds the 30 day goal challenging. Once the client receives the letter, she/he then hands in the documents the EVP worker needs to review the documents, determine if an in-person or a phone interview is needed, complete the interview, and outcome the case. Quite a few clients need the suspend letter before they follow up.

The EVP process in SAMS takes longer than it did in SMDT. It’s more of a challenge to navigate the system and find the information needed, as well as it takes longer to outcome than it did in SDMT.

Files with translators will take longer to complete.

Family Support Resource Team FSRT
The Family Support Resource Team is in response to legislative changes by the Province to social assistance and provides the Region of Waterloo with an opportunity to mobilize efforts to reduce poverty and the impact poverty has on Waterloo Region residents. It refocuses staff efforts away from pursuing support to reduce the OW allowance and toward pursuing support in order to enhance the household income -making the work of the FSRT a poverty reduction program. With this change, the FSRT focus will expand to a broader focus on all Divisions within Community Services and potentially families receiving services from Public Health and the Ontario Disability Support Program (ODSP) to assist individuals in pursuing child and/or spousal support that will provide a direct benefit to individuals in receipt of social and health care programs. Ultimately, the goal of this change is to increase household income and reduce the negative impacts of poverty.

Participation Agreements
Participation Agreements are vehicles to assist participants in obtaining skills that support progress towards sustainable employment. All applicants and participants are provided with access to the supports they need to achieve these goals. Supports are available through several sources, for example:

- Employment Resource Areas (ERAs) at three sites;
- Job search, support, referral and assessment;
- Employment counselling;
- Psycho-Social Groups;
- Psycho-Vocational Assessments;
- Language Counselling and Assessment;
- Intensive Case Management including Social Work Intervention;
- Group Employment Programs;
  - Planning for Employment
  - Toward Employment
  - Follow-up Group
  - Employment Options Program
  - 30 Ways to Shine
- Literacy Programs and Services, including the Family Literacy Program;
- Community Placement;
- Experience Matters (skill based training);
- Employment Placement Services;
- Self-Employment Development; and
- Learning, Earning and Parenting Program (LEAP).
- 1:1 assistance with job coaching and resume writing in the ERA; and
- Immediate resume writing supports.

### 3.2 Oversight Strategy

The Region of Waterloo has well established financial management policies and procedures that govern the corporation’s accountability and oversight for public funds. The Region of Waterloo has a Treasury Services team under the direction of the Region’s Chief Financial Officer that is primarily dedicated to support the Ontario Works program. This team is comprised of a supervisor and staff that provide business support to Ontario Works for financial information and processes, including payment administration and budgeting. Although this team receives its formal direction through the Chief Financial Officer, this team is located on site with Ontario Works and is integrated with the Ontario Works management in order to effectively support the Ontario Works service plan.

In addition, the Region of Waterloo is committed to ensuring that the Ontario Works program is delivered in accordance with legislative requirements, program directives and standards as well as to establish appropriate controls to mitigate identified risks. A continued focus on OW program integrity and quality management will be of high priority for 2017-18 due to (a) the impacts of SAMS on the integrity and reliability of data; and (b) the continued implementation of the Province’s Social Assistance Accountability Framework (SAAF).

The Program Development team, within the Quality Assurance unit, is responsible to assist with interpretation, communication and tracking of legislative changes, policies and procedures. All provincial legislation is reviewed and disseminated to staff in a timely manner. When necessary, local policies are developed to assist in the interpretation/implementation of legislated changes.

The following processes of accountability and identification of risks and areas for improvement are also currently in place:

- Staff accurately track and maintain records and supporting documentation for all social assistance related expense and recoveries;
- The Region participates in the back logged subsidy claim strategy. The online process is functioning;
- Expectations, daily reports and follow-up procedures are enacted so all overpayment processes receive due diligence to ensure accuracy and communication responsibilities are met;
- A thorough review of exit codes in SAMS is currently underway so that file termination responsibilities are clear and accurate and all benefits are presented to users of OW;
A strategically aligned data metrics system development is underway. This will allow for continuous program evaluation and informed program improvement strategies. Data and financial reports are reviewed regularly; and identified issues are addressed;

- Paylists are reviewed and approved daily;
- Purchase of service agreements are monitored and tracked;
- Regular team meetings are used to discuss issues and seek staff input;
- Monthly management team meetings are held to review issues, outcome performance and ideas for improvement; and
- The local Administrator and Provincial Program Supervisor meet regularly to review programme expenditures, performance, emerging issues and outcomes.

### 3.3 Analysis of Resources

The Region is adequately resourced to manage the financial and administrative activities and responsibilities to support the program. Throughout 2017-18, the Region will continue normalizing service delivery using the SAMS technology. The Region will also be reviewing its resource allocations, service alignment and program delivery models to achieve employment outcomes.

### 3.4 Overview of Learning Supports

SAIL will continue to be promoted throughout 2017-18 through creative strategies to maintain interest in the concepts as developed by a direct service staff SAIL advisory group. Children’s Services, Community Outreach, Public Health, and Housing Services staff have joined the SAIL advisory group. The next series of SAIL training and staff engagement will be to support the modernization changes toward increased integration.

The Region’s Performance Development Program permits staff, with the support of their supervisor, to shape their own personal development plan. Staff are supported to attend conferences and courses through the Association for Municipal Employment Services (AMES); OMSSA (e.g., FSW training, Policy Writing); as well as local workshops dealing with issues such as addiction and inter-agency events. Our tuition refund program continues to be fully utilized each year as staff use formal education opportunities to upgrade skills.

### 3.5 Business Practices

In order to improve the service experience of our clients, Community Services is breaking down barriers for clients with a pilot project that involves integrated service delivery. The pilot is located at 235 King in Kitchener and led by Arran Rowles, Manager of Departmental Services. A team of Community Services staff work together to meet the needs of some Kitchener residents – including many clients of OW. Caseworkers in OW work alongside staff from Children’s Services and Housing Services to provide better integrated and wrap-around services for citizens.
There are several reasons for doing an integrated pilot:

- Managers and supervisors identified that integrated service delivery would be key in providing better client service experience
- It will help us understand what it takes to provide more integration services and which service delivery model is right for us
- We want to measure how much staff knowledge and capacity increases in a co-located model
- Allows us to better understand what it takes to deliver service in Kitchener

With easier access to supports and services that are flexible and tailored to their needs, these clients have access to a better quality of life. The intent is to provide seamless services to clients and is not intended or anticipated to change our staffing complements.

Requiring strong coordination and collaboration among team members and divisions, work on the pilot began with determining what clients want and expect from their experience with Community Services; what the current service pathway/experience looks like, what the new pathway/experience will look like, and how clients will access and receive service from the integrated service delivery team. There is also an evaluation component built into the pilot that is helping us to learn as we develop our new integrated processes. The results of the initiative will inform further changes towards more integrated service for the public accessing Regional services and programs.

**Wait Time from Screening to Eligibility**

Income Support Services have recently put a strategy in place to reduce the number of business days from screening to financial eligibility decision to enhance our performance and meet provincial targets. This new strategy is being monitored to ensure targets are being met and resource capacity is being utilized appropriately, while ensuring improved customer service. Other business practices will be reviewed and changed as needed, to meet or exceed service delivery standards, employment outcomes and expectations of participants and staff. We are already seeing a slight improvement in our outcomes and will continue to monitor our performance to enhance our customer service and results indicators.

**Risk Management Certificate of Assurance Development**

The Provincial government is developing a Certificate of Assurance (COA) process supported by risk and control identification and assessment. The intention of this program is to establish a standardized set of issues relevant to all municipalities for the delivery of Ontario Works and the Ontario Disability Support Program. The Region of Waterloo has participated in the development of measurement tools that will be used to identify the effectiveness of processes for the delivery of programs and services. In 2017 all municipalities will participate in a province-wide pilot. The goal is to establish a consistent set of priority risks to
ensure that each municipality has processes in place to mitigate the likelihood of a negative event happening, or the impact of the situation if it does occur. Once priority risks are established and communicated, processes are developed and managed locally in order to ensure that they are suited to the needs of local clients.

### Section 4: Outcome Strategies

#### 4.1 Service Strategy Rationale

Through 2017 and 2018 we will implement and evaluate a redesigned service approach that leverages our Employment Ontario activities with OW employment mandate through the following activities:

- A redesigned intake service so return to employment plans are developed early in the application process;
- Reduced caseload sizes so caseworker time can be devoted to deeper conversations with individuals in low income situations;
- A redesigned, modern employment service designed to effect quicker returns to employment and ensure that no individual is “dropped” from achieving this service outcome;
- Work with MCSS to establish a risk based service management model that achieves solid accountability while improving OW participants quality of life indicators;
- Renewed collaborations and agreements with community partners so resources are effectively utilized and citizens better served; and
- Participation in a corporate and divisional approach to achieve employment related Key Performance and Results Indicators to monitor service achievement and improvement.

These activities also prepare us for integrated activities within the Community Services Department in the region of Waterloo and emerging provincial integration initiatives. The activities outlined above are meant to be adaptive.

#### 4.2 Linking Strategies to Outcome Measures

The outcome targets for the 2017 budget are an increase of 1.5%. In setting outcome targets for the 2017 budget, the following factors were taken into consideration:

- Availability and integrity of SAMS data;
- Continued work towards SAMS normalization
- The 2014 caseload profile, service delivery statistics and labour market analyses which report a blend of strong and weak-performing indicators that may impact achievement of employment outcomes;
- Recent economic forecasts for Canada
• Unemployment Rate

Table 4.2.1

<table>
<thead>
<tr>
<th>Ontario Works Outcomes*</th>
<th>2017 Baseline</th>
<th>2017 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average monthly employment earnings per case</td>
<td>$771.8</td>
<td>$780 (+1%)</td>
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<tr>
<td>% of caseload with employment earnings</td>
<td>13.48%</td>
<td>13.68% (+1.5%)</td>
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<tr>
<td>% of terminations exiting to employment</td>
<td>12.79%</td>
<td>12.91% (+1%)</td>
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<tr>
<td>% of caseload exiting to employment</td>
<td>.73%</td>
<td>.73% (+1%)</td>
</tr>
<tr>
<td>ODSP recipients participating in OW Employment Assistance</td>
<td>206</td>
<td>209 (+1%)</td>
</tr>
</tbody>
</table>

*As reported in the Social Assistance Operations Performance Reports. Some data may not match the SAOPR Report averages and the 2016 YTD Reports data due to the method of calculating quarterly averages that was changed from Dec 2016 to Jan 2017

4.3 Action Steps and Resources

The Region through Community Services continues to participate in local initiatives to reduce poverty including leadership in a poverty reduction strategy for the corporation and implementation of the Canada Learning Bond and free income tax services and supports for those living in low income. E&IS continues to build on its past experience and learning through continued evaluation and ongoing internal working groups, which often directly involve program participants. Much of our energy in the next two years will be going into finishing planning and then implementing the many pieces of the E&IS Modernization. Managers and Supervisors participated in training on Key Performance Indicators in April and May. Staff will be provided training to support E&IS Modernization through SAIL and All Staff meetings. The implementation plan for the E&IS Modernization is available upon request.

4.4 Stakeholder Linkages

A holistic approach is utilized to maximize the employment attainment of its OW participants and the successful achievement of employment outcomes. The community employment agencies the Region funds and refers clients to are: Project READ, Conestoga College, St. Louis Adult Learning Centre, Lutherwood, and The Working Centre. The Region has an internal referral process for Employment Ontario which is located at all three of locations.

Some of the stakeholder linkages that are being leveraged include:

• Strong, effective partnerships with other levels of government, including the Ministry of Advanced Education and Skills Development (MAESD)
- Purchase of Service contracts with several employment organizations to deliver services that are targeted to identified caseload needs and outcomes.
- Protocols and linkages with Employment Ontario
- Partnerships with Project READ, Conestoga College, and St. Louis Adult Learning Centre are vital in supporting participants’ progress towards improved literacy, skill upgrading and career training, in preparation for employment.
- Partnerships with community agencies, such as Lutherwood, to provide a menu of supports to participants.
- Formal and informal connections with the Workforce Planning Board Waterloo Wellington Dufferin to better understand the local labour market and industry trends.
- Employer connections with Employment Services staff to maintain and enhance the effectiveness of training and placement programs.
- New partnerships with local banking institutions and Service Canada, through work on the Canada Learning Bond initiative and facilitating access to bank accounts for participants.
- Caseworkers and Employment Services staff work closely with several community agencies through referrals to appropriate programs and services.
- Ontario Works staff are able to directly connect with other Region of Waterloo colleagues in Housing Services, Child Care Services and Public Health to offer an integrated and holistic approach to offering service to participants.
- The division relies upon its relationships with the community through our Employment and Income Support Advisory Council (EISCAC) made up of OW and ODSP participants, as well as a wide cross-section of community agencies, including the local workforce planning board, Chamber of Commerce, employment agencies, multicultural services, mental health, community placement, housing stability system, education, literacy and regional labour council. EISCAC provides opportunity for stakeholders to provide input to identify service gaps and provide input to improve program delivery and employment outcomes.

4.5 Addressing Service Gaps

Service gaps are identified through our commitment to service excellence in a variety of ways. Issues can be raised in a forum such as the Employment and Income Support Community Advisory Committee or the Community Employment Linkages Committee for discussion and potential coordinated action. The Social
Assistance Directors’ Forum for Central West Region has been an excellent resource to identify and potentially resolve issues with Provincial Staff. The annual caseload and labour market profiles ensure the division is current with the needs of program participants and labour market trends.

More recently, the Management Team of E&IS collected the learnings from two recent program reviews, discussed current service gaps, and responded by rolling out an E&IS Modernization plan. Two managers and a Social Planning Associate are dedicated to this E&IS Modernization full time through 2017 and perhaps beyond. The Modernization will include a first phase where a team of E&IS integrated staff (employment staff, income support staff, and social worker) will provide more comprehensive and employment-focused service. The plan is that all staff will follow in the footsteps of this first team after we learn from their experiments and discoveries of what works well.

4.6 Increased Employability Strategies

The Region has put in place a number of strategies to enhance employability. At the core of increased employability strategies are the Caseworker and the principles of SAIL. As stated in section 1.4, one of the division’s priorities for 2017-18 is to revise our client service pathway to ensure an employment-centered service that is adaptive to individual and labour requirements through a variety of strategic and evaluative initiatives.

Currently, the Region offers a variety of employment programs to support positive employment and earnings outcomes for program participants. Programs such as, Individual Supports Towards Employment (iSTEP), and Social Work Intake provide participants with life stabilization supports and basic skills for employment. Creating Opportunities, for example, provides participants with encouragement and a greater sense of hope, and support to identify their strengths, skills and barriers along their career journey. Planning for Employment, Community Placement, and Focus for Change and Working from Home programs are uniquely tailored programs to support participants in preparing for Employment. STAR (Sharing Tips and Resources) provides participants with practical information to live well on a small budget. The Region offers several foundational courses for employment, such as job searching, resume writing, interviewing, and employment placements. Employment Resource Centres provide participants with a variety of resources and staff assistance to support their employment or training goals.

Industry specific job training or skills training program that may be required to move towards employment are also provided through several programs delivered by the Region. The Region has also continued the GED program to support participants wishing to obtain a high school equivalency certificate, in response to the high number of OW participants without a high school certificate (45 per cent
in 2016 had less than 12 years of education3).

All the above mentioned employment programs mentioned are undergoing a review for continued viability. Recent reviews of our program conducted by a group of management and direct service staffs recommended a renewed and more modern approach to employment services. These will include working with the Employment Ontario structure and its supply demand model to redesign program alignment. It is anticipated this will result in significant staff reallocations, as we reduce caseload levels and increase efforts to market our employment services and client base to employers in The Region of Waterloo.

4.7 Monitoring Service Strategies

The division is moving toward a more client-centred and outcome-based approach. All Management and Management Support staff will participate in three full days of training in April and May on Key Performance Indicators to help shift our thinking and work to focus more on outcomes. We will be deciding on specific indicators to track and monitor to better measure our outcomes. We will also communicate better to all staff the targets and other indicators that we are measuring. We will build the monitoring of outcomes into team meetings.

As a corporation, we are adding Lean Six Sigma to the fabric of our culture and work. A Manager of Corporate Performance was hired in 2016 who is a Black Belt in Lean Six Sigma (LSS) and who is rolling out LSS training to 10 Region staff a year. She is also building a community of practice to support LSS projects throughout the Region. The E&IS division has dedicated one staff person to this LSS training and looks forward to including LSS projects and philosophy in our ongoing shift to modernize E&IS. Staff will implement more data-driven E&IS programming in 2018.

The Region also participates in the Municipal Benchmarking Network of Canada (MBN Canada) and the division has additionally set its own Individual Performance Management Targets. These performance indicators or measures further enhance accountability and promote effective service delivery.

Section 5: Next Steps

5.1 Next Steps

The priorities identified at the outset of this document are reviewed by the senior management team regularly throughout the year and updates are shared with staff electronically. In 2018 an update to this plan will be submitted as a Service Plan Addendum. The update will capture changes in external influences such as the labour market and caseload demographics; report any changes in service delivery and/or business processes; and outline any changes in service strategies for 2018.

3 Ontario Works Caseload at a Glance Report January 2017
EIS MODERNIZATION
Project

COURSE CHART

Current State
- Service delivery focused primarily on income support
- Silos within the division/department
- Multiple handoffs, client could tell story many times
- Many job descriptions, difficult to easily adjust resources to work flow, changing needs
- Inconsistent service delivery and overlapping program functions
- Limited performance measures and transparency on the client and system outcomes being achieved
- Limited effectiveness of moving clients to employment
- Inconsistent accessibility to services
- Compliance/rules based
- Dashboard
- 10 – 30+ days to referral to Employment Services
- Caseload: 8700
- Avg. Months on Assistance: 30
- Exits to Employment: 13%
- Earners on Caseload: 13%

2018 Future State
- Focused on supporting clients to improved quality of life and employment
- Integration, whole department approach, multidisciplinary teams
- Client tells story less often, clients know who their worker is, high value interactions
- Fewer job descriptions, nimble to adjust resources where needed most
- Standardized service assessments and service planning
- Outcomes guide our work at all levels within the organization
- Improved client outcomes (quality of life)
- Improved client experience, access and usability
- Risk Management
- Dashboard
- 4 Days to Cheque Issuance
- 7 days to Cpl. Assessment
- Decreased case load (+9.700)
- Lower Months on Assistance
- Exits
- Earners
- Qol. Index

Vision: A community where everyone can reach their potential.
Appendix B: EIS Organizational Charts
Region of Waterloo
Community Services
Departmental Services

To: Chair Geoff Lorentz and Members of the Community Services Committee

Date: September 12, 2017
File Code: S14-20

Subject: Grants to Community Organizations at the Region of Waterloo

Recommendation:

That the Regional Municipality of Waterloo take the following actions with respect to Grants to Community Organizations as outlined in Report CSD-DES-17-03 dated September 12, 2017:

1. Continue grants to the agencies identified in Appendix 1 at the noted levels for one additional year (2018) allowing them to prepare for transition to either a new funding model or discontinuation of Region of Waterloo funding as detailed in report CSD-DES-17-03 dated September 12, 2017; and

2. Approve in principle entering into Purchase of Service Agreements, effective January 1, 2019, with those organizations identified in Appendix 2 providing programs which directly support the Region’s programs, services and role as Consolidated Municipal Service Manager (CMSM) for housing and homelessness, social assistance, or childcare.

Summary:

In 2016, Regional Council approved the transfer of current Grants to Community Organizations (grants) to designated program areas (CC-16-01, dated May 3, 2016). A total of $159,972, through 12 grants to 11 different agencies, was transferred to Community Services Department. Council directed staff to review all funded organizations during 2017 to determine which organizations currently receiving funding should continue to receive funding and through what funding mechanism.
Staff conducted a detailed review which included interviews with each agency receiving grant funding. Based on the review, it is recommended that rather than an annual grant process, purchase of service agreements should be in place for those programs that directly support the Region’s programs, services and role as CMSM. A Purchase of Service agreement is seen as the most effective method of flowing funding, tracking the use of and accountability for the taxpayer funds. Seven of the 12 programs currently receiving grants are recommended for new or amendments to existing purchase of service agreements, effective January 1, 2019:

- Food Bank of Waterloo Region for emergency food collection and distribution;
- Kaljas Homes for supportive housing;
- Community Justice Initiatives for mediation and conflict resolution services for Waterloo Region Housing;
- Volunteer Action Centre for providing links to volunteer opportunities and build community capacity for volunteerism;
- Wilmot Family Resource Centre for rural-specific support to access community and Regional services and information;
- Woolwich Community Services rural-specific support to access community and Regional services and information; and
- K-W Multicultural Centre for interpretation and translation services.

**Report:**

1.0 Background and Purpose

The Region of Waterloo has been providing grants to community organizations since the establishment of the Region in 1973 (see Appendix 1). In 2016, Regional Council approved the transfer of current Grants to Community Organizations to designated Departments within the Region (CC-16-01 dated May 3, 2016). Regional Council also requested a review of all funded organizations be conducted in 2017 to determine:

1. The extent to which each of the organization’s programs and services directly support the Region’s 2015-2018 Strategic Objectives;
2. Whether or not the organization(s) should continue to receive Regional funding support in future years (beyond 2017); and
3. If the form of funding provided to the organization(s) should be changed to a purchase of service agreement or other funding form.

A total of $159,972, through 12 grants to 11 different agencies, was transferred to Community Services, which is the focus of this report.

2.0 Grants to Community Organizations Review and Methodology

In response to Regional Council’s request (CC-16-01 dated May 3, 2016), the Grants to
Community Organizations were reviewed by Community Services staff in 2017. The review included interviews with each of the 11 agencies receiving grants, interviews with key internal stakeholders, and a review of grant applications and budgets. Data was analyzed to provide an overview of the funded organizations and their respective programs and services. Findings were used to respond to and develop recommendations based on Regional Council’s review questions.

A full evaluation of the quality of each program was considered out-of-scope for this review.

Staff from Community Services worked with Public Health and Emergency Services staff throughout the grant review process to share findings and align approaches and recommendations, where appropriate.

3.0 Overview of Key Findings and Recommendations

The agencies and programs receiving grants are diverse in size, mandate, population served, activities, other funding sources and budgets and outputs and outcomes. All of the programs have a local mandate, with most serving residents across Waterloo Region and two programs providing service in a rural context (Woolwich Community Services and Wilmot Family Resource Centre).

The nature of the services provided by programs receiving grants fell into at least one of three general categories:

1. community capacity building, with activities focused on collective impact;
2. system navigation, with activities focused on individual impact; and
3. specialized supports, with activities focused on individual impact.

All programs identified they were meeting an important need in the community and many expressed that there were no other agencies doing the same work with the same population. In reviewing the links between each program and the Strategic Objectives, it was found that all organizations align with the Healthy, Safe and Inclusive Communities Focus Area; however, some programs are more directly aligned with specific Strategic Objectives than others.

All of the community programs receiving grants have been receiving funding since before the current term of Council, and most have been receiving funding for at least 10 years. Since the original grants were issued, Waterloo Region has grown and evolved significantly and new organizations and programs have developed to meet changing local needs. Given that few, if any new grants have been approved in the last 10 years, some organizations not currently receiving grants now offer programs that are similar to those receiving grants. Additionally, there are many new agencies and programs providing services that meet unique needs in the Region that could benefit from Regional funding.
To ensure equity for all community agencies in accessing Regional funds, it is recommended to discontinue funding through grants unless a new process with an open call for eligible applications, updated decision-making criteria and processes and revised accountability measures is established. Instead, it is recommended that the form of funding for programs currently receiving grants be changed from grant funding to purchase of service agreements, where programs are eligible. Funding would discontinue for programs not eligible for purchase of service agreements after a proposed one year transition period. Purchase of service agreements have a number of benefits including: ensuring continuity of service for participants; clear service expectations; efficient administration when aligned with existing processes and agreements; specific reporting requirements; alignment with Regional programs and services; transparent funding process; and increased accountability for funding.

Based on a detailed evaluation of each program against the criteria described in Section 4.0 of this report, seven of the 12 programs are recommended for changes to existing or new purchase of service agreements, effective January 1, 2019. Additional information about each recommended purchase of service is provided in Section 5.0.

4.0 Criteria for Purchase of Service Eligibility

The Purchasing By-Law (by-law number 16-032) identifies “Services for the purpose of providing identified supports to vulnerable or at risk populations through public health or social service programs” as exempt from the purchasing policies established in the by-law. By that definition, all programs identified in this report are exempt from the by-law. While the grant programs are exempt from the by-law, the recommended approach is based on principles and values of fairness, transparency, efficiency, and accountability, which is consistent with the objectives identified in the by-law.

The criteria for eligibility for purchase of service agreements were selected by staff based on the principles above as well as internal feedback. The purpose of the criteria is to identify agencies receiving grants that are the sole community provider of an important service that directly supports the Region’s programs, services and role as a Consolidated Municipal Service Manager (CMSM). If the grant funding currently supports both program activities that meet the criteria and activities that do not meet the criteria (e.g., agency is sole provider for one service but there are multiple providers for another service), only those activities that meet the purchase of service criteria will be included in the purchase of service.

To determine eligibility for purchase of service agreements from existing grant recipients programs must meet all of following criteria:

1. Program activities directly support the Region’s programs, services and role as CMSM for housing and homelessness, social assistance, or childcare and:
   a. agency is already in a purchase of service relationship with the Region;
b. the Region would be required to provide the service through another method (e.g., through hiring additional Regional staff) if the program were not operating AND there are no other programs providing the same service to the same population;

2. Program activities directly support the Region of Waterloo’s Strategic Objectives 2015-2018; and

3. Program activities directly support Community Service’s Quality of Life framework.

5.0 Agencies and Programs Recommended for Purchase of Service

Each of the agencies and programs described in this section are recommended for purchase of service agreements based on the three criteria identified above. In some cases, the proposed purchase of service is narrower in scope than the activities currently funded through the grant (e.g., focused only on services to a specific population rather than the general population). Given potential changes in service scope and expectations, exact amounts for each purchase of service will be determined through agreement negotiations with each agency. Existing budget processes will be used to guide agreement negotiations, wherever applicable. As discussed in section 7.0 Transition and Next Steps, it is recommended that transitional grants be provided for all agencies in 2018 at 2017 levels to allow adequate time for service planning and agreement negotiations.

Food Bank of Waterloo Region (2017 Grant: $24,047)

The Food Bank of Waterloo Region is already in a purchase of service agreement with the Region of Waterloo to act as the lead agency to provide a range of food hamper and food security services through Waterloo Region (CSD-EIS-16-09 dated May 3, 2016) (criteria 1a). It is recommended that the current purchase of service agreement be reviewed and adjusted as required to include the additional funding received from the grant. The grant funding supports the Food Bank in its capacity to gather and distribute emergency food, which directly supports Strategic Direction 4.2 – Mobilize efforts to reduce poverty and the impacts it has on Waterloo Region residents (criteria 2). The activities of the food security activities improve quality of life of recipients in the areas of economic well-being and physical and emotional well-being (criteria 3).

Kaljas Homes (2017 Grant: $11,306)

Kaljas Homes receives funding through the Region of Waterloo’s Community Homelessness Prevention Initiative Supportive Housing program (criteria 1a). The current grant funding is used to support property taxes of the properties used for this program. It is recommended that the current purchase of service
agreement be reviewed and adjusted as required to include the additional funding received from the grant. The supportive housing offered through Kaljas Homes directly supports Strategic Direction 4.3 – Increase the supply and range of affordable and supportive housing options (criteria 2). Supportive housing strongly impacts tenants’ quality of life in the areas of economic well-being, social inclusion and equity, physical and emotional well-being, and relationships (criteria 3).

Community Justice Initiatives (2017 Grant: $20,046)

Community Justice Initiatives provides mediation and conflict-resolution support for tenants living in Waterloo Region Housing buildings. This conflict-resolution support is part of Waterloo Region Housing’s eviction prevention strategy. Without this community program, Regional staff would be required to spend more time resolving disputes (criteria 1b). There are no other community programs providing free mediation and conflict-solution services (criteria 1b). It is recommended that the Region enter into a new purchase of service agreement for the mediation and conflict-resolution services provided specifically to Waterloo Region Housing’s tenants. Conflict-resolution services provided to the general community would not be eligible for this purchase of service agreement. The conflict-resolution program directly supports Strategic Direction 4.5 - Enhance community safety and crime prevention and 4.3 – Increase the supply and range of affordable and supportive housing options (criteria 2). This program improves quality of life for tenants in the areas of social inclusion and equity, physical and emotional well-being, skills development, and relationships (criteria 3).

Volunteer Action Centre (2017 Grant: $27,591)

The Volunteer Action Centre provides information about volunteering and links to volunteer opportunities. This service is used by Ontario Works participants, who volunteer as a way of building employment related skills and experiences. Employment and Income Support staff direct participants interested in volunteering as part of their employment plan to the Volunteer Action Centre. Without this community service Ontario Works staff would need to play a more active role in finding volunteer opportunities (criteria 1b). These programs directly support Strategic Objective 4.2 – Mobilize efforts to reduce poverty and the impacts it has on Waterloo Region residents (criteria 2). The volunteer services improve quality of life in the areas of economic well-being, social inclusion and equity, and skills development (criteria 3).

Wilmot Family Resource Centre (2017 Grant: $15,122) and Woolwich Community Services (2017 Grant: $15,122)
Wilmot Family Resource Centre and Woolwich Community Services are separate organizations with similar mandates and activities, that each serve a different local rural geography. These organizations are currently funded to provide support to low-income individuals to access community and Regional services and information. For example, they may support people to complete Community Housing applications or to gather the necessary information to apply for Ontario Works. These organizations are a significant source of support to rural residents, and without their programs, Regional staff would be required to provide additional supports to rural participants (criteria 1b). They are the only organizations providing this kind of support to any rural resident (criteria 1b). It is recommended that the Region enter into purchase of service agreements with both agencies to support their work with low-income rural residents. The activities of these organizations directly support 4.2 – Mobilize efforts to reduce poverty and the impacts it has on Waterloo Region residents (criteria 2). The holistic services provided to rural residents improve quality of life in the areas of economic well-being, social inclusion and equity, physical and emotional well-being, skills development, and relationships (criteria 3).

K-W Multicultural Centre (2017 Grant: $16,396)

K-W Multicultural Centre provides settlement, employment, and interpretation and translation services to new Canadians in Waterloo Region, including those who may not be supported through other streams of government funding. The organization is currently in a purchase of service agreement with the Region of Waterloo to provide interpretation and translation services (criteria 1a). Without this service, Region staff would be required to provide interpretation and translation in order to meet our accessibility standards (1b). It is recommended that the current purchase of service agreement be reviewed and adjusted as required to include the additional funding received from the grant. This service directly supports 4.2 – Mobilize efforts to reduce poverty and the impacts it has on Waterloo Region residents (criteria 2). Providing interpretation and translation services contribute to quality of life, including areas of economic well-being and social inclusion and equity (criteria 3).

6.0 Agencies and Programs Not Recommended for Purchase of Service

There are four agencies and five programs that do not meet at least one of the three criteria for purchase of service and are therefore not recommended for purchase of service agreements:

- Central Ontario Developmental Riding Program (2017 Grant: $2,733), for financial subsidies for children with disabilities to participate in horseback riding lessons;
- Child Witness Centre of Waterloo Region (2017 Grant: $9,156), for supporting
children and families who are victims of crime to navigate the court system;

- Waterloo Region Block Parent Program (2017 Grant: $5,000) for the community safe homes network and Walking School Bus program; and

- Independent Living Centre for access and awareness programming (2017 Grant: $4,162) and the Kids on the Block program (2017 Grant: $9,291).

This recommendation does not reflect the value of the programs and services to the community, but rather the lack of fit for purchase of service with the Region of Waterloo. As described above, continuing grant based funding without a revised, open process would be inequitable to other community agencies also meeting important needs in the community that have not had the opportunity to apply for Regional funding.

7.0 Transition and Next Steps

It is recommended that one additional year of grant funding (2018) at 2017 funding levels be provided to all organizations receiving grants in 2017, to support the transition from the Grants to Community Organizations program. Any changes to program scope as part of the recommended purchase of service agreements would not take effect until January 1, 2019. For agencies with programs recommended to receive a purchase of service agreement, during the 2018 transitional period staff will work with agencies to determine service requirements, appropriate funding levels, and other agreement details such as reporting requirements. For agencies with programs not recommended to receive a purchase of service agreement, the 2018 transitional period will provide agencies with additional time to plan for the change in funding.

It is anticipated that some of the total $159,972 in grants funding for Community Services will remain after entering into eligible purchase of service agreements. Although Council has not requested recommendations for the remaining funds, some initial options have been identified and a future report can be provided to Council when the exact amount remaining is known.

**Relation to Quality of Life Indicators:**

The programs recommended for purchase of service agreements all align with at least two Quality of Life Indicators (economic well-being, social inclusion and equity, physical and emotional well-being, skills development, and relationships).

**Corporate Strategic Plan:**

Grants to Community Organizations do not fall directly under the objectives of the Corporate Strategic Plan; however the provision of the grants distributed by Community Service supports the Healthy, Safe and Inclusive Communities focus area. The specific grants recommended for future purchase of service agreements support: Objective 4.2 – Mobilize efforts to reduce poverty and the impacts it has on Waterloo Regions;
Objective 4.3 – Increase the supply and range of affordable and supportive housing options; and 4.5 – Enhance community safety and crime prevention.

Financial Implications:

The 2017 Community Services operating budget includes $159,972 for grants to community organizations. With the recommendations in this report, the same amounts would be included in the 2018 base budget. It is expected that the amounts for the recommended purchase of service agreements would fall within this total as part of the 2019 base budget. The plan for distribution of any remaining funds would be developed during 2018 and any budget changes would be considered as part of the 2019 budget process.

Other Department Consultations/Concurrence:

Staff in Public Health and Emergency Services have been consulted regarding the recommendations in this report.

Attachments

Appendix 1 – 2017 Grants to Community Organizations – Community Services
Appendix 2 – Programs Recommended for Purchase of Service Agreements in 2019

Prepared By: Bethany Wagler-Mantle, Social Planning Associate, Children’s Services

Lynn Liao, Social Planning Associate, Employment and Income Support

Arran Rowles, Manager, Departmental Services

Approved By: Douglas Bartholomew-Saunders, Commissioner, Community Services
### Appendix 1

2017 Grants to Community Organizations – Community Services

<table>
<thead>
<tr>
<th>Organization</th>
<th>2017 Grant Amount</th>
<th>Recommended for Purchase of Service Agreement</th>
<th>2018 Grant Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Justice Initiatives</td>
<td>$20,046</td>
<td>Yes</td>
<td>$20,046</td>
</tr>
<tr>
<td>Food Bank of Waterloo Region</td>
<td>$24,047</td>
<td>Yes</td>
<td>$24,047</td>
</tr>
<tr>
<td>Kaljas Homes</td>
<td>$11,306</td>
<td>Yes</td>
<td>$11,306</td>
</tr>
<tr>
<td>K-W Multicultural Centre</td>
<td>$16,396</td>
<td>Yes</td>
<td>$16,396</td>
</tr>
<tr>
<td>Volunteer Action Centre</td>
<td>$27,591</td>
<td>Yes</td>
<td>$27,591</td>
</tr>
<tr>
<td>Wilmot Family Resource Centre</td>
<td>$15,122</td>
<td>Yes</td>
<td>$15,122</td>
</tr>
<tr>
<td>Woolwich Community Services</td>
<td>$15,122</td>
<td>Yes</td>
<td>$15,122</td>
</tr>
<tr>
<td>Central Ontario Developmental Riding Program</td>
<td>$2,733</td>
<td>No</td>
<td>$2,733</td>
</tr>
<tr>
<td>Child Witness Centre of Waterloo Region</td>
<td>$9,156</td>
<td>No</td>
<td>$9,156</td>
</tr>
<tr>
<td>Independent Living Centre - Access and Awareness</td>
<td>$4,162</td>
<td>No</td>
<td>$4,162</td>
</tr>
<tr>
<td>Independent Living Centre - Kids on the Block</td>
<td>$9,291</td>
<td>No</td>
<td>$9,291</td>
</tr>
<tr>
<td>Waterloo Region Block Parent Programs</td>
<td>$5,000</td>
<td>No</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$159,972</strong></td>
<td></td>
<td><strong>$159,972</strong></td>
</tr>
</tbody>
</table>
### Appendix 2

**Programs Recommended for Purchase of Service Agreements in 2019**

Note: Amounts for each purchase of service agreement will be negotiated during 2018.

<table>
<thead>
<tr>
<th>Agency</th>
<th>Program Focus for Purchase of Service</th>
<th>Directly supports the Region’s programs, services and role as CMSM</th>
<th>Directly supports the Region’s Strategic Objectives 2015-2018</th>
<th>Directly supports Community Service’s Quality of Life framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaljas Homes</td>
<td>Supportive housing for people with a history of experiencing homelessness</td>
<td>Yes – CHPI supportive housing program</td>
<td>Yes – 4.3 Increase the supply and range of affordable and supportive housing options</td>
<td>Yes - economic well-being, social inclusion and equity, physical and emotional well-being, and relationships</td>
</tr>
<tr>
<td>Food Bank of Waterloo Region</td>
<td>Emergency food collection and distribution</td>
<td>Yes – part of the Discretionary Benefits program</td>
<td>Yes – 4.2 Mobilize efforts to reduce poverty and the impacts it has on Waterloo Region residents</td>
<td>Yes - economic well-being and physical and emotional well-being</td>
</tr>
<tr>
<td>Community Justice Initiatives</td>
<td>Mediation and conflict-resolution support for Waterloo Region Housing tenants</td>
<td>Yes – Waterloo Region Housing</td>
<td>Yes – 4.5 Enhance community safety and crime prevention and 4.3 – Increase the supply and range of affordable and supportive housing options</td>
<td>Yes - social inclusion and equity, physical and emotional well-being, skills development, and relationships</td>
</tr>
<tr>
<td>Volunteer Action Centre of K-W and Area</td>
<td>Provide links to volunteer opportunities and build community capacity for volunteerism</td>
<td>Yes – Ontario Works participants access the services as part of their employment journey</td>
<td>Yes – 4.2 Mobilize efforts to reduce poverty and the impacts it has on Waterloo Region residents</td>
<td>Yes - economic well-being, social inclusion and equity, and skills development</td>
</tr>
<tr>
<td>Organization</td>
<td>Service Description</td>
<td>Yes – Rural community members are supported to access Regional services such as Ontario Works and Community Housing</td>
<td>Yes – 4.2 Mobilize efforts to reduce poverty and the impacts it has on Waterloo Region residents</td>
<td>Yes - economic well-being, social inclusion and equity, physical and emotional well-being, skills development, and relationships</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Wilmot Family Resource Centre</td>
<td>Rural-specific support to low-income individuals to access community and Regional services and information</td>
<td>Yes – Rural community members are supported to access Regional services such as Ontario Works and Community Housing</td>
<td>Yes – 4.2 Mobilize efforts to reduce poverty and the impacts it has on Waterloo Region residents</td>
<td>Yes - economic well-being, social inclusion and equity, physical and emotional well-being, skills development, and relationships</td>
</tr>
<tr>
<td>Woolwich Community Services</td>
<td>Rural-specific support to low-income individuals to access community and Regional services and information</td>
<td>Yes – Rural community members are supported to access Regional services such as Ontario Works and Community Housing</td>
<td>Yes – 4.2 Mobilize efforts to reduce poverty and the impacts it has on Waterloo Region residents</td>
<td>Yes - economic well-being, social inclusion and equity, physical and emotional well-being, skills development, and relationships</td>
</tr>
<tr>
<td>K-W Multicultural Centre</td>
<td>Interpretation and translation services</td>
<td>Yes – New Canadians are supported to access Regional services such as Ontario Works and Employment Services</td>
<td>Yes - 4.2 Mobilize efforts to reduce poverty and the impacts it has on Waterloo Region residents</td>
<td>Yes - economic well-being, social inclusion and equity</td>
</tr>
</tbody>
</table>
Region of Waterloo

Community Services

Children’s Services

To: Chair Geoff Lorentz and Members of the Community Services Committee

Date: September 12, 2017  File Code: S15-01

Subject: Journey Together Update

Recommendation:

For Information

Summary:

In November 2016, the Ministry of Education announced the availability of funding to support the Ministry of Education early years initiative under “The Journey Together: Ontario’s Commitment to Reconciliation with Indigenous Peoples” (The Journey Together). The Journey Together initiative is part of the Province’s early years commitments in response to the Truth and Reconciliation Commission Calls to Action. The early years initiative intends to enhance access to culturally relevant, indigenous-led early years programs and services off-reserve, including child care and child and family programs.

This report provides an update to Report CSD-CHS-17-04 (February 14, 2017) with new information regarding a proposed funding opportunity available through The Journey Together. As part of the Province’s plan to close gaps and reduce barriers for Indigenous peoples, the Province has requested Consolidated Municipal Service Manager’s (CMSMs) (Children’s Services, Region of Waterloo) to collaborate with local Indigenous partners to complete The Journey Together proposal package. The package includes a needs assessment and program proposal.

Children’s Services contracted consultant services through the Healing of the Seven Generations to complete the proposal (Appendix ‘A’). The proposal outlines funding needs to build and operate child care and family support programs. Region staff support the request for funding to create Indigenous-led child care and a child and family centre. If approved in full, the new programs would provide 77 new licensed child care spaces,
a new family centre that would serve approximately 540 families each year and an Early Childhood Education scholarship program for up to ten Indigenous students in the first two years. The Ministry requires joint proposals to be submitted by September 29, 2017.

**Report:**

As part of the government-wide action plan announced on May 30, 2016 in The Journey Together, the Province has committed to working with partners to increase the number of culturally relevant child care spaces and expand access to child and family programs for Indigenous children and families off reserve. The commitment is that these programs will be delivered by Indigenous-led organizations, working with service system managers.

By investing $250 million over the next three years, Ontario is working to address the legacy of residential schools, close gaps and remove barriers, support Indigenous culture, and reconcile relationships with Indigenous peoples. Investment will go toward programs and actions focused on reconciliation. Ontario has committed to responding to gaps and removing barriers by addressing social and economic challenges now faced by Indigenous communities after centuries of colonization and discrimination.

The Region, Children’s Services Division values its relationship with Indigenous partners and recognizes the importance of its role in joint planning. The Journey Together initiative is an important step in our local journey of reconciliation with Indigenous peoples. This report represents a commitment to working together to honour Indigenous knowledge and to guide local service system planning for the early years.

To help promote healthy child development and support family well-being, Ontario and the Region commit to working with Indigenous people to identify needs and make more child and family programs available in communities. These investments are a step toward a broader child care and early years strategy for Indigenous communities in Ontario and are connected to the Provincial government’s vision where all families have access to a range of high-quality, inclusive and affordable early years and child care programs and services that are child-and-family-centred and contribute to children’s learning, development and well-being.

This initiative will also align to the Ontario Early Years Child and Family Centres project, which will transform and integrate child and family programs across the province.

**Community Engagement**

Since February 2017, the Region has engaged in meaningful and collaborative discussions with the Healing of the Seven Generations to develop and submit a joint proposal to expand access to culturally relevant child care and child and family programs. The Healing of the Seven Generations was awarded a $50,000 contract from...
an expression of interest (EOI) process. Funding fulfilled the aims to develop the proposal and support capacity building in our local Indigenous community and seek to build meaningful relationships between child care operators, child and family centres and Indigenous peoples.

Outcomes

The proposal seeks to achieve the Ministry’s objectives of The Journey Together initiative to:

- Increase access to culturally-relevant early years programs and services and licensed child care spaces for Indigenous children and families off reserve;
- Enhance Indigenous control of service design and delivery;
- Foster greater opportunities for Indigenous children to learn about their culture and language from an early age; and
- Support improved outcomes for Indigenous children including healthy child development, parent and family supports and greater participation in employment and training for parents.

Journey Together Proposal

Waterloo Region is surrounded by five First Nation’s reservations within 100-km radius, including; Six Nations of the Grand River; the Mississaugas of the New Credit First Nation; Munsee-Delaware Nation; Oneida Nation of the Thames; and Chippewas of the Thames First Nation. The Healing of the Seven Generations estimates the number of Indigenous peoples in Waterloo Region to be 25,000-30,000 (much higher than recorded figures in the 2011 Census of 15,000 Indigenous peoples), with an estimated population of children aged 0-4 of 2,500. There are currently no Indigenous-led child care or child and family centres in Waterloo Region. Additional gaps in service were noted by the Healing of the Seven Generations to include programs and services designed to provide healing, restore cultural languages, provide teachings, stories, and cultural traditions, and provide a balanced, holistic approach.

Funding under this initiative is intended to support programs that are flexible, culturally responsive, reflective of communities and supportive of Indigenous children and families, within broad requirements and parameters of existing Ministry of Education-funded early years programs. This means that proposals for new or enhanced child care programs should: align with requirements set out in the Child Care and Early Years Act; reflect allowable expenditures outlined in the Ontario Child Care and Family Support Program Service Management and Funding Guideline; align with the key Goals and mandatory Core Services sections set out in the Ontario Early Years Child and Family Centres Planning Guidelines; and/or support The Journey Together objectives outlined above.
The proposal has been developed in close collaboration with local Indigenous organizations and/or communities, and is reflective of information and input provided by the Healing of the Seven Generations and considers the local needs and opportunities as shared with Region staff. As a result, the proposal will include a request for funding related to capital and operating costs associated with delivering child care, child and family programs, and culturally relevant programs. The province has requested that a proposed and scaled version be presented for consideration. The proposed version outlines the full proposal as it is envisioned, whereas the scaled version identifies areas where costs could be scaled back if necessary.

### Estimated Funding Request

<table>
<thead>
<tr>
<th>Model /Year</th>
<th>Capital – One-Time</th>
<th>Operating – One-Time</th>
<th>Operating -Ongoing</th>
<th>Admin</th>
<th>Scholarship Funding</th>
<th>Total funding requested per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed 2018</td>
<td>4,740,000</td>
<td>70,150</td>
<td>790,772</td>
<td>100,000</td>
<td>50,000</td>
<td>5,750,922</td>
</tr>
<tr>
<td>Proposed 2019</td>
<td>4,000,000</td>
<td>651,600</td>
<td>1,152,090</td>
<td>200,000</td>
<td>90,000</td>
<td>6,093,690</td>
</tr>
<tr>
<td>Scaled 2018</td>
<td>4,692,000</td>
<td>27,650</td>
<td>632,206</td>
<td>80,000</td>
<td>30,000</td>
<td>5,461,856</td>
</tr>
<tr>
<td>Scaled 2019</td>
<td>3,200,000</td>
<td>500,000</td>
<td>927,265</td>
<td>150,000</td>
<td>52,000</td>
<td>4,829,265</td>
</tr>
</tbody>
</table>

*Note: See Appendix B for list of included costs
**Note: The Scholarship funding request will extend past 2019

The proposed new child care centre would serve 62 children 0-4 years of age during daytime hours, Monday to Friday and an additional 15 children 0-12 years of age during evening and weekend hours. This would create a total of 77 new spaces. The table below shows the proposed age groupings and estimated parent fees.

### Child Care Spaces (Net New)

<table>
<thead>
<tr>
<th>Age Grouping</th>
<th># of Spaces</th>
<th>Estimated Daily Parent Fees (per space) *before fee subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>10</td>
<td>$71.26</td>
</tr>
<tr>
<td>Toddler</td>
<td>20</td>
<td>$50.00</td>
</tr>
<tr>
<td>Preschool</td>
<td>32</td>
<td>$45.00</td>
</tr>
<tr>
<td>JK/SK &amp; School-Age</td>
<td></td>
<td>$43.00</td>
</tr>
<tr>
<td>Family Grouping (0-12) (evenings and weekends only)</td>
<td>15</td>
<td>As above</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>77</strong></td>
<td></td>
</tr>
</tbody>
</table>

A family centre will also be part of the proposal and will provide an opportunity to create a “hub” of services for Indigenous children and families that is culturally safe and
responsive to the needs of their community. The family centre will provide comprehensive programs for parents, as well as referral support and access to materials and resources. Daily drop-in programs will allow families to learn alongside their children. It is anticipated that the family centre will serve approximately 540 families the first year, with the numbers building year over year. The family centre will employ approximately 9.25 FTE’s.

The timeline for the proposed new child care and family centre would see acquisition of property, design, and development of the property over 2018 and 2019, with an anticipated opening in 2020. An interim plan to address some of the need for additional supports and services has been recommended by the Healing of the Seven Generations and will go forward as part of the request. The interim plan includes:

- An interim child care program for up to 15 children 0-12 years of age during evening and weekend hours (through a partnership with a community child care operator)
- Pop-up play programs to support parents and their children to learn alongside one another
- Creation of a Parent Helpline where parents can receive support and advice
- An Outreach Worker to provide in-home assistance to families
- A Resource and Training Consultant to create and deliver cultural competency training to the broader community.

Lastly, to build capacity within the Indigenous community to self-deliver services in the proposed child care centre and family centre, a request for funding to support a scholarship program for Indigenous students wishing to pursue their diploma in Early Childhood Education will go forward with the proposal.

The submission date for the joint proposal to the Ministry of Education is September 29, 2017.

**Relation to Quality of Life Indicators:**

The Journey Together proposal, as described in this report aligns with Social Inclusion and Equity; Physical and Emotional Well-Being; Skills Development; and Relationships QOL indicators.

**Corporate Strategic Plan:**

This report addresses the Region’s Corporate Strategic Plan 2015-2018, Focus Area 4: Healthy, Safe and Inclusive Communities and Strategic Objective 4.1: Support early learning and development.
Financial Implications:

This project, should the proposal be accepted will be 100% funded by the Provincial Government.

Other Department Consultations/Concurrence:

The assistance of Human Resources & Citizen Service as well as Corporate Services is required to manage the transition plans and funding analysis.

Attachments

Appendix A – The Journey Together – Region of Waterloo, prepared by Healing of the Seven Generations. (Available Electronically)

Appendix B - Funding Request – Cost Inclusions (Available Electronically)

Prepared By: Tamara Kerr, Social Planning Associate
Kim Sangüesa, Manager, Early Learning Services
Barb Cardow, Director, Childrens’ Services

Approved By: Douglas Bartholomew-Saunders, Commissioner, Community Services
Region of Waterloo

Planning, Development and Legislative Services

Cultural Services

To: Chair Geoff Lorentz and Members of the Community Services Committee

Date: September 12, 2017

File Code: R03-80(A)

Subject: Curatorial Centre Expansion Project Deferral

Recommendation:

That the Regional Municipality of Waterloo defer the existing Curatorial Centre Storage Expansion Capital Project (42046) to 2019 – 2021; and

That the Regional Municipality of Waterloo provide pre-budget approval of the $11.83 million for the project as outlined in PDL-CUL-16-10 dated September 13, 2016; and

That the Regional Municipality of Waterloo accept the Canada Cultural Spaces Fund $1.0 million grant contribution with proposed deferral to 2019-2021 and enter into any required agreements, subject to the approval of the Regional Solicitor.

Summary: Nil.

The Curatorial Centre expansion project was to take place commencing in 2017 and ending in 2019. The Federal Government originally approved funding of $1 million for this project on the assumption that the funds would be expended in this time period. The acceptance of these funds would have required the Region to add $10.15 in new debt over that time period. This report requests that the Curatorial Centre expansion project be deferred until 2019 to align with the retirement of existing Cultural Site debt. Costs for the project have also been reviewed to ensure the 2019-2021 capital budget contains up-to-date construction costs.

Report:

The Region of Waterloo’s museums care for more than 53,000 objects, plus an estimated 1,000,000 archaeological objects. The Region strategically plans for and
implements collections management upgrades at its museum sites. Major upgrades have been undertaken twice, in the 1980s when storage was added to Joseph Schneider Haus and in 1995 when the Curatorial Centre was opened at the Waterloo Region Museum campus (formerly Doon Heritage Crossroads). Artifact storage at Schneider Haus presently exceeds capacity and stands at 90% capacity at the Curatorial Centre. Consultants in 2014 prepare a schematic design for an expansion of the Curatorial Centre, with a preliminary cost estimate of $11.15M. The design increases artifact storage space by 47.6% (from 20,828 ft\(^2\) to 30,731 ft\(^2\)), accommodating collections growth for the next 25-30 years. The Curatorial Centre Expansion Project is included in the Region’s 2017-2026 Capital Program for a total value of $11,156,000 ($931,000 in 2017; $7,945,000 in 2018; $2,280,000 in 2019).

As directed by Regional Council through Report PDL-CUL-16-02 dated February 24, 2016 (link to the report attached), staff made application to Canadian Cultural Spaces Fund (CCSF) in June 2016, seeking grant funding for eligible components of the project, including architectural fees, construction, storage systems and related expenses.

**Funding from the Federal Government**

On August 18, 2016, the Department of Canadian Heritage requested that the Region show explicit confirmation, providing, at a minimum, matching funds for the project or the application could not proceed to further review. Pre-budget approval of $11.15 million was requested from Council on September 13, 2016, “subject to the amount of the awarded grant being satisfactory to Regional Council” (link to the report attached).

The Department of Canadian Heritage (DCH) advised the Region in March 2017 that the Region had received CCSF approval for a $1.0 million contribution toward the project, to be expensed in fiscal 2017/18. DCH initially insisted that recipients not be allowed to alter their projects substantially (i.e., addressing secondary needs in 2017/18 and postponing primary work to 2020); also, that their contribution could not be deferred. If the Region were to accept the funding and proceed with the project in 2017/18, its share of the capital cost would be approximately $10.15 million, which would need to be entirely debenture financed.

Funding $10.15 million from debentures raised concerns about the timing for the project. Staff entered into discussions with the DCH about the potential deferral of the project. The intent of these discussions was to align the expansion project more closely with the retirement of existing cultural site debt. DCH agreed to defer their funding until the 2019–2021 time frame, provided a commitment could be received from Council of its intent to proceed with the project in 2019.

By the end of 2021, there will be savings in the museum operating budget of $2.4 million as existing debentures are retired, reducing the associated debt servicing costs. This will create capacity to fund debt servicing and other operating costs related to the
Curatorial Centre expansion project.

**Project Cost Update**

Facility Services was consulted about the project costs. With the deferral of the project, staff wanted to ensure the most up to date costs were included in the capital budget. As outlined in the Financial Implications, costs for the project have been reviewed and the revised project is $11.83 million. Additional costs include but are not limited to consulting services, electrical work for new electrical service and repairs, heat detectors, dust collection, requirement to meet Class A Cultural Property designation standards and monitoring capabilities to museum staff to monitor temperature in collection spaces.

**Corporate Strategic Plan:**

Supporting initiatives that enhance arts, culture and heritage opportunities to enrich the lives of residents and attract talent and visitors are directly related to a Thriving Economy.

**Financial Implications:**

The 2017-2026 Waterloo Region Museum's approved Capital Plan includes $11.15 million for Curatorial Centre Storage expansion (Project 42046) commencing in 2017, to be funded from debentures. The cost estimate revisions, outlined in the table below will be included in the Cultural Services preliminary 2018 capital program.

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<tr>
<th>Project Cost Estimate ($000s)</th>
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<td>Cost estimate revisions (2017)</td>
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<td>$11,826</td>
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Total annualized operating costs are anticipated to be $1.46 million, for utilities, building maintenance, and debt servicing costs once the facility is operational. This would be more than offset by debt servicing cost reductions due to retirement of existing Museum debt. Debt is assumed to be issued over a term of 10 years and at an interest rate of 3%. There is no planned increase in staffing. The following table provides anticipated incremental impacts to future operating budgets for this option, assuming no additional funding is received:
### Other Department Consultations/Concurrence:

Corporate Services, Facilities Management led the schematic design and preliminary cost estimating process for the proposed expansion of the Region of Waterloo Curatorial Centre. Subject to Council approval, Facilities Management would oversee implementation of the construction project.

**Attachments**

- Link to report PDL-CUL-16-02 – Overview of Museum Collections Storage Needs and Possible Federal Funding Towards Expansion of Curatorial Centre dated February 23, 2016 (print copies available upon request).

- Link to report PDL-CUL-16-10 – Possible Expansion to Region of Waterloo Curatorial Centre dated September 13, 2016 (print copies available upon request).

**Prepared By:** Adèle Hempel, Manager/Curator, Region of Waterloo Museums

**Approved By:** Rod Regier, Commissioner, Planning, Development and Legislative Services
Region of Waterloo
Public Health and Emergency Services
Medical Office/ Epidemiology and Health Analytics

To: Chair Geoff Lorentz and Members of the Community Services Committee
Date: September 12, 2017 File Code: P03-80

Recommendation:
For information.

Summary:
As per Ontario’s Health Protection and Promotion Act (HPPA), a number of infectious diseases must be reported to local public health units. This report presents highlights from the monitoring of reportable infectious diseases in 2016.

In general, the rates of most reportable diseases in Waterloo Region were consistent with or lower than provincial rates.

Key trends highlighted in the report include:

- Among enteric (i.e. intestinal) diseases, salmonellosis and campylobacteriosis were the most frequently reported infectious diseases. Waterloo Region rates of most enteric diseases were similar or lower compared to those for all of Ontario. Travel outside of the province was a common risk factor for several enteric diseases.
- There were no human cases of West Nile virus in Waterloo Region in 2016 and Waterloo Region remains an area of low risk for the acquisition of Lyme disease.
- Chlamydia continues to be the most frequently reported sexually transmitted infection (STI) and the most common reportable disease overall, with high rates in young adults 20 to 29 years of age. Chlamydia rates have been steadily rising throughout the province since 2007. The provincial rates have been significantly higher than those observed in Waterloo.
The provincial rate of gonorrhea has been increasing in recent years, and this trend has also been observed locally. Reasons for the province-wide increase in rates are unclear and are being studied by the provincial government.

In order to support access to services for sexually transmitted infections, Region of Waterloo Public Health offers free and confidential sexual health counselling and clinics, two of which are specifically for youth. Public health offers other supportive services including a sexual health phone line staffed by a public health nurse, as well as public health nurse availability at Waterloo Region District School Board secondary schools on a weekly basis.

Influenza was the most common vaccine preventable disease for the 2016-2017 season, accounting for more than three-quarters of vaccine preventable diseases reported in Waterloo Region. Influenza activity during the 2016-2017 season was similar to the historical average. The local rate of influenza was lower than that for the province as a whole.

Local rates of invasive pneumococcal disease (IPD) were higher than those of the province in 2016. Specific reasons for this are unknown. Region of Waterloo Public Health initiated the Invasive Pneumococcal Diseases Prevention Campaign in the 2016-2017 respiratory season which aims to increase pneumococcal vaccination rates among priority and high risk individuals.

Waterloo Region experienced a typical season in terms of enteric outbreaks, demonstrating a peak during the winter months. Enteric outbreaks were most frequently reported in child-care facilities.

The number of influenza outbreaks was slightly higher in 2016-2017 compared to previous seasons in Waterloo Region, but still within what can be expected in a normal influenza season due to variations from year to year. More than half of institutional outbreaks occurred in long-term care homes.

Local rates of other infectious diseases were stable in 2016 compared to previous years, and similar to or lower than those of the province.

Report:

Background

Infectious diseases (IDs) are illnesses caused by microorganisms such as bacteria, viruses and parasites which may cause serious illness or be transmitted to large numbers of individuals. In accordance with the Ontario Public Health Standards (OPHS), one of the mandates of local public health units in Ontario is to work on the prevention and control of infectious diseases of public health importance. As such, the purpose of this report is to assess Waterloo Region’s rates of infectious diseases of public health importance and to monitor trends over time. This information will be used to aid in planning and evaluating evidence-based public health policies, programs, interventions, and related services so as to mitigate the frequency and impact of
infectious diseases in the local community. This report presents Waterloo Region’s rates of reportable diseases for 2016, historical rates for 2006-2015, comparisons to the historical 5-year average, and comparison of local rates to those of the province of Ontario. Basic epidemiology, exposure and risk factor information are also provided where appropriate.

Key Findings

Overall

In 2016 there were 2,897 cases of reportable infectious diseases in Waterloo Region. The top five infectious diseases reported in 2016 were chlamydia, influenza, gonorrhea, salmonellosis and campylobacteriosis, which accounted for 84.4 per cent of all cases. In general, the rates of most reportable diseases in Waterloo Region were consistent with or lower than provincial rates.

Enteric Diseases

Among enteric (i.e. intestinal) disease, salmonellosis and campylobacteriosis were the most frequently reported infectious diseases. Waterloo Region rates of most enteric diseases were similar to or lower compared to those for all of Ontario. Travel outside of the province was a common risk factor for many enteric diseases, including amebiasis, cryptosporidiosis, cyclosporiasis, giardiasis, hepatitis A, salmonellosis, shigellosis and typhoid/paratyphoid fever. Travellers are reminded to follow good hand hygiene practices, avoid consumption of potentially contaminated food such as raw fruits and vegetables (unless they have been washed, peeled or cooked), consume water that is potable, and avoid risky behaviours such as swimming in contaminated water.

Region of Waterloo Public Health works to manage and control enteric diseases by following up on reported cases and their contacts, providing education regarding risk factors and prevention, and supporting long-term care homes, hospitals and daycares in the prevention and control of enteric outbreaks. Region of Waterloo Public Health also performs routine inspections of food premises, long-term care homes and retirement facilities, residential facilities, day nurseries, personal service settings, and recreational water facilities (e.g., public pools, hot tubs and splash pads) to prevent the occurrence and transmission of infectious and foodborne illness. In addition, Region of Waterloo Public Health collaborates with federal and provincial partners to identify and remove sources of contaminated food products from the consumer marketplace. Public Health also provides free access to bacteriological testing for private well water and aids in the interpretation of such testing for well owners.

Vector-borne and Zoonotic Diseases

Vector-borne diseases (e.g., malaria, West Nile Virus, Lyme disease) and zoonotic
diseases (e.g., rabies) are relatively uncommon in Waterloo Region.

There were no human cases of West Nile virus in Waterloo Region in 2016 and Waterloo Region remains an area of low risk for the acquisition of Lyme disease. There are areas in Ontario that are considered higher risk for the acquisition of Lyme disease due to the presence of black-legged ticks. It is important for residents in Waterloo Region to be aware of precautions they can take to protect themselves against Lyme disease, especially when they travel to areas of higher risk. Region of Waterloo Public Health continues to work to reduce risk of exposure to Lyme Disease and West Nile Virus through public education, investigation of suspect human cases, vector surveillance and the implementation of vector control measures.

There were no rabies cases in 2016. While the risk for the general public of acquiring rabies remains low in Waterloo Region, wildlife in the region and surrounding areas have recently tested positive for rabies. It is important for individuals with an exposure (i.e. bite or scratch) to raccoons, skunks, other wildlife or any other animals to receive prompt assessment in order to determine the possible need for rabies post exposure prophylaxis. Public Health continues to investigate all reported animal biting incidents, provide recommendations regarding post-exposure prophylaxis, and dispense rabies vaccine.

**Sexually Transmitted and Blood-borne Infections**

Among all sexually transmitted and blood-borne infections, chlamydia, gonorrhea and hepatitis C contributed the greatest number of cases in Waterloo Region in 2016. As in previous years, chlamydia remains the most common infectious disease in Waterloo Region overall, with higher rates in young adults 20 to 29 years of age, and among 15 to 24 year old females. Chlamydia rates have been steadily rising throughout the province since 2007, including in Waterloo Region. The provincial rates have been significantly higher than those observed in Waterloo.

The rate of gonorrhea in Ontario has been increasing in recent years, and this trend has also been observed locally. Reasons for the province-wide increase in rates are unclear, and are being studied by the provincial government. The most commonly reported risk factors for local cases of gonorrhea included not using a condom and having multiple sexual partners.

The increased rates in sexually transmitted infections among youth may be attributed in part to more awareness of the need for testing, increased access to testing and new testing methods; however this does not completely explain the increase. Research also suggests that social determinants of health, in particular low socioeconomic status and limited access to health care, as well as the stigmatization and fear of being diagnosed with an STI contribute to higher incidence in young people. In order to support access to services, Region of Waterloo Public Health offers free and confidential sexual health
counselling and clinics, two of which are specifically for youth. Public Health also offers supportive services including a sexual health phone line staffed by a public health nurse, as well as public health nurse availability at Waterloo Region District School Board secondary schools on a weekly basis to provide sexual health services.

There was an increase in acute hepatitis B cases in Waterloo Region in 2016 compared to recent years, although case numbers were still low and within normal fluctuations. Follow-up of local cases indicated that there were no known links between cases. Fluctuations in sporadic acute hepatitis B cases are expected as vaccination coverage continues to vary, particularly in those who were born prior to the start of routine school-based hepatitis B immunization for grade 7 students. In addition, behavioural factors and immigration from endemic countries are unpredictable and can contribute to hepatitis B disease transmission. Region of Waterloo Public Health will continue to provide school-based hepatitis B immunization clinics to grade 7 students, promote hepatitis B immunization to health care providers, promote screening in individuals travelling from countries with high hepatitis B prevalence, and participate in harm reduction activities such as needle syringe programs.

Local rates of hepatitis C, and HIV/AIDS all remained relatively stable and below those of the province in 2016. Region of Waterloo Public Health continues to engage in harm reduction strategies which include the provision of needle syringe programs, condom distribution, and other related services at several locations in the region.

Vaccine Preventable Diseases

Influenza was the most common vaccine preventable disease for the 2016-2017 season, accounting for more than three-quarters of vaccine preventable diseases reported in Waterloo Region. Influenza activity during the 2016-2017 season was similar to the historical average. In addition, the local rate of influenza was significantly lower than that for the province as a whole. Region of Waterloo Public Health continues efforts to manage influenza seasons by distributing influenza vaccines to health care providers and providing influenza immunization clinics by appointment for families, to complement the many pharmacies, physicians’ offices and other providers of influenza vaccine in our region. Public Health also works with long-term care and retirement homes to increase staff and resident immunization coverage rates, and follows up on influenza cases and outbreaks in Waterloo Region.

Local rates of invasive pneumococcal disease (IPD) were higher than those of the province in 2016. Invasive pneumococcal incidence rates in Waterloo Region have historically been higher than those of the province, although rates have varied from year to year. Specific reasons for this are unknown; however, Region of Waterloo Public Health initiated an Invasive Pneumococcal Disease Prevention Campaign in the 2016-2017 respiratory season. This project aims to prevent invasive pneumococcal disease in the community by increasing pneumococcal vaccination rates among priority and high
risk individuals. Promotional packages were distributed to primary care providers, specialists and specialty clinics, pharmacists and labs. Public Health plans to evaluate the effectiveness of the IPD Campaign and make recommendations for further action in the future.

Rates of pertussis, varicella, mumps, invasive meningococcal disease (IMD) and measles were either stable or decreased in 2016, and remained similar to or lower than provincial rates. Region of Waterloo Public Health supports the prevention of vaccine-preventable illnesses through the provision of vaccine delivered through health care providers and public health immunization clinics. It also works to achieve and maintain high immunization rates among children in elementary and secondary schools through the Immunization of School Pupils Act, and continues to conduct health education and promotion activities to increase immunization coverage rates.

**Other Infectious Diseases**

Local rates of legionellosis in 2016 were higher than the province but were not statistically different and are expected to fluctuate from year to year. Investigation of cases did not identify any common exposures or epidemiological links among cases in the region.

**Outbreaks**

Waterloo Region experienced a typical season in terms of enteric outbreaks which were most often due to norovirus-like illness, in the 2016-2017 season. As expected, enteric outbreaks were most frequently reported in child care facilities and peaked in the winter months.

The 2016-2017 non-influenza respiratory outbreak season was similar to previous seasons in Waterloo Region. Non-influenza respiratory outbreaks were most frequently reported in long-term care homes and retirement homes.

The number of influenza outbreaks was slightly higher in 2016-2017 compared to previous seasons in Waterloo Region, but still within what can expected in a normal influenza season due to variations from year to year. Influenza outbreaks peaked in February. More than half of institutional influenza outbreaks occurred in long-term care homes, followed by retirement homes.

Region of Waterloo Public Health follows up with child care centres, hospitals, residential/group homes, long-term care homes and retirement homes that have reported an outbreak to assist with and support outbreak management efforts. In addition, Region of Waterloo Public Health hosts infection control education forums for long-term care homes, retirement homes, and child care centres, and participates on committees and networks that address infection prevention and control issues in facility settings.
Conclusion

Infectious diseases have the potential to cause serious illness and can have community-wide implications. As such, Region of Waterloo Public Health undertakes a number of activities to prevent or reduce the burden of infectious diseases in the community. The Infectious Diseases in Waterloo Region Surveillance Report for 2016 provides an update to the community on the local status of infectious diseases and the findings from this report will continue to be used to inform local public health programming in the prevention and transmission of reportable, infectious diseases in Waterloo Region.

Ontario Public Health Standards:

Under the Health Protection and Promotion Act, Region of Waterloo Council serves as Waterloo Region’s Board of Health. Boards of Health are expected to adhere to the Ontario Public Health Standards, which outline the expectations for providing public health programs and services. This report provides information to meet the surveillance and population health assessment requirements of the Infectious Diseases Standard in the Ontario Public Health Standards.

Corporate Strategic Plan:

The Infectious Diseases in Waterloo Region Surveillance Report contributes to the strategic objective 4.4 Promote and support health living and prevent disease and injury in the Healthy, Safe and Inclusive Communities focus area in the 2015-2018 Strategic Plan.

Financial Implications:

Activities related to Infectious Diseases programming are accomplished within the approved Public Health Department base budget for Public Health Mandatory Programs; the budgets are established by Regional Council (as the Board of Health). The majority of the programs are funded up to 75% by the province with the remainder (25%) funded by the local tax levy. To a lesser extent, there is some additional 100% provincial funding to allow for increased capacity in specific initiatives such as Safe Water, Safe Food and Outbreak Response.

Other Department Consultations/Concurrence:

Nil
Attachments

The full report is available online at: 

Prepared By: Arianne Folkema, Epidemiologist, Epidemiology and Health Analytics

Approved By: Anne Schlorff, Acting Commissioner
Dr. Hsiu-Li Wang, Acting Medical Officer of Health
Region of Waterloo
Public Health and Emergency Services
Central Resources

To: Chair Geoff Lorentz and Members of the Community Services Committee

Date: September 12, 2017  File Code: A24-40

Subject: Review of Community Grants Assigned to Public Health and Emergency Services

Recommendation

That the Regional Municipality of Waterloo discontinue the annual grant to the Canadian Mental Health Association (Waterloo, Wellington and Dufferin Branch) Distress Centre, effective December 31, 2017, and discontinue the grant to Telecare Cambridge effective December 31, 2018, and that the respective allocations of $23,700 and $4,600 (gross and net levy) be removed from the PHE base budget in 2018 and 2019.

Summary

In 2016, Regional Council approved the transfer of Grants to Community Organizations to designated program areas (CC-16-01, dated May 3, 2016). A total of $28,300 through two grants to Telecare Cambridge and to the Canadian Mental Health Association (Distress Centre, was transferred to Public Health and Emergency Services. Based on Council’s 2016 direction, grants were maintained at 2016 levels for 2017 and both organizations have received the grant for this year. Receiving Departments were directed to consider whether the organizations receiving grants directly supported the Region’s strategic objectives, whether the organizations should continue to receive support beyond 2017, and whether that support should be changed to a purchase of service agreement. Staff conducted a detailed review and based on the findings, it is recommended that the $23,700 annual grant to the Canadian Mental Health Association (Waterloo, Wellington and Dufferin Branch) Distress Centre be discontinued effective December 31, 2017; that the $4,600 annual grant to Telecare Cambridge be discontinued effective December 31, 2018, and that the corresponding base budget amounts be eliminated in 2018 and 2019 respectively.
Report

In 2016, Regional Council approved the transfer of current Grants to Community Organizations to designated program areas (CC-16-01, May 3, 2016). Regional Council also requested a review of all funded organizations be conducted in 2017 to determine:

1. The extent to which each of the organization’s programs and services directly support the Region’s 2015-2018 Strategic Objectives,
2. Whether or not the organization(s) should continue to receive Regional funding support in future years (beyond 2017),
3. If the form of funding provided to the organization(s) should be changed to a purchase of service agreement or other funding form.

Two grants totalling $28,300 to Telecare Cambridge and to the Canadian Mental Health Association (Waterloo, Wellington and Dufferin Branch) Distress Centre were transferred to Public Health and Emergency Services. Based on Council's 2016 direction, grants were maintained at 2016 levels for 2017 and both organizations have received the grant for this year. Staff conducted a detailed review which included a review of grant applications and budgets and interviews with each agency at their service location. Data was analyzed to provide an overview of the organizations and the respective programs and services being funded through the grants. Findings were used to develop recommendations. The review did not include an evaluation of the quality of service, which was considered out of scope.

Staff from Public Health and Emergency Services worked with Community Services staff throughout the grant review process to consult on approaches, findings and recommendations. The following is a summary of the two grants reviewed by Public Health and Emergency Services:

1) Telecare Cambridge Distress Centre. Award for 2017: $4,600

Telecare Cambridge Distress Centre is one of a number of telephone-based distress lines in Ontario, providing 24/7 Telecare services to individuals in particular distress situations. Its organizational objectives generally align with the Region of Waterloo’s strategic objectives relating to Healthy, Safe and Inclusive Communities. It reports an average of around 700 calls per month and refers callers to a range of service providers as well as providing direct distress support. The organization has operated since 1981 and has received Regional support since at least 1985. The Region’s grant amount represents approximately 19 per cent of the organization’s estimated 2016 income and operating expenses. The organization has limited and variable funding outside of the Regional support and significant gaps in organizational capacity were identified through the review. Based on the application materials and interview, it appears that their current ability to sustain that service is uncertain.
2) Canadian Mental Health Association (Waterloo, Wellington and Dufferin Branch) Distress Centre. Award for 2017: $23,700

The Canadian Mental Health Association (CMHA) has received Regional grant support for its Combined Distress Centre since 2013, and has received wider organizational support since at least 1985. Its objectives generally align with the Regional strategic objectives relating to Healthy, Safe and Inclusive Communities. In 2016 just over 60% of calls (approximately 10,500 calls) originated from within the Region of Waterloo. The grant covers broad activities within the Distress Centre, however CMHA also holds the contract to deliver the Provincial ‘Here 24/7’ crisis service, and there is uncertainty about the boundaries between the two functions. The grant amount represents approximately 0.06 per cent of the Waterloo Wellington and Dufferin Branch estimated 2016 revenue, and around 9 per cent of estimated operating expenses for the Distress Centre itself. A proportion of the Region’s grant is put toward staffing costs for the Here 24/7 Service, which also receives support from the Waterloo-Wellington Local Health Improvement Network and potentially four Provincial Ministries (Community & Social Services, Children & Youth Services, Training, Colleges & Universities, and Health & Long Term Care).

Assessment Summary

Mental health factors strongly in the provision of distress supports and services. Although mental health is mentioned in the draft modernized Ontario Standards for Public Health Programs and Services (2017), as a topic of consideration for health promotion, direct mental health supports such as distress lines or telecare-type services are neither explicitly referenced nor implied. The rationale for Public Health and Emergency Services to administer or ensure the provision of such support is therefore debatable; there is no direct connection to the mandate of Public Health.

In addition to the two organizations reviewed, searches have identified a range of telecare-type distress services available to Waterloo Region residents including some which are targeted to specific populations (e.g., Kids Help Phone, Victim Services of Waterloo Region, Sexual Assault Support Centre), as well as others that are more general in nature (e.g., Carizon Family and Community Services, Mental Health Help Line). Any grant application process would need to be open to these and potentially other organizations wishing to apply.

The review indicates that the two grant applications have been approved based on self-reported information and that neither organization has been asked to report on their activities. Establishing the Departmental capacity within Public Health and Emergency Services to administer applications and monitor a formal grants process would not represent good value for money given the combined grant amount.
Implications

Both grant recipients noted that based on the Region of Waterloo’s letter of April 28th 2016, advising them of the intention to review community grants, they were under the impression that the current funding relationship was ending. This review process has confirmed that the Region’s approach to grants has evolved, and neither organization expressed an expectation for continued support.

Telecare Cambridge’s funding is limited and variable aside from the Region’s contribution which makes up a substantial part of their revenue. Not renewing support may have significant implications for the organization. As an organization, CAMH has a greater and more diverse revenue base, of which the Region’s contribution is a relatively small proportion.

Recommendation

Based on the assessment it is recommended that the $23,700 annual grant to the Canadian Mental Health Association (Waterloo, Wellington and Dufferin Branch) Distress Centre be discontinued effective December 31, 2017. In order to provide more time for sustainability planning, it is recommended that the $4,600 annual grant to Telecare Cambridge be discontinued effective December 31, 2018. The corresponding base budget amounts would be eliminated in 2018 and 2019 respectively.

Ontario Public Health Standards:

The current version of the Ontario Public Health Standards makes no mention of mental health. Mental health is noted in the draft modernized Ontario Standards for Public Health Programs and Services (2017), as a topic of consideration for health promotion, however, direct mental health supports such as distress lines or telecare-type services are neither explicitly referenced nor implied.

Corporate Strategic Plan

The content of this report aligns with the following Focus Areas within the Region Municipality of Waterloo’s Strategic Plan:

- Healthy Safe and Inclusive Communities
  - Objective 4.4: Promote and support healthy living and prevent disease and injury
  - Objective 5.2: Provide excellent citizen-centered services
  - Objective 5.4: Ensure regional programs and services are efficient, effective and provide value for money
Financial Implications:

Discontinuation of the two grants and elimination of the corresponding budget would result in $28,300 in savings to the regional levy.

Other Department Consultations/Concurrence:

Staff from Public Health and Emergency Services engaged with Treasury Services and worked with Community Services staff throughout the grant review process to share findings and consult on approaches and recommendations.

Attachments

Nil.

Prepared By:  Tyrone Kidney, Strategic and Quality Improvement Specialist
Celina Sousa, Manager, Strategic and Quality Initiatives

Approved By:  Anne Schlorff, Director, Central Resources/Acting Commissioner
Dr. Hsiu-Li Wang, Associate Medical Officer of Health /Acting Medical Officer of Health
Region of Waterloo

Community Services

Immigration Partnership

To: Chair Geoff Lorentz and Members of the Community Services Committee

Date: September 12, 2017  File Code: A02-40

Subject: Immigration Partnership Update

Recommendation:

That the Regional Municipality of Waterloo approve entering into agreements with agencies or consultants, as determined by the Commissioner of Community Services from time to time, to support implementation of the Waterloo Region Immigration Partnership Community Action Plan for the period 2017-2019, subject to receipt of Federal Government funding;

That the Regional Municipality of Waterloo approve the continuation of temporary staffing within the Immigration Partnership of 2.9 FTE for the period April 1, 2017 – March 31, 2020; and

That the Regional Municipality of Waterloo approve an increase in the 2017 Operating Budget for the Immigration Partnership by $141,605 gross and $0 net Regional Levy as outlined in report CSD-IP-17-03, dated September 12, 2017.

Summary:

The Waterloo Region Immigration Partnership is a comprehensive collaboration between a broad range of community partners, including the Region of Waterloo. The Partnership develops and implements strategies to facilitate the successful settlement, integration and community involvement of immigrants and refugees in Waterloo Region. The Region of Waterloo is the host of the Immigration Partnership, which is funded through a contribution agreement with Immigration, Refugees and Citizenship Canada. As host, the Region is responsible for housing and supervising staff as well as all legal and financial aspects. The Federal Government has committed funding for an additional three years, for the period April 1, 2017 – March 31, 2020, in the amount of $999,753.
Report:

Waterloo Region has always welcomed and benefited from immigration. Today, about 23% of Waterloo Region residents are immigrants or refugees from diverse regions of the world, with expected growth to 30% by 2031. Waterloo Region is one of the top communities in Canada for recent immigrants/refugees on a per capita basis.

The Immigration Partnership is a community-wide initiative consisting of a leadership Council as well as Steering Groups representing three different pillars: Settle, Work and Belong. Planning for the Immigration Partnership began in 2009 and it officially launched in 2011, incorporating the former Waterloo Region Immigrant Employment Network.

Based on extensive community consultation, Immigration Partnership’s strategic directions are set out in its new Community Action Plan 2017-2019 (CAP). The CAP focuses on actions that can be accomplished by building upon existing community strengths and through the formation of strong partnerships.

The CAP identifies issues and includes focused purposeful and actionable activities for change. The CAP includes 10 overarching action areas and many possible activities across the pillar areas. It reflects a deep appreciation that the Immigration Partnership is focused on complex community issues, and that needs and community conditions change over time.

The evolution of the new CAP also corresponds with the Immigration Partnership’s increased presence, strong relationships in the community and ability to mobilize system change activity. The development of awareness, relationships, collaboration and responsiveness among a broad base of community actors via the Immigration Partnership have most tangibly been demonstrated through the very strong and coordinated community response to the welcoming of a large number of Syrian and other refugees. As immigration levels grow, the value and need for a collaborative table such as the Immigration Partnership will continue.

Relation to Quality of Life Indicators:

The collaborative work undertaken by community partners in Waterloo Region through the Immigration Partnership align with the following with the following QOL indicators: economic well-being, social inclusion and equity, physical and emotional well-being, skills development and relationships.

Corporate Strategic Plan:

This report addresses the Region’s Corporate Strategic Plan 2015-2018, Focus Area 4: Healthy, Safe and Inclusive Communities and Strategic Objective 4.2: Mobilize efforts to reduce poverty and the impacts it has on Waterloo Region residents; Focus Area 5:
Responsive and Engaging Government Services and Strategic Objective 5.2: Provide excellent citizen-centred services.

Financial Implications:

Funding for the Immigration Partnership initiative is provided by the federal and provincial governments and United Way Waterloo Region Communities. In addition, the Region contributes $50,000 per year as well as in-kind costs to support this community initiative.

Immigration, Refugees and Citizenship Canada’s allocation to Waterloo Region for the period April 1, 2017 to March 31, 2020 is $999,753. In addition to operating costs, these funds will support 2.9 FTE temporary staffing to work with community partners to implement the Waterloo Region Immigration Partnership Community Action Plan.

The following table summarizes the funding approval for the three years:

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<td>$285,894</td>
<td>$256,535</td>
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Federal Subsidy $457,324 $285,894 $256,535 $999,753
Regional Contribution $0 $0 $0 $0

Of the $457,324 approved for 2017-18, it is projected that $342,993 will be spent before December 31, 2017. This is $141,605 greater than the 2017 budget. Any funds not spent during 2017 will be carried forward to 2018. The 2018 to 2020 Budgets will be based on this approval.

Other Department Consultations/Concurrence:

Legal Services was consulted regarding development of the Contribution Agreement. Corporate Services / Treasury Services provided support in preparing and overseeing the budget. Human Resources and Citizen Service provides support regarding staffing.
requirements.

Attachments


Prepared By: Tara Bedard, Executive Director, Immigration Partnership

Approved By: Douglas Bartholomew-Saunders, Commissioner, Community Services
### Council Enquiries and Requests for Information

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<td>B. Vrbanovic</td>
<td>Update on Evening Street Outreach Actions</td>
<td>Community Services</td>
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THE JOURNEY TOGETHER-
REGION OF WATERLOO

First Peoples Early Years Programming for the Region of Waterloo
Needs Assessment and Programming Proposal

Funded by:

Region of Waterloo

Ontario

MINISTRY OF EDUCATION

AUGUST 2017
Nia:wen/Miigwetch/Yaw’ko/Kinanaskomitin/Wanishi/Iwgwien/ ᐄᔨᔯᐦᑯᔨᓂ !

We would like to thank all the participants who communicated their stories, took part in our surveys, interviews, or sharing circles and hope that we have captured your voices and experiences in a meaningful and respectful way.

A NOTE ON TERMS FROM THE HEALING OF THE SEVEN GENERATIONS:

Within the Healing of the Seven Generations organization, we highly prefer the term First Peoples to Indigenous, Aboriginal, Native, First Nations, FNMI, etc. and will employ this preferred nomenclature over the course of this document. This preference is not uniform across our First Peoples’ community. There were hundreds of languages and dozens of distinct First Peoples cultural groups or “nations” in North America prior to the formation of the Canadian state, each with their own descriptors for how they preferred to be described. These groups have been categorized, from the outside, as one cohesive entity without understanding or respect for their diversity. In this context, the terms used as descriptors for our communities serve to subtly reinforce and remind us of policies that worked to erase our identities, and often come loaded with negative connotations. We feel it is important to acknowledge this erasure and work to redefine our terms on our own terms in our path towards reconciliation.

This report was prepared by:

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*This report is supplemented by the Journey Together- Region of Waterloo: Curriculum document by the same authors, which outlines the evidence-base and curriculum development for this proposal.
# Historical and Societal Context

Residential Schools and their Impact on First Peoples

Scientific, Academic, Linguistic, and Cultural Losses

Lasting Intergenerational Effects

Continued Oppression

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Family Learning Centre

Parental Helpline

The Journey Together for the Region of Waterloo 2017
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Historical and Societal Context

Residential Schools and their Impact on First Peoples

In 1876, the government of Canada enhanced its genocidal campaign against First Peoples, creating a devastating legacy that continues to this day (TRCC 2015). Lawmakers, politicians, religious institutions, the media, and the general population labelled First Peoples as “savages”, backwards relics of the past that desperately needed to “modernize” or become more “civilized”. The eradication of First Peoples’ traditional cultural practices and languages through forced assimilation was seen as the only way to “save” these souls. The government believed that children would be the easiest to mould, and that the best way to mould them would be to separate them from their parents and place them into boarding schools where they could be better prepared for the Canadian cultural reality. It was posited that First Peoples would become more integrated and “productive” members of Canada’s individualistic society through forced assimilation. The results were not as hoped. First Peoples instead became the most at-risk and most poorly integrated ethnic group in the country, with limited economic and societal opportunities still felt more than a century later.

The schools were legislated as mandatory for First Peoples between the ages of 7 and 16 years of age.1 As a result, some 150,000 First Nations, Inuit, and Métis children were forcibly removed from their parent’s homes and their entire lives disrupted (TRCC 1, 2015). The students often lived in substandard conditions, exposed to deadly diseases, unsanitary conditions, and neglect; some eating only grey, bug-filled “mush” for every meal. Students were often physically, mentally, sexually, and/or culturally abused and faced violent reprimand for speaking their mother tongues or practicing cultural traditions (TRCC 4, 2015). Students in residential schools had a greater chance of dying than soldiers fighting during World War II (Schwartz 2015); and one in five students was molested or sexually assaulted (Naumetz 2009). Students learned to feel shame in themselves, their families, and their cultures. Their sense of self-worth and belonging in their communities was completely disrupted (TRCC 4, 2015). They often left the schools with no where to go. They were not employable because of their “Indian” status and the stereotypes that came with it, and struggled to find places to live. Many entered the school with no concept of money and no real understanding of individualistic societies, but now found money and competition necessary for their survival. They no longer fully belonged in their old communities or homes; and often felt as if they no longer fit in anywhere. The attachments they had to their earlier life, eroded after years away. Many could no longer even remember their own languages, or were too terrified to speak them, and found themselves unable to even communicate with their own families. They hadn’t gone through the traditional ceremonies that recognize their belonging and place in their community, and as a result, their communities often shunned them. The students came home with new ways that seemed strange to their old communities or looked down their noses at their community, after learning to hate what they now saw as “savagery”. It left the students in a desperate state, with no sense of belonging, no community or support, little employment opportunity, and an entirely damaged psyche, facing severe trauma all on their own. Many turned to drugs and alcohol or lives of crime to simply survive.

1 From 1884 to 1908, compulsory attendance was legislated for children between 7 and 16 years of age (TRCC 2, 2015). This changed in 1908 to children between 6 and 15 years of age. Compulsory attendance officially ended in 1948, though coercive government policies ensured continued attendance until the schools’ closure (TRCC 3, 2015).

2 The Mohawk Institute Residential School in Brantford, the school many of our community members or their families attended, was nicknamed the “Mush Hole” by students because of the low-quality, mushy oatmeal served for every meal. Evidence elicited through community sharing circles, interviews, and TRCC documentation (TRCC 2, 3 & 4, 2015).
Scientific, Academic, Linguistic, and Cultural Losses

The schools continued for more than a century until the mid-nineteen-nineties, resulting in long-standing cultural devastation and oppression for First Peoples across the country. More than 80,000 residential school survivors still live in Canada today (Schwartz 2015). This horrible legacy resulted in the extinction of hundreds of different languages and dialects and their corresponding cultural practices and knowledge, with only three languages thought to survive past this generation (Langlois 2014). Only around 15% of First Peoples are fluent in their mother tongues (StatsCan 2015) and educational language programs in the province are scarce. This has been a devastating blow to humanity’s body of knowledge that is only beginning to be fully realised. Language is the root of First Peoples’ cultures, and much of our knowledge is contained within our stories and traditions that rely on the languages for continuity. For years, First Peoples’ knowledge was dismissed as useless, a relic of the past with no relevance to the future. Researchers in many areas are now looking to the long-standing teachings, stories, and cultural traditions of First Peoples to fill in the gaps in their knowledge (Mortillaro 2016; CBC Radio 2017). Medicine wheels have been reborn as meditative and therapeutic practices (Hill and Coady 2003), and have helped to advance more holistic medical practices through the focus on life balance instead of the relief of specific symptomology. Ancient sites and ships labelled as “lost” are “found” thanks to the stories saved and passed on by First Peoples communities (CBC News 2014). The antiseptic and antibacterial properties of our smudgings (Mohagheghzadeh 2006) and the effectiveness of our traditional healing medicines and methods are being revisited by the scientific community and have inspired countless medical advances (Tilburt 2008). Our dispute resolution and justice methods are being hailed by legal and conflict experts as incredibly effective, and successful in lowering recidivism rates (Zehr 2005). Our environmental stewardship and knowledge of land and sacred Earth balance are being explored to help reduce environmental catastrophes and slow climate change (Reid 2002; Hill 2017). Despite significant effort to eradicate our populations and our cultures, we have persevered. First Peoples are strong, capable, and an asset to this country, the body of human knowledge, and the preservation of our global environment. Our cultural knowledge and memory is valuable but faces real extinction if an effort is not made to preserve it and pass it on to the next generations.

Lasting Intergenerational Effects

The rippling effects of the residential school system have left First Peoples as the most “at-risk” ethnic population in the country, with the highest incidences of unemployment (Usalcas 2011), poverty (Macdonald and Wilson 2013), incarceration (Office of the Correctional Investigator 2013), being victims of murder/assault/or other violence (Scrim 2009), early mortality (Park et al. 2015, Allard et al. 2004), infant mortality (Smylie et al. 2010), and suicide (FNIGC 2012), among many others. The National Health Indicator Profile released by Statistics Canada for 2011-2014 (CANSIM 2016; Gionet 2015) found that First Peoples have higher incidences of arthritis, asthma, diabetes, high blood pressure, heart disease, stroke, mood disorders, other chronic conditions, pain that interferes with daily activities, and respiratory problems than non-First Peoples. They are more likely to be overweight or obese, to binge drink, to smoke or be exposed to second-hand smoke; and are less likely to have a regular medical doctor, be satisfied with their lives, or to eat fresh fruit and vegetables on a daily basis. These statistics outpace every other ethnic group, by significant percentages in many cases. These are all indicators of severe crises that can not be easily rectified and will require a comprehensive and holistic approach over a sustained period to make real and lasting change.

Researchers have evidence that massive generational trauma, such as the genocidal policies enacted against the First Peoples of Canada, can potentially be passed down epigenetically for over a dozen generations, literally altering the genetic instructions of a family’s DNA for centuries (Yehuda et al 2015). Studies done on the descendants of Holocaust survivors, for example, show that they frequently have lower levels of the hormone DNA for centuries.
cortisol, which helps your body bounce back after trauma, even through three and four generations. There have been limited studies on the medical and genetic effects of the residential school system on First Peoples, but a recent article in the Canadian Medical Association Journal suggests that chronic hunger and malnutrition, which was central to the experiences of residential school survivors, is a contributing factor to First Peoples having a higher risk for obesity, diabetes, heart disease, and other chronic conditions (Mosby and Galloway 2017). The authors reference studies that followed famines in China, Russia, and the Netherlands that show chronic hunger and malnutrition led to hormone changes, greater insulin sensitivity, lower insulin levels, chronic diseases, fertility issues (stillbirths), and made individuals more prone to develop Type 2 diabetes, with effects lasting several generations. The residential school legacy then, is not only lasting emotionally, it is physically and potentially even genetically affecting First Peoples’ communities, likely for generations to come.

Continued Oppression

Sadly, many policies continue to devastate First Peoples in our country, specifically those in the child welfare and justice systems. The legacy of removing children from their homes, for instance, continues to this day. The Ontario Incidence Study of Reported Child Abuse and Neglect from 2013 found that First Peoples children in the Province of Ontario are 130 per cent more likely to be investigated as victims of child abuse or neglect than Caucasian children, 15 per cent more likely to have maltreatment confirmed, and 168 per cent more likely than Caucasians to be taken from their homes and placed into protective care (Fannon et al 2015). This is significantly greater than every other ethnic group in the country. In fact, nearly half of the children in protective care in this country are of First Peoples’ heritage, despite representing only around 4-10%3 of the overall population (Statistics Canada 2016). These numbers reveal the desperate need for more adequate social supports as a preventive measure. Removing children, after the fact, only continues this desperate cycle, creating more adults with low self-esteem and self-confidence, attachment issues, lack of culture, and traumatic long-lasting psychological effects.

First Peoples continue to face oppression in Canada on many fronts, significantly impacting their quality of life and their families’ sense of belonging and well-being. The Ontario Human Rights Commission (2017) found that First Peoples face significant discrimination in policing and justice practices, and the Canadian Human Rights Tribunal (2016) ruled that the Government of Canada (including Indigenous and Northern Affairs Canada) racially discriminates against First Peoples children. The United Nations Human Rights Office of the High Commissioner (2015) has spoken out about the inequitable and inadequate responses of the Government of Canada to the plight of First Peoples. First Peoples are 2.1 times more likely to be unemployed, have a median income that is only 60% of the national average, are 10 times more likely to be incarcerated, 6.1 times more likely to be killed in a homicide, 2.3 times more likely to die in infancy, 2.7 times more likely to drop out of school, and live significantly shorter lives than non-First Peoples (Gilmore 2015). These discriminations have been well documented, but yet somehow, are continuously ignored (Blackstock 2016).

Path to Reconciliation

The Truth and Reconciliation Commission of Canada was established to hear the stories and experiences of the residential school survivors, and to record the intergenerational impacts the system has made. The Commission itself did not come out of a recognition of wrong-doing by the government or a desire to make amends, but rather, was forced through a class-action suit taken on behalf of former residents. The Commission created 94

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3 Our organization estimates that the 4% statistic gathered by StatsCan significantly underestimates the numbers of First Peoples living in the country. First Peoples are often afraid or weary of answering surveys, and if able to pass as another ethnicity, will do so. This is described in greater detail in the Demographics section.
“Calls to Action” to help reconcile the damage done by these historical policies and restore a sense of balance to our country so that we can all move forward together in peace (TRCC 5 2015). It urges all levels of government— federal, provincial, territorial, and First Peoples—to work together to change policies and programs in a concerted effort. If action is not taken by these different levels of government in a timely fashion, and the statistics not bettered, there will likely be more class-action suits of human rights abuses in the future.

This proposal seeks to address these specific Calls from the TRCC:

1. We call upon the federal, provincial, territorial, and Aboriginal governments to commit to reducing the number of Aboriginal children in care by:
   
i. Monitoring and assessing neglect investigations.
   ii. Providing adequate resources to enable Aboriginal communities and child-welfare organizations to keep Aboriginal families together where it is safe to do so, and keep children in culturally appropriate environments, regardless of where they reside.
   iii. Ensuring that social workers and others who conduct child-welfare investigations are properly educated and trained about the history and impacts of residential schools.
   iv. Ensuring that social workers and others who conduct child-welfare investigations are properly educated and trained about the potential for Aboriginal communities and families to provide more appropriate solutions to family healing.
   v. Requiring that all child-welfare decision makers consider the impact of the residential school experience on children and their caregivers.

2. We call upon the federal government, in collaboration with the provinces and territories, to prepare and publish annual reports on the number of Aboriginal children (First Nations, Inuit, and Metis) who are in care, compared with non-Aboriginal children, as well as the reasons for apprehension, the total spending on preventative and care services by child-welfare agencies, and the effectiveness of various interventions.

3. We call upon all levels of government to fully implement Jordan’s Principle.

5. We call upon the federal, provincial, territorial, and Aboriginal governments to develop culturally appropriate parenting programs for Aboriginal families.

8. We call upon the federal government to eliminate the discrepancy in federal education funding for First Nations children being educated on reserves and those First Nations children being educated off reserves.

10. We call on the federal government to draft new Aboriginal education legislation with the full participation and informed consent of Aboriginal peoples. The new legislation would include a commitment to sufficient funding and would incorporate the following principles:
   
i. Providing sufficient funding to close identified educational achievement gaps within one generation.
   ii. Improving education attainment levels and success rates.
   iii. Developing culturally appropriate curricula.
   iv. Protecting the right to Aboriginal languages, including the teaching of Aboriginal languages as credit courses.
   v. Enabling parental and community responsibility, control, and accountability, similar to what parents enjoy in public school systems
   vi. Enabling parents to fully participate in the education of their children.

12. We call upon the federal, provincial, territorial, and Aboriginal governments to develop culturally appropriate early childhood education programs for Aboriginal families.

14. We call upon the federal government to enact an Aboriginal Languages Act that incorporates the following principles:
i. Aboriginal languages are a fundamental and valued element of Canadian culture and society, and there is an urgency to preserve them.

iii. The federal government has a responsibility to provide sufficient funds for Aboriginal-language revitalization and preservation.

iv. The preservation, revitalization, and strengthening of Aboriginal languages and cultures are best managed by Aboriginal people and communities.

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Metis, Inuit, and off-reserve Aboriginal people.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools,

33. We call upon the federal, provincial, and territorial governments to recognize as a high priority the need to address and prevent Fetal Alcohol Spectrum Disorder (FASD), and to develop, in collaboration with Aboriginal people, FASD preventative programs that can be delivered in a culturally appropriate manner.

38. We call upon the federal, provincial, territorial, and Aboriginal governments to commit to eliminating the overrepresentation of Aboriginal youth in custody over the next decade.

57. We call upon federal, provincial, territorial, and municipal governments to provide education to public servants on the history of Aboriginal peoples, including the history and legacy of residential schools, the United Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous laws, and Aboriginal-Crown relations. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

62. We call upon the federal, provincial, and territorial governments, in consultation and collaboration with Survivors, Aboriginal peoples, and educators, to:

iii. Provide the necessary funding to Aboriginal schools to utilize Indigenous knowledge and teaching methods in classrooms.”

Our First Peoples community is now experiencing a great revitalization and renaissance of culture, with an overwhelming desire to save this stolen and almost lost legacy. First Peoples are finally allowed to express our cultures, learn our languages, and practice our traditions in public spaces, after generations of being forbidden. The time for healing is now. If we do not act with expediency, the opportunity (and great amounts of cultural legacy) will be lost, and another generation will suffer. Trust is the greatest thing that has been lost to our people. The most at-risk First Peoples are not accessing any of the supportive government services, at all, because trust has been completely broken4. They see any government organization, no matter the good they may do, as something that’s going to hurt them, disrespect them, and oppress them. They don’t fill out censuses. They will walk away from surveys. They don’t have set addresses. They are living on couches. In cars. In parks. Sometimes

44 As elicited in interviews and sharing circles described in the Needs Assessment section.
their children are living with them in these places. Sometimes they are fighting to get them back, and sometimes they are so broken, they have given up the fight entirely. Our intended programs seek to aid these most at-risk parents and youth, and give them the non-judgmental support they need to thrive. We want to encourage our parents to have greater trust in the existing systems through gradual exposure in a safe environment and guide them to make more informed parental choices so that we can break these desperate cycles in the next generation. There is no time to delay.

**Sources for this section:**


CANSIM. 2016. “Health indicator profile, by Aboriginal identity, age group and sex, four year estimates, Canada, provinces and territories”. Statistics Canada. Table 105-0512. Available at: <http://www5.statcan.gc.ca/cansim/a05?lang=eng&id=1050512>


The Journey Together for the Region of Waterloo 2017
Demographics

The Region of Waterloo is listed as the fourth largest city centre by population in Ontario (StatsCan 2016) and is surrounded by five First Peoples reserves all within a 100-km radius (Six Nations of The Grand River, the Mississaugas of the New Credit First Nation, Munsee-Delaware Nation, Oneida Nation of the Thames, and Chippewas of the Thames First Nation; Zimmer 2016). The fastest-growing segment of the Canadian population is First Peoples, more than half of whom reside in urban areas (INAC 2010). The fastest-growing segment of the First Peoples population, unlike the rest of Canadian society, is young people. Approximately 28% of the urban First Peoples’ population is under the age of 15, nearly double that of non-First Peoples. There are more First Peoples women than men in urban areas, many who are single parents living with their children. Larger families with three or more children are becoming increasingly common in First Peoples’ communities, and our surveys and interviews suggest that parents want and are planning for even larger families in the future. The parents are young, often under the age of 25, and are frequently unprepared for parenthood. Many have grown up in abusive situations, due to the intergenerational impacts of the residential school system, and have received little positive parental modelling and affection in their lives. Most are desperate for love of any kind, and see dependent children as the best way to fill that void. They want their children to thrive and have better lives than they did, but often don’t have the skills or resources necessary to provide their children with secure and successful futures.

If we use the extremely conservative estimate of approximately 15,000 First Peoples living in the Region of Waterloo suggested by Census data (StatsCan 2011), and assume 6% of that population is aged 0-4 (based on Regional statistics; Region of Waterloo 2011), then there are at least 900 Early Years children of First Peoples heritage currently residing in our area. The Waterloo Wellington Local Health Integration Network (WW LHIN 2011) suggested a minimum of a 34% growth rate in population in the two Regions from 2002 to 2011, and interviews with local experts suggest it continues to grow exponentially. Local First Peoples organizations estimate the number of First Peoples in the Region to be at least double the Census estimates. Many First Peoples are fearful or distrustful of surveys or identifying themselves officially as “Indigenous”, or have been conditioned through years of genocidal policies to see their own Indigeneity as shameful or as something to erase from their history. They fear reporting their Indigeneity will result in further oppression against them. Those who can “pass” as other ethnicities, often go to great lengths to erase their heritage in public. Many others live in transient or nomadic states, moving from place to place, and as such, are not accurately included in census data. Since we know that First Peoples have higher percentages of youth than non-First Peoples, the 6% figure is also likely to be significantly higher.

The Healing of the Seven Generations estimates there are probably closer to 2,500 First Peoples Early Years children currently living in the Region of Waterloo, and yet there are no child care services particularly designed to meet their complex needs, and severe cultural barriers for the most at-risk to access mainstream services. A high percentage of these children enter school already behind, often severely impoverished, and living with insecurity, abuse, and trauma. High numbers live in constant insecurity, changing homes, and even families, some dozens of times before they ever reach kindergarten. Many regularly witness abuse in their homes, and/or are themselves abused or neglected. High numbers have parents who are severely impoverished, struggle with addictions, are frequently incarcerated, and struggle to cope with their own trauma. We know from interviews

5 Evidence elicited through surveys and interviews outlined in the Needs Assessment.
6 ibid
7 See Needs Assessment for more details
First Peoples are more likely to be unemployed (Usalcas 2011), homeless (Region of Waterloo 2010), in single-parent families (StatsCan 2015), incarcerated (OCI 2013), placed in protective care (Fannon et al. 2015), face discrimination (OHRC 2017), and are in high risk groups for every other indicator of well-being in the country. The legacy of the residential school system has left First Peoples in cycles of abuse, poverty, and trauma that seem to be worsening and ongoing oppressive policies that leave funding gaps and insufficient capacity to make lasting changes (Macdonald 2016; Fannon et al. 2015; etc.). Prevention is better (and usually cheaper) than reaction. We need to stop these cycles before they start by educating and supporting the parents of our Early Years children to ensure the success and well-being of their families from the very start and provide them with the resources and materials necessary for their children to have the best possible future. The sooner we start, the better (Picard 2017).

SOURCES for this section:


Needs Assessment

Methodology:

The researcher conducted a series of surveys, formal and informal interviews, and sharing circles with self-identified First Peoples parents or caregivers of Early Years children (ages 0-6) living in the Region of Waterloo and surrounding areas. The researcher facilitated 124 surveys, 26 formal interview sessions with parents, 23 interviews with experts or local service providers, 6 interviews or consultations with provincial First Peoples-led childcare organizations, 2 parental sharing circles, 1 Elders circle, 1 community circle, and attended several healing/sharing circles and social events within the community to hear the community’s stories and try to solicit more participants. The researcher also studied the Truth and Reconciliation Commission reports, news articles, research papers, and other relevant reports to elicit demographic and contextual information. Most of the in-person surveys were followed by informal discussions/interviews with the researcher, several on a near weekly basis over a series of four months. The researcher would attend the Community Lunches, Healing Circles, and other local First Peoples events and talk to those who attended to hear their stories. This method was selected after attempts to distribute surveys, run sharing circles, or do formal or recorded interviews initially proved unsuccessful. Approximately 15 First Peoples parents regularly shared their struggles with the researcher over the course of the four months, and four of those parents were chosen as case studies to give a more personalized context to the report.

Strengths and Limitations:

Soliciting information was exceedingly difficult. High numbers of the surveys were originally left blank or incomplete and participants appeared to be more comfortable speaking off the record than putting anything to print. First Peoples in our Region have been subjected to at least five needs assessments and research surveys over the last decade\(^8\), and frequently reported or complained that they have not seen changes to cultural accessibility or increased services or programming as a result. This community has historically been distrustful and fearful of surveys and being participants in research processes, because they have repeatedly resulted in oppressive results for them and their families in the past. The informal interview process was chosen because many who were asked to complete surveys outright refused, but were frequently seen by the researcher at the Healing of the Seven Generations centre as parents seemingly in the most need of support. Most of the participants were reluctant to talk until they became more comfortable with the researcher, with an average of four informal meetings/social activities at the centre with each subject before they would agree to fully speak, and even then, only on a casual basis, without the use of recording materials or directed questioning. Many of those who originally refused to do the survey, eventually agreed after several meetings with the researcher. Some of these participants only agreed to answer through conversations and refused to have any answers recorded at the time of the interview. The presence of recording materials appeared to make most participants extremely agitated or upset. As directed questioning was highly resisted, some questions were not able to be solicited in the interview process. Recording for most of the interviews was done immediately after speaking with the individuals from the memory of the researcher, and so has potential to be distorted or details forgotten.

In two cases where interview participants eventually agreed to take the full survey, the participants requested the researcher to read the questions and record their answers, citing literacy issues. In both cases, the interviewed parents responded with multiple conflicting answers between the interviews and survey. Several other participants requested the researcher ask the questions, and record the answers for them, but did not cite their

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\(^8\) Solicited from interviews and documents obtained from staff at local First Peoples organizations.
reasoning. Three surveys were handed back to the researcher entirely blank, even after the respondents had initially showed a great deal of interest in participating. The researcher regrets that some of the more sensitive questions of abuse and upbringing may have been triggering to some respondents and resulted in them reversing their participation. Many of the questions were left blank among the overall surveys taken, but not consistently the same question, and not questions one would expect to be so poorly represented. For example, nearly 14% of respondents refused to indicate their gender and nearly 10% refused to answer their age. Questions about trauma, abuse, and violence, were more likely to be answered than these simple, fact-based questions. This leads the researcher to believe that the quality of the findings may be significantly affected by trust, survey fatigue, and potentially literacy issues.

The resulting findings may not be fully representative of the overall First Peoples population in the Region of Waterloo, as the vast majority of surveys and interviews were facilitated through the Healing of the Seven Generations Centre or the KW Urban Native Wigwam Project. The participants were primarily attending these centres for either healing services, court supports, or housing services, and likely had higher chances of being in at-risk groups. Most are referred to these centres through courts, child welfare services, or following severe crises, as the centres are not highly advertised or well-known outside of small community circles. First Peoples are one of the hardest groups to identify and survey in the community, because they are often fearful or hesitant to identify as such, especially if they are able to “pass” as another ethnicity. Many indicated in interviews that they refuse to answer honestly on any surveys and are tired of being “used as guinea pigs” by the government. The Healing of the Seven Generations centre proved to the easiest place to gain the trust of participants, and so was chosen as the prime location to solicit.

Most of the parents interviewed do not have consistent access to the internet and do not own computers, and so distributing surveys in that fashion was limited. Approximately 20% of the surveys were submitted online, after calls went out into the community through local bulletins and online networks. The online surveys were less likely to have answers in high-risk categories than those answered offline. The researcher suggests that poverty may be significantly correlated to whether First Peoples enter into high-risk categories.

The researcher’s initial survey was originally lengthier than the one provided in the Appendices but proved to appear overwhelming to participants. The original survey included questions about nutrition, health factors, happiness, addictions, and social supports, among other things that had to be paired down into a shorter survey. The difficulty in acquiring willing research participants limited the survey sample size below the hoped participant levels of the researcher.

The researcher suggests, however, based on the informal interviews, conversations, and sharing circles; that the findings of this needs assessment are indicative of those in high-risk groups within the First Peoples community in the Region and that the needs assessment has revealed the types of supports that are necessary for this population. The researcher regularly encountered a minimum of 100 highly at-risk parents willing to talk who were seeking supports at different local organizations and appeared desperate for more services; and at least 25-30 parents who refused to participate all together, but were speculated to be the most at-risk. Subsequent interviews with the staff, volunteers, and Elders in the community, confirmed those speculations. The researcher believes that the number of high-risk participants attending the main First Peoples organizations was significant enough on its own to merit the need for the proposed services. It is impossible to calculate exactly how many

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9 This is due to funding shortfalls described later in this section.
10 Several participants used the phrase “being used as guinea pigs” (or slightly different wordings) over the course of the interviews.
First Peoples individuals who are in high-risk groups and not accessing (or even aware of) services are living in our Region, but the researcher speculates the numbers are cause for concern, and that the government and local organizations need to develop new ways to access, communicate, and build trust with these populations.

Summary of Findings:

Overall, our interviews and sharing circles found that our parents demonstrated a high degree of love and care for their children, but many appeared that they had never learned how to accept or express love in any tangible way, had difficulty forming attachments to others, and struggled with their own self-worth and sense of belonging. The only model for childcare most ever received involved abuse and/or neglect, and so they may have never learned non-violent discipline techniques or how to care for their children or even themselves. They are often afraid to ask for help, because they distrust the government, churches, and NGOs; or because when they do ask for help, their children are taken away from them.

The parents are facing multiple, compounding risk factors, including homelessness or housing instability, unemployment, poverty, mental illness, trauma and abuse, and a surprisingly high number of disabilities. Few of the parents speak their mother tongues, but all expressed First Peoples' cultural literacy as high priority for their children. In a high number of these cases, parents reported to the researcher that they had had children removed from their home and placed in protective care in the recent past, with many of the children still in foster or adoptive care. Dozens of these parents continue to have regular Access visits with their child(ren) and open court cases for custody. All parents interviewed and more than 90% of those surveyed indicated that they had grown up in some form of abuse, in many cases compounding physical, emotional, sexual, and spiritual abuses; and yet, none of those interviewed, and only 2 of those surveyed, had reported receiving adequate therapies or other assistance to deal with their trauma.

These parents need assistance in an environment where they feel safe and respected, where they can trust the facilitators to have an open dialogue without judgement, where the staff understand their cultural reality and traumas, and where they can receive intensive healing and support in an holistic way, preferably all in one place. They need positive parental modelling, and respite from their children to seek employment and educational opportunities so that they can ensure the stability of their homes. They need support to access services to improve the quality of their lives. They need ways to teach to their children their stolen cultures and languages, and to learn themselves so that they can preserve their own cultural heritage and dignity in their Indigeneity.

This research found that there are significant funding gaps for self-led First Peoples services in the Region of Waterloo, despite the government’s commitment to the Jordan Principle (INAC 2017), and that the Region lags significantly behind other Regions in Ontario in its provision of First Peoples services.

Preferred Terms: Our surveys found that 27% of respondents preferred the term Native, 27% preferred Aboriginal, 18% First Peoples, 18% Indigenous, and 9% First Nations. These mixed results suggest, as mentioned in the Note on Terms at the top of this document, that there is no overwhelming agreement on what terms First Peoples in our community prefer. In subsequent interviews many indicated strong negative connotations to particular terms and articulated a variety of reasons for why they preferred the term they did.

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11 Decimals have been rounded up or down to the nearest place accordingly throughout the findings
Gender: Respondents did not consistently answer this question. Seventeen of the 124 (almost 14%) respondents left this question blank. The question asked respondents “How would you describe your gender”, with the choices being “female”, “male”, “non-binary”, “trans”, “two-spirited”, “agender”, and “other”. Of the answered surveys, 76% of respondents identified as female, 20% identified as male, and 4% identified as non-binary, trans, two-spirited, or other. This ratio appeared to be similar composed among the interview participants.

Ethnicity or Cultural Group: Respondents were asked to describe their ethnicity or cultural group. Fifty-nine respondents in the surveys self-identified as Algonquin/Ojibwe or an associated cultural group or some combination of Algonquin/Ojibwe and another ethnic or cultural group (most often reported as Cree, Metis, or Mikmaq), 23 respondents self-identified as Mikmaq or Metis, 20 as Mohawk/Haudenosaunee, and 8 as various other cultural groups/ethnicities. More than 20 different First Peoples cultural backgrounds were recorded from the surveys and interviews in total, many of these from overlapping cultural groups such as Anishnabeg, Ojibwe, or Chippewa. The different reported cultural groups included Anishnabeg, Haudenosaunee, Sioux, Cree, Oji-Cree, Oneida, Cayuga, Seneca, Onondaga, Tuscarora, Nipissing, Odawa, Potawatomi, Chippewa, and Inuit. This question was the second most unanswered, with 14 respondents leaving the question blank. Subsequent interviews suggest this is because many do not know how to precisely label which cultural group or clan they come from, or are fearful to indicate their heritage on forms due to the legacy of the residential school system.

Age: A high number of the parents (22%) reported being under the age of 20, 26% were aged 20-25 years old, 25% were aged 25-30, 9% aged 30-35, and 7% aged 40-45. Nearly 10% of the surveys were left blank in this section. Younger parents were more likely than all other age groups to report a desire for larger families or be home insecure.

Housing: Approximately 75% of parents reported living in one of the three main city centres (Kitchener, Waterloo, or Cambridge), most for five years or more; 13% reported living in neighbouring hamlets or outlying communities (specifically in Wellington and Oxford counties), and 13% reported living elsewhere in Ontario, and only temporarily residing in the Region. Subsequent interviews and discussions with participants found that many of those who reported living elsewhere in Ontario remained in the Region for specific services, court processes or had bail conditions that prevented them from leaving. These individuals often reporting being extremely lonely, having limited family or support in the Region, and very few, if any, friends.

When asked if they would describe their housing situation as stable, only 63% of respondents answered “yes”. Almost 17% responded “most of the time”, 5% responded “no”, and nearly 15% did not respond at all or had marked the form in ambiguous ways in this section. Several interview participants indicated they were currently homeless, and almost all of those interviewed indicated that they had experienced homelessness either recently or in the recent past. Among the interviews, all but 2 reported regular instability in their housing. More than a third of respondents in the surveys indicated that they had borders, roommates, or other unrelated adults living in their home with them and their child(ren). Many indicated in subsequent interviews, that they had left their child(ren) with these unrelated adults on more than one occasion.

Family Size and Composition: Nearly 13% of respondents indicated that they had 4 or more children, 46% had 3 children, 25% had 2 children, and 12% had 1 child. When asked if they were planning to have more children in the future, nearly 67% indicated that they wanted at least one or two more children, 14% indicated that they weren’t actively planning at this time but would consider it in the future, and only 12% said that they were not planning any more children. In every single interview, the parents indicated wanting larger families. Just less than half of respondents in the surveys lived with their child’s other parent, and nearly one quarter of respondents indicated that their child’s other parent was not very involved or not involved at all in their child’s life. Of those parents

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Financial Security: Almost half of the participants indicated that their main source of income was through social assistance of some sort (OW, ODSP, EI, WSIB, etc.), and nearly half indicated that they were struggling to make ends meet. Around one-third of participants indicated that they were currently working, and only around 12% indicated they had steady employment. Of those that were currently employed, nearly three-quarters of those indicated that they worked irregular or temporary hours, often in the evenings or on weekends, and many reported in subsequent interviews that available childcare options were unable to meet their schedule. The question regarding income brackets was consistently marked ambiguously, but more than half of those filled in correctly indicated an income below the poverty line.

Special Needs: Forty-eight percent of participants indicated that they had some sort of disability themselves, for which they needed special assistance, with the most commonly reported assistance needed being tied to mental health issues, diabetes, or learning disabilities. Interviews suggest that many of the participants or their child(ren) had conditions or disabilities in addition to those reported, that were going undiagnosed, and that the parents were struggling to access comprehensive medical care for themselves and their child(ren). Participants who were Status individuals often reported jurisdictional disputes between provincial and federal governments when accessing medical care, specifically special needs testing, and assistive devices, that had resulted in long waiting periods to receive support. One fourth of participants indicated that their child had a disability or were special needs, with the most commonly requested assistance needed related to autistic spectrum disorders. Several parents in surveys indicated that they had experienced long delays (sometimes years) for special needs testing.

Cultural Literacy: None of the participants in surveys or interviews indicated that they spoke their respective First Peoples language(s) fluently, and less than one-fifth spoke at a self-described beginner or intermediate level. Almost 90% of those surveyed indicated that they had limited cultural education in their childhood, and all of those interviewed indicated that they had been dissuaded by parents, caregivers, or other individuals from learning about their cultures or languages. Every single respondent in the surveys and interviews expressed that they wanted their children to learn their culture and languages and that this was a high priority for their families.

Trust in Local Organizations: Participants were asked to rate their trust of the local government agencies, child welfare services, and local First Peoples organizations. When asked to rate their trust of local government agencies, only 5 respondents indicated a score of 3 or higher, where 1 was “no trust” and 5 was “absolute trust”. No respondents indicated higher than a 4. For child welfare services, only 1 respondent indicated a score of 4, and no respondents indicated a 5. Most of the surveys scored below a 3. When asked to rate their trust of local First Peoples organizations, the vast majority (87%) of respondents, indicated a 3 or higher, with only 7 respondents indicating a 2, and none below. These results suggest that First Peoples are highly distrustful of local government agencies and child welfare services, but have a high degree of confidence in the local First Peoples organizations. The researcher believes that this demonstrates that services will likely be better accessed if they are First-Peoples-led.

Other Risk Factors: Only 4 participants in the surveys or interviews indicated using daycare services of any kind, and of those 4, only two said they currently used daycare services on a regular basis. The most common reasons for not accessing services were cultural or financial barriers, and lack of day care for evening or weekend shifts or
drop in care to cover temporary work. Every single parent interviewed and more than 90% of those surveyed indicated that they had grown up in abusive situations, many indicating multiple forms of abuse including physical, mental, sexual, and spiritual abuse. Nearly 31% of respondents had indicated that they had been sexually abused as a child, and more than 40% of respondents indicated they had witnessed the abuse of others during their childhood. More than three-quarters of those surveyed and all of those interviewed indicated that their parents fought in front of them on a regular basis as children. More than 2/3 of those surveyed and all of those interviewed indicated that they had some dealings with Family and Child Services over their lifetime, and less than six of those participants indicated neutral or positive experiences. Several informal interview participants indicated that they had informally fostered family or clan members or the children of other close friends when those parents were struggling, adding additional strain on their already limited resources, time, and energy; but that they did so to keep them the children out of child welfare agencies. Almost one in three participants surveyed indicated that they had been involved with the justice system at one point in their life, and all but two of those interviewed indicated they were currently involved in the justice system in some way (currently incarcerated, on bail, or in courts processes). Around one-third of participants indicated that they were currently working, and only around 12% indicated they had steady employment. Of those currently employed, many indicated that they worked irregular shifts, often on evening or weekend hours.

**Case Studies:**

* individuals kindly consented to having their stories used as case studies for the sake of this proposal, but names and any identifying characteristics have been changed to protect their identities

**Case Study Subject #1: Female, Linda*, age 28, 3 children:**

Linda grew up with the lasting intergenerational impacts of the residential school system. She has developmental delays and learning disabilities that mildly impact her ability to care for her children. Her mother is severely ill and not in a position to support her, and her father was convicted as a pedophile and has little interactions with her. Linda found herself in multiple abusive relationships, had three children with three separate fathers at a young age, and was left as a single parent with limited support. She has three children, all under the age of 12, and all three are disabled in some way. Linda has struggled to keep secure and adequate housing, steady employment, and to find supportive partners.

Linda was struggling to fully support her children’s needs with her disabilities, and called Family and Child Services for help. Linda was subsequently found to be neglectful of her children, and they were removed from her home. Linda is not abusive to her children, and was not suspected as such. She has no addiction, crime, or visible or reported anger issues and regularly attends healing services to deal with her own traumas. She was not offered adequate support for her disabilities or needs by Family and Child Services, and at the time her children were taken, had no real understanding of where she was lacking in the care of her children. She expresses and demonstrates a great desire to give the best care she possibly can to her children, and followed all the instructions and advice provided by Family and Child Services to the letter. The only negative note in Linda’s file came after she miscarried during an Access visit and was subsequently scolded by FNCS workers for bleeding during the visit and having to leave early to seek medical care. Linda religiously attends Access Visits with her children, always bringing freshly homemade foods for them to eat and interacts and bonds with them on a high level. She vigorously monitors the health and well-being of her children and advocates to ensure they have the care they need in their foster families. She attended educational classes to better understand how to care for her children, and made every effort to meticulously learn how to be the best parent she could. She built a support network at the Healing of the Seven Generations centre to help her access services and ensure she is meeting the
needs of her children. Linda was referred by the centre to an organization that specializes in assisting disabled adults to live with dignity, and acquired a case worker who would provide some in-home support. The children appear to relish in the time spent with their mother and appear greatly attached and bonded to her. Despite these efforts, her children are on track to become wards of the state, and she will likely lose all custody or visitation with them in the coming months. The reasoning appears to lie in the fact that they have been out of her custody for several years, and the judge appears reluctant to uproot them again at this point or have any confusion in their bonding and attachment to their new parents. There were also concerns about Linda’s past choices in partners, though Linda repeatedly told the researcher that she’d rather have her kids and be single forever, than live without them, and had sought to move on her own to get custody.

Linda’s case sounds like an outlier, but similar details and stories were found among many interview and sharing circle participants. Participants frequently cited that they had not received adequate supports to help their situation, and often articulated that couldn’t even understand why their children had been taken from them. Linda is a prime example of a case that could have gone entirely differently. If Linda had called a helpline when she was having difficulty, received direction to supportive services, had outreach support, and come to family learning programs, her children would likely still be in her care. Instead, she struggled on her own until it was too late, and little could be done to help her case.

Case Study Subject #2: Male, Brian*, age 28, 6 children:

Brian grew up in Winnipeg, Manitoba, among a family of survivors of the residential school system. At the age of twelve, Brian ran away from home and discovered solace and acceptance within a First Peoples’ gang subculture. He quickly learned how to effectively commit crimes, such as selling drugs and intimidating other people to achieve the desired means. Brian recalls that the immediate pleasure experienced by effectively executing the various crimes was followed by a sense of emptiness that was never fulfilled while he was a part of the gang subculture. Because of his criminal actions and involvement with the gang, Brian was in and out of prisons for petty thefts, possessions, and assaults until the age of 28. Brian’s court dates were also made particularly difficult for him as he was denied legal aid several times, even though he was homeless and unemployed. Brian also faced significant discrimination and obstacles in securing stable housing or employment upon release due to his ethnicity, and criminal past.

Brian met a First Peoples woman on the reserve in Winnipeg with whom he became romantically involved. This woman was originally from Kitchener, Ontario, so both Brian and the woman moved to Kitchener to escape the detrimental subculture he was involved in. Brian’s girlfriend suffered from the residual effects of the residential schools as well, and both their perceptions of love appeared grossly distorted. The relationship between Brian and the woman was unstable, and he reported both physical and emotional abuse within the relationship.

Brian was referred to the Healing of the Seven Generations centre by a friend and was provided with access to a supportive community, composed of social workers, counsellors, and court support workers, that assisted him in getting on a better track. Through the teachings of the Seven Grandfathers’—the cultural equivalent of programs such as Partner Assault Response (PARS)—Brian took part in sweats, smudging, and men’s drum circle to get on the path of healing. During Brian’s involvement at the centre, he and the woman conceived a child and the birth of this child seemed to have changed both his outlook on life and his perceived definition of love. The children were apprehended by FNCS after a situation where the mother left the baby in a car-seat in the driveway in the middle of the winter and called Brian to say she was done caring for her. Shortly after he picked up the child, the
mother called the police and reported the child as kidnapped. Brian was surrounded by squad cars and taken to jail, where he was ultimately acquitted. He turned to the Healing of the Seven Generations for guidance and assistance on addressing the problems between the couple to ensure that the physical and emotional abuse they suffered would not translate into the life of their child. Brian began working with Child and Family Services to obtain supervised overnight visits with the child, and secured more stable housing. He worked hard on his sobriety and was on waiting lists for several different programs and skills training. It is the researcher’s opinion that Brian and the mother of his child would benefit greatly from family learning programs and couples/family counselling where they could receive modelling and education to help them break the cycle of abuse and trauma.

Unfortunately, Brian had a temporary lapse in his healing journey following a difficult personal situation, and was recently caught up in new criminal charges. Given his past charges, he likely now faces several years in prison, despite his last year’s progress towards rehabilitation, his mental illness, and the Gladue process that is supposed to take into account the personal situations of First Peoples defendants in sentencing. Brian’s child will likely spend her most formative years away from her parents in protective care and after that point is unlikely to be rehomed with her family or have any attachments to them. Brian’s case demonstrates the needs for collaborative approaches to care, and the multi-faceted realities of traumatized individuals who are in need of multiple, coordinated supports.

Case Study Subject #3, Amy, female, age 16, 1 child:

Amy was born into a family that struggled with the intergenerational effects of the residential school system. She grew up as a ward of the state, as her mother was a severe drug addict, but had regular visitations with her birth family. Amy dropped out of school the first chance she could and had her first child at 16 years of age. Two days after her C-section, Amy’s baby was taken into protective care because it was deemed she would be unable to support the child. Amy was subsequently transferred to a group home in in the Region after being declared a ward of the state herself, more than a hundred kilometers from her home and baby, because of lack of local availability. She has Access visits with her child four days a week for two hours at a time. This requires more than two hours of travel time each visit, and almost $200 in travel costs each time. The constant travel makes it incredibly difficult for her to attend any training, education programs, or seek steady employment, and the costs are prohibitive for an impoverished individual. It is the researcher’s opinion that Amy is not a bad mother, but is just woefully unprepared for the realities of raising a baby and is in desperate need of supports. Amy would benefit greatly from family learning programs that would give her tools to form attachments and bond with her child. She also would benefit from ongoing therapy and outreach work. Going forward, Amy needs comprehensive programming to get her life on track, that includes ways to retain custody of her child, take educational programs or skills training, and find stable housing. Family Learning Programs would significantly help her chances, and access to a cultural-trained Social Worker would help connect her to services.

Case Study Subject #4, Bonnie, female, age 21, 1 child (and one on the way):

Bonnie grew up with the intergenerational impacts of the residential school system. Her mother was a ward of the state, and Bonnie also became a ward in early childhood and was raised in foster care her entire life. Bonnie’s baby was apprehended by FNCS at the time of their birth because they deemed she had not properly followed up on prenatal care. Bonnie dropped out of school at a young age, and didn’t complete high school. The baby’s father fought for custody, but was newly partnered with a woman who was suspected of having addictions issues. Bonnie made threats to her former partner in an effort to visit the baby, and subsequently faces criminal charges.

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The researcher first met Bonnie at the Healing of the Seven Generations centre and observed that she had difficulty attaching and bonding with her child, and frequently became frustrated when she couldn’t calm it from screaming. She expressed visible sadness when others would seemingly calm the baby the moment it left her arms. Bonnie currently has weekly Access visits with her child and is desperately trying to find ways to bond with it in the limited time she has. Bonnie is a condemnation of the current child welfare system for First Peoples. Both her mother and her spent their lives in supposed protective care, but yet were deemed uncappable of being parents even before they had the chance. Bonnie would benefit greatly from parental programs and other services, but her trust in the system is greatly broken and she will not attend government-run services unless forced to do so. She attends the Healing of the Seven Generations on a regular basis as her main source of support, but they are unable to meet all her needs.

Programming Needs:

Parents most commonly requested cultural programming for their children, off-hours daycare, or drop-in care that involved educational parenting workshops. Parents indicated they wanted programming to include outdoor learning to promote greater connections to the land, accessibility supports for disabled children, and wanted Elders and other community members to be involved in mentorship roles. Several parents requested CPR and First Aid learning modules and more “truthful” and “realistic” information on the realities of parenthood and each stage of development. Many expressed that any resources or courses they had taken prior to becoming parents did not fully prepare them for the realities. Many parents also reported that they wish they had received support for depression associated with the birthing process and raising children on their own. Age may be a significant factor in these findings and may indicate that more comprehensive birth control and educational programs on relationships may be needed for these communities at younger ages, as well as youth programs to teach them skills and keep them involved in productive activities. Parents also strongly indicated preferences for their children and themselves to learn their respective mother tongues.

Current Services for First Peoples in the Region:

First Peoples, especially the most at-risk, are not accessing the services they need in the Region of Waterloo, and often cite cultural barriers or finances (mostly involved with transportation) as their reasoning. The researcher observed several subtle factors that would dissuade First Peoples from wanting to access local government services. For example, within several Regional government offices, a “welcome” sign with ‘welcome’ written in dozens of different languages hung with prominence in the entry ways, however, not a single First Peoples language was included in the sign. Subtle factors such as these, can lead First Peoples, who already have severe trust issues with the government, to feel that they are unwelcome in their own country. The Region was advised of this issue, and made immediate efforts to rectify it. These subtle factors demonstrate the need for increased First Peoples’ consultation and education for staff within the government agencies to ensure that they are not subtly discriminating in their practices.

The Region of Waterloo is home to the following First Peoples organizations, most of which focus on skills training and resources for adults: The Healing of the Seven Generations (First Peoples cultural healing and court services), White Owl (mental health for children), Anishnabeg Outreach (employment), K-W Urban Native Wigwam Project (housing), Niagara Peninsula Aboriginal Area Management Board (employment and skills training for youth) and Waterloo Aboriginal Education Centre (educational resources and support for First Peoples students at the University of Waterloo).
Almost every other city centre of similar size in Ontario currently has multiple organizations offering comprehensive child care programming and/or health/learning centres for First Peoples’ families. The Region of Waterloo is severely lacking in this area and has no comprehensive health or child services, and limited programming within each of the organizations. The no is organization in the Region of Waterloo and its surrounding area currently offering services specified to First Peoples Early Years children, but limited childcare programming is offered at Wholistic Child and Youth within the White Owl Native Ancestry Association. This organization only offers mental health services for First Peoples youth and limited and sporadic preventative programming as funding allows.

The following table indicates some of the child care services available in a selected group of cities in Ontario, as a comparison.

<table>
<thead>
<tr>
<th>First Peoples Family Services</th>
<th>Location</th>
<th>First Peoples Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wholistic Child and Youth (mental health only)</td>
<td>Waterloo Region</td>
<td>13,230 (StatsCan 1, 2011)</td>
</tr>
<tr>
<td>1. Ska’Na Family Learning Centre and Day Care (2 campuses)</td>
<td>Lambton County</td>
<td>4,735 (StatsCan 2, 2011)</td>
</tr>
<tr>
<td>2. Little Friends Day Care</td>
<td></td>
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<tr>
<td>3. Aboriginal Children’s Resource Centre</td>
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<tr>
<td>4. Can-Am Indian Friendship Centre</td>
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<tr>
<td>5. Southwest Ontario Aboriginal Health Access Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The Ottawa Inuit Children’s Centre</td>
<td>Ottawa</td>
<td>18,180 (StatsCan 3, 2011)</td>
</tr>
<tr>
<td>2. First Nations Child and Family Caring Society of Canada</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Odawa Native Friendship Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Makonsag Aboriginal Head Start</td>
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<td></td>
</tr>
<tr>
<td>5. Wabano Centre for Aboriginal Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Minwaashin Lodge-Aboriginal Women’s Support Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Tungasuvvingat Inuit-Urban Inuit Community Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. First Nations, Metis, and Inuit Learning Centre</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Funding Discrepancies:

The limited programming for First Peoples in our Region is not sufficient to meet their complex needs, and interviews and surveys reveal that it is resulting in greater strains and costs in the local healthcare system, justice and policing systems, educational systems, and welfare systems, among others. The biggest challenge faced by local First Peoples organizations is sufficient and sustainable funding. The limited funding leaves these organizations severely understaffed, and the limited staff overworked and underpaid\(^\text{12}\). The core staff, overall, in these organizations, appear to be dedicated individuals who stay in the position, despite the pay inequities, workload, and working hours; because of their commitment to improving the lives of First Peoples in our community. Despite often doing double or even triple duties, interviews and research found that most of these

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\(^{12}\) Elicited through interviews with staff, financial records, and observations of the researcher.
staff are paid well below the average salary and benefits for their designated positions, and often work through their lunch hours, and even late into the evening. Most of these organizations reported that specific funding had been reduced, or cutback in recent years, especially those for capital expenses and salaries, despite ample evidence of the need for increased funding. Calls for increasing funding to meet the growing demands are often met with rejection, or only partial funding that limits the efficacy of programming or results in lowered wages or increased workload for staff. All of the programs for First Peoples in the Region appear to be understaffed and underfunded, and as such, are full of gaps in the services that they can provide and waiting lists for programming.

Thorough tracking and reporting cannot be done with the limited capacity. This lack in tracking/reporting and limited organizational capacity makes it difficult to properly apply for funding sources, and leads to further instability and decreased efficacy in the organizations.

For example, at the Healing of the Seven Generations, there are only two main staff to direct all programming at the centre, an Executive Director and a Court Worker. The Executive Director runs all the cultural programming, oversees and trains all the volunteers, does all the cultural counselling and referral services (more than a thousand per year), advocates for the needs of First Peoples in the Region, does the majority of the administrative work (including answering phones), all on top of her Executive Director duties. The Court Worker, runs and administers all the youth programming, all the restorative justice programming, does daily outreach work, advocates within the justice system for First Peoples, and handles more than a thousand cases each year from all five courts in the Region by himself. Both are working for salaries under $20/hour with no benefits, and are working many hours per week beyond that for which they get paid. Occasionally they are able to hire assistants for limited grant periods, but have been unable to retain the necessary stable administrative staff. The centre is housed in a tiny residence that it has long outgrown and no longer has room to run its necessary programming. A similar reality is reflected across all the First Peoples organizations in the Region of Waterloo.

The demand for services for First Peoples in our Region has grown exponentially in recent years but funding has not increased to meet the demand. The staff of these different organizations are unable to keep up with the growing demand, are facing burn-out, and do not have the capacity or time to fill out quality grant proposals or seek sustainable funding. The different organizations often have waiting lists for services or rely on volunteers instead of staff to fill in the gaps in essential programming. Stated government goals to promote self-led services and programming is rarely the reality, as First Peoples research methodologies, processes, or procedures are dismissed and replaced with exacting standards that are government directed. Programs and organizations are often forced to adapt to these directions to receive funding. First Peoples organizations often face significant cultural barriers in the granting process because the language and style used and expected in the grant does not easily align with the language and style employed by First Peoples, who often use a more narrative approach to answer questions or have practices that are not comprehensible to the grantors. Grantors often have difficulty understanding First Peoples’ practices, cultures, or ways, and underestimate their importance or value. Some traditional or sacred First Peoples’ practices or ceremonies must be protected from corruption or misunderstanding and can not be fully or adequately described in granting processes, often resulting in a grant’s rejection. On one occasion witnessed by the researcher, a potential Grantor cited their incorrect belief that there was an abundance of funding already in place for First Peoples in the Region and more than adequate services for them. Funding was ultimately denied in this instance. On more than one occasion, at government-led events, the researcher heard comments from employees of child service providers that implied there was no longer discrimination or oppression against First peoples in this country and that they are presently adequately serviced and funded.
During the time of this research, several granting opportunities became available to the observed First Peoples organizations. In at least four cases, applications were sent to the organizations from funding bodies within a week of the grant deadline\(^{13}\), leaving inadequate time to complete the applications, and inquiries to the funding bodies often went unreturned for long periods of time\(^{14}\). Little support is offered for the preparation of the grants, even though significant cultural barriers exist in their creation. For example, in only one case out of more than 15 grant attempts at the Healing of the Seven Generations centre, did a granting body (the KW Community Foundation), acknowledge the cultural barriers facing First Peoples organizations in the granting process and contact the centre to discuss assistance in future grants, strategies to achieve their grants, and alternate funding opportunities within their organization. Despite this recognition, the initial grant with this organization was rejected. During the observation period only approximately one in twelve grant requests resulted in funding, and none resulted in the full amount being granted.

**Recommendations:**

The researcher makes the following recommendations to ensure the needs of First Peoples are being met in the Region of Waterloo:

- that the Ministry of Education funds the full budget of the proposed Early Years and Family Learning programs for the Region of Waterloo following the Government of Canada’s commitment to the Jordan Principle (INAC 2017) to help bridge the gap in services and improve regional statistics for First Peoples
- that the different Ministries and other government bodies come together to coordinate their funding and support to create a “hub” location in the Region of Waterloo for First Peoples organizations so that services for their complex needs can be coordinated and more easily accessible, specifically the Region of Waterloo, the Ministry of Education, the Ministry of Health and Long Term Care, the Ministry of Children and Youth Services, Employment Ontario, the Ministry of Housing, and the Local Health Integration Network (LHIN)
- that the federal, provincial, and regional governments honour their commitment to the Jordan Principle (INAC 2017) and increase their funding for other essential services for First Peoples living in the Region of Waterloo, which includes cultural programming, to meet the complex needs of this community
- that the federal, provincial, and regional governments provide more thorough training for all their employees and agencies working with First Peoples communities and organizations so that they can better understand the value of First Peoples’ research methodologies, practices, cultural realities, the intergenerational impacts of the residential school system, and the level of discrimination faced by First Peoples, and increase their consultations with First Peoples groups in government processes to help reduce bias and discrimination within government services and to make them more culturally accessible
- that all major government funding bodies conduct thorough needs assessments of their funding strategies to ensure that their granting processes are not discriminatory against First Peoples or resulting in the types of funding discrepancies and shortfalls explained above, and that they provide increased support in the preparation of grants for First Peoples organizations and groups to help overcome any cultural barriers
- that the proposed programming is advertised in significant ways, specifically the parent’s hotline, to help to connect the most at-risk community members (who are currently not accessing any services) to the supports they need and encourage them to attend programming

\(^{13}\) In one case 4 days before the deadline.

\(^{14}\) Until the day before the deadline, in one case; not at all in another.
Foundations for Programming

The programming for this proposal was developed using a combination of the current best practices found in the How Does Learning Happen? and HighScope pedagogies, in combination with consultation of specialists in child development and well-being, and the guidance of local Elders and Knowledge Keepers on traditional teachings and ceremonies.

The sacred teachings of the traditional Medicine Wheel, which focuses on overall health balance, was used as a starting point to ensure the programming employed an holistic approach that would address all the multi-faceted needs of Early Years children and their parents. Elements of health are divided into four quadrants: Spiritual, Physical, Intellectual, and Emotional, which correspond to the four directions of the Wheel. The Medicine Wheel conceptualizes life balance, and is used in sweat lodges, healing circles, pow-wows, and other ceremonies as a sacred healing tool. The model features a circle divided into four sections corresponding to their related directions (north, east, south, and west), and represented as four colours (white, yellow, red, and black). Each of these quadrants must be equally nurtured for an individual to be healthy and well-balanced through their development. The Medicine Wheel directs us through an almost guided meditation to focus on each area and set appropriate goals in each area to better our path. Different First Peoples’ cultural groups have different representations, colour and directional pairings, meanings, associations, and the direction one travels within the

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15 See section on Partners and Support for more details.
circle. For the purposes of this proposal, the quadrants were assigned as follows and move in a clockwise direction:

Subsequently, the main elements of the *How Does Learning Happen?* pedagogy, including well-being, engagement, expression, and belonging, were added to the Wheel and became the foundation upon which the curriculum and programming was developed. The diagram “Foundations” in the *Appendices* outlines this process and its correlating focuses.

The overall goals for each quadrant were then added, along with an outline of programming needs to reach each goal, as described in the diagram “Strategy Wheel” in the *Appendices*. The programming needs were fully fleshed out in each quadrant to include all the necessary programs for Early Years Children and their parents to achieve life balance and a state of overall well-being. This is described in the diagram “Programming Needs” in the *Appendices*.

It is vital to the success of this programming that this holistic approach is maintained, as focus on one quadrant, without the others, will be unbalanced and ultimately not as successful.

The full curriculum is described in the *Journey Together- Region of Waterloo: Curriculum* document by the same authors attached to this proposal.
Fulfilling Obligations to the Calls to Action of the Truth and Reconciliation Commission of Canada

As mentioned above in the Historical and Societal Context section, the Truth and Reconciliation Commission of Canada has identified 94 Calls to Action to address the inequities faced by First Peoples in Canada. These Calls have been identified as ways to lessen the intergenerational impacts of the residential school system and help bridge the gaps in services for Canada’s most at-risk population. These Calls serve as a starting point to heal this trauma and will be foundational to any programming that will be developed. Sixteen of the Calls to Action fall within the direct scope of this programming and can be fulfilled for Early Years children and their families if proper funding is approved to develop holistic Early Years programming in our Region. The table below describes the ways these Calls to Action can be fulfilled by our proposal.

<table>
<thead>
<tr>
<th>Calls to Action</th>
<th>Ways to Fulfill Calls to Action</th>
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<tbody>
<tr>
<td>1. We call upon the federal, provincial, territorial, and Aboriginal governments to commit to reducing the number of Aboriginal children in care by:</td>
<td>• Family Learning Centre with full programming</td>
</tr>
<tr>
<td>i. Monitoring and assessing neglect investigations.</td>
<td>• Family Resource Centre</td>
</tr>
<tr>
<td>ii. Providing adequate resources to enable Aboriginal communities and child-welfare organizations to keep Aboriginal families together where it is safe to do so, and keep children in culturally appropriate environments, regardless of where they reside.</td>
<td>• Daycare Centre</td>
</tr>
<tr>
<td>iii. Ensuring that social workers and others who conduct child-welfare investigations are properly educated and trained about the history and impacts of residential schools.</td>
<td>• Helpline for parents</td>
</tr>
<tr>
<td>iv. Ensuring that social workers and others who conduct child-welfare investigations are properly educated and trained about the potential for Aboriginal communities and families to provide more appropriate solutions to family healing.</td>
<td>• Education for social workers and child-welfare staff on cultural accessibility and best practices</td>
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<tr>
<td>v. Requiring that all child-welfare decision makers</td>
<td>• Increased access to culturally trained social workers, therapists</td>
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<tr>
<td></td>
<td>• Outreach support for at-risk families</td>
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<td></td>
<td>• Visiting clinics at the Family Learning Centre to increase access to comprehensive medical care</td>
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<tr>
<td></td>
<td>• Cultural Summer Day Camp</td>
</tr>
<tr>
<td></td>
<td>• Increased access to cultural programming</td>
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<tr>
<td></td>
<td>• ECE Scholarship program to ensure self-led services</td>
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<tr>
<td>Consider the impact of the residential school experience on children and their caregivers.</td>
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<tr>
<td>2. We call upon the federal government, in collaboration with the provinces and territories, to prepare and publish annual reports on the number of Aboriginal children (First Nations, Inuit, and Metis) who are in care, compared with non-Aboriginal children, as well as the reasons for apprehension, the total spending on preventative and care services by child-welfare agencies, and the effectiveness of various interventions.</td>
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<tr>
<td>• Research and advocacy by Resource and Advocacy staff to provide consultation and to ensure the full context is provided in government reports</td>
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<tr>
<td>3. We call upon all levels of government to fully implement Jordan’s Principle.</td>
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<tr>
<td>• Full funding to provide comprehensive and effective programming from government Ministries and the Region of Waterloo to implement</td>
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<tr>
<td>• Resource and Advocacy staff to advocate for legislation and fair treatment</td>
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<tr>
<td>5. We call upon the federal, provincial, territorial, and Aboriginal governments to develop culturally appropriate parenting programs for Aboriginal families.</td>
<td></td>
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<tr>
<td>• Family Learning Centre</td>
<td></td>
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<tr>
<td>• Family Resource Centre</td>
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<tr>
<td>• Day Care centre</td>
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<tr>
<td>• Parental Advisory Board</td>
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<tr>
<td>8. We call upon the federal government to eliminate the discrepancy in federal education funding for First Nations children being educated on reserves and those First Nations children being educated off reserves.</td>
<td></td>
</tr>
<tr>
<td>• Recognition from the different levels of government and their associated Ministries in the importance of off-reserve education and child care programming specified for First Peoples needs that results in proper funding and legislation to provide comprehensive and effective services</td>
<td></td>
</tr>
<tr>
<td>• Resource and Advocacy staff to advocate for legislation</td>
<td></td>
</tr>
<tr>
<td>10. We call on the federal government to draft new Aboriginal education legislation with the full participation and informed consent of Aboriginal peoples. The new legislation would include a commitment to sufficient funding and would incorporate the following principles:</td>
<td></td>
</tr>
<tr>
<td>i. Providing sufficient funding to close identified educational achievement gaps within one generation.</td>
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<tr>
<td>ii. Improving education attainment levels and success rates.</td>
<td></td>
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<tr>
<td>iii. Developing culturally appropriate curricula.</td>
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<tr>
<td>iv. Protecting the right to Aboriginal languages, including the teaching of Aboriginal languages as credit courses.</td>
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<tr>
<td>v. Enabling parental and community responsibility, control, and accountability, similar to what parents enjoy in public school systems</td>
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</tr>
<tr>
<td>• Recognition from the different levels of government and their associated Ministries in the importance of off-reserve education and child care programming specified for First Peoples needs that results in proper funding and legislation to provide comprehensive and effective services</td>
<td></td>
</tr>
<tr>
<td>• Resource and Advocacy staff to advocate for legislation</td>
<td></td>
</tr>
<tr>
<td>• Daycare</td>
<td></td>
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<tr>
<td>• Family Learning Centre</td>
<td></td>
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<tr>
<td>• Family Resource Library</td>
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<td></td>
<td>Enabling parents to fully participate in the education of their children.</td>
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<td>---</td>
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<tr>
<td>12.</td>
<td>We call upon the federal, provincial, territorial, and Aboriginal governments to develop culturally appropriate early childhood education programs for Aboriginal families.</td>
</tr>
</tbody>
</table>
|   | • Day Care centre  
|   | • Family Learning Centre  
|   | • Family Resource Centre  
|   | • Cultural Summer Day Camp  
|   | • ECE Scholarship program to ensure self-led services  
| 14. | We call upon the federal government to enact an Aboriginal Languages Act that incorporates the following principles:  
|   | i. Aboriginal languages are a fundamental and valued element of Canadian culture and society, and there is an urgency to preserve them.  
|   | iii. The federal government has a responsibility to provide sufficient funds for Aboriginal-language revitalization and preservation.  
|   | iv. The preservation, revitalization, and strengthening of Aboriginal languages and cultures are best managed by Aboriginal people and communities. |
|   | • Day Care centre that incorporates First Peoples languages into programming  
|   | • Family Learning Centre that incorporates First Peoples languages into programming  
|   | • Family Resource Centre that provides families with First Peoples language resources  
|   | • Resource and Advocacy staff to advocate for legislation  
| 18. | We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties. |
|   | • Visiting clinics at the Family Learning Centre to increase access to comprehensive medical care  
|   | • Financial assistance for assistive devices or special needs testing  
|   | • Family Learning programs at the Family Learning Centre on health  
|   | • Increased access to therapy, social workers  
|   | • Resource and Advocacy staff to train local clinicians and service providers on cultural accessibility  
| 19. | We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services. |
|   | • Family Learning Programs at the Family Learning Centre on health  
|   | • Visiting clinics at the Family Learning Centre to increase access to comprehensive medical care  
|   | • Increased access to therapy and social workers  
|   | • Resource and Advocacy staff to train clinicians and service providers in cultural accessibility and consult on research  
| 20. | In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Metis, Inuit, and off-reserve Aboriginal people. |
|   | • Recognition from the different levels of government and their associated Ministries in the importance of off-reserve education and child care programming specified for First Peoples |
| 21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools,... | • Creation of a hub that will be a centre to address the holistic needs of First Peoples
• Recognition from the different levels of government and their associated Ministries in the importance of off-reserve education and child care programming specified for First Peoples needs that results in proper funding and legislation to provide comprehensive and effective services
• Resource and Advocacy staff to advocate for legislation |
| --- | --- |
| 33. We call upon the federal, provincial, and territorial governments to recognize as a high priority the need to address and prevent Fetal Alcohol Spectrum Disorder (FASD), and to develop, in collaboration with Aboriginal people, FASD preventative programs that can be delivered in a culturally appropriate manner. | • Family Learning programs at the Family Learning Centre that deal with FASD
• Outreach programming
• Increased access to therapy and social workers
• Resource and Advocacy staff to advocate and educate on FASD |
| 38. We call upon the federal, provincial, territorial, and Aboriginal governments to commit to eliminating the overrepresentation of Aboriginal youth in custody over the next decade. | • Creation of a hub that will be a centre to address the holistic needs of First Peoples
• Family Learning programs at the Family Learning Centre
• Referral services to employment, housing, and addictions counselling, etc.
• Outreach programming
• Increased access to culturally trained social workers |
| 57. We call upon federal, provincial, territorial, and municipal governments to provide education to public servants on the history of Aboriginal peoples, including the history and legacy of residential schools, the United Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, Indigenous laws, and Aboriginal-Crown relations. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism. | • Resource and Advocacy staff to train local service providers and government entities on cultural issues |
| 62. We call upon the federal, provincial, and territorial governments, in consultation and collaboration with Survivors, Aboriginal peoples, and educators, to:  
   iii. Provide the necessary funding to Aboriginal schools to utilize Indigenous knowledge and teaching methods in classrooms. | • Day Care centre
• Family Learning Centre
• Family Resource Centre |
Partners and Support

During the research phase of this project, several potential partners were consulted and recognized the value in creating First Peoples-led child care and family learning programs for the Region of Waterloo. The following partners/supporters have expressed interest in consulting on program development or supporting this proposal in diverse ways using their various expertise. Many of these partners have offered ongoing mentorship and support to implement this project, and will be integral to ensuring the quality of overall programming. Support letters from several of these partners have been included in the Appendices at the end of this document.

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>Contact</th>
<th>Area of Expertise/support</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region of Waterloo Community Services, Children's Services</td>
<td>Barb Cardow, Director 519-883-2177 <a href="mailto:bcardow@regionofwaterloo.ca">bcardow@regionofwaterloo.ca</a></td>
<td>Proposal and funding support, licensing and implementation</td>
<td>Waterloo, ON</td>
</tr>
<tr>
<td></td>
<td>Tamara Kerr 519-575-4757 ext. 5684 <a href="mailto:tkerr@regionofwaterloo.ca">tkerr@regionofwaterloo.ca</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ontario Early Years Waterloo Region</td>
<td>Stacey McCormick 519-741-8585 <a href="mailto:smccormick@ckwymca.ca">smccormick@ckwymca.ca</a></td>
<td>Day care and family learning programs, support with pop-up programs, licensing, and program development</td>
<td>Region of Waterloo, ON</td>
</tr>
<tr>
<td></td>
<td>Jaime Jacomen 519-741-8585 ext. 243 <a href="mailto:jjacomen@ckwymca.ca">jjacomen@ckwymca.ca</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Healing of the Seven Generations</td>
<td>Donna Dubie 519-570-9118 <a href="mailto:7generations@bellnet.ca">7generations@bellnet.ca</a></td>
<td>Healing from the intergenerational impacts of the residential school system, justice programming, and cultural services, support for program development, referral services for justice programming and cultural services</td>
<td>Kitchener, ON</td>
</tr>
<tr>
<td>University of Waterloo,</td>
<td>Karen Bloom 519-888-4567 x32936</td>
<td>Knowledge mobilisation or</td>
<td>Waterloo, ON</td>
</tr>
<tr>
<td>Department of Developmental Psychology</td>
<td><a href="mailto:kbloom@uwaterloo.ca">kbloom@uwaterloo.ca</a></td>
<td>research impact of developmental psychology, consult on how to translate research on child development into quality and effective programming</td>
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<tr>
<td>Conestoga College</td>
<td>Goranka Vukelich 519-748-5220, ext. 3393 <a href="mailto:Gvukelich@conestogac.on.ca">Gvukelich@conestogac.on.ca</a></td>
<td>ECE education, support with scholarship program, research support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Samantha Burns (519) 748-5220 ext. 3840 <a href="mailto:sburns@conestogac.on.ca">sburns@conestogac.on.ca</a></td>
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<tr>
<td></td>
<td>Cathy O'Toole 519-748-5220 ext. 3603 <a href="mailto:Cotoole@conestogac.on.ca">Cotoole@conestogac.on.ca</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Salima Alam-Hafeez 519-748-5220 ext. 2492 <a href="mailto:salamhafeez@conestogac.on.ca">salamhafeez@conestogac.on.ca</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Six Nations Day Care</td>
<td>Sherry Lickers 519-445-4411 <a href="mailto:slickers@sixnations.ca">slickers@sixnations.ca</a></td>
<td>First Peoples day care consult, mentorship in program development</td>
<td></td>
</tr>
<tr>
<td>Ska’Na Family Learning Centre</td>
<td>Faith Hail 519-903-4253 <a href="mailto:faith@skanaflc.com">faith@skanaflc.com</a></td>
<td>First Peoples day care consult, mentorship in program development, consult for licensing</td>
<td></td>
</tr>
<tr>
<td>Little Friends Child and Family Development Centre</td>
<td>Naomi Wilson 519-339-0945 <a href="mailto:naomi@skanaflc.com">naomi@skanaflc.com</a></td>
<td>First Peoples day care consult, mentorship in program development, materials and resource acquisition</td>
<td></td>
</tr>
<tr>
<td>Anishnabeg Outreach</td>
<td>Lee Ann Hundt 519-742-0300 <a href="mailto:apatiwin@anishnabegoutreach.org">apatiwin@anishnabegoutreach.org</a></td>
<td>First Peoples employment services,</td>
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The Journey Together for the Region of Waterloo 2017
<table>
<thead>
<tr>
<th>Organization</th>
<th>Contact Person</th>
<th>Services</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>The KW Urban Wigwam Project</td>
<td>Tiara Jacobs-Grant</td>
<td>First Peoples housing services, referrals for housing</td>
<td>Kitchener, ON</td>
</tr>
<tr>
<td></td>
<td>519-743-5868</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:kwnativehousing@bellnet.ca">kwnativehousing@bellnet.ca</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centre for Child Studies, University of Waterloo</td>
<td>Daniella O’Neil</td>
<td>Language acquisition and research on early years children, consult</td>
<td>Waterloo, ON</td>
</tr>
<tr>
<td></td>
<td>(519) 888-4567, ext. 32545</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:doneill@uwaterloo.ca">doneill@uwaterloo.ca</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KW Habilitation</td>
<td>John Martin</td>
<td>Accessibility and dignity for individuals with disabilities, consult and referral services for individuals with disabilities</td>
<td>Waterloo, ON</td>
</tr>
<tr>
<td></td>
<td>519-744-6307 X 1319</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:jmartin@kwhab.ca">jmartin@kwhab.ca</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Niagara Peninsula Aboriginal Area Management Board</td>
<td>Crystal Goulet</td>
<td>First Peoples employment and training, assistance with scholarship program, referral for employment and skills training</td>
<td>Cambridge, ON</td>
</tr>
<tr>
<td></td>
<td>226-533-9979</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td><a href="mailto:YSO_KW@npaamb.com">YSO_KW@npaamb.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Six Nations Polytechnic</td>
<td>Carly Jamieson</td>
<td>First Peoples Education, support and assistance with scholarship program</td>
<td>Oshweken and Brantford, ON</td>
</tr>
<tr>
<td></td>
<td>226-493-1245 X 170</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:Carly.jamieson@snpolytechnic.com">Carly.jamieson@snpolytechnic.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our Place Family Resource and Early Years Centre</td>
<td>Jennifer Jordan</td>
<td>Family Learning Programs, mentorship and support in program development</td>
<td>Kitchener, ON</td>
</tr>
<tr>
<td></td>
<td>519-571-1626 X 26</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><a href="mailto:jjordan@ourplacekw.ca">jjordan@ourplacekw.ca</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Elders</td>
<td>Contact point- Donna Dubie at the Healing of the Seven Generations</td>
<td>Traditional protocols and experience, community memory, ongoing support in program</td>
<td>Region of Waterloo</td>
</tr>
<tr>
<td></td>
<td>• Dozens of respected Elders in our community who attended circles or participated in interviews or consultations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Knowledge Keepers, Medicine People, and Seers | Contact point- Donna Dubie at the Healing of the Seven Generations  
  - Respected Knowledge Keepers, Medicine People, and Seers who are the vessels for cultural information in the First Peoples’ community | Traditional protocols, cultural experts, community memory, ongoing support in program development and implementation | Region of Waterloo, Brantford, Oshweken, and elsewhere in ON |
Programming Goals

- Encouraging intergenerational interactions, building trust, and fostering a co-learning environment between Early Years children, parents, families, educators, Elders, the community, service providers, and the land
- Helping to break the cycles of abuse, poverty, and low self-worth of First Peoples by providing parents of Early Years children with adequate supports, skills training, and education
- Reconnecting children to the land through comprehensive outdoor learning curricula that involves traditional teachings and ceremonies
- Introducing children to their cultures, histories, values, traditions, and languages through immersive cultural programming and providing them a safe space to explore their culture with their families and community
- Reducing the number of First Peoples Early Years children in protective care in the Region of Waterloo by advocating for and educating parents, and supporting their access to social and healing supports
- Providing healing, educational, advocacy, cultural/spiritual, and social service supports for First Peoples Early Years children and their parents
- Preparing First Peoples Early Years children for greater success in their later years by providing comprehensive and holistic programming using the best practices explored in the How Does Learning Happen document, HighScope pedagogy, and Medicine Wheel teachings, blended with traditional learning practices and values
- Foster a greater sense of well-being, belonging, self-worth, and dignity of First Peoples Early Years children and their parents
- Explore and secure long-term funding strategies to support First Peoples Early Years Programming for the Region of Waterloo and ensure its sustainability
- Increase access to crisis therapy, family therapy, couples counselling, and play therapy for First Peoples Early Years children and their families to encourage healing, reconciliation, family bonding and security
- Research and advocate for Regional and Provincial policies that ensure the well-being of First Peoples Early Years children and their families living in the Region of Waterloo
- Educate the people of the Region of Waterloo on issues affecting First Peoples, their stories and cultures, to promote understanding and to dispel common myths and stereotypes of First Peoples in an effort to foster greater tolerance, trust, and belonging
- Educate Regional service providers on First Peoples issues, practices, norms, and cultures, so that they can provide more culturally safe, accessible, and equitable services to their First Peoples clientele, and facilitate referrals to culturally trained service providers
- Work with Regional educational institutions to develop curricula that educate students to be more culturally safe, accessible, and equitable with regards to First Peoples upon graduation, specifically those that deal with Early Childhood Education, and social services provision
Programming Proposal

This proposal seeks to create the following programming to meet the needs of First Peoples Early Years children living in the Region of Waterloo: a day care centre with 117 permanent spaces and 30 interim spaces, a family learning centre with drop-in programming, a parental helpline, a cultural day camp with 80 spaces per year, a family resource library, scholarships for First Peoples in the Early Childhood Education (ECE) program at Conestoga College, ongoing professional development and incentives for staff retention, a full time Resource and Advocacy staff member who will run educational programs for local communities, service providers, and educational institutions; a full time Social Worker, a part-time Play-Therapist, a full time Outreach Worker, a Parental Advisory Board, visiting clinics with various clinicians, spaces and equipment to accommodate special needs, interim pop-up programming with the YMCA, and assistance to hire a fundraiser to ensure organizational sustainability and greater self-sufficiency. The researcher highly suggests that the Ministry of Education, the Region of Waterloo, and the organization that leads the implementation of this proposal will work with the Local Health Integration Network (LHIN) for Waterloo and Wellington Regions, the Ministry of Health and Long Term Care\textsuperscript{16}, and other Ministries and government bodies, to develop a “hub” location so all the support services for First Peoples can be contained within one location to make them more accessible and comprehensive.

Day Care Centre:

Some 36\% of parents in Ontario have their Early Years children in organizational daycare, and another 19\% have their children in home day cares (Sinha 2015). This means there is likely a minimum of 324 First Peoples children in our Region currently using or needing a day care option, and likely significantly more, at a number closer to a thousand. We know from our surveys and interviews, that our parents are distrustful of the current organizational child care options available and often choose to secure private child care options or simply do without. Only 2 of our 124 surveyed parents currently use organizational or licensed home day care options, and a high percentage of those interviewed suggested they struggled to find teenaged babysitters or often leave children with family. Considering nearly all our respondents indicated they had grown up in abusive families, this increases the risk of exposure to abusive situations. Many respondents suggested they had only used these options because they felt they had no choice due to limited finances, resources, accessibility, or distrust for government organizations. Some respondents described leaving children with unrelated roommates, neighbours, or even strangers, especially in situations where they had secured temporary employment without prior notice. Several described turning down work opportunities in recent months because they were unable to secure adequate childcare. All the parents surveyed and interviewed indicated they wanted their children raised learning their cultures and languages, and wished there were more options for them to do so.

This proposal seeks to create 117 permanent spaces for First Peoples Early Years children in day care, in programming that will offer a blend of tradition and modernity, with a heavy focus on outdoor and intergenerational learning as well as incorporating First Peoples languages, cultures, values, and traditions into daily activities. We will also offer 30 interim spaces for Early Years children that will be offered at a YMCA location

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\textsuperscript{16} The WW LHIN and MOHLTC are currently reviewing a proposal conducted by the Sustainable Societies Consulting Group, Ltd. to develop a ‘hub’ wellness centre for First Peoples in the Region of Waterloo.

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until such time as a new space is secured. The programming will prioritize individuals of First Peoples’ heritage, but any available spaces will be offered to the general public through the regular Regional processes.

<table>
<thead>
<tr>
<th>Type of Space</th>
<th># of Spaces</th>
<th># of Staff needed</th>
<th># of Rooms needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant (younger than 18 months)</td>
<td>10</td>
<td>2 fulltime ECEs, 1 fulltime Assistant</td>
<td>1</td>
</tr>
<tr>
<td>Toddler (18-30 months)</td>
<td>15</td>
<td>2 fulltime ECEs, 1 fulltime Assistant</td>
<td>1</td>
</tr>
<tr>
<td>Pre-school (30 months-6 years)</td>
<td>32</td>
<td>3 fulltime ECEs, 1 fulltime Assistant</td>
<td>2</td>
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<tr>
<td>After school program (44 months – 13 years)</td>
<td>30</td>
<td>1 fulltime ECE, 1 fulltime Assistant</td>
<td>1</td>
</tr>
<tr>
<td>Float</td>
<td>0</td>
<td>+ 4 full time ECE float, 2 full time Assistant float, 6 casual ECEs, 6 casual Assistants, 2 casual Supervisors</td>
<td>0</td>
</tr>
<tr>
<td>Evening Care Program (mixed ages) 3pm-11pm, Weekend Care Program (mixed ages)</td>
<td>15 (evening), 15 (weekend)</td>
<td>3 full time ECEs, 2 full time Assistants, 3 part-time ECEs (weekend), 2 part-time Assistants (weekend)</td>
<td>1</td>
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<tr>
<td>Interim Evening Care Program at YMCA (mixed ages), Interim Weekend Care Program at YMCA (mixed ages)</td>
<td>15 (evening), 15 (weekend)</td>
<td>*3 full time ECEs, 2 full time Assistants, 3 part-time ECEs (weekend), 2 part-time Assistants (weekend)</td>
<td>1</td>
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<tr>
<td>TOTAL</td>
<td>147 (117 permanent spaces)</td>
<td>2 casual Supervisors, 16 full time ECEs, 3 part-time ECEs, 6 casual ECEs, 8 full time Assistants, 2 part-time Assistants, 6 casual Assistants</td>
<td>7</td>
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</table>

*these staff will not be included in the overall total, because they will be merged into the Evening Care Program and Weekend Care Program once the centre is built and the Interim Programs are ceased

In addition to the above, the Day Care will require one full time Operations Manager, 2 full time Supervisors (one day time, one evening), 1 part time Supervisor (weekend), 1 full time Administrator, food preparation staff, maintenance staff, and volunteers (specifically Elders) for enhanced programming such as story-telling or the Adopt a Grandparent Mentorship Program that will run concurrently through the enhanced Cultural programming run at the Healing of the Seven Generations centre. All education staff will need to be properly qualified as ECEs or EAs, be trained to work with traumatized individuals and comprehend First Peoples languages and cultures, administer First Aid and CPR, as well as participate in ongoing quarterly training and feedback sessions to improve service delivery. All food preparation staff needs to be trained in safe food handling, and

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preferably have interest or experience in the preparation of local, traditional foods. We hope to offer seasonally available local and traditional dishes to our children and families as much as possible to encourage connection to the land and culture.

The space needs to have an extensive outdoor learning area, including covered outdoor areas for each age group so that outdoor learning can continue in all weather conditions. We hope to have space to build an outdoor fire for ceremony and space for a learning garden.

Many of our parents are struggling to find secure employment, and as such, work on a temporary or contract basis, often on hours outside of the traditional work week, and often with only a few hours advanced notice. We want to offer one classroom of mixed ages to provide evening and weekend childcare options for parents who work outside of the 9 to 5 pm schedule. One shift will run in the evenings, and another will run on weekend days. This flexibility will allow our parents the ability to take employment when/where they can find it, and help encourage them to stay employed.

Our daycare will offer opportunities for parents and families to enroll in part-time or time-sharing child-care options, so they only pay for the care they need. There will also be a few spots reserved for drop-in care that will be secured on a first-come, first-serve basis. This will allow us to enroll more overall children in programming, and allow children to attend daycare on a part-time or casual basis, as needed. It will also provide the added support our parents need to explore work, schooling, and volunteer opportunities. This follows the model the researcher observed at the Ska’Na Family Learning Centres in Windsor and Little Friends in Sarnia.

We hope to offer the wages presented in the following table to our educational staff members in order to acquire and retain quality staff. We want staff that is thoroughly trained in trauma-focused care and those who have experience working in First Peoples’ environments. We hope to be able to provide benefits packages for all full-time employees and opportunities for all staff to attend cultural healing retreats as necessary to ensure their own health needs are met.

<table>
<thead>
<tr>
<th>Employee Type</th>
<th>Type (FT, PT, C)</th>
<th>Minimum $/hr</th>
<th>Maximum $/hr</th>
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<tr>
<td>Operations Manager</td>
<td>Full time</td>
<td>$32/hr + benefits (15%)</td>
<td>$35/hr + benefits (15%)</td>
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<tr>
<td>Supervisor</td>
<td>Full time</td>
<td>$27/hr + benefits (15%)</td>
<td>$30/hr + benefits (15%)</td>
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<tr>
<td>Supervisor</td>
<td>Part time</td>
<td>$27/hr</td>
<td>$30/hr</td>
<td></td>
</tr>
<tr>
<td>ECE</td>
<td>Full time</td>
<td>$20/hr + benefits (15%)</td>
<td>$25/hr + benefits (15%)</td>
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<td>ECE</td>
<td>Part time</td>
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<td>$23/hr</td>
<td>20-30 hours/week</td>
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<tr>
<td>ECE</td>
<td>Casual</td>
<td>$18/hr</td>
<td>$23/hr</td>
<td>Max. 15 hours/week</td>
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<tr>
<td>Assistant</td>
<td>Full time</td>
<td>$15/hr + benefits (15%)</td>
<td>$16/hr + benefits (15%)</td>
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</tr>
<tr>
<td>Assistant</td>
<td>Part time</td>
<td>$15/hr</td>
<td>$15/hr</td>
<td>20-30 hours/week</td>
</tr>
<tr>
<td>Assistant</td>
<td>Casual</td>
<td>$15/hr</td>
<td>$15/hr</td>
<td>Max. 15 hours/week</td>
</tr>
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</table>

**Family Learning Centre:**

Educating and supporting parents is of the utmost importance to the success of this type of programming. The Family Learning Centre will be a location for First Peoples families to explore how to be co-learners with their children in a culturally safe, nonjudgmental, and respectful environment. We will provide comprehensive educational programs for parents, as well referral support and access to materials to ensure the success of our
Early Years children. Daily drop-in programs will allow families to learn alongside their children and give them a chance to socialize with other families in a culturally safe space.

Our Family Learning Programs will include, but not be limited to:

- Disciplining, methods to control negative behaviours and encourage good behaviour
- Enhancing attachment
- Parents as co-learners
- What to expect in each phase of life
- Parental modelling
- Emotional literacy
- Self-care/self-coping
- Healthy development
- Cooking/meal prep, meal planning, and household budgeting
- Safety and security concerns for Early Years children
- Healthy babies, and programs on childhood fitness and physical health
- Mentoring/pairing with elders
- CPR/First Aid
- How to access services in the community, talks from local service providers (medical, social services, etc)
- First Peoples cultural programming
- Adopt a Grandparent mentorship

We hope to have regular support and sharing circles for parents to talk about their frustrations with other parents in a more informal environment. The Family Learning Centre will require 2 full time facilitators (preferably RECEs) who will run day programming and a full time Supervisor who will oversee the centre. It will work in unison with the Healing of the Seven Generations’ cultural programming and volunteer placement program (specifically the Adopt a Grandparent/Elder and Mentorship programs) which are currently being enhanced to meet the upcoming demand, as well as Anishnabeg Outreach (employment and skills building for parents), and KW Native Urban Wigwam Project (housing). The hope is to house all the First Peoples organizations in a hub environment, so that impoverished families can get access to all the services they need in one location. The Waterloo Wellington Local Health Integration Network and the Ministry of Health and Long Term Care are currently working with other consultants in this pursuit, and we are hoping to build our day care and family learning centre in concert with these other entities to save costs and enhance services and accessibility.

**Parental Help Line:**

We hope to train our Outreach Worker and some of the ECE Float staff to run a parental help line during the day time hours where parents can call anonymously with questions or concerns about their children and get helpful, nonjudgmental advice or reassurance on where to go, how to interact and properly care for their children, what’s normal, what to expect, etc. We hope that this line will help our most at-risk parents, and gently encourage them to come into the centre for services.

**Summer Day Camp:**

We want to offer a week-long summer day camp for children that enhances their cultural identity and self-worth as a First Peoples person. The programming would offer intensive cultural exploration through outdoor activities, traditional learning, and ceremony. We would like to offer spaces for up to 80 children to attend over a four-week
period in the summer months (20 per week), and provide subsidies for financially insecure children to attend. The camp will be offered for children aged 4 through 12, and potentially have an overnight hunting/trapping or bush experience with parents and Elders. The camp would require 1 Director, 4 ECE/Counsellors, and several Counsellors-in-Training who will be older students we hope to encourage into ECE training and scholarship programs.

**Family Resource Library:**

The Family Resource Library will be an access space for materials and information for First Peoples’ families and will be housed inside the Family Learning Centre. It will have home-learning backpacks for parents, children, and families to check out to encourage at-home literacy and continuation of learning, as well as children’s books and available literature on child development and well-being. The home-learning backpacks will feature special topics for families to explore at their own pace, in their own homes, with hands on activities, literature, and other materials to enhance the learning experience. The Resource Library will also feature materials such as musical instruments, laptops, and tablets that families would otherwise not have access to, that they can take home on loan. It will also feature a Human Library, which will be a place where real people are on loan to “readers” who will hear their stories and ask questions for half hour sessions one or two days of the week. This will encourage tolerance, diversity, and understanding, and will frequently highlight stories of residential school survivors, First Peoples storytellers, or inspirational First Peoples. The Resource Library will be staffed by the full time Resource and Advocacy staff member, as described below in the Advocacy section.

**Scholarships and Professional Development for Staff:**

Our community’s capacity is currently severely limited and needs to be enhanced before we can begin offering quality and self-led programming. We want to encourage First Peoples in our community to complete the ECE or other educational programming to upgrade their skills. We are hoping that we can offer up to 5 new scholarships per year over the first 3 years to First Peoples in our community to attend ECE programming at Conestoga College. This will ensure we build our local capacity and so that it has ample staff to run self-led First Peoples Early Years programming. We hope to continue to offer ongoing scholarships after this time to at least one First Peoples student per year in the ECE program to ensure sustainability and self-led programming to our growing Early Years population in the years to come. Apprenticeship ECE scholarships at Conestoga College will hopefully be prioritized to Day Care Assistants currently working with the centre who want to upgrade their education to help build our organizational capacity.

We would also like to provide ongoing bursary opportunities for the professional development of staff members, as an incentive for staff retention, and to encourage staff to achieve higher qualifications and specializations so that they can be more effective or informed in their work, specifically those geared to working with traumatized or First Peoples communities. We want to encourage staff to help develop and enhance programming on their own, and give them the freedom to innovate new types of programming to better blend traditional cultural elements with modern pedagogical practices and research. Staff retention is important to the quality of the programming, and we want to develop incentives for staff to stay with the organization. To ensure this, we must provide them with competitive wages and benefits packages, and create a work environment that promotes trust, respect, understanding, and creativity. We want to offer staff access to a traditional healing retreat once a year, that they would attend collectively. This would help enhance the working environment to ensure staff retention, create solidarity among co-workers, and ensure staff have the skills necessary to cope with the stress related to working with traumatized individuals daily. The retreat would also be a chance for staff to further
develop their own cultural understandings as they participate in ceremony and learn traditional ways of dealing with stress and trauma.

It is imperative that staff learns First Peoples languages and cultures to a base level so that they can incorporate the languages and cultures into their programming as much as possible. We want staff to take language classes (in Ojibwe and/or Mohawk, or other languages, where facilitators are available) and cultural classes so that they can provide more immersive childcare services to our Early Years children. They must also receive training in working with traumatized individuals and be regularly certified in CPR/First Aid. We want to offer thorough initial training for all staff for a minimum of three months prior to the opening of the centre that includes all these elements, and ongoing training to keep them up to date on current pedagogy and procedures and practiced in the languages. The education staff will learn strategies of play-based trauma therapies to use in daily practice, types of violence and how to spot it, how to listen to the children and their families for risk factors, and how to address the risk factors without escalating or exacerbating a situation.

**Advocacy and Cultural Training:**

We want to hire a full time Resource and Advocacy staff to stock and run the Family Resource Library, as well as be an access point for families for resources and how to find them. This person would also advocate for parents, Early Years children, and their families in legislative processes within the Region, run training and information sessions with the broader community and local service providers, as well as conduct and oversee ongoing research on First Peoples Early Years children’s access to services, their well-being, and their changing needs. This staff member will provide ongoing recommendations for the Day Care, Family Learning Centre, and policy for the Region, and will also facilitate sessions of the Parental Advisory Board. The Resource and Advocacy staff member will create a resource package for First Peoples parents that will include information on nutrition, health, what to do at each stage of development, and how to find local support services and programs.

**Social Worker, Play-Therapist, Outreach Worker, Referral Services:**

Given the multi-faceted problems our families are facing, we see it as essential that they have access to a culturally safe social worker at the point of delivery of these family and childcare services. The social worker will help families get access to essential social services, as well help them with one-on-one, couples, and family counselling to better ensure a stable home environment.

Many of our children have faced adverse trauma throughout their short lives, and require comprehensive or crisis therapy to help them realize their full potential. Very few of our community members are accessing these types of services on their own, due to financial constraints, wait-lists, cultural accessibility, or safety/trust factors of going to traditional therapists or social workers. We would like to hire a full time Social Worker and contract a service agreement with a Play-Therapist, preferably both of First Peoples heritage (or at least experienced working with First Peoples communities and respectful of culture), to provide these services out of the Family Learning Centre.

Our most at-risk community members need additional in-home help. We would like to hire a full-time Outreach Worker who will go into the homes of our most at-risk community members to help them with behavioural issues and skills building and provide them with more one-on-one support. This is a preventative measure to help reduce the population of First Peoples children in protective care and ensure the families are better prepared to raise their Early Years children in environments free of abuse and neglect. The Outreach Worker will also assist and oversee Access Visits at the Family Learning Centre for parents of children currently in protective care, when necessary, and answer questions on the helpline.
We will refer parents and families out to the necessary services already provided in the community, specifically those that are First Peoples led organizations or those who have participated in cultural training. This will include, but not be limited to: housing assistance (KW Urban Wigwam Project), employment and job skills building (Anishnabeg Outreach), mental health services (White Owl), disability assistance (KW Habilitation, Bridges to Belonging), and other therapy/healing services.

**Parental Advisory Board:**

We want to ensure that our programming is meeting the needs of our community, and that our parents and families have a voice in their child’s care. The Parental Advisory Board will meet once a month to discuss ongoing issues, and run quarterly sharing circles with parents to elucidate feedback. It will consist of 10-12 members. They will help the organization adapt to the changing needs of our community. The Parental Advisory Board will run quarterly sharing circles with parents to elucidate their needs and wants for the centre.

**Visiting Clinics:**

Many of our community members are not accessing the full range of medical services available to them, often due to trust issues, finances, or cultural accessibility. We want to bring in a range of different clinicians on an informal basis to the Family Learning Centre to provide basic information on a wide range of health issues, and to familiarize our parents so they are more comfortable accessing these types of services. We also want to highlight free or subsidized programs and opportunities that exist in the community for children’s health. This will include, but is not limited to: physicians, audiologists, ophthalmologists, dentists, child psychiatrists, and behavioural specialists.

**Special Needs, Assistive Devices, and Financial Assistance:**

The Centre will create space that accommodates a variety of special needs, and will include a quiet room for those with sensory needs, accessibility-trained staff, and other accommodative measures in the building design. We would like to include a special allowance for assisting financially insecure parents to get the assistive devices and special needs testing required for their children in a timely fashion. Many Status individuals face exceedingly long waiting periods or receive only partial funding for medical devices or special needs testing and often simply go without for extended periods of time due to the nature of jurisdictional funding disputes, despite the government’s promise of the Jordan Principle (INAC 2017). This can delay the child’s development, endanger their health, and make it much more difficult for them to succeed. We would also like to offer bus tickets to our most impoverished members to attend the Family Learning Centre programming. We are hoping to explore fundraising options to cover this portion.

**Pop-Up Programming:**

We would like to provide pop-up programming for our community members at the Healing of the Seven Generations Centre until the Day Care and Family Learning Centre can be created to help familiarize our families to this type of service. This program will be provided with the assistance of the YMCA, which currently provides pop-up programs for at-risk populations and would work with us to develop culturally appropriate interim programming. The YMCA would provide one ECE for this purpose, and this proposal would cover a second ECE to include cultural components. A small amount of materials and resources would need to be acquired for the programming, and potentially space rented outside of government-sponsored facilities.

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17 Evidence elicited from interviews and sharing circles.
Interim Daycare:

Once licensing is secured, we will work with the YMCA to offer one evening and one weekend mixed-age day care option at a YMCA location for up to 30 children over 2 rooms. This will require 1 full-time Supervisor, 1 part-time Supervisor, 3 full-time ECEs, 2 Assistants, 3 part-time ECEs, 2 part-time Assistants, and 2 casual ECEs. A small amount of materials and resources would need to be acquired for the programming. The YMCA will potentially donate in-kind rental space for this purpose.

Sustainability:

We would like to contract a fundraising consultant to develop a fundraising plan for the organization over the first six months of this proposal to help cover the costs of the renovations, start-up, and ongoing opportunities. This will help to ensure any funding gaps are addressed, and to enhance the building with more cultural aspects or allow for subsidized learning field trips, necessary subsidies, or opportunities, as needed and ensure the sustainability and self-sufficiency of the organization.

Proposal Timeline

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Start Date</th>
<th>End Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set up and enroll students in scholarship program for ECE at Conestoga College</td>
<td>January 2018</td>
<td>January 2021 (last year for enrollment) 2023 (last year of schooling)</td>
<td>5 students per year X 3 years, ECE program runs 2 years total</td>
</tr>
<tr>
<td>Ongoing ECE scholarship program at Conestoga College</td>
<td>January 2021</td>
<td>Ongoing</td>
<td>1 student per year</td>
</tr>
<tr>
<td>Incorporate Day Care and Family Learning Centre as new entity</td>
<td>January 2018</td>
<td>June 2018</td>
<td>Licensing and legalities necessitate the need for a separate organization</td>
</tr>
<tr>
<td>Develop Pop-Up programming</td>
<td>January 2018</td>
<td>June 2018</td>
<td>Provided through YMCA programming, programming to begin June 2018</td>
</tr>
<tr>
<td>Set up Parental Advisory Board</td>
<td>June 2018</td>
<td>Ongoing</td>
<td>10-12 members meeting once a month, + quarterly sharing circles/open forums for parents</td>
</tr>
<tr>
<td>Write Procedures Manual for operations at Day Care and Family Learning Centre</td>
<td>January 2018</td>
<td>January 2019</td>
<td>Also, employee handbook, handbook for parents/families, etc.</td>
</tr>
<tr>
<td>Secure licensing and safety protocols</td>
<td>January 2018</td>
<td>January 2019</td>
<td>Consultant Faith Hale</td>
</tr>
<tr>
<td>Develop full curricula and programming</td>
<td>January 2018</td>
<td>January 2019</td>
<td>Consults with development experts</td>
</tr>
<tr>
<td>Task Description</td>
<td>Start Date</td>
<td>End Date</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Secure Location and Construction Management Firm</td>
<td>January 2018</td>
<td>June 2018</td>
<td></td>
</tr>
<tr>
<td>Physical construction of site</td>
<td>June 2018</td>
<td>January 2020</td>
<td>Building, renovations, and retrofit</td>
</tr>
<tr>
<td>Hire and train staff</td>
<td>June 2019 (hiring completed)</td>
<td>January 2020 (training completed)</td>
<td>Ongoing training will be provided on a quarterly basis</td>
</tr>
<tr>
<td>Secure materials for Day Care and Family Learning Centre</td>
<td>January 2019</td>
<td>January 2020</td>
<td>Includes all physical materials for Family Resource Library, Family Learning Centre, and Day Care</td>
</tr>
<tr>
<td>Offer pop-up programs for childcare with the assistance of the YMCA at the current centre</td>
<td>January 2018</td>
<td>January 2020</td>
<td>To be provided at the current H7G centre until the new centre is created</td>
</tr>
<tr>
<td>Creation of Summer Camp Curricula</td>
<td>January 2018</td>
<td>June 2018</td>
<td></td>
</tr>
<tr>
<td>Summer Day camp starts</td>
<td>July 2018</td>
<td>August 2018</td>
<td>Continues every summer thereafter</td>
</tr>
<tr>
<td>Day Care and Family Learning Centre opens and programming begins</td>
<td>January 2020</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
Proposed Budget

One-time Costs:

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Funds Proposed</th>
<th>Estimated Funds Scaled</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2,680,000</td>
<td>$1,883,000</td>
</tr>
<tr>
<td>2</td>
<td>$1,524,000</td>
<td>$846,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$4,204,000</td>
<td>$2,729,000</td>
</tr>
</tbody>
</table>

Ongoing Operating Costs:

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated Funds Proposed</th>
<th>Estimated Funds Scaled</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>$3,228,000</td>
<td>$2,965,000</td>
</tr>
<tr>
<td>4+</td>
<td>$3,158,000</td>
<td>$2,965,000</td>
</tr>
</tbody>
</table>

Potential Annual Income After Year 3:

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Details</th>
<th>Estimated Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equity</td>
<td>Equity in real estate assets</td>
<td>$300,000</td>
</tr>
<tr>
<td>Income from childcare fees</td>
<td>Fees for childcare services (average fee $1,000 /month X 117 children)</td>
<td>$1,404,000</td>
</tr>
<tr>
<td>Ongoing Fundraising and Other Income Generation</td>
<td>Annual events or other income generation activities planned by Fundraising Consultant</td>
<td>$500,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>$2,204,000</td>
</tr>
</tbody>
</table>

Year One:

<table>
<thead>
<tr>
<th>Expenditure Type</th>
<th>Expenditure Description</th>
<th>Cost Breakdown</th>
<th>Estimated Funds Proposed</th>
<th>Estimated Funds Scaled</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECE Scholarship Fund</td>
<td>Providing ECE Scholarship for 5 students to build capacity</td>
<td>Proposed: $8,574 per student/year X 5 students, development of program and selection/mentorship of</td>
<td>$50,000</td>
<td>$30,000</td>
</tr>
</tbody>
</table>

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18 Conestoga College. 2017. “Early Childhood Education ECE”. Available at: <https://www.conestogac.on.ca/fulltime/early-childhood-education-ece#domestic-fees-link-noncoop>

The Journey Together for the Region of Waterloo 2017
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Budget</th>
</tr>
</thead>
</table>
| Pop-up programming  | Provision of pop-up programming in collaboration with the YMCA until centre can be created | Proposed: ECE staff $25/hour X 8 hours/week, necessary materials, rental space (if necessary)  
Scaled: ECE staff $20/hour X 6 hours/week, necessary materials, rental space (if necessary)  
$15,000  
$7,000 |
| Ensuring self-sufficiency and sustainability | Contracting a fundraising specialist to cover gaps in funding and ensure sustainability, including offering financial assistance programs, specialized training or programs, etc. and to assist with the construction costs of new centre | One-time fee of $35,000 with expected results of $1-2 million  
$35,000  
$0 |
| Interim Daycare     | Proposed: Creating an interim daycare program over 2 rooms with up to 30 children (mixed ages), evenings and weekends  
Scaled: Creating an interim daycare program over 1 room with up to 15 | Proposed: 1 full time Supervisor at $30/hour, 1 part time Supervisor at $27/hour for 25 hours/week, 3 full time ECEs at $25/hour, 2 full time Assistants at $16/hour, 3 part-time ECEs at $23/hour X 25 hours/week, 2 part-time Assistants $15/hour X 25 hours/week, materials, rented space (may be in kind at YMCA)  
Scaled: 1 full time Supervisor at $27/hour, 1 full time ECE at $22/hour, 1 casual ECE (10 hours per week) at $20/hour, 1 full  
$425,000  
$145,000 |
<table>
<thead>
<tr>
<th><strong>The Journey Together for the Region of Waterloo 2017</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>children (mixed ages-evenings only)</strong></td>
</tr>
<tr>
<td>time Assistant at $15/hour, 1 casual Assistant (10 hours per week) at $15/hour, materials, rental space (may be in kind at YMCA)</td>
</tr>
<tr>
<td><strong>Parent’s Helpline, Outreach Worker, Resource and Advocacy Staff, Play Therapist, and Social Worker</strong></td>
</tr>
<tr>
<td>Proposed: Hiring and retaining an Outreach Worker who will provide in-home assistance and staff the parent’s helpline, contracting a part-time Social Worker, hiring a full-time Resource and Advocacy Staff to create and run educational training programs, contracting a part-time Play Therapist to run counselling</td>
</tr>
<tr>
<td>Full time Outreach Worker at $20/hour for 40 hours/week + benefits, part-time Social Worker at $35/hour for 25 hours/week, full time Resource and Advocacy Staff at $26/hour + benefits, part-time Play Therapist at $30/hour for 25 hours/week, purchasing a vehicle, gas and travel costs, phone costs, advertising, creation of resource package for parents</td>
</tr>
<tr>
<td>$250,000</td>
</tr>
<tr>
<td>Scaled: Hiring and retaining a part-time Outreach Worker, part-time Resource and Advocacy Staff, part-time Social Worker</td>
</tr>
</tbody>
</table>

<p>| <strong>Summer Day Camp</strong> |
| Proposed: Develop and implement a cultural summer daycamp for up to 80 participants |
| Proposed: 1 full time Director to develop programming $30/hour X 40 hours/week X 7 months + benefits, 4 full time ECEs at $25/hour for 1 month, consultations with Elders, Knowledge Keepers, Medicine People, and Seers; materials, subsidies for programming for 60 participants, in kind donation of site from YMCA |
| $70,000 | $45,000 |</p>
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Cost 1</th>
<th>Cost 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scaled: Develop and implement a cultural summer daycamp for up to 40 participants</strong></td>
<td>Scaled: 1 fulltime Director to develop programming $27/hour X 40 hours/weeks X 7 months, 4 full time ECEs at $22/hour for 3 weeks, consultations with Elders, KK, MP, Seers, materials, subsidies for 30 participants, in kind donation of site from YMCA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parental Advisory Board</strong></td>
<td>Creation and implementation of Parental Advisory Board meeting monthly, and quarterly sharing sessions with parents $100 per parent per meeting X 10-12 parents X 16 meetings (1 per month + quarterly), rental space for meetings, food for meetings ($25-50 per session)</td>
<td>$25,000</td>
<td>$25,000</td>
</tr>
<tr>
<td><strong>Daycare Location</strong></td>
<td>Securing location of day care site, hiring architects and engineers, hiring construction firm Purchase: $100/sqft for 20,000 sqft of space minimum, $150/sqft for construction=&lt;$5,000,000&gt;, approx. $350,000 mortgage payments/year + 20% down-payment</td>
<td>$1,500,000</td>
<td>$1,200,000</td>
</tr>
<tr>
<td><strong>Daycare and Family Learning program development</strong></td>
<td>Developing the daycare daily curriculum and Family Learning programming, securing licensing, incorporating childcare organization Program Coordinator $35/hour for 40 hours per week + benefits, consultations, licensing consult $15,000, consultations with Elders and KK, MP, and Seers</td>
<td>$110,000</td>
<td>$110,000</td>
</tr>
<tr>
<td><strong>Administrative Costs</strong></td>
<td>Proposed: Approx. 15% of budget Scaled: Approx. 10% of budget</td>
<td>$200,000</td>
<td>$171,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>$2,680,000</td>
<td>$1,883,000</td>
</tr>
</tbody>
</table>
### Year 2:

<table>
<thead>
<tr>
<th>Expenditure Type</th>
<th>Expenditure Description</th>
<th>Cost Breakdown</th>
<th>Estimated Funds Proposed</th>
<th>Estimated Funds Scaled</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECE Scholarship Fund</td>
<td>Providing ECE Scholarship for 5 students to build capacity</td>
<td>Proposed: $8,574 per first year student/year X 5 students&lt;sup&gt;19&lt;/sup&gt;, $8,365 per 2&lt;sup&gt;nd&lt;/sup&gt; year student X 5 students, development of program/selection of applicants ($25/hour for 40 hours), advertising Scaled: only 3 students</td>
<td>$90,000</td>
<td>$52,000</td>
</tr>
<tr>
<td>Pop-up programming</td>
<td>Provision of pop-up programming in collaboration with the YMCA until centre can be created</td>
<td>Proposed: ECE staff $25/hour X 8 hours/week X 50 weeks, necessary materials, rental space (if necessary) Scaled: ECE staff $20/hour X 6 hours/week X 50 weeks, necessary materials, rental space (if necessary)</td>
<td>$15,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>Interim Daycare</td>
<td>Creating an interim daycare program over 2 rooms with up to 30 children (mixed ages)</td>
<td>1 full time Supervisor at $30/hour, 1 part time Supervisor at $27/hour for 25 hours/week, 3 full time ECEs at $25/hour, 2 full time Assistants at $16/hour, 3 part-time ECEs at $23/hour X 25 hours/week, 2 part-time Assistants $15/hour X 25 hours/week, materials, rented</td>
<td>$425,000</td>
<td>$145,000</td>
</tr>
</tbody>
</table>

<sup>19</sup>Conestoga College. 2017. “Early Childhood Education ECE”. Available at:<https://www.conestogac.on.ca/fulltime/early-childhood-education-ece#domestic-fees-link-noncoop>
<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scaled: Creating an interim daycare program over 1 room with up to 15</td>
<td>Scaled: 1 full time Supervisor at $27/hour, 1 full time ECE at $22/hour, 1 casual ECE (10 hours per week) at $20/hour, 1 full time Assistant at $15/hour, 1 casual Assistant (10 hours per week) at $15/hour, materials, rental space (may be in kind at YMCA)</td>
<td>$210,000</td>
</tr>
<tr>
<td>children (mixed ages - evenings only)</td>
<td></td>
<td>$127,000</td>
</tr>
<tr>
<td>Parent's Helpline, Outreach Worker, Resource and Advocacy Staff, Play</td>
<td>Full time Outreach Worker at $20/hour for 40 hours/week + benefits, part-time Social Worker at $35/hour for 25 hours/week, full time Resource and Advocacy Staff at $26/hour + benefits, part-time Play Therapist at $30/hour for 25</td>
<td>$210,000</td>
</tr>
<tr>
<td>Therapist, and Social Worker</td>
<td>hours/week, phone costs, advertising</td>
<td></td>
</tr>
<tr>
<td>Hiring and retaining an Outreach Worker who will provide in-home assistance</td>
<td>Scaled: Outreach Worker $20/hour for 25 hours/week, Resource and Advocacy Staff at $25/hour for 25 hours/week, Social Worker $35/hour for 25 hours/week, purchasing a vehicle, gas and travel costs, phone costs, advertising, creation</td>
<td></td>
</tr>
<tr>
<td>and staff the parent’s helpline, contracting a part-time Social Worker,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hiring a full-time Resource and Advocacy Staff to create and run educational</td>
<td></td>
<td></td>
</tr>
<tr>
<td>training programs, contracting a part-time Play Therapist to run counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scaled: Hiring and retaining a part-time Outreach Worker, part-time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resource and Advocacy Staff, part-time Social Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
<td>Resource Package</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Summer Day Camp</strong></td>
<td>Develop and implement a cultural summer daycamp for up to 80 participants</td>
<td>1 full time Director to develop programming $30/hour X 40 hours/week X 2 months, 4 full time ECEs at $25/hour for 1 month, honorariums for Elders, Knowledge Keepers, Medicine People, and Seers; materials, subsidies for programming for 60 participants, in kind site donation from YMCA</td>
</tr>
<tr>
<td></td>
<td>Scaled: Develop and implement a cultural summer daycamp for up to 40 participants</td>
<td>Scaled: 1 fulltime Director to develop programming $27/hour X 40 hours/weeks X 2 months, 4 full time ECEs at $22/hour for 3 weeks, consultations with Elders, KK, MP, Seers, materials, subsidies for 30 participants, in kind donation of site from YMCA</td>
</tr>
<tr>
<td><strong>Parental Advisory Board</strong></td>
<td>Creation and implementation of Parental Advisory Board meeting monthly, and quarterly sharing sessions with parents</td>
<td>$100 per parent per meeting X 10-12 parents X 16 meetings (1 per month + quarterly), rental space for meetings, food for meetings ($25-50 per session)</td>
</tr>
<tr>
<td><strong>Daycare and Family Learning program development</strong></td>
<td>Developing the daycare daily curriculum and Family Learning programming, writing</td>
<td>Program Coordinator $35/hour for 40 hours per week + benefits, consultations,</td>
</tr>
<tr>
<td>Expenditure Type</td>
<td>Expenditure Description</td>
<td>Cost Breakdown</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Daycare and Family Learning Centre Location</strong></td>
<td>Mortgage or rental costs</td>
<td>Proposed: $344,000 mortgage costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scaled: $10/sq ft/year</td>
</tr>
<tr>
<td><strong>Administrative Costs</strong></td>
<td></td>
<td>Proposed: Approx. 15% of budget</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scaled: Approx. 10% of budget</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Ongoing Yearly Costs:**

<table>
<thead>
<tr>
<th>Expenditure Type</th>
<th>Expenditure Description</th>
<th>Cost Breakdown</th>
<th>Estimated Funds Proposed</th>
<th>Estimated Funds Scaled</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ECE Scholarship Fund</strong></td>
<td>Providing ECE Scholarship for 5 students to build capacity</td>
<td>Proposed: $8,574 per first year student/year X 5 students, $8,365 per 2nd year student X 5 students, development of program/selection of applicants ($25/hour for 40 hours), advertising</td>
<td>$90,000 (year 3 only)</td>
<td>$18,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scaled: only 3 students</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Year 4+: $8,574 per first year student, $8,365 per 2nd year student, selection of applicants ($25/hour for 40 hours)</td>
<td>$20,000 (year 4 onwards)</td>
<td></td>
</tr>
<tr>
<td><strong>Parent’s Helpline, Outreach Worker, Resource and</strong></td>
<td>Proposed: Retaining a full-time Outreach Worker who will</td>
<td>Full time Outreach Worker at $22/hour for 40 hours/week</td>
<td>$230,000</td>
<td>$175,000</td>
</tr>
</tbody>
</table>

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20Conestoga College. 2017. “Early Childhood Education ECE”. Available at: [https://www.conestogac.on.ca/fulltime/early-childhood-education-ece#domestic-fees-link-noncoop](https://www.conestogac.on.ca/fulltime/early-childhood-education-ece#domestic-fees-link-noncoop)
<p>| Advocacy Staff, Play Therapist, and Social Worker | provide in-home assistance and staff the parent’s helpline, contracting a full-time Social Worker, hiring a full-time Resource and Advocacy Staff to create and run educational training programs, contracting a part-time Play Therapist to run counselling. Scaled: Part-time Outreach Worker, part time Social Worker, full time Resource and Advocacy Staff, part-time Play Therapist | benefits, full-time Social Worker at $35/hour for + benefits, full time Resource and Advocacy Staff at $30/hour + benefits, part-time Play Therapist at $30/hour for 25 hours/week, phone costs, advertising. Scaled: Outreach at $20/hr for 25hr/week, Social Worker at $35/hr for 25hr/week, Resource and Advocacy Staff at $30/hr + benefits, Play Therapist at $30/hr for 25 hours/week, phone costs, advertising. |
| Summer Day Camp | Develop and implement a cultural summer daycamp for up to 80 participants. Scaled: Develop and implement a cultural summer daycamp. | 1 full time Director to develop programming $30/hour X 40 hours/week X 2 months, 4 full time ECEs at $25/hour for 1 month, honorariums for Elders, Knowledge Keepers, Medicine People, and Seers; materials, subsidies for programming for 60 participants, in kind site donation from YMCA. Scaled: 1 fulltime Director to develop programming $27/hour X 40 hours/weeks X 2 |
|  |  | $30,000 | $25,000 |
| Summer Daycamp for up to 40 participants | months, 4 full time ECEs at $22/hour for 3 weeks, consultations with Elders, KK, MP, Seers, materials, subsidies for 30 participants, in kind donation of site from YMCA |  |
| Parental Advisory Board | Creation and implementation of Parental Advisory Board meeting monthly, and quarterly sharing sessions with parents | $100 per parent per meeting X 10-12 parents X 16 meetings (1 per month + quarterly), rental space for meetings, food for meetings ($25-50 per session) | $25,000 | $25,000 |
| Daycare Costs | Running and staffing of Daycare | Full time Operations Manager at $35/hr + benefits, 2 fulltime Supervisors at $30/hr + benefits, 1 part-time Supervisor at $30/hr, 1 full time Administrator at $25/hr + benefits, 17 full time ECEs at $25/hour + benefits, 3 part-time ECEs at $23/hour for 25 hours/week, 6 casual ECEs at $23/hour at 10 hours/week, 8 full time Assistants at $15/hour + benefits, 2 part-time Assistants at $15/hour for 25 hours/week, 6 casual Assistants at $15/hour for 10 hours/week, food preparation staff, maintenance staff, honorariums for Elders + mortgage costs | $2,300,000 | $2,300,000 |</p>
<table>
<thead>
<tr>
<th>Family Learning Centre Costs</th>
<th>Running Family Learning Centre</th>
<th>Full time Supervisor at $30/hr + benefits, 2 fulltime ECEs at $25/hr + benefits</th>
<th>$180,000</th>
<th>$180,000</th>
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<tr>
<td>Administrative Costs</td>
<td>Proposed: Approx. 15% of costs</td>
<td>$373,000</td>
<td>$242,000</td>
<td></td>
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<tr>
<td></td>
<td>Scaled: Approx. 10% of costs</td>
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<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td>$3,158,000</td>
<td>$2,965,000</td>
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</tbody>
</table>

Appendices

1. Survey Questions ........................................................................................................... 57
2. Foundations Diagram ........................................................................................................ 63
3. Strategy Wheel Diagram ................................................................................................... 64
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YMCA’s of Cambridge & Kitchener-Waterloo
UW Centre for Child Studies
KW Habilitation
The Healing of the Seven Generations
Conestoga College
Kimberly Lem RECE, Pedagogical Consultant
Appendix 1- Survey Questions

Are you a Native/First Peoples/Indigenous/Aboriginal/FNMI parent or primary caregiver of a child 0-6 years old living in the Region of Waterloo? We want to hear from you!

We are collecting information relating to your experiences with Early Years (ages 0-6) services as a Indigenous person. The goal of this survey is to identify the particular needs in our community, so that we can better provide appropriate programming.

Some of the questions will be of a personal nature and will touch briefly on issues of abuse and trauma. You can skip any question you feel uncomfortable answering. This information will be used to help us better understand the home environments and challenges that our Early Years participants and their parents are experiencing so that we can better serve and understand your needs. There is no shame or judgement in your answers and we ask you to please answer honestly and with as much detail as possible. Privacy will be protected and all answers will be anonymous.

If you would like to share further experiences, concerns, or questions with the researcher, or if you need assistance filling out this survey, please leave your email or contact information in the box below and the researcher will contact you.

This survey is part of the Journey Together program and will form part of a report that is sent to the Region of Waterloo and the Ministry of Education.

Questions will take approximately 20-30 minutes to complete.

If you would like more information about this survey or project, please contact Rebecca at sargent.c.rebecca@gmail.com or call 519-570-9118.

Thank you for your participation.

1. Do you live in the Region of Waterloo?
   a) Yes, and I have lived here 5 years or more
   b) Yes, but I am new to the Region (5 years or less)
   c) I live in a neighbouring area (Oxford or Wellington Counties)
   d) I live elsewhere in Ontario
   e) I don’t live in Ontario, but I live elsewhere in Canada
   f) Other, please specify

2. I prefer the term:
   a. Native
   b. Indigenous
   c. First Nations
   d. First Peoples
   e. Aboriginal
   f. Other, please specify

3. How would you describe your gender?
   a. Female
   b. Male
   c. Non-binary
   d. Trans
   e. Two-spirited
4. Please describe your ethnicity/clan/cultural group.
5. How old are you?
   a. Under 17 years old
   b. 17-20
   c. 20-25
   d. 25-30
   e. 30-35
   f. 40-45
   g. 45-50
   h. 50+
6. What is your relationship to the Early Years child(ren) in your life?
   a. Mother
   b. Father
   c. Step-parent
   d. Adoptive-parent
   e. Grandparent
   f. Aunt or Uncle
   g. Other related caregiver/guardian
   h. Non-related caregiver/guardian
   i. Other, please specify
7. How many children are currently in your care?
   a. 1
   b. 2
   c. 3
   d. 4
   e. 5+
8. How many biological children do you currently have?
   a. 1
   b. 2
   c. 3
   d. 4
   e. 5+
9. Please indicate the age(s) of your child(ren)?
10. How do you currently meet your financial needs?
    a. I am employed
    b. My spouse/partner is employed
    c. My parents or someone else supports me
    d. Social assistance (OW, ODSP, etc.)
    e. Other, please specify
11. How would you describe your current state of employment?
    a. Steady, full time hours
    b. Steady, part time hours
    c. Irregular, but mostly full time hours
d. Irregular hours, less than full time  
e. Temporary or contract work  
f. I am not currently working  
g. Other, please specify  

12. How would you describe the state of your finances? 
   a. Living in luxury  
b. Comfortable, I have what I need  
c. Struggling to make ends meet  
d. Other, please specify  

13. My current annual household income is:  
   a. Over $100,000  
b. Between $75,000-$99,999  
c. Between $50,000-$74,999  
d. Between $25,000-$49,999  
e. Under $25,000  

14. Are you currently dealing with any chronic conditions (physical or mental) or any disabilities (learning or physical) for which you need supports? 
   a. Yes, if so please describe the type of supports you require (ie. Ramp/wheelchair access, literature in brail, sign language interpreter, accessible transport, etc.)  
b. No  

15. Does your child(ren) have any kind of chronic condition (physical or mental), or any disabilities (learning or physical) for which they need supports? 
   a. Yes, if so, please describe the type of supports you require (ie. Ramp/wheelchair access, literature in brail, sign language interpreter, accessible transport, etc.)  
b. No  

16. Would you describe your housing situation as stable?  
   a. Yes  
b. Most of the time  
c. Some of the time  
d. No  
e. No, and I am currently homeless  
f. Other, please describe  

17. Who currently lives in your home with you? (ie. Spouse, other children, step-children, foster children, adoptive children, parents, grandparents, roommates, borders, etc.)  

18. Is your child’s other parent involved in the child’s life?  
   a. Yes, they live in the home with us  
b. Yes, they have custody or regular visitation/access  
c. Not regularly  
d. No, not at all  
e. Other, please specify  

19. If your child’s other parent is involved in their lives, how well would you say you get along with each other?  
   a. We always get along  
b. We get along most of the time  
c. We get along some of the time
d. We don’t get along at all
  e. My child’s other parent is not involved in their life
  f. Other, please specify

20. If your child’s other parent is involved in their life, do you ever argue or fight in front of the child(ren)?
   a. Never
   b. It’s happened a couple of times
   c. Infrequently
   d. Sometimes
   e. Most of the time (ie. Weekly)
   f. Every day
   g. My child’s other parent is not involved in their life

21. Is any of your family supportive (emotionally physically, financially, intellectually, etc.) in your child’s care?
   a. Yes, if so please describe who supports you and how
   b. No

22. Do you currently use any supports for your childcare needs (babysitters, daycare, spousal support, family, friends, parenting groups/classes, educational programs, drop-in programs, etc.)? If so, please describe. If not, why not? Are there any barriers preventing you from accessing these types of programs?

23. Have you used any Early Years programming in the past? If so, which kind (ie. Babysitters, daycare, after/before school programs, breakfast programs, parenting classes, support groups, drop-in programming, etc.)? Which are most helpful to you, and why? If not, why not? Are there any barriers preventing you from accessing these types of programs?

24. Have you ever had any personal dealings with the courts or prison systems?
   a. No
   b. Yes, in the past
   c. Yes, currently on parole
   d. Yes, currently awaiting trial
   e. Yes, currently on probation
   f. Other, please specify

25. Did you grow up with any abuse in your home? (to you personally, or witnessing abuse of others). Check all that apply.
   a. No
   b. Yes, physical abuse
   c. Yes, emotional/verbal abuse
   d. Yes, sexual abuse
   e. Yes, spiritual or cultural abuse
   f. Yes, witnessing the abuse of others
   g. Other, please specify

26. If you did experience abuse in your childhood, did you receive adequate therapy or other assistance to cope with the trauma/abuse?
   a. Yes, I did receive adequate therapy or assistance for my trauma/abuse
   b. I received therapy or assistance, but it was not adequate
   c. No, I did not receive any therapy or assistance for my trauma/abuse (if no, is there a reason you didn’t get therapy or assistance, please explain)
   d. I did not experience abuse
27. Which discipline methods did your parents/caregivers use when you were a child (ie. Time outs, spanking, scolding, etc)? Which discipline methods do you currently use?

28. Did your parents/caregivers fight in front of you as a child?
   a. Never
   b. Once or twice
   c. Infrequently
   d. Sometimes
   e. Often
   f. Every day

29. Were your biological parent(s) active in raising you?
   a. Yes, both my parents were active in raising me
   b. Yes, my mother was active in raising me
   c. Yes, my father was active in raising me
   d. Yes, for part of my childhood (death, illness, custody loss, change of situation, etc)
   e. They were around, but not active
   f. My biological parents were not part of my life
   g. Other, please specify

30. Were you raise learning traditional teachings, languages, practices, or connected to your Indigenous culture as a child?
   a. Yes, very much so
   b. Yes
   c. A little bit
   d. Not at all
   e. Other, please specify

31. Would you like your child to be raised learning traditional teachings, languages, or practices connected to your Indigenous culture?
   a. Yes, definitely, very much so
   b. Yes, I’d like it to be part of their upbringing
   c. Somewhat
   d. Not at all
   e. Other, please specify

32. Are you currently the primary caregiver of your child(ren)?
   a. Yes
   b. No
   c. No, but I am fighting for access/visitation
   d. Other, please specify

33. Have you had any experiences with the Family and Child Services, Children’s Aid Society or other child welfare agency? If so, how was your experience(s)? In your opinion, how could these agencies better serve your needs as an Indigenous person?

34. What types of Early Years programming (for ages 0-6 years old) or parental support would you like to see for Indigenous people in the Region of Waterloo? Please describe.

35. What do you wish you had known about what it would be like to be a parent before your child was born? What is your biggest struggle as a parent? What type of programming do you think could have helped you with those struggles?
36. When would you need Early Years programming such as daycare/educational programs, etc.? Select all that apply.
   a. Before/after work
   b. Mornings
   c. Afternoons
   d. Evenings
   e. Weekdays
   f. Weekends
   g. It varies

37. Are you planning to have any more children?
   a. Yes, many more
   b. Yes, one or two
   c. I am not currently planning more children, but may in the future
   d. No, I’m done
   e. Other, please specify

38. Do you speak your Indigenous mother tongue?
   a. Yes, I am fluent
   b. Yes, at an intermediate level
   c. Yes, at a beginner level
   d. No, but I would like to
   e. No, but I don’t want to
   f. Other, please specify

39. How would you rate your trust in local government agencies?
   1 (I do not trust them at all)
   2 (I don’t trust them very much)
   3 (I have a fair amount of trust)
   4 (I trust them just about always/most of the time)
   5 (I have absolute trust in them)

40. How would you rate your trust in child welfare services in the Region (ie. Family and Child Services, Children’s Aid Society, etc.)
   1 (I do not trust them at all)
   2 (I don’t trust them very much)
   3 (I have a fair amount of trust)
   4 (I trust them just about always/most of the time)
   5 (I have absolute trust in them)

41. How would you rate your trust in local Indigenous organizations?
   1 (I do not trust them at all)
   2 (I don’t trust them very much)
   3 (I have a fair amount of trust)
   4 (I trust them just about always/most of the time)
   5 (I have absolute trust in them)

Thank you for your participation!
ENVIRONMENT

GOAL: BELONGING

- Rooted in Creator’s Laws and teachings with a focus on healing and responsibility, sharing, generosity, honesty, and kindness

FAMILY

GOAL: WELL-BEING

- Comprehensive programming that addresses physical, intellectual, emotional, and spiritual needs of Early Years children

CHILD

GOAL: EXPRESSION

- Community belonging and healing emotional support

EDUCATOR

GOAL: ENGAGEMENT

- Advocacy and policy development for the advancement of the needs of First Peoples

FINANCE

GOAL: WELL-BEING

- Comprehensive programming that addresses physical, intellectual, emotional, and spiritual needs of Early Years children
GOALS:
ROOTED IN CREATOR'S LAWS
• Seven Grandfather Teachings
• Longhouse Teachings
• Mino Bimaadziwin - "The Good Life"
• Other gifts from the Creator
• Self-healing, changing path/journey
• Community/trauma healing and balance restoration

GOALS:
COMPREHENSIVE PROGRAMMING
• Programming to ensure the healthy physical, emotional, intellectual, and spiritual well-being of First Peoples youth and their parents
• Secure long term funding for programming

GOALS:
POLICY DEVELOPMENT
• Advocacy for families
• Developing policies to ensure the well-being of First Peoples; restoring a sense of pride, dignity, and self-worth
• Keeping children with families and culture
• Ensuring long term funding for programming by developing good relationships with government and other agencies
• Working to educate and inform policy and create awareness for First Peoples' issues

PROGRAMMING NEEDS
• Ensuring children stay with their families and build a secure attachment
• Programs on emotional health
• Community events to encourage sense of belonging
• Counselling and support groups for parents
• Access to culturally sensitive social workers, social support, links to services
• Access to Healing Circles
• Building intergenerational connections
• Socialization with other children

PROGRAMMING NEEDS
• Access to physical activities/equipment
• Education on physical fitness and nutrition
• Education on good sleep hygiene
• Programs to develop motor skills and fitness
• Access to comprehensive, stable, medical care
• Training on cultural needs and sensitivities to local medical and other service providers
• Education and skills building for parents (breastfeeding, pre/post natal care, parenting classes, etc.)
• Secure housing
• Keeping children with families/culture
• Access to clean water and healthy foods
• Food and meal prep education/practice

PROGRAMMING NEEDS
• Establishing cultural connections at birth
• Access to Cultural Advisor to guide learning
• Community interaction between generations
• Interaction with the wider community, building a sense of belonging
• Access to smudges, ceremonies, and medicines
• Early Language/cultural instruction
• Access to land, outdoor traditional activities
• Teachings, stories, oral traditions, crafts

GOALS:
COMMUNITY BELONGING/HEALING SUPPORT
• Creating a strong sense of belonging in culture, First Peoples community, and wider community
• Establishing relationships and support between generations
• Building self-worth, dignity, pride
• Dispelling myths about mental health

PROGRAMMING NEEDS
• Programs to develop cognitive development
• Language programs (Mohawk, Ojibwa, other languages)
• Ensuring materials for successful education
• Access to learning materials and support
• Access for parents to social supports, counselling, housing, educational training, and skills training
• Sing alongs, play based learning, socialization
• Head-start and school readiness programs

GOALS:
STRATEGY WHEEL
The North
The East
The West
The South

Physical
Spiritual
Emotional
Intellectual

PROGRAMMING NEEDS
• Access to physical activities/equipment
• Education on physical fitness and nutrition
• Education on good sleep hygiene
• Programs to develop motor skills and fitness
• Access to comprehensive, stable, medical care
• Training on cultural needs and sensitivities to local medical and other service providers
• Education and skills building for parents (breastfeeding, pre/post natal care, parenting classes, etc.)
• Secure housing
• Keeping children with families/culture
• Access to clean water and healthy foods
• Food and meal prep education/practice
To Whom It May Concern,

On behalf of the YMCAs of Cambridge & Kitchener-Waterloo, I am pleased to submit this letter of support of The Journey Together, First Peoples Early Years program proposal by The Healing of the Seven Generations in concert with the Region of Waterloo.

As a lead agency of Ontario Early Years in Waterloo Region, we understand the need and importance of the proposed Family Learning and Child Care Centre where all First Peoples can access Early Years programs and services, healthy child development and well-being resources, in a welcoming, safe, and inclusive environment addressing the educational, physical, spiritual, cultural and emotional needs of First People.

The YMCA values our partnerships and connections with Indigenous communities locally and across the country. We will support the planning, implementation and delivery of the proposed Early Years centres through sharing of space and resources as well as further exploration of how together we can create a bright future for all children and families in our community.

We appreciate the opportunities we have had to partner with The Healing of the Seven Generations in the past and look forward to further connections and partnership in serving children and families in Waterloo Region.

Sincerely,

Jaime Jacomen
General Manager, Early Years and Family Supports
YMCAs of Cambridge & Kitchener-Waterloo
August 11, 2017

Re: Letter of Support for First Peoples Early Years Programming for the Region of Waterloo

To Whom it May Concern,

In April 2017, I was contacted by Rebecca Sargent, Research Consultant for The Healing of the Seven Generations (Kitchener, ON) and learned about the proposal to develop more comprehensive Early Years Programming for First Peoples living in the Region of Waterloo.

In this letter I would like to extend and confirm my support for this proposal, with respect to the lending of my expertise in area of early communicative development, early social-cognitive development, and other areas of early childhood development (e.g., play) as they relate to different aspects and best practices in early years programming. I have been a developmental psychology professor at the University of Waterloo for 22 years, where I founded and am director of the UW Centre for Child Studies. My research over this time has focused on communicative and cognitive development largely among children under 5 years of age. Through my research, I have also I developed the Language Use Inventory (LUI), a standardized tool to assess early spoken language in children 18-47 months of age that is used by speech-language professionals worldwide to help detect early spoken language delay or impairment and aid in the early identification of children in need of monitoring and/or intervention.

I am honoured to have been asked to lend my expertise to this initiative to develop more comprehensive early years programming for First Peoples in the Region of Waterloo.

Sincerely,
Daniela O’Neill

Professor
Dept. of Psychology
University of Waterloo
Waterloo, ON N2L 3G1 Canada
doneill@uwaterloo.ca | (519) 888-4567
Faculty profile: https://uwaterloo.ca/psychology/people-profiles/dr-daniela-oneill
Lab website https://uwaterloo.ca/centre-for-child-studies/
July 12, 2017

Ms. Donna Dubie  
Executive Director  
The Healing of the Seven Generations  
300 Frederick Street  
Kitchener, ON  N3H 2N5

Re: First Peoples Early Years Programming for the Region of Waterloo

Dear Ms. Dubie,

I had the chance recently to meet with Rebecca Sargent, Research Consultant, who has been working with you on the proposal for First Peoples Early Years Programming for the Region of Waterloo. Rebecca visited us at our main office which is the administrative hub for our Early Years, Child Care and Family Resources service. I had the chance to share with her the service provided by our Early Learning program. In our community we work under the funding provided by the Ministry of Education (Ontario), for Child Care and Child and Family Program Service for the Waterloo Region. Within this funding envelope are directives for Special Needs Resourcing (SNR) Expenditure Requirements and Staffing. Consolidated Municipal Service Managers (Region of Waterloo) are required to spend a minimum percent of their total child care allocation on SNR. Under this model KW Habilitation provides all resource consultant services, Enhanced Staffing under a 100% Purchase of Service (POS) model, volunteer and student placements, as well as psychology services to licensed early learning and care programs throughout the Region, for all specialized needs. Needless to say, in speaking with Rebecca and her sharing your plans for the First Peoples Early Years Programming in our Region we are excited to think about the possibilities of working directly with you in licensed programs, supporting children and families.

Our work in Special Needs Resourcing lends to your programming goals of “Preparing First People Early Years children for greater success in their later years by developing comprehensive programming and using the pedagogical best practices explored in the How Does Learning Happen document, along with consultations from experts in Early Years development and well-being”. In addition, our Resource Consultants focus on fostering a sense of well-being, belonging, self-worth and dignity for all children and their parents throughout the Region of Waterloo. That is our philosophy in our work as
educators and as employees of KW Habilitation we promote the belief that we are a community where everyone belongs and participates.

The best to you and your staff as you begin the next steps in this journey to reconciliation. We certainly look forward to our potential partnerships working together. Please let me know if there is anything I can provide to you in supporting your work plan as you move forward.

Sincerely,

John Martin
Director
Early Learning, Child Care and Family Resources
KW Habilitation
August 29, 2017

Healing of the Seven Generations
300 Frederick St.
Kitchener, ON,
N3H 2N5

Dear Sir/Madam,

I am pleased to provide this letter of support for the development of a Day Care and Family Drop-In/Learning Centre for First Peoples living in the Region of Waterloo. As an academic institution committed to excellence in education, innovation and community engagement, we believe that a Resource Centre that proposes to offer programs that address the educational, physical and cultural needs of First Peoples children and their families will support individuals to achieve their potential and add great value to our diverse community.

Our Conestoga family of early childhood education programs would be honoured to work with this project team in developing curricula that empowers children and families, respects culture and diversity, and creates pathways to transition First Nations’ Peoples into college education.

Sincerely,

Dr. Barbara Kelly
Vice President, Academic Administration
Conestoga College Institute of Technology and Advanced Learning
Date: August 11, 2017

Re: Letter of Support for First Peoples Early Years Programming for the Region of Waterloo

To Whom it May Concern,

In April 2017, I was contacted by Rebecca Sargent, Research Consultant for The Healing of the Seven Generations (Kitchener, ON) and learned about the proposal to develop more comprehensive Early Years Programming for First Peoples living in the Region of Waterloo.

In this letter, I would like to confirm my support for this proposal, with respect to the lending of my expertise in the area of programming for children in the early years in regards to Ontario’s Pedagogy, “How Does Learning Happen” (2014).

I have been in the ECE field since 2006 and have held a range of positions as an RECE. I recently completed a term appointment as a Pedagogical Consultant for pilot project funded through the Region of Waterloo in partners with Conestoga College. In this position, I consulted and conducted workshops with a variety of child care centres, WRDSB, educators and individual consultations on a broad spectrum of topics regarding quality programing and best and promising practices for the early years.

This fall I resume my teaching duties as an RECE at St. John’s Christian Nursery School in Waterloo.
I look forward to being involved in this project.

Sincerely,

Kim Lem, RECE
### Appendix B

<table>
<thead>
<tr>
<th>One-Time Capital ($8,740,000)</th>
<th>Proposed Budget</th>
<th>Scaled Budget</th>
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<tbody>
<tr>
<td></td>
<td>▪ Looking for property in/near the Kitchener downtown core to maximize accessible from all parts of the Region, as centrally located and easy access when taking Public Transit</td>
<td>▪ Looking for property in/near the Kitchener downtown core to maximize accessible from all parts of the Region, as centrally located and easy access when taking Public Transit</td>
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<tr>
<td></td>
<td>▪ Opportunities for co-location with local school boards was examined but currently there is no vacant space available in schools in the Kitchener downtown core and no new Capital Priorities have been identified in this area.</td>
<td>▪ Opportunities for co-location with local school boards was examined but currently there is no vacant space available in schools in the Kitchener downtown core and no new Capital Priorities have been identified in this area.</td>
</tr>
<tr>
<td></td>
<td>▪ A Stand-a-lone build with a school has also been examined and has proven difficult as the schools in the downtown core have limited available space for expansion on their sites</td>
<td>▪ A Stand-a-lone build with a school has also been examined and has proven difficult as the schools in the downtown core have limited available space for expansion on their sites</td>
</tr>
<tr>
<td></td>
<td>▪ Although we remain open to all of these possibilities and will continue to look for opportunities – we have budgeted for the purchase of land for the construction of a building or the purchase of a property with a building where a major retrofit would be required.</td>
<td>▪ Although we remain open to all of these possibilities and will continue to look for opportunities – we have budgeted for the purchase of land for the construction of a building or the purchase of a property with a building where a major retrofit would be required.</td>
</tr>
</tbody>
</table>
|                               | ▪ Year 1 (2018) costs include:  
  - Purchase of property – up to $4,500,000  
  - Architect fees - up to $240,000 (used 6% of building cost as estimate) | ▪ Year 1 (2018) costs include:  
  - Purchase of property - up to $4,500,000  
  - Architect fees – 192,000 |
|                               | ▪ Year 2 (2019) cost include:  
  - Construction of Building or building retrofit – up to 4,000,000 | ▪ Year 2 (2019) costs include:  
  - Construction of Building or building retrofit up to 3,200,000  
  - Impact: Reduction in licensed capacity of the centre to 51 (4 classrooms) |
<table>
<thead>
<tr>
<th>One-Time Operating (start-up)</th>
<th>Proposed Budget</th>
<th>Scaled Budget</th>
</tr>
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<tbody>
<tr>
<td><strong>Year 1 (2018) costs include:</strong></td>
<td></td>
<td><strong>Year 1 (2018) costs include:</strong></td>
</tr>
<tr>
<td>➢ Child Care Centre</td>
<td></td>
<td>➢ Child Care Centre</td>
</tr>
<tr>
<td>o equipment for Interim evening and weekend care</td>
<td></td>
<td>o equipment for Interim evening and weekend care and Summer care</td>
</tr>
<tr>
<td>o advertising cost for Interim care options</td>
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<td>o advertising cost</td>
</tr>
<tr>
<td>o New Licensing</td>
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<td>o New licensing</td>
</tr>
<tr>
<td>o Incorporation fee as a NFP organization</td>
<td></td>
<td>o Incorporation fee as a NFP org</td>
</tr>
<tr>
<td>o 2 Laptop Computers &amp; Printer</td>
<td></td>
<td>o 2 Laptops and B&amp;W printer</td>
</tr>
<tr>
<td>➢ Child and Family Centre</td>
<td></td>
<td>➢ Child and Family Centre</td>
</tr>
<tr>
<td>o for culturally relevant equipment and materials for pop-up play program and for PT Social Worker (Outreach worker)</td>
<td></td>
<td>o culturally relevant equipment and materials for pop-up play program and for PT Social Worker (Outreach Worker)</td>
</tr>
<tr>
<td>o Phone hook up for Helpline at community Agency</td>
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- Food (catered)

- Licensing Renewal and Revision

- Playground Inspection

- Reduction in pop-up play. Reduced access to the Summer Camp program

- Year 2 (2019) costs include:

  - Child Care Centre & Family Centre
  - FT and PT Staff Wages and Benefits
  - Casual Staffing costs
  - Overtime
  - Staff Training
  - Office Supplies
  - Play Equipment
  - Phone
  - Cell Phones/Blackberry
  - Casual Mileage
  - Insurance
  - Rent
  - Food
  - Licensing Renewal and Revision
  - Playground Inspection

- Impacts: Reduce Service delivery - reduced hours for Outreach Worker, Social Worker, helpline supports and Resource & Advocacy Staff as well as reduction in pop-up play. Reduced access to the Summer Camp program
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Message from the Medical Officer of Health

One of the mandates of local public health units in Ontario is to prevent or reduce the burden of infectious diseases of public health importance. Region of Waterloo Public Health and Emergency Services fulfills this mandate by working to prevent the transmission of infectious and other reportable diseases in the region. These diseases are important since they have the ability to cause serious illness and/or be transmitted to large numbers of individuals. Public Health’s disease-related programs are guided by the Ontario Public Health Standards (OPHS) and local needs.

In fulfilling its mandate related to infectious disease, Public Health monitors the occurrence of these diseases, associated risk factors and emerging trends. Through the provision of reports such as Local Influenza Surveillance Bulletins and previous Waterloo Region Infectious Disease Status Reports, Region of Waterloo Public Health and Emergency Services is committed to providing the public with timely and accurate information on the local status of infectious diseases.

To add to this body of knowledge, I am pleased to release the Infectious Diseases in Waterloo Region Surveillance Report for 2016. This annual report builds on previous reports and not only presents local disease trends, but also provides a provincial comparison of rates.

I hope you find the information contained in this report both interesting and useful. As always, Region of Waterloo Public Health and Emergency Services continually works to improve its programs, services and reporting related to infectious diseases in an effort to build healthy and supportive communities.

Dr. Liana Nolan
Commissioner/Medical Officer of Health
Region of Waterloo Public Health and Emergency Services
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Executive Summary

Background
Infectious diseases (IDs) are illnesses caused by microorganisms such as bacteria, viruses and parasites which may cause serious illness or be transmitted to large numbers of individuals. In accordance with the Ontario Public Health Standards (OPHS), one of the mandates of local public health units in Ontario is to work on the prevention and control of infectious diseases of public health importance. As such, the purpose of this report is to assess Waterloo Region’s rates of infectious diseases of public health importance and to monitor trends over time. This information will be used to aid in planning and evaluating evidence-based public health policies, programs, interventions, and related services so as to mitigate the frequency and impact of infectious diseases in the local community. This report presents Waterloo Region’s rates of reportable diseases for 2016, historical rates for 2006-2015, comparisons to the historical 5-year average, and comparison of local rates to those of the province of Ontario. Basic epidemiology, exposure and risk factor information are also provided where appropriate.

Key Findings

Overall
In 2016 there were 2,897 cases of reportable infectious diseases in Waterloo Region. The top five infectious diseases reported in 2016 were chlamydia, influenza, gonorrhea, salmonellosis and campylobacteriosis, which accounted for 84.4 per cent of all cases. In general, the rates of most reportable diseases in Waterloo Region were consistent with or lower than provincial rates.

Enteric Diseases
Among enteric (i.e. intestinal) disease, salmonellosis and campylobacteriosis were the most frequently reported infectious diseases. Waterloo Region rates of most enteric diseases were similar to or lower compared to those for all of Ontario. Travel outside of the province was a common risk factor for many enteric diseases, including amebiasis, cryptosporidiosis, cyclosporiasis, giardiasis, hepatitis A, salmonellosis, shigellosis and typhoid/paratyphoid fever. Travellers are reminded to follow good hand hygiene practices, avoid consumption of potentially contaminated food such as raw fruits and vegetables (unless they have been washed, peeled or cooked), consume water that is potable, and avoid risky behaviours such as swimming in contaminated water.

Region of Waterloo Public Health works to manage and control enteric diseases by following up on reported cases and their contacts, providing education regarding risk
factors and prevention, and supporting long-term care homes, hospitals and daycares in the prevention and control of enteric outbreaks. Region of Waterloo Public Health also performs routine inspections of food premises, long-term care homes and retirement facilities, residential facilities, day nurseries, personal service settings, and recreational water facilities (e.g., public pools, hot tubs and splash pads) to prevent the occurrence and transmission of infectious and foodborne illness. In addition, Region of Waterloo Public Health collaborates with federal and provincial partners to identify and remove sources of contaminated food products from the consumer marketplace. Public Health also provides free access to bacteriological testing for private well water and aids in the interpretation of such testing for well owners.

**Vector-borne and Zoonotic Diseases**

Vector-borne diseases (e.g., malaria, West Nile Virus, Lyme disease) and zoonotic diseases (e.g., rabies) are relatively uncommon in Waterloo Region.

There were no human cases of West Nile virus in Waterloo Region in 2016 and Waterloo Region remains an area of low risk for the acquisition of Lyme disease. There are areas in Ontario that are considered higher risk for the acquisition of Lyme disease due to the presence of black-legged ticks. It is important for residents in Waterloo Region to be aware of precautions they can take to protect themselves against Lyme disease, especially when they travel to areas of higher risk. Region of Waterloo Public Health continues to work to reduce risk of exposure to Lyme Disease and West Nile Virus through public education, investigation of suspect human cases, vector surveillance and the implementation of vector control measures.

There were no human rabies cases in 2016. While the risk for the general public of acquiring rabies remains low in Waterloo Region, wildlife in the region and surrounding areas have recently tested positive for rabies. It is important for individuals with an exposure (i.e. bite or scratch) to raccoons, skunks, other wildlife or any other animals to receive prompt assessment in order to determine the possible need for rabies post exposure prophylaxis. Public Health continues to investigate all reported animal biting incidents, provide recommendations regarding post-exposure prophylaxis, and dispense rabies vaccine.

**Sexually Transmitted and Blood-borne Infections**

Among all sexually transmitted and blood-borne infections, chlamydia, gonorrhea and hepatitis C contributed the greatest number of cases in Waterloo Region in 2016. As in previous years, chlamydia remains the most common infectious disease in Waterloo Region overall, with higher rates in young adults 20 to 29 years of age, and among 15 to 24 year old females. Chlamydia rates have been steadily rising throughout the province.
since 2007, including in Waterloo Region. The provincial rates have been significantly higher than those observed in Waterloo.

The rate of gonorrhea in Ontario has been increasing in recent years, and this trend has also been observed locally. Reasons for the province-wide increase in rates are unclear, and are being studied by the provincial government. The most commonly reported risk factors for local cases of gonorrhea included not using a condom and having multiple sexual partners.

The increased rates in sexually transmitted infections among youth may be attributed in part to more awareness of the need for testing, increased access to testing and new testing methods; however this does not completely explain the increase. Research also suggests that social determinants of health, in particular low socioeconomic status and limited access to health care, as well as the stigmatization and fear of being diagnosed with an STI contribute to higher incidence in young people. In order to support access to services, Region of Waterloo Public Health offers free and confidential sexual health counselling and clinics, two of which are specifically for youth. Public Health also offers supportive services including a sexual health phone line staffed by a public health nurse, as well as public health nurse availability at Waterloo Region District School Board secondary schools on a weekly basis to provide sexual health services.

There was an increase in acute hepatitis B cases in Waterloo Region in 2016 compared to previous years, although case numbers were still low and within normal fluctuations. Follow-up of local cases indicated that there were no known links between cases. Fluctuations in sporadic acute hepatitis B cases are expected as vaccination coverage continues to vary, particularly in those who were born prior to the start of routine school-based hepatitis B immunization for grade 7 students. In addition, behavioural factors and immigration from endemic countries are unpredictable and can contribute to hepatitis B disease transmission. Region of Waterloo Public Health will continue to provide school-based hepatitis B immunization clinics to grade 7 students, promote hepatitis B immunization to health care providers, promote screening in individuals travelling from countries with high hepatitis B prevalence, and participate in harm reduction activities such as needle syringe programs.

Local rates of hepatitis C, and HIV/AIDS all remained relatively stable and below those of the province in 2016. Region of Waterloo Public Health continues to engage in harm reduction strategies which include the provision of needle syringe programs, condom distribution, and other related services at several locations in the region.
Vaccine Preventable Diseases
Influenza was the most common vaccine preventable disease for the 2016-2017 season, accounting for more than three-quarters of vaccine preventable diseases reported in Waterloo Region. Influenza activity during the 2016-2017 season was similar to the historical average. In addition, the local rate of influenza was significantly lower than that for the province as a whole. Region of Waterloo Public Health continues efforts to manage influenza seasons by distributing influenza vaccines to health care providers and providing influenza immunization clinics by appointment for families to complement the many pharmacies, physicians' offices and other providers of influenza vaccine in our region. Public Health also works with long-term care and retirement homes to increase staff and resident immunization coverage rates, and follows up on influenza cases and outbreaks in Waterloo Region.

Local rates of invasive pneumococcal disease (IPD) were higher than those of the province in 2016. Invasive pneumococcal incidence rates in Waterloo Region have historically been higher than those of the province, although rates have varied from year to year. Specific reasons for this are unknown; however, Region of Waterloo Public Health initiated an Invasive Pneumococcal Disease Prevention Campaign in the 2016-2017 respiratory season. This project aims to prevent invasive pneumococcal disease in the community by increasing pneumococcal vaccination rates among priority and high risk individuals. Promotional packages were distributed to primary care providers, specialists and specialty clinics, pharmacists and labs. Public Health plans to evaluate the effectiveness of the IPD Campaign and make recommendations for further action in the future.

Rates of pertussis, varicella, mumps, invasive meningococcal disease (IMD) and measles were either stable or decreased in 2016, and remained similar to or lower than provincial rates. Region of Waterloo Public Health supports the prevention of vaccine-preventable illnesses through the provision of vaccine delivered through health care providers and public health immunization clinics. It also works to achieve and maintain high immunization rates among children in elementary and secondary schools through the Immunization of School Pupils Act, and continues to conduct health education and promotion activities to increase immunization coverage rates.

Other Infectious Diseases
Local rates of legionellosis in 2016 were higher than the province but were not statistically different and are expected to fluctuate from year to year. Investigation of cases did not identify any common exposures or epidemiological links among cases in the region.
Outbreaks
Waterloo Region experienced a typical season in terms of enteric outbreaks which were most often due to norovirus-like illness, in the 2016-2017 season. As expected, enteric outbreaks were most frequently reported in child care facilities and peaked in the winter months.

The 2016-2017 non-influenza respiratory outbreak season was similar to previous seasons in Waterloo Region. Non-influenza respiratory outbreaks were most frequently reported in long-term care homes and retirement homes.

The number of influenza outbreaks was slightly higher in 2016-2017 compared to previous seasons in Waterloo Region, but still within what can be expected in a normal influenza season due to variations from year to year. Influenza outbreaks peaked in February. More than half of institutional influenza outbreaks occurred in long-term care homes, followed by retirement homes.

Region of Waterloo Public Health follows up with child care centres, hospitals, residential/group homes, long-term care homes and retirement homes that have reported an outbreak to assist with and support outbreak management efforts. In addition, Region of Waterloo Public Health hosts infection control education forums for long-term care homes, retirement homes, and child care centres, and participates on committees and networks that address infection prevention and control issues in facility settings.

Conclusion
Infectious diseases have the potential to cause serious illness and can have community-wide implications. As such, Region of Waterloo Public Health undertakes a number of activities to prevent or reduce the burden of infectious diseases in the community. The Infectious Diseases in Waterloo Region Surveillance Report for 2016 provides an update to the community on the local status of infectious diseases and the findings from this report will continue to be used to inform local public health programming in the prevention and transmission of reportable, infectious diseases in Waterloo Region.
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<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>CI</td>
<td>Confidence interval</td>
</tr>
<tr>
<td>GBS</td>
<td>Group B streptococcus</td>
</tr>
<tr>
<td>HBV</td>
<td>Hepatitis B virus</td>
</tr>
<tr>
<td>HCV</td>
<td>Hepatitis C virus</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HPI</td>
<td>Health Protection and Investigation</td>
</tr>
<tr>
<td>HPPA</td>
<td>Health Protection and Promotion Act</td>
</tr>
<tr>
<td>IDDSH</td>
<td>Infectious Diseases, Dental and Sexual Health</td>
</tr>
<tr>
<td>iGAS</td>
<td>Invasive Group A streptococcal disease</td>
</tr>
<tr>
<td>IMD</td>
<td>Invasive meningococcal disease</td>
</tr>
<tr>
<td>IPD</td>
<td>Invasive pneumococcal disease</td>
</tr>
<tr>
<td>iPHIS</td>
<td>Integrated Public Health Information System</td>
</tr>
<tr>
<td>MOHLTC</td>
<td>Ministry of Health and Long-Term Care</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NACRS</td>
<td>National Ambulatory Care Reporting System</td>
</tr>
<tr>
<td>OPHS</td>
<td>Ontario Public Health Standards</td>
</tr>
<tr>
<td>PHO</td>
<td>Public Health Ontario</td>
</tr>
<tr>
<td>SRR</td>
<td>Standardized rate ratio</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>VTEC</td>
<td>Verotoxin producing <em>Escherichia coli</em></td>
</tr>
<tr>
<td>WNV</td>
<td>West Nile virus</td>
</tr>
</tbody>
</table>
Introduction

Infectious diseases are illnesses caused by microorganisms, such as bacteria, viruses and parasites, which may cause serious illness or be transmitted to large numbers of individuals. As per Ontario’s Health Protection and Promotion Act (HPPA), any case of a number of diseases must be reported to the local Medical Officer of Health (refer to Appendix C for a full list).

This technical report, Infectious Diseases in Waterloo Region: Surveillance Report 2016, presents Waterloo Region’s rates of reportable diseases for 2016, provides comparisons of rates to the previous ten years (2006 to 2015) for historical context, as well as comparisons to provincial rates. Cases of disease included in this report are for individuals who were residents of Waterloo Region at the time of the onset of their illness.

For ease of reference, the diseases in this report are categorized as follows:

- Enteric diseases
- Vector-borne and zoonotic diseases
- Sexually transmitted and blood-borne infections
- Vaccine preventable diseases
- Other infectious diseases
- Outbreaks

Disease-specific data is presented in alphabetical order within each section and follows a standard format. Diseases are described individually if five or more cases were reported during 2016 or if Public Health undertakes specific measures to prevent transmission of the disease.
# Infectious Diseases in Waterloo Region – Surveillance Report 2016

## Overall Findings

Table 1. Numbers and age-standardized incidence rates per 100,000 for all reportable diseases, Waterloo Region, 2016 and 2011-2015, and 2006-2015

<table>
<thead>
<tr>
<th>Rank</th>
<th>Disease¹</th>
<th># Cases in 2016</th>
<th>2016 Age-Standardized Rate per 100,000</th>
<th>Five-year average rate per 100,000 (2011-2015)</th>
<th>Ten-year average rate per 100,000 (2006-2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chlamydia</td>
<td>1,583</td>
<td>278.8</td>
<td>228.9</td>
<td>205.2</td>
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<tr>
<td>2</td>
<td>Influenza²</td>
<td>376</td>
<td>69.0</td>
<td>65.4</td>
<td>54.5</td>
</tr>
<tr>
<td>3</td>
<td>Gonorrhea</td>
<td>234</td>
<td>41.2</td>
<td>30</td>
<td>26.7</td>
</tr>
<tr>
<td>4</td>
<td>Salmonellosis</td>
<td>126</td>
<td>22.9</td>
<td>21.9</td>
<td>22</td>
</tr>
<tr>
<td>5</td>
<td>Campylobacteriosis</td>
<td>125</td>
<td>22.8</td>
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<td>29.2</td>
</tr>
<tr>
<td>6</td>
<td>Hepatitis C</td>
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<td>21.9</td>
<td>23.6</td>
</tr>
<tr>
<td>7</td>
<td>Invasive pneumococcal disease</td>
<td>56</td>
<td>10.6</td>
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<td>12.4</td>
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<tr>
<td>8</td>
<td>Giardiasis</td>
<td>31</td>
<td>5.7</td>
<td>10.9</td>
<td>12.1</td>
</tr>
<tr>
<td>9</td>
<td>Amebiasis³</td>
<td>28</td>
<td>5.2</td>
<td>5.3</td>
<td>5.2</td>
</tr>
<tr>
<td>10</td>
<td>Encephalitis/meningitis</td>
<td>26</td>
<td>4.7</td>
<td>2.5</td>
<td>2.7</td>
</tr>
<tr>
<td>11</td>
<td>Group A streptococcal disease, invasive (iGAS)</td>
<td>22</td>
<td>4.1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>Syphilis, other⁴</td>
<td>21</td>
<td>3.9</td>
<td>4.2</td>
<td>5.1</td>
</tr>
<tr>
<td>13</td>
<td>Syphilis, infectious⁵</td>
<td>19</td>
<td>3.4</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>14</td>
<td>HIV/AIDS</td>
<td>18</td>
<td>3.3⁸</td>
<td>2</td>
<td>2.7</td>
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<tr>
<td>15</td>
<td>Cryptosporidiosis</td>
<td>17</td>
<td>3.0⁸</td>
<td>2.8</td>
<td>3.2</td>
</tr>
<tr>
<td>16</td>
<td>Pertussis (whooping cough)³</td>
<td>13</td>
<td>2.3⁶</td>
<td>4.8</td>
<td>3.8</td>
</tr>
<tr>
<td>17</td>
<td>Tuberculosis (active)</td>
<td>11</td>
<td>2.0⁶</td>
<td>2</td>
<td>2.5</td>
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<tr>
<td>17</td>
<td>Yersiniosis</td>
<td>11</td>
<td>2.0⁶</td>
<td>1.1</td>
<td>1.7</td>
</tr>
<tr>
<td>18</td>
<td>Legionellosis</td>
<td>10</td>
<td>1.8⁸</td>
<td>2.2</td>
<td>1.3</td>
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<tr>
<td>19</td>
<td>Malaria</td>
<td>9</td>
<td>1.7⁸</td>
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<td>0.9</td>
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<tr>
<td>19</td>
<td>Shigellosis</td>
<td>9</td>
<td>1.6⁸</td>
<td>1.4</td>
<td>1.4</td>
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<tr>
<td>20</td>
<td>Cyclosporiasis</td>
<td>8</td>
<td>1.5⁶</td>
<td>1</td>
<td>0.8</td>
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<tr>
<td>21</td>
<td>Verotoxin-producing <em>Escherichia coli</em> (VTEC)</td>
<td>7</td>
<td>1.3⁶</td>
<td>2.2</td>
<td>2.9</td>
</tr>
<tr>
<td>22</td>
<td>Hepatitis B</td>
<td>6</td>
<td>1.1⁶</td>
<td>0.3</td>
<td>0.7</td>
</tr>
<tr>
<td>22</td>
<td>Hepatitis A</td>
<td>6</td>
<td>1.0⁸</td>
<td>1.1</td>
<td>1.1</td>
</tr>
<tr>
<td>23</td>
<td>Lyme disease³</td>
<td>4</td>
<td>0.7⁶</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>24</td>
<td>Q Fever</td>
<td>1</td>
<td>0.2⁸</td>
<td>0.1</td>
<td>0.1</td>
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<tr>
<td>24</td>
<td>Typhoid/paratyphoid fever</td>
<td>1</td>
<td>0.2⁸</td>
<td>0.8</td>
<td>0.7</td>
</tr>
<tr>
<td>Disease Category</td>
<td>Cases</td>
<td>Rate per 100,000 Population</td>
<td>Relative SE (%)</td>
<td>RSE %</td>
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<tr>
<td>------------------------------------------</td>
<td>-------</td>
<td>----------------------------</td>
<td>-----------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Group B streptococcal disease, neonatal</td>
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<td>0.26</td>
<td>0.3</td>
<td>0.3</td>
<td></td>
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<tr>
<td>Listeriosis</td>
<td>1</td>
<td>0.26</td>
<td>0.4</td>
<td>0.4</td>
<td></td>
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<tr>
<td>Mumps</td>
<td>1</td>
<td>0.26</td>
<td>0.3</td>
<td>0.5</td>
<td></td>
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<tr>
<td>Botulism</td>
<td>0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.1</td>
<td></td>
</tr>
<tr>
<td>Brucellosis</td>
<td>0</td>
<td>0.0</td>
<td>0.1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Creutzfeldt-Jakob disease</td>
<td>0</td>
<td>0.0</td>
<td>0.1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae B (Hib)</td>
<td>0</td>
<td>0.0</td>
<td>0.1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Invasive meningococcal disease</td>
<td>0</td>
<td>0.0</td>
<td>0.1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>0</td>
<td>0.0</td>
<td>0.1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rabies</td>
<td>0</td>
<td>0.0</td>
<td>0.1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>West Nile virus (WNV)</td>
<td>0</td>
<td>0.0</td>
<td>0.2</td>
<td>0.1</td>
<td></td>
</tr>
</tbody>
</table>


1 Disease ranking does not include latent tuberculosis or varicella infections.
2 Influenza data is reported for the 2006-7 season to the 2016-17 season which runs from September 1st through August 31st each year. Note that the 2015-16 data is not provided for the complete season and only includes data from September 1st, 2016 to April 30th, 2017.
3 Includes both confirmed and probable cases of amebiasis, mumps, Lyme disease, pertussis and WNV due to case definition changes in 2009 (see Appendix B for more information).
4 Other syphilis includes all other types of syphilis such as late latent or unspecified (the other category excludes early congenital syphilis).
5 Primary, secondary and early latent syphilis are all considered infectious (includes early latent; primary genital; primary other sites; secondary of skin and mucous membranes; secondary, other; infectious neurosyphilis and primary anal).
6 Rates are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.
Enteric Diseases

The following enteric diseases are included in this section:

- Amebiasis
- Brucellosis
- Campylobacteriosis
- Cryptosporidiosis
- Cyclosporiasis
- Giardiasis
- Hepatitis A
- Listeriosis
- Salmonellosis
- Shigellosis
- Typhoid/paratyphoid fever
- Verotoxin-producing *Escherichia coli* (VTEC)
- Yersiniosis
Table 2. Numbers and age-standardized incidence rates per 100,000 for enteric diseases, Waterloo Region & Ontario, 2016 and 2011-2015 (five-year annual average)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Waterloo Region</th>
<th>Ontario</th>
<th>2016 Standardized Rate Ratio (95% Confidence Interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Cases 2016</td>
<td>2016 Age-standardized rate per 100,000</td>
<td>5-year average rate per 100,000 (2011-2015)</td>
</tr>
<tr>
<td>Salmonellosis</td>
<td>126</td>
<td>22.9</td>
<td>21.9</td>
</tr>
<tr>
<td>Campylobacteriosis</td>
<td>125</td>
<td>22.8</td>
<td>28.6</td>
</tr>
<tr>
<td>Giardiasis</td>
<td>31</td>
<td>5.7</td>
<td>10.9</td>
</tr>
<tr>
<td>Amebiasis^2</td>
<td>28</td>
<td>5.2</td>
<td>5.3</td>
</tr>
<tr>
<td>Cryptosporidiosis</td>
<td>17</td>
<td>3^3</td>
<td>2.8^3</td>
</tr>
<tr>
<td>Yersiniosis</td>
<td>11</td>
<td>2^3</td>
<td>1.1^3</td>
</tr>
<tr>
<td>Shigellosis</td>
<td>9</td>
<td>1.6^3</td>
<td>1.4^3</td>
</tr>
<tr>
<td>Cyclosporiasis</td>
<td>8</td>
<td>1.5^3</td>
<td>1.0^3</td>
</tr>
<tr>
<td>VTEC</td>
<td>7</td>
<td>1.3^3</td>
<td>2.2^3</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>6</td>
<td>1.0^3</td>
<td>1.1^3</td>
</tr>
<tr>
<td>Typhoid/paratyphoid fever</td>
<td>1</td>
<td>0.2^3</td>
<td>0.8^3</td>
</tr>
<tr>
<td>Listeriosis</td>
<td>1</td>
<td>0.2^3</td>
<td>0.4^3</td>
</tr>
<tr>
<td>Brucellosis</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Standardized rate ratio (SRR) refers to the ratio of the Waterloo Region age-standardized rate for 2016 compared to the Ontario age-standardized rate for 2015. The 95% confidence interval indicates the statistical significance of the SRR (if the 95% confidence interval contains 1.00, the two rates are not statistically different from one another). SRRs indicating significant differences between Ontario and Waterloo in 2016 are highlighted in yellow.

Includes both confirmed and probable amebiasis cases.

Rates are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.
Public Health Activities for Enteric Diseases

Region of Waterloo Public Health and Emergency Services:

- Receives, confirms, and investigates reports of enteric illness in the Region.
- Follows up with all cases and their contacts to adequately address and manage the infectious disease (e.g., reviews risk factors for disease acquisition and provides education for prevention; enforces work restrictions of food handlers and care providers; recommends that a case speak with their physician about treatment; provides and facilitates delivery of vaccine as indicated, etc.)
- Provides information to the public and various stakeholder groups including long-term care and child care centres on enteric diseases, transmission, risk factors and prevention strategies.
- Performs routine inspections of food premises, long-term care homes and retirement homes, residential facilities and day nurseries in order to prevent the occurrence and transmission of infectious and foodborne illness; the results of food premises and personal service settings inspections in Waterloo Region are available on Public Health’s website at http://checkit.regionofwaterloo.ca/Search.
- Performs routine inspections of recreation water facilities (e.g., pools, hot tubs, splash pads) in order to prevent the occurrence and transmission of infectious and waterborne illness; the results of public recreational water inspections in Waterloo Region are available on Public Health’s website at http://checkit.regionofwaterloo.ca/Search.
- Works in cooperation with federal and provincial partners including the Ministry of Health and Long Term Care, Ontario Ministry of Agriculture and Rural Affairs, and Canada Food Inspection Agency to identify and remove sources of contaminated food products from the consumer marketplace.
- Conducts disease surveillance and provide timely updates on local disease status to area health care providers and other stakeholders.
- Provides health education for staff of daycares, long-term care homes and retirement homes.
- Inspects and monitors water quality for small drinking water systems within the region and provides access to free bacteriological testing for private well water by offering sample pick-up and drop-off at eight locations within Waterloo Region, encouraging private well owners to sample their well water.
- Assists private well owners with understanding well water testing results, and follows up on all samples that test positive for E. coli or are overgrown with bacteria.
Amebiasis

Background

- Amebiasis is caused by a parasite called *Entamoeba histolytica*, which lives in human intestines (i.e., the gut) and is passed in the feces.
- It is spread mainly through ingestion of contaminated food and water but can also be spread through fecal-oral contact.
- Some who are infected may have no symptoms while others may have severe diarrhea and pain. It could also lead to infections involving the liver, lungs and brain.
- Although anyone can acquire amebiasis, those who are most at risk include: recent immigrants or visitors who have returned from countries with poor sanitation; persons who live in institutions; and men who have sex with men. The very young, the elderly, and pregnant women are most at risk of developing complications from this infection.
In 2016, there were 26 probable and two confirmed cases for a total of 28 cases of amebiasis in Waterloo Region (age-standardized incidence rate of 5.2 cases per 100,000); this is similar to the previous five-year annual average rate for 2011-2015 of 5.3 per 100,000.

Due to changes in testing protocols from 2012 to 2013, nearly all amebiasis cases in the province since 2013 are defined as ‘probable’ cases. Previous provincial testing protocols typically yielded ‘confirmed’ amebiasis case results. This distinction in the case definition does not preclude the follow-up on cases performed by Region of Waterloo Public Health.

Amebiasis rates in the region have fluctuated over time, ranging from a low of 3.3 cases per 100,000 in 2006 to a high of 7.0 cases per 100,000 in 2015.
• Local amebiasis rates have consistently remained similar to or lower compared to provincial rates over the last ten years; in 2016, the local rate was not significantly different than that of the province (SRR = 0.88 [CI: 0.61-1.25]).
• In 2016, there were twice as many cases among males (N=19) than females (N=9), and the highest age-specific rates were among 25-29 year olds and 60-64 year olds (9.7 and 9.6 respectively).
• Of the 2016 Waterloo Region cases that had risk factor information available (N=13), 84.6 per cent were related to travel outside of the province.
• Due to the small number of cases in 2006 and 2014 and resulting unstable rates, caution should be used when interpreting this data.
Brucellosis

Background
- Brucellosis is an infectious disease caused by *Brucella* bacteria.
- People can get the disease when they consume infected meat or unpasteurized milk or if they come in close contact with an infected animal. Animals which are most commonly infected include sheep, cattle, goats, pigs, and dogs.
- In humans, brucellosis causes non-specific flu-like symptoms such as fever, sweating, anorexia (loss of appetite), headache, muscle pain, back pain, and physical weakness. Some severe infections of the brain or heart and long lasting symptoms (e.g., recurrent fevers, joint pain, pain in the testicles, fatigue, and depression) can also occur.
- Those at higher risk for the disease include slaughterhouse workers, meat inspectors, animal handlers, veterinarians, and laboratory workers.

Local Picture
- There were no cases of brucellosis in Waterloo Region in 2016. The last reported case in the region was in 2012.
- In 2016, there were 3 brucellosis cases in Ontario; the provincial 5-year annual average rate was of 5.4 per 100,000.
Infectious Diseases in Waterloo Region – Surveillance Report 2016

Campylobacteriosis

Background

- Campylobacteriosis is a disease caused by bacteria called *Campylobacter*. It is one of the most common causes of diarrhea-related illness in Canada and around the world.
- The most common way to become infected is by ingestion of undercooked meats such as poultry and/or raw or unpasteurized milk. The infection can also spread by cross-contamination (e.g., cutting meat on a cutting board, and then using the unwashed cutting board or utensil to prepare vegetables or other raw or lightly cooked foods).
- Common symptoms include mild to severe diarrhea, stomach pain, cramps, nausea, vomiting, fever, headache, and muscle pain.
- Although anyone can acquire the infection, those at higher risk of complications include infants and young children, pregnant women, the elderly, and people with weakened immune systems.

Local Picture

Figure 2. Age-standardized campylobacteriosis incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016

• Campylobacteriosis is the second most common enteric (intestinal-related) illness in Waterloo Region and Ontario.
• In 2016, there were 125 reported cases of campylobacteriosis in Waterloo Region (annual age-standardized incidence rate of 22.8 cases per 100,000).
• The current year’s incidence rate was lower than the previous five-year annual average for 2011-2015 (28.6 cases per 100,000).
• Over the last ten-year period, local campylobacteriosis rates have remained relatively stable, and consistent with rates at the provincial level; in 2016, the local rate was not significantly different compared to the provincial rate (SRR = 0.93 [CI: 0.78-1.11]).
• Increases in campylobacteriosis are generally seen in warmer months, with almost half (46.4 per cent) of local cases in 2016 occurring between June and September.
• In 2016, cases of campylobacteriosis were fairly evenly distributed among males (N=64) and females (N=61), and occurred in both young and older individuals; the highest age-specific rates were in the 0 to 4 year age group (51.4 cases per 100,000).
• Of the 2016 Waterloo Region cases that had risk factor information available (N=103), 30.1 per cent were related to travel outside of the province. For the remaining cases that did not report travel as a risk factor (N=72), the most common risk factors included possible consumption of undercooked poultry or meat (75.0 per cent) and contact with animals (e.g., pets, farm animals or petting zoo) (59.7 per cent).
Cryptosporidiosis

Background
- Cryptosporidiosis is a diarrheal illness caused by the parasite Cryptosporidium.
- It is transmitted through the fecal-oral route, which includes person-to-person contact, animal-to-person contact (e.g., from pets and farm animals), and food-borne transmission. Cryptosporidiosis can also be transmitted by waterborne contact, i.e., by drinking contaminated water or swallowing untreated recreational water (e.g., lakes or rivers).
- The main symptom is watery diarrhea. Other symptoms include abdominal cramps, fatigue, nausea, vomiting, and fever.
- Children under the age of two, animal handlers, travellers, men who have sex with men, and close contacts of infected people are at higher risk of infection.

Local Picture

Figure 3. Age-standardized cryptosporidiosis incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


1The Waterloo Region rates for 2008, 2012 and 2014-2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.
In 2016, there were 17 cases of cryptosporidiosis in Waterloo Region (age-standardized incidence rate of 3.0 cases per 100,000); this rate is similar to the previous five-year annual average for 2011-2015 (2.8 per 100,000).

In 2016, local and provincial rates of cryptosporidiosis were similar (SRR = 0.95 [CI: 0.59-1.52]), and have remained relatively stable over the last ten-year period.

Cryptosporidiosis cases in were higher among males (N=12) than females (N=5) in Waterloo Region in 2016, and the highest age-specific rates were among 20-24 year olds (12.4 cases per 100,000). There were very few cases among older adults.

A seasonal trend for cryptosporidiosis was observed among local cases in 2016 and in preceding years, with a pronounced peak in the number of reported cases between July and September; more than half of all local cases (59 per cent) occurred in July through September in 2016. Seasonal trends associated with cryptosporidiosis may correspond to an increase in outdoor activities, such as recreational swimming in outdoor lakes and rivers that occurs during the summer months.

Of the 16 cases in Waterloo Region in 2016 with available risk factor information, 25.0 per cent were related to travel outside of the province. Among locally-acquired cases (N=12), the most commonly reported risk factor was contact with animals (83.3 per cent) and poor hand hygiene (58.3 per cent).

Due to the small number of cases in 2008, 2012 and 2014-2016 and resulting unstable rates, caution should be used when interpreting this data.
Cyclosporiasis

Background

- Cyclosporiasis is a disease caused by a parasite called *Cyclospora cayetanensis*. The parasite infects the small intestines of humans.
- It is not very common in Waterloo Region and is usually associated with travel; cyclosporiasis is more common in tropical or subtropical countries.
- *Cyclospora* is spread when people eat or drink food or water that has been contaminated with infected feces.
- Cyclosporiasis usually causes watery diarrhea. Other common symptoms include: loss of appetite, weight loss, stomach cramps, bloating/gas, nausea, vomiting, fever, and fatigue.

Local Picture

Figure 4. Age-standardized cyclosporiasis incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


1The Waterloo Region rates for 2006 to 2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.
In 2016, there were eight cases of cyclosporiasis in Waterloo Region (age-standardized incidence rate of 1.5 cases per 100,000); this rate is slightly higher than the previous five-year annual average rate for 2011-2015 (1.0 per 100,000).

While the number of cases and incidence rates fluctuate, Waterloo Region rates have remained similar to provincial rates since 2006 (SRR=0.74 [CI: 0.40-1.36] in 2016).

There were no notable differences in case distribution by sex or age in Waterloo Region in 2016.

Seasonal increases in cyclosporiasis are typically observed in warmer months, with the majority of cases occurring from June to September. During this period in 2016, 87.5 per cent of local cases were reported.

In 2016, all Waterloo Region cases had risk factor information available. A majority (75.0 per cent) had travelled outside of the region during the 14-day incubation period; there were no known risk factors among locally-acquired cases.

Cyclosporiasis is not endemic in Canada and its occurrence is most frequently associated with consumption of contaminated imported food or travel to endemic countries.

Due to the small number of cases and resulting instability in rates, caution should be used when interpreting this data.
Giardiasis

Background

- Giardiasis is a diarrheal infection caused by a parasite called *Giardia lamblia*.
- It is one of the most common waterborne illnesses in North America. Giardiasis can be spread through ingestion of contaminated food or water, such as through swallowing untreated recreational water (e.g., lakes or rivers), or directly from fecal-oral contact such as in child care settings or through sexual contact.
- Giardiasis can cause watery diarrhea, foul smelling bowel movements, weight loss, bloating, and stomach pain/cramps.
- Travelers to countries where giardiasis is common, those who are in close contact with someone who has the illness, people who swallow contaminated drinking water (e.g., untreated water from lakes or rivers), and men who have sex with men are among those at higher risk of infection.

Local Picture

Figure 5. Age-standardized giardiasis incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016

• In Waterloo Region and Ontario, giardiasis was the third most common enteric disease reported in 2016.
• In 2016, there were 31 reported cases of giardiasis in Waterloo Region (age-standardized incidence rate of 5.7 cases per 100,000); this rate was significantly lower than that of the previous year (9.7 cases per 100,00 in 2015), and lower than that of the previous five-year annual average rate (10.9 cases per 100,000).
• In Waterloo Region and Ontario, the rate of giardiasis has been gradually decreasing since 2006 (from 13.5 cases per 100,000 in 2006 to 5.7 cases per 100,000 in 2015). Although rates of giardiasis have demonstrated a decreasing trend since previous years, this change may be in part due to a case definition update in early 2015 that specified that a person must be symptomatic to meet the case definition.
• In 2016, the local age-standardized rate was significantly lower compared to the Ontario rate (SRR = 0.66 [CI: 0.49-0.88]).
• There were no notable differences in giardiasis case distribution in Waterloo Region in 2016 by sex.
• The local rate of giardiasis in 2016 was highest among adults aged 30 to 34 years (12.7 cases per 100,000).
• In 2016, most giardiasis cases occurred in the months of May through August.
• Of the 2016 Waterloo Region giardiasis cases that has risk factor information available (N=31), 38.7 per cent reported travel outside of the province. Common risk factors reported by non-travel related cases included consumption of raw/unwashed fruits and vegetables (68.4 per cent), and contact with animals (47.4 per cent).
Hepatitis A

Background

- Hepatitis refers to the inflammation of the liver which can be due to a number of causes. In a hepatitis A infection, the cause is the hepatitis A virus.
- Hepatitis A is spread when the hepatitis A virus is taken in by mouth from contact with objects, food, or drinks contaminated by the feces of an infected person. This can occur through person to person contact or ingestion of contaminated food or water.
- Symptoms are often abrupt and include tiredness, fever, abdominal pain, loss of appetite, nausea, diarrhea and jaundice (yellowing of the skin and eyes). Some people may have no symptoms, and adults are more likely to have symptoms than children.
- Those at higher risk of contracting hepatitis A include travellers to regions with poor sanitation and/or high rates of hepatitis A, sexual contacts of infected persons, men who have sex with men, and household contacts of cases.
Local Picture

Figure 6. Age-standardized hepatitis A incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


1The Waterloo Region rates for 2006 to 2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016, there were six reported cases of hepatitis A in Waterloo Region (age-standardized incidence rate of 1.0 cases per 100,000).
- Since 2006, the local annual rate of hepatitis A has fluctuated but remained relatively similar over time; the current year’s incidence rate is very similar to that of the previous five-year annual average rate for 2011-2015 (1.1 cases per 100,000).
- Over the past ten years, local rates of hepatitis A have been similar to provincial rates; the rate in 2016 was not significantly higher than the provincial rate (SRR = 0. [CI: 0.54-3.70]).
- Among Waterloo Region hepatitis A cases in 2016, travel outside of the country was the most common risk factor (66.7 per cent). All travel cases were reported that they were not immunized for hepatitis A. Locally-acquired cases reported
consumption of raw fruits and vegetables and close contact with a case as the most common risk factors.

- Due to the small number of cases and resulting instability in rates, caution should be used when interpreting this data.
Listeriosis

Background

- Listeriosis is an illness caused by eating food contaminated with bacteria called *Listeria monocytogenes*. The bacteria are commonly found in the environment (i.e., water and soil).
- Some foods are more likely to carry listeria than others. Those that present a higher risk include raw or unpasteurized milk, soft cheeses and ready-to-eat meats such as hot dogs, pâté and deli meats.
- The disease primarily affects the elderly, newborns, pregnant women, and those with weakened immune systems. These individuals should avoid eating the foods mentioned above to reduce the risk of becoming infected with listeriosis.
- Listeriosis usually causes fever and muscle aches. More severe consequences of listeriosis include septicemia (infection of blood and organs) and meningitis (infection of the lining of the brain). Infections during pregnancy can lead to complications such as miscarriage and infection of the newborn.

Local Picture

Figure 7. Age-standardized listeriosis incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


The Waterloo Region rates for 2006 to 2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.
• In 2016, there was one reported case of listeriosis in Waterloo Region (incidence rate of 0.2 cases per 100,000); this rate is similar to the previous five-year annual average for 2011-2015 (0.4 cases per 100,000).
• The local rate of listeriosis in 2016 was significantly lower compared to the provincial rate (SRR = 0.27 [CI: 0.10-0.75]).
• Provincial incidence rates of listeriosis have remained relatively stable from 2006 to 2016, with the exception of 2008, when a large national outbreak occurred associated with ready-to-eat deli meats.
• Due to the small number of cases and resulting instability in rates, caution should be used when interpreting this data.
Salmonellosis

Background
- *Salmonella* are a group of bacteria that is commonly found in the intestines of animals and birds. The bacteria can be transmitted to people when they eat foods contaminated with animal feces.
- Eating contaminated foods is the most common cause of infection with *Salmonella* bacteria. Contaminated foods could include raw or under cooked eggs or egg products, meat, poultry, raw fruit and vegetables. It can also be spread from person-to-person (e.g., through inadequate hand washing after using the toilet).
- Symptoms of salmonellosis include fever, headache, diarrhea, nausea and stomach cramps.
- Those at higher risk of getting the infection include infants, the elderly, and persons with weakened immunity (e.g., those with HIV or taking corticosteroids). Owning a bird or reptile can also put a person at risk, since these animals can be carriers of the bacteria without having any symptoms.

Local Picture

Figure 8. Age-standardized salmonellosis incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016

Salmonellosis was the most common enteric infection in Waterloo Region, with 126 cases reported in 2016.

Local incidence rates of salmonellosis have remained similar to provincial rates over the previous 10-year period; in 2016, the local age-standardized incidence rate was 22.9 cases per 100,000 which was similar to that of the province (SRR = 1.03 [CI: 0.86-1.23]).

Since 2006, the local rate has remained relatively stable; the current year’s rate is similar to the previous five-year annual average rate for 2011-2015 (21.9 cases per 100,000).

In 2016, there were no notable differences in salmonellosis distribution by sex or age group; the highest age-specific incidence rate occurred among the 25 to 29 year age group (37.3 cases per 100,000).

Seasonally, the highest rates in Waterloo Region are typically seen in the months of July and August, although cases occur all throughout the year.

Among 2016 cases with risk factor information available (N=102), 39.2 per cent of cases reported a risk factor of travel outside of the province during the incubation period. Among non-travel-related cases, consumption of raw or undercooked poultry, eggs and meat, or cross-contamination of ready-to-eat foods (such as raw fruits and vegetables) with raw poultry or meat were common risk factors for salmonellosis cases.
Shigellosis

Background

- Shigellosis is an enteric infection that is caused by a group of bacteria called Shigella.
- These bacteria live in the intestines of infected persons.
- Shigella is passed from person to person by the fecal-oral route. It can spread if hands are not properly washed, especially after going to the toilet or changing diapers, through certain sexual activities (e.g., anal-oral sex), and by eating food or drinking water that has been contaminated with the bacteria.
- Shigellosis commonly causes diarrhea (even bloody diarrhea), fever, nausea, stomach cramps, and sometimes vomiting.
- Those at higher risk of infection include children, men who have sex with men, persons with weakened immune systems, and the elderly.

Local Picture

Figure 9. Age-standardized shigellosis incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


The Waterloo Region rates for 2006 to 2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.
• In 2016, there were nine reported cases of shigellosis in Waterloo Region for an age-standardized incidence rate of 1.6 cases per 100,000, which is similar to the average annual rate for the previous five years (1.4 cases per 100,000).
• Local rates have generally remained similar to or lower than provincial rates over the past 10-year period; in 2016, the local rate of shigellosis was not significantly different from that of the province (SRR = 0.61 [CI: 0.36-1.03]).
• The majority of cases in 2016 were among males (77.8 per cent), and due to the small number of cases there were no discernible trends across age groups or by season.
• Of the nine Waterloo Region cases reported in 2016 with risk factor information, 44.4 per cent were associated with travel outside the province during the incubation period. Locally acquired cases largely reported risk factors related to consumption of raw/unwashed fruits or vegetables and anal-oral contact.
• Due to small numbers and resulting instability in rates, caution should be used when interpreting this data.
Typhoid/Paratyphoid Fever

Background
- Typhoid fever is a disease caused by bacteria called *Salmonella typhi*. Paratyphoid fever is caused by bacteria called *Salmonella paratyphi*. These diseases are similar, but typhoid fever tends to be more common and severe than paratyphoid fever.
- The bacteria that cause typhoid and paratyphoid fever are found in the feces of infected people. It is commonly spread by eating food or drinking water that has been contaminated with the bacteria. It is also spread from person to person by the fecal-oral route (e.g., hands not properly washed after using the toilet or changing diapers, or through certain sexual activities such as anal-oral sex).
- The symptoms can range from mild to severe and include fever, headache, malaise (general discomfort), lack of appetite, and constipation or diarrhea.
- The greatest risk of infection for Canadians occurs while they are traveling to areas with poor sanitation. Children and people with weakened immune systems are at greater risk of getting the infection.
Local Picture

Figure 10. Age-standardized typhoid/paratyphoid fever incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016

The Waterloo Region rates for 2006 to 2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016, there was one case of typhoid/paratyphoid fever reported in Waterloo Region (age-standardized incidence rate of 0.2 cases per 100,000); this is lower than the previous five-year annual average rate for 2011-2015 (0.8 cases per 100,000).
- Local incidence rates have remained similar to or lower than provincial rates over the previous 10 years; in 2016, the local typhoid/paratyphoid fever rate was significantly lower than that of the province (SRR =0.26 [CI: 0.10-0.70]).
- Cases among Waterloo Region residents have been due to travel outside of the province.
- Due to the small number of cases and resulting instability in rates, caution should be used when interpreting this data.
Verotoxin producing *Escherichia Coli* (VTEC)

**Background**

- *Escherichia coli* or *E. coli* is a bacterium with many subtypes. Most subtypes of *E. coli* are harmless and live in the intestine (gut) of humans and animals. However, there are other subtypes of *E. coli* such as verotoxin-producing *Escherichia coli* (VTEC) that produce toxins and can cause severe illness. The most common strain from the VTEC group is *E. coli* O157:H7.
- *E. coli* is spread through eating contaminated food or drinking contaminated fluids (e.g., water, unpasteurized juice or milk). *E. coli* is found in feces and can also spread from person to person as a result of inadequate hand washing, and through improper food handling.
- The symptoms of *E. coli* infection include severe stomach pain/cramps, diarrhea/bloody diarrhea, nausea, vomiting, and fever. Some people may develop complications involving the kidneys (hemolytic uremic syndrome), which can be life-threatening.
- Those at higher risk of complications include: children, the elderly, and those with weakened immune systems. Eating undercooked ground beef, cheese or milk products made from raw or unpasteurized milk, and drinking unpasteurized milk and fruit juices are key risk factors for getting the infection.
Local Picture

Figure 11. Age-standardized VTEC incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


The Waterloo Region rates for 2006-2011 and 2013-2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016, there were seven cases of VTEC reported in Waterloo Region, for an age-standardized incidence rate of 1.3 cases per 100,000; this is lower than the previous five-year annual average for 2011-2015 (2.2 cases per 100,000).
- From 2006 to 2016, the annual incidence rate of VTEC has generally declined in Waterloo Region by approximately 80%. This is consistent with a steady decrease in provincial rates over the same period.
- In 2016, the local incidence rate of VTEC was similar to the provincial rate (SRR = 1.01 [CI: 0.47-2.15]). The local incidence rates in 2006 and 2012 were significantly higher than the provincial rate; otherwise local rates were not statistically different from provincial rates over the last 10-year period.
- The increase in cases in 2006 was due, in part, to an outbreak in a child care centre. The increase in VTEC cases in 2012 was due to 10 cases linked to family clusters (multiple family members becoming ill from a common source and then through person to person spread).
• In 2016, more than two-thirds of cases (N=5) occurred among females, and the highest age-specific rate occurred in those aged 15 to 19 years (6.0 cases per 100,000).

• Increases in cases of VTEC are typically observed in the warmer months; locally, half of all cases (N=5) in 2016 were reported in July through September.

• Of the seven local cases with risk factor information available, common exposures included consumption of raw unwashed vegetables and fruits, consumption of ground beef (eating undercooked ground beef is a key risk factor for infection), and consumption of raw/unpasteurized juice or cider.

• Due to the small number of cases and resulting instability in rates, caution should be used when interpreting this data.
Yersiniosis

Background

- Yersiniosis is an infection caused by a bacterium of the genus *Yersinia*. Most human infections are caused by *Yersinia enterocolitica*. Yersiniosis is more common in children.
- People get infected with yersiniosis by drinking contaminated fluids and eating contaminated food, especially raw or undercooked pork products.
- If proper hand washing is not practiced after using the toilet or handling raw meat, an infected person can transfer the bacteria to food and objects. A child can become infected if they consume contaminated food made by a parent or caretaker.
- *Y. enterocolitica* can also be spread to humans by infected pets through fecal-oral transmission.
- The symptoms of yersiniosis include fever, abdominal pain and diarrhea (often bloody).
- Those who are at a higher risk of infection and severe illness include people with weakened immune system (e.g., with HIV/AIDS), those undergoing chemotherapy, young children, and the elderly.
Local Picture

Figure 12. Age-standardized yersiniosis incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016

- In 2016, there were 11 cases of yersiniosis in Waterloo Region (age-standardized incidence rate of 2.0 cases per 100,000); this is slightly higher than the previous five-year annual average for 2011-2015 (1.1 per 100,000).
- The local annual incidence rate of yersiniosis has shown a slight increasing trend in recent years, although current rates are still lower than they were 10 years ago; a similar trend has been observed provincially during the same time period.
- In 2016, the Waterloo Region yersiniosis age-standardized incidence rate was similar to that of the province (SRR = 1.07 [CI: 0.57-2.00]); local rates have been similar to or lower than that of the province over the past 10 years.
- In 2016, there were no discernible trends across age groups or by season.
- Yersiniosis typically occurs more frequently in colder seasons, although there were no clear seasonal trends in Waterloo Region in 2016.
- Of the 10 local cases of yersiniosis in 2016, 40.0 per cent reported travelling outside the province within the 11-day incubation period before illness onset. Other risk factors among non-travel-related cases included consumption of undercooked pork, contact with animals and having a compromised immune system.
- Due to the small number of cases and resulting instability in rates, caution should be used in interpreting this data.
Vector-Borne and Zoonotic Diseases

For the purposes of this report, diseases transmitted by vectors (e.g., mosquitos, ticks) and animals include:

- Lyme disease
- Malaria
- Rabies
- West Nile virus (WNV)

Table 3. Numbers and age-standardized incidence rates per 100,000 for vector-borne and zoonotic diseases, Waterloo Region & Ontario, 2016 and 2011-2015 (five-year annual average)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Waterloo Region</th>
<th>Ontario</th>
<th>2016 Standardized rate ratio (95% confidence interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Cases in 2016</td>
<td>2016 Age-standardized rate per 100,000</td>
<td>5-year average rate per 100,000 (2011-2015)</td>
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<td>Malaria</td>
<td>9</td>
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<td>0.92^2</td>
</tr>
<tr>
<td>Lyme disease^3</td>
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<td>West Nile virus^3</td>
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<tr>
<td>Rabies</td>
<td>0</td>
<td>0.0^2</td>
<td>0.0^2</td>
</tr>
</tbody>
</table>


1 Standardized rate ratio (SRR) refers to the ratio of the Waterloo Region age-standardized rate for 2015 compared to the Ontario age-standardized rate for 2015. The 95% confidence interval indicates the statistical significance of the SRR (if the 95% confidence interval contains 1.00, the two rates are not statistically different from one another). SRRs indicating significant differences between Ontario and Waterloo in 2016 are highlighted in yellow.

2 Rates are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

3 Includes both confirmed and probable Lyme disease and West Nile virus cases.
Public Health Activities for Vector-Borne and Zoonotic Diseases

Region of Waterloo Public Health and Emergency Services:

- Reduces the risk of exposure to Lyme disease and West Nile virus through public education, investigation of suspect human cases, vector surveillance, and the implementation of vector control measures.
- Raises awareness about diseases through the provision of information regarding the disease, its transmission, risk factors, and prevention strategies.
- Investigates all reported animal to human biting incidents, provides recommendations regarding post-exposure prophylaxis, and dispenses rabies vaccine.
- Investigates and confirms human cases of WNV, Lyme disease and malaria identified by health care providers and laboratories.
Lyme Disease

Background

- Lyme disease is an infection caused by the bacteria *Borrelia burgdorferi*. In Ontario, the tick species responsible for transmitting Lyme disease to people is the black-legged tick, also known as the deer tick. While this tick is not currently established in Waterloo Region, areas along the north shores of Lake Erie and Lake Ontario and the east shore of Lake Huron have been identified as endemic for the black-legged tick that can transmit Lyme disease. Public Health Ontario has identified certain areas of the province which are considered higher risk for the acquisition of Lyme. A map can be found at: https://www.publichealthontario.ca/en/eRepository/Lyme_disease_risk_areas_map.pdf.

- The common symptoms of Lyme disease may include a red bull’s eye rash (also called erythema migrans), fever, headache, muscle/joint pain, and fatigue. If untreated, the disease can progress to cause infections of the heart, brain and lining surrounding the brain, and inflammation of joints.

The risk of acquiring infection may be increased by spending time outdoors in woody or grassy areas where blacklegged ticks are present; having exposed areas of skin while visiting places where such ticks are commonly found; not using an insect repellant containing DEET or Icaridin; and not removing blacklegged ticks attached to the body within 24 hours.
Local Picture

Figure 13. Age-standardized Lyme disease\(^1\) incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016\(^2\)


\(^1\) Includes both confirmed and probable Lyme disease cases.

\(^2\) The Waterloo Region rates for 2006-2009 and 2011-2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016, there were four cases of Lyme disease among Waterloo Region residents, for an age-standardized incidence rate of 0.7 cases per 100,000; this is slightly higher than the previous five-year average annual rate for 2011-2015 (0.8 cases per 100,000).
- The local rate of Lyme disease has remained similar to or lower than that of the province since 2006; in 2016, the age-standardized incidence rate was significantly lower than that of the province (SRR=0.27 [CI: 0.16-0.45]).
- Lyme disease acquisition typically occurs in the warmer summer months (i.e., June to September). The Lyme disease cases reported among Waterloo Region residents in 2016 is consistent with this seasonal trend and all cases occurred in the months of June, July and August.
• At the present time, Waterloo Region is not an endemic area for the black-legged tick. The cases reported in Waterloo Region in 2016 were not locally acquired, and were related to travel to a high-risk area in Ontario or outside of the province.
• Due to the small number of cases and resulting instability in rates, caution should be used when interpreting this data.
Malaria

Background

- Malaria is a common and life-threatening parasitic disease in many tropical and subtropical countries. The disease is transmitted by the female *Anopheles* mosquitoes.
- Malaria is currently endemic in over 100 countries, many of which are popular travel destinations. It is not endemic to Canada and cases diagnosed in Canada are acquired during travel to an endemic area.
- Infection may be marked by an acute fever and other clinical symptoms. Some forms of malaria may remain dormant in the liver and cause relapses in illness for up to five years after initial exposure.
- Travellers to endemic areas and persons returning to visit their country of origin in such areas are at increased risk for infection if anti-malarial medication and precautions to reduce mosquito bites are not taken.
- Young children, pregnant women and persons with human immunodeficiency virus (HIV) are most at risk from malaria and its complications.
Local Picture

Figure 14. Age-standardized malaria incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


The Waterloo Region rates for 2006 to 2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016, there were nine cases of malaria reported among residents of Waterloo Region. The age-standardized incidence rate for 2016 was 1.7 cases per 100,000 which is higher than the previous five-year average annual rate for 2011-2015 (0.9 cases per 100,000).
- The local malaria rate in 2016 was similar to the provincial rate (SRR = 1.10 [CI: 0.55-2.21]). Local rates have remained similar or lower compared to provincial rates over the previous 10-year period.
- Due to the small number of cases and resulting instability in rates, caution should be used in interpreting this data.
Rabies

Background
- Rabies is a disease of the central nervous system that can affect humans and other mammals.
- Infection can occur when an infected animal bites a person, or when the saliva from an infected animal gets into persons eyes, nose, mouth or an open wound.
- Rabies infection in humans is almost always fatal, making prevention extremely important.
- Risk factors include being bit by animals, especially animals that are common rabies carriers, and travel to a country where rabies is endemic in animals.

Local Picture
- There have been no reports of human cases of rabies in the Waterloo Region from 2006 to 2016.
- Although rare, the possibility of human rabies acquired from animal bites continues to exist, as rabies in animals can be found on occasion in Waterloo Region.
- While the risk for the general public of acquiring rabies remains low in Waterloo region, wildlife in the region and surrounding areas have recently tested positive for rabies. It is important for individuals with an exposure (i.e., bite or scratch) to raccoons, skunks and other wildlife or animals to receive prompt assessment in order to determine the possible need for rabies post exposure prophylaxis.
- The last case of (fatal) human rabies reported by the province occurred in 2012, however this case contracted the disease outside of Canada.
West Nile Virus (WNV)

Background

- West Nile virus (WNV) is a virus transmitted to humans through the bite of an infected mosquito. Mosquitoes can transmit the virus after feeding on an infected bird.
- The risk of infection is low with less than one per cent of people infected becoming ill enough to be hospitalized. Around one in five people will experience symptoms. Symptoms can include fever, headache, nausea/vomiting, body ache, skin rash and swollen glands. While most cases are asymptomatic or present with mild illness, WNV can cause neurological symptoms (i.e. encephalitis) as well.
- Anyone can be infected with WNV, but the elderly and those with a weakened immune system (e.g., having HIV/AIDS, undergoing chemotherapy, taking corticosteroids) are at greater risk.
Local Picture

Figure 15. Age-standardized West Nile virus\(^1\) incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016\(^2\)

There were no cases of West Nile virus in Waterloo Region in 2016; there were 55 cases of West Nile virus reported in Ontario during the same year at an age-standardized incidence rate of 0.5 cases per 100,000.

There was a spike in West Nile virus activity across the province in 2012, but the incidence has decreased since that time; local incidence rates have remained similar to or lower than provincial rates since 2006.

Due to the small number of cases locally and resulting instability in rates, caution should be used when interpreting the data.

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\(^{1}\) Includes both confirmed and probable West Nile virus cases.

\(^{2}\) The Waterloo Region rates for 2011-2012 and 2015, and the Ontario rates for 2007-2010 and 2014 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.
Sexually Transmitted and Blood-borne Infections

For the purposes of this report, sexually transmitted and blood-borne infections include:

- Chlamydia
- Gonorrhea
- Hepatitis B
- Hepatitis C
- HIV/AIDS
- Syphilis (infectious and other)

Table 4. Numbers and age-standardized incidence rates per 100,000 for sexually transmitted and blood-borne infections, Waterloo Region & Ontario, 2016 and 2011-2015 (five-year annual average)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Waterloo Region</th>
<th>Ontario</th>
<th>2016 Standardized rate ratio (95% confidence interval)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Cases in 2016</td>
<td>2016 Age-standardized rate per 100,000</td>
<td>5-year average rate per 100,000 (2011-2015)</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>1583</td>
<td>278.8</td>
<td>228.9</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>234</td>
<td>41.2</td>
<td>30</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>116</td>
<td>21</td>
<td>21.9</td>
</tr>
<tr>
<td>Syphilis, other²</td>
<td>21</td>
<td>3.9</td>
<td>4.2</td>
</tr>
<tr>
<td>Syphilis, infectious³</td>
<td>19</td>
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<td>4</td>
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<tr>
<td>HIV/AIDS</td>
<td>18</td>
<td>3.3⁴</td>
<td>2.0⁴</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>6</td>
<td>1.1⁴</td>
<td>0.3⁴</td>
</tr>
</tbody>
</table>


¹ Standardized rate ratio (SRR) refers to the ratio of the Waterloo Region age-standardized rate for 2015 compared to the Ontario age-standardized rate for 2015. The 95% confidence interval indicates the
statistical significance of the SRR (if the 95% confidence interval contains 1.00, the two rates are not statistically different from one another). SRRs indicating significant differences between Ontario and Waterloo in 2016 are highlighted in yellow.

2 Other syphilis includes all other types of syphilis such as late latent or unspecified (the other category excludes early congenital syphilis).

3 Primary, secondary and early latent syphilis are all considered infectious (includes early latent; primary genital; primary other sites; secondary of skin and mucous membranes; secondary, other; infectious neurosyphilis and primary anal).

4 Rates are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.
Public Health Activities for Sexually Transmitted and Blood-Borne Infections

Region of Waterloo Public Health and Emergency Services:

- Provides sexual health clinics at Public Health offices and other community locations which offer free testing, treatment and counselling for sexually transmitted and blood-borne infections; two of these clinics are specifically for youth.
- Receives and investigates positive laboratory reports of sexually transmitted and blood-borne infections in the Region.
- Offers supportive services including a sexual health phone line and actively promotes healthy sexuality through general preventive counselling, including risk reduction counselling, and the promotion and distribution of free condoms.
- Provides free and confidential testing for HIV, provides counselling (pre- and post-test) regarding exposure, HIV disclosure requirements, risk reduction and safer/safe sex practices.
- Distributes free medication for sexually transmitted infections (STIs) to health care providers for the treatment of chlamydia, gonorrhea and syphilis.
- Works with health care providers to support them in following current provincial treatment guidelines.
- Developed and is implementing the Waterloo Region Sexual Health Youth Strategy in partnership with community stakeholders. The strategy outlines a multi-year action plan to promote healthy sexuality among youth in Waterloo Region, and to provide strategic direction for youth sexual health education, programs, and services for implementation. It focuses on three key focus areas: access to programs and services, education and parents.
- Supports students and educators (i.e., public health nurse availability onsite on a weekly basis to provide sexual health services, curriculum support, staff consultation, one-on-one counselling with students) in Waterloo Region District School Board secondary schools, and provides support to educators (i.e., curriculum support, consultations with staff) in Waterloo Catholic District School Board schools.
- Collaborates with community partners to improve harm reduction programs and services. Harm reduction strategies are most effective against blood-borne infections such as hepatitis B, C and HIV/AIDS.
- Provides needle syringe programs both directly and in partnership with several community agencies in Waterloo Region.
• Performs routine inspections of personal service settings (i.e., beauty and body art businesses) in order to prevent the occurrence and transmission of blood-borne infections, and provide education to staff.
• Investigates infection prevention and control complaints in regulated health care settings to determine the risk of transmission of infectious diseases and provides recommendations and practice requirements to reduce the risk.
• Provides free hepatitis B vaccine to students in Grade 7 through the Region of Waterloo Public Health school immunization program as per the Immunization of School Pupils Act; also provides the vaccine to those at higher risk of acquiring hepatitis B.
• Provides presentations about healthy sexuality to parents, community professionals, and community groups.
• Provides support and consultation to designated officers (i.e., first responders) after occupational exposures to facilitate assessment, source testing and results.
Chlamydia

Background

- Chlamydia is one of the most common sexually transmitted infections (STIs). It is caused by a bacterium called *Chlamydia trachomatis*, and is both preventable and curable.
- Chlamydia is spread through unprotected anal, oral or vaginal sex with an infected person. It can also be passed from an infected mother to her baby during delivery. A person remains infectious until properly treated.
- Chlamydia can occur in both men and women. Some infected persons, usually women, may not show symptoms. Women who have symptoms experience increased vaginal discharge and/or irritation, bleeding during or after sexual intercourse, pain during sex, and painful or burning urination. Untreated chlamydia can lead to infertility and complicated (ectopic) pregnancy in women. Men who have symptoms experience discharge and/or itching from the penis, pain or swelling in the testicles, and painful or burning urination.
- Those at risk of acquiring chlamydia include any sexually active person, particularly individuals who:
  - do not use condoms
  - had more than one sexual partner in the last six months
  - had a new sexual partner in the last two months
Infectious Diseases in Waterloo Region – Surveillance Report 2016

Local Picture

Figure 16. Age-standardized chlamydia incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016

- Chlamydia is the most commonly reported infectious disease in Waterloo Region and constitutes the vast majority of STI cases both locally (79.3 per cent) and provincially (74.6 per cent).
- In 2016, there were 1,583 chlamydia cases reported in Waterloo Region, with an age-standardized incidence rate of 278.8 cases per 100,000. This rate is slightly higher than the previous five-year annual average for 2011-2015 (228.9.2 cases per 100,000).
- Chlamydia rates have been steadily increasing over the last 10 years, both locally and provincially (70.4 per cent increase and 74.5 per cent increase between 2006 and 2016, respectively). The cause of the increasing trend in the incidence of chlamydia, both locally and in Ontario, has not been fully explained; although, there has been an annual increase (10 to 15 per cent) in the number of Chlamydia tests conducted in Ontario each year.
- The local rate of chlamydia in 2016 was significantly lower than the provincial rate (SRR = 0.92 [CI: 0.88-0.96]), and has remained significantly lower since 2006.
Figure 17. Chlamydia cases and age-specific incidence rates per 100,000 among 15 to 24 year olds, by sex and year, Waterloo Region, 2006-2016


- Rates of chlamydia are particularly high among females in the 15 to 24 year age group; in 2016, females aged 20 to 24 years had the highest age-specific incidence rate (2,032.4 cases per 100,000), followed by females aged 15 to 19 years (1386.7 cases per 100,000).
- Among males in 2016, those aged 20 to 24 years had the highest age-specific incidence rate (1129.4 cases per 100,000), followed by males aged 25 to 29 years (826.7 cases per 100,000).
- In 2016, 98 cases of chlamydia were concurrently infected with gonorrhea; co-infections were highest in the 25 to 29 year age group (N=28), followed by the 20 to 24 year (N=26). Cases with co-infections were evenly distributed among males and females.
Among chlamydia cases in Waterloo Region with self-reported risk factor information in 2016 (N= 1,407), the most common risk factors included not using a condom (91.6 per cent), having a new sexual partner in the last two months (42.9 per cent), and having more than one sexual partner in the last six months (37.3 per cent).

Increased rates in sexually transmitted infections in youth may be attributed in part to more awareness of the need for testing, increased access to testing and new testing methods. Research also suggests that social determinants of health, in particular low socioeconomic status and limited access to health care, as well as the stigmatization and fear of being diagnosed with an STI contribute to higher incidence in young people.
Gonorrhea

Background

- Gonorrhea is one of the most common sexually transmitted infections (STIs). It is caused by a bacterium called *Neisseria gonorrhoeae*, and is both preventable and curable.
- Gonorrhea is spread through unprotected anal, oral or vaginal sex with an infected person. It can also be passed from an infected mother to her baby during birth.
- Gonorrhea can occur in both men and women. Many may not have any symptoms. The common symptoms that may occur for women include pain during urination, bleeding during or after sex, and white or yellow vaginal discharge. Symptoms that may be seen in men include discharge from the penis, itching around the penis, frequent or painful urination and pain or swelling in the testicles.
- If untreated, gonorrhoea can lead to serious and permanent complications such as pelvic inflammatory disease in women and epididymitis (inflammation of the tubes of the testicles) in men. Gonorrhea can also spread to the blood and joints. Untreated gonorrhea can increase a person’s risk of acquiring or transmitting HIV.
- Those at risk of acquiring gonorrhea include any sexually active person, particularly individuals:
  - Who do not use condoms
  - Had more than one sexual partner in the last six months
  - Had a new sexual partner in the last two months
Local Picture

Figure 18. Age-standardized gonorrhea incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016

- In 2016, the age-standardized incidence rate of gonorrhea was 41.2 cases per 100,000 (N=234), making it the second most common reportable STI/blood-borne infection in Waterloo Region; this rate was higher than the previous five-year average annual rate for 2011-2015 (30.0 cases per 100,000).
- Since 2009, the rate of gonorrhea has been increasing locally (162.4 per cent increase) and provincially (81.5 per cent increase), with a peak in 2014. Reasons for the increases are not known and are being studied by the provincial government.
- Waterloo Region rates have remained similar to or lower than provincial rates over the past 10 years; In 2016, the local rate was significantly lower than the provincial rate (SRR = 0.84 [CI: 0.74-0.74]).
• Gonorrhea cases were distributed fairly evenly among males and females in 2016. Age-specific incidence rates were highest among 20 to 24 year-olds (161.8 cases per 100,000) followed by 25 to 29 year-olds (128.8 cases per 100,000) and 30 to 24 year-olds (104.0 cases per 100,000).
• Of the 2016 Waterloo Region gonorrhea cases that reported risk factor information (N=197), the most commonly reported risk factors included not using a condom (85.2 per cent), having a new sexual partner in the past two months (51.8 per cent), and having more than one sexual partner in the last six months (43.1 per cent).
• Changes were made to the provincial gonorrhea treatment guidelines in 2013 in order to tackle the problem of multi-resistant strains of the infection. In 2016, 56.2 per cent of primary care providers treated confirmed cases according to these new provincial guidelines.
• Increased rates in sexually transmitted infections in youth may be attributed in part to more awareness of the need for testing, increases access to testing and new testing methods. Research also suggests that social determinants of health, in particular low socioeconomic status and limited access to health care, as well as the stigmatization and fear of being diagnoses with an STI contribute to higher incidence in young people.
Hepatitis B

Background

- Hepatitis B infection is an infection of the liver caused by the hepatitis B virus (HBV). About six to ten per cent of all those infected in adulthood will carry the virus for life and can infect others. Chronic hepatitis can lead to cirrhosis and liver cancer. HBV is 100 times more infectious than HIV.
- Hepatitis B is spread through contact with infected blood, semen, and other body fluids, mainly through sexual contact with an infected person; sharing of contaminated needles, syringes or other injection drug equipment; needle stick/sharp instrument injuries; and transmission at birth. Babies born to hepatitis B carriers have a 90 per cent chance of developing the disease unless they are vaccinated immediately after birth.
- Symptoms may include weakness, nausea, vomiting, dark urine, and jaundice (yellowing of the skin and eyes).
- Those at risk of getting hepatitis B include unimmunized people with multiple sexual partners; men who have sex with men; sexual partners of those infected; people who use injection drugs; those who received a tattoo or body piercing using unsterilized equipment or; occupations with a high risk of exposure to blood and body fluids (e.g., healthcare workers, police officers, etc.); and those who have come from countries with high rates of HBV.
- There is a vaccine for hepatitis B which is an effective way to help prevent the infection. In Ontario, a universal vaccination program is administered by public health units through a school-based program to students in grade 7. In addition, publicly funded hepatitis B vaccines are provided for specific populations including those at higher risk due to lifestyle, or due to being a contact of an infected person, being a carrier, or having been diagnosed with acute liver disease.
Local Picture

Figure 19. Age-standardized hepatitis B incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


The Waterloo Region rates for 2006 to 2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016, there were six acute hepatitis B case reported in Waterloo Region for an age-standardized incidence rate of 1.1 cases per 100,000; there were 115 cases in Ontario the same year (age-adjusted incidence rate of 0.8 cases per 100,000).
- Since 2006 to 2011, the local hepatitis B incidence rates have fluctuated around the provincial rate. In 2016, the local rate was not significantly different from the province (SRR = 1.34 [CI: 0.52-3.43]).
- Follow-up of local cases indicated that there were no known links between cases and fluctuations in sporadic acute hepatitis cases are expected as vaccination coverage continue to vary, particularly in those who were born prior to the start of routine school-based hepatitis B immunization for grade 7 students. In addition, behavioural factors and immigration from endemic countries are unpredictable and can contribute to hepatitis B disease transmission.
Due to the small number of cases and the resulting instability in rates, caution should be used when interpreting this data.
Hepatitis C

Background

- Hepatitis C infection is an infection of the liver caused by the hepatitis C virus (HCV). Up to 80 per cent of people with HCV become chronically infected. HCV is a slowly progressive disease that may lead to liver cirrhosis (scarring) or liver cancer.

- HCV spreads through contact with the blood of an infected person, mainly through: sharing of contaminated needles, syringes or other drug equipment; blood transfusions prior to 1992 before screening became available; use of unsterile tattoo or body piercing equipment; sexual contact with an infected person; and/or, being born to an infected mother.

- The early symptoms may include fatigue, loss of appetite, nausea, or jaundice (yellowing of the skin and/or eyes). Many infected people do not initially have symptoms and may look and feel well for many years.

- Those at risk of getting HCV include: current or past injection drug users; those who received blood or blood products or an organ transplant before 1992; those who received a tattoo or body piercing using unsterilized equipment; occupations with a high risk of exposure to blood and body fluids (e.g., healthcare workers, police officers, etc.); people with multiple sexual partners; sexual partners of those infected; and those born to an infected mother.

- There is no vaccine to prevent HCV infection. Newer treatments, which are now available in Canada, can be effective in curing hepatitis C.
Local Picture

Figure 20. Age-standardized hepatitis C incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016

- In Waterloo Region in 2016, the age-adjusted incidence rate of HCV was 21.0 cases per 100,000 (N=116), making it the third most common reportable STI/blood-borne infection in Waterloo Region.
- Local incidence rates of HCV have fluctuated over the past five years, but the rate in 2016 was similar to that of the previous five-year average annual rate for 2011-2015 (21.9 cases per 100,000).
- Local rates have been consistently and significantly lower than those of the province since 2006 (in 2016, SRR = 0.68 [CI: 0.58-0.79]).
- In 2016, the rate of HCV was higher among males compared to females in Waterloo Region (26.8 cases per 100,000 versus 15.6 cases per 100,000, respectively).
• In 2016, the age-specific rate was highest among 60 to 64 year-olds (44.7 cases per 100,000), followed by 30 to 34 year-olds (44.7 cases per 100,000). Age-specific rates were lowest in children and adolescents less than 15 years of age.

• Among HCV cases in Waterloo Region that had risk factor information available in 2016 (N=112), the most common risk factors reported included injection drug use (58.9 per cent), inhalation drug use (49.1 per cent), receiving a tattoo or piercing (30.4 per cent), and being under-housed or homeless (20.5 per cent).
HIV/AIDS

Background

- Human immunodeficiency virus (HIV) infection is a blood-borne infection that attacks the immune system (the body’s internal defence system). HIV can lead to acquired immunodeficiency syndrome (AIDS) which is a disease of the immune system that makes the person at risk of getting other infections and diseases.
- HIV is spread through direct blood-to-blood contact and direct contact with certain infected body fluids such as semen, and vaginal or rectal fluids.
- People at risk of getting HIV/AIDS include: people who have unprotected anal or vaginal sex; those who have multiple sex partners; people who use injection drugs; people who received blood transfusions before 1985; and those born to an infected mother. Effective treatment of an HIV positive mother can lower the risk of her child becoming infected to less than two per cent.
- People infected with HIV may initially experience fever, fatigue, night sweats, headaches, diarrhea, sore throat and/or rash. They can then be symptom free for years. Over time, the immune system continues to weaken and leads to the person becoming vulnerable to other infections.
Local Picture

Figure 21. Age-standardized HIV/AIDS incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


1The Waterloo Region rates for 2009-2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016, there were 18 HIV/AIDS cases in Waterloo Region for an age-adjusted incidence rate of 3.3 cases per 100,000.
- In 2014, Public Health adjusted how it defined Waterloo Region cases. Individuals who were previously diagnosed with HIV (outside of Ontario or Canada) were not included in Waterloo Region case counts as they were in previous years. This may affect comparability to data from previous years.
- Since 2006, local incidence rates have remained significantly lower than provincial rates (SRR = 0.50 [CI: 0.36-0.70] in 2016).
- Of the cases in 2016 in Waterloo Region, four also had AIDS.
- In 2016, the rate among males (5.5 cases per 100,000) was higher than that among females (0.7 cases per 100,000), and all cases were 15 years of age or older; the highest age-specific incidence rate occurred in adults 45 to 49 years of age (10.5 cases per 100,000).
• Of the HIV/AIDS cases in 2016 in Waterloo Region with risk factor information (N=15), 68.67 per cent reported not using a condom and 66.7 per cent reported having sex with the same sex.

• Due to the small number of cases and resulting instability in rates, caution should be used in interpreting this data.
Syphilis

Background
- Syphilis is a sexually transmitted infection (STI) caused by the *Treponema pallidum* bacterium.
- Syphilis is spread by unprotected vaginal, anal or oral sex. Syphilis can be transmitted during pregnancy from a mother to her unborn baby, and cause fetal deformity or stillbirth.
- Syphilis can be infectious or non-infectious and is further classified based on the progression of the infection. Syphilis is considered infectious in the primary, secondary or early latent stages; otherwise, syphilis is generally considered to be non-infectious.
- Symptoms also vary according to the progression of the infection. Initially, a painless sore or ulcer (called chancre) appears in the mouth, anus, penis, cervix or vagina. Other symptoms such as rash, hair loss, fatigue and warts found in the anus or genital area could appear. Later stages of syphilis, which can be many years after the initial infection, can cause irreversible damage to the brain and spinal cord (neurosyphilis), heart, eyes and bones.
- Those at risk of getting syphilis include any sexually active person, particularly those with multiple partners, individuals infected with HIV, those who do not use condoms, men who have sex with men, people who use injection drugs, and babies born to infected mothers.
Local Picture

Figure 22. Age-standardized infectious syphilis\(^1\) incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016\(^2\)


\(^1\)Primary, secondary and early latent syphilis are all considered infectious (includes early latent; primary genital; primary other sites; secondary of skin and mucous membranes; secondary, other; infectious neurosyphilis and primary anal).

\(^2\)The Waterloo Region rates for 2006-2011 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016, the age-standardized incidence rate of infectious syphilis in Waterloo Region was 3.4 cases per 100,000 (N=19); this is higher than the previous five-year annual average rate for 2011-2015 (4.0 cases per 100,000).
- While local rates have fluctuated in the last few years, provincial infectious syphilis rates have continued to increase.
- Waterloo Region rates have consistently remained lower than provincial rates over the last 10 years. In 2016, the local rate was significantly lower than that of the province (SRR = 0.67 [CI: 0.48-0.92]).
- Almost all infectious syphilis cases in 2016 were among males (94.7 per cent), and the age-specific rate was highest among 40-44 year-olds (10.8 cases per
100,000), followed by 50-54 year-olds (9.8 cases per 100,000). Age-specific rates were lowest in children and adolescents less than 15 years of age.

- Among Waterloo Region cases in 2016 with risk factor information (N=9), the most common self-reported risk factors included having sex with the same sex (100.0 per cent), not using a condom (89.0 per cent), and having more than one sexual partner in the last six months (67.0 per cent).
- Due to the small number of cases and resulting instability in rates, caution should be used in interpreting the data.

Figure 23. Age-standardized other syphilis\(^1\) incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016\(^2\)

![Figure 23](image)


\(^1\)Other syphilis includes all other types of syphilis such as late latent or unspecified (the other category excludes early congenital syphilis)

\(^2\)The Waterloo Region rates for 2010 and 2012 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In Waterloo Region in 2016, there were 21 cases of non-infectious and unspecified syphilis with an age-standardized incidence rate of 3.9 cases per 100,000. This rate is slightly lower than the previous five-year annual average rate for 2011-2015 (4.2 per 100,000).
- Between 2006 and 2016, local rates have generally been lower or similar compared to those of Ontario; in 2016, the local rate was not significantly different from the provincial rate (SRR = 0.79 [CI: 0.53-1.16]).
• There were more non-infectious and unspecified syphilis cases among males (N=15) than females (N=6), and all cases occurred among individuals aged 20 years or older.

• Among Waterloo Region cases in 2016 with risk factor information (N=6), the most frequently reported risk factors were not using a condom (67.0 per cent), having more than one sexual partner in the last 6 months (33.0 per cent), and having sex with the same sex (33.0 per cent).

• Due to the small number of cases and the resulting instability in rates, caution should be used in interpreting this data.
Vaccine Preventable Diseases

Vaccine preventable diseases presented in this section of the report include:

- Influenza
- Invasive meningococcal disease (IMD)
- Invasive pneumococcal disease (IPD)
- Measles
- Mumps
- Pertussis
- Varicella

Table 5. Numbers and age-standardized incidence rates per 100,000 for vaccine preventable diseases, Waterloo Region & Ontario, 2016 and 2011-2015 (five-year annual average)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Waterloo Region</th>
<th>Ontario</th>
<th>2016 Standardized rate ratio (95% confidence interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Cases in 2016</td>
<td>2016 Age-standardized rate per 100,000</td>
<td>5-year average rate per 100,000 (2011-2015)</td>
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<tr>
<td>Influenza</td>
<td>376</td>
<td>69</td>
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<td>Invasive pneumococcal disease</td>
<td>56</td>
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<tr>
<td>Pertussis (whooping cough)</td>
<td>32</td>
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<td>4.3</td>
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<tr>
<td>Invasive meningococcal disease</td>
<td>2</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Mumps</td>
<td>0</td>
<td>0</td>
<td>0.4</td>
</tr>
<tr>
<td>Measles</td>
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<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>


1 Disease list does not include varicella. Reporting of individual cases of varicella is incomplete. As such, ambulatory care visits (visits to emergency departments and hospital outpatient visits) were used as a proxy measure to determine severity of the disease.

2 Standardized rate ratio (SRR) refers to the ratio of the Waterloo Region age-standardized rate for 2015 compared to the Ontario age-standardized rate for 2015. The 95% confidence interval indicates the statistical significance of the SRR (if the 95% confidence interval contains 1.00, the two rates are not
statistically different from one another). SRRs indicating significant differences between Ontario and Waterloo in 2016 are highlighted in yellow.

3 Influenza data is reported for the 2011-2012 season to the 2016-2017 season which runs from September 1st through August 31st each year. Note that the 2015-2016 data is not provided for the complete season and only includes data from September 1, 2016 to April 30th, 2017.

4 Rates are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

Public Health Activities for Vaccine Preventable Diseases

Region of Waterloo Public Health and Emergency Services:

- Offers immunization at public health clinics by appointment for families to complement the many pharmacies, physicians’ offices and other providers of influenza vaccine in Waterloo Region to protect individuals against vaccine preventable diseases.
- Distributes vaccine to health care providers, including family physicians, hospitals, long-term care homes, retirement homes, and pharmacies.
- Provides immunization clinics in schools and enforces the Immunization of School Pupils Act (ISPA) to ensure all students attending school are immunized as per the Act. The ISPA requires children and adolescents to provide proof of immunization against meningococcal disease, pertussis (whooping cough), varicella (chicken pox), tetanus, diphtheria, poliomyelitis, measles, mumps and rubella. Students who are not up-to-date with ISPA mandated immunizations, or do not have a valid exemption on file, are suspended from school.
- Collects and maintains the immunization records of children enrolled in licensed child care centres.
- Provides health education (e.g., via website, written resources, site visits, educational forums) for health care providers, including family physicians, long-term care homes, pharmacies, etc.
- Provides health promotion activities to increase immunization coverage rates, especially among priority and/or high risk populations.
- Receives and investigates reports of vaccine preventable diseases from health providers, laboratories, and members of the community.
- Investigates contacts of confirmed cases of vaccine preventable diseases and recommends post-exposure prophylaxis or immunization as required.
- Receives and investigates reports of adverse events following immunization, and reports them to the Ministry of Health and Long-Term Care.
- Conducts disease surveillance and provides timely updates on local disease status to area health care providers and other stakeholders as needed.
• Initiated the Invasive Pneumococcal Prevention Campaign in the 2016-2017 respiratory season to prevent IPD in the community by increasing pneumococcal vaccinations among priority and high risk individuals. Promotional packages were distributed to primary care providers, specialists and specialty clinics, pharmacists and labs. Public Health plans to evaluate the effectiveness of the IPD Campaign and make recommendations for further promotion.
Influenza

Background

- Influenza (commonly known as the “flu”) is a viral infection that circulates on a yearly basis causing seasonal outbreaks (usually October to April in Canada) of respiratory illness. The severity of the influenza season varies each year and can be mild to severe.
- The flu is spread by breathing in droplets that an infected person coughs or sneezes into the air. The influenza virus can also survive outside the body on unwashed hands, tissues or clothing, and on surfaces.
- Influenza symptoms can include headache, runny nose, sneezing, chills, cough, fever, loss of appetite, muscle aches and fatigue (feeling weak). Nausea, vomiting and diarrhea may also occur, particularly in children.
- Influenza vaccine is produced every year to provide protection against the strains of influenza that are expected to circulate that year.
- All individuals are at risk for contracting the influenza virus. Individuals who receive the seasonal vaccine are offered protection against the anticipated circulating strains. Certain segments of the population, such as older people, young children and those with underlying health conditions, are more susceptible to acquiring influenza and may experience further complications.
Infectious Diseases in Waterloo Region – Surveillance Report 2016

Local Picture

Figure 24. Age-standardized influenza incidence rates per 100,000, by season, Waterloo Region & Ontario, 2011-2012 to 2016-2017¹

<table>
<thead>
<tr>
<th></th>
<th>Number of cases</th>
<th>Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waterloo cases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011-2012</td>
<td>160</td>
<td>30.4</td>
</tr>
<tr>
<td>2012-2013</td>
<td>394</td>
<td>77.6</td>
</tr>
<tr>
<td>2013-2014</td>
<td>314</td>
<td>59.2</td>
</tr>
<tr>
<td>2014-2015</td>
<td>419</td>
<td>80.3</td>
</tr>
<tr>
<td>2015-2016</td>
<td>433</td>
<td>79.5</td>
</tr>
<tr>
<td>2016-2017</td>
<td>376</td>
<td>69.0</td>
</tr>
<tr>
<td>Ontario Rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011-2012</td>
<td>29.9</td>
<td>7.2</td>
</tr>
<tr>
<td>2012-2013</td>
<td>72.6</td>
<td>7.3</td>
</tr>
<tr>
<td>2013-2014</td>
<td>73.2</td>
<td>9.6</td>
</tr>
<tr>
<td>2014-2015</td>
<td>96.5</td>
<td>87.9</td>
</tr>
<tr>
<td>2015-2016</td>
<td>87.9</td>
<td>81.6</td>
</tr>
<tr>
<td>2016-2017</td>
<td>80.0</td>
<td>81.6</td>
</tr>
</tbody>
</table>


¹ Data is reported for the 2011-2012 season to the 2016-17 season which runs from September 1st through August 31st each year. Note that the 2016-17 data is not provided for the complete season and only includes data from September 1st, 2016 to April 30th, 2017.

- Influenza accounts for over three-quarters of vaccine preventable diseases reported in Waterloo Region.
- 2016-2017 was a moderate year for influenza. During the 2016-2017 flu season (September 1, 2016 to April 30, 2017), there were 376 laboratory confirmed cases of influenza in Waterloo Region. The age-adjusted incidence rate was 69.0 cases per 100,000. This is similar to the previous five-year annual average rate for the 2011-2012 to 2015-2016 seasons (65.4 cases per 100,000).
- The influenza rate for the 2016-2017 season for Waterloo Region was significantly lower than that for the province (SRR=0.85 [CI: 0.77-0.93]).
- The 2016-2017 influenza season was slightly less severe compared to previous seasons based on the number of hospitalizations and deaths. A total of 104 confirmed cases of influenza in Waterloo Region were hospitalized during the 2016-2017 influenza season, for a rate of 18.9 hospitalizations per 100,000.
average number of hospitalizations per season over the previous five influenza seasons in Waterloo Region was 117.

- During the 2016-2017 season, there was 5 deaths in Waterloo Region where influenza was a contributing cause of death, for a rate of 0.9 deaths per 100,000; this is similar to the number of deaths compared to the previous influenza five-season average (average 7 deaths per season).
- Influenza activity peaked in January and February in Waterloo Region which is typical of annual season influenza activity.
- Influenza A was the overall predominant circulating virus type for the 2016-2017 season, although influenza B became more common in the latter part of the season when there was less overall influenza activity.
Invasive Meningococcal Disease (IMD)

**Background**

- Meningococcal disease is caused by the *Neisseria meningitidis* bacterium. About 10 per cent of people carry the bacteria in their throat or nose without feeling sick. In a rare number of cases, the bacteria can cause serious diseases such as meningitis (inflammation of the lining surrounding the brain) and septicemia (widespread infection of the blood and organs).

- Invasive meningococcal disease (IMD) is spread from person to person, by coming in contact with infected mucus or saliva (through kissing, sharing food or drinks, etc.).

- IMD can cause high fever, neck stiffness, headache, vomiting, sensitivity to light, rash, confusion and in severe cases, coma.

- Children under one year of age and adolescents between 15 to 18 years are at a higher risk of acquiring IMD in addition to those living in crowded conditions, having medical conditions involving the spleen or cochlear implants, and travellers to areas with high rates of IMD (e.g., sub-Saharan Africa).

- In Ontario, a vaccine against the C-strain of *Neisseria meningitis* is funded for children after their first birthday. A vaccine to protect against strains A, C, Y and W-135 is funded for grade 7 students.

- As part of the investigation of a case of IMD, Public Health identifies close contacts at increased risk if infection and facilitates the provision of preventative antibiotics to these contacts.
Local Picture

Figure 25. Age-standardized invasive meningococcal disease (IMD) incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


1The Waterloo Region rates for 2006-2011 and 2015 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016, there were no cases of IMD in Waterloo Region.
- Provincially, there has been a gradual decline in incidence rates over the past 10-year period; there were 28 cases of IMD in 2016 (age-adjusted incidence rate of 0.2 cases per 100,000).
- Due to the small number of cases and resulting instability in rates, caution should be used in interpreting this data.
Invasive Pneumococcal Disease (IPD)

**Background**
- Invasive pneumococcal disease (IPD) is a serious infection which is caused by the bacterium known as *Streptococcus pneumoniae*. It can cause infections such as pneumonia (lungs), meningitis (the lining of the brain), and sepsis (infection of the blood).
- IPD can cause a number of symptoms including fever, chills, headache, ear pain, cough, chest pain, neck stiffness, and breathing difficulty.
- Risk factors for IPD include being under two years of age or over 65 years of age; chronic diseases of the lung, heart, kidney, or liver; diabetes; cancer; intravenous (IV) drug use; a weakened immune system (e.g., those with HIV/AIDS); smoking; and alcoholism.
- Many strains of IPD are preventable by immunization.

**Local Picture**

Figure 26. Age-standardized invasive pneumococcal disease (IPD) incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016

- In Waterloo Region in 2016, there were 56 cases of IPD with an age-standardized incidence rate of 10.6 cases per 100,000.
- The IPD incidence rate has fluctuated over the past 10 years in Waterloo Region. The local incidence rate in 2016 is lower than the previous five-year annual average for 2011-2015 (12.7 cases per 100,000).
- Local rates of IPD have been generally higher than those of the province for the last 10 years; in 2016, local IPD rates were significantly higher than Ontario’s rate (SRR = 1.43 [CI: 1.04-1.97]).
- In 2016, cases of IPD in Waterloo Region were fairly equally distributed among males and females; adults 65 years and older had the highest age-specific rates (28.05 cases per 100,000).
- There were seven deaths associated with IPD in Waterloo Region in 2016; this is similar to the number of IPD-associated deaths reported in the previous five years (the average annual number of deaths for 2011-2015 was 7.4).
- Among the 2016 Waterloo Region cases with risk factor information available (N=48), the most common self-reported risk factors included having a chronic illness or underlying medical condition (81.3 per cent), being unimmunized (54.1 per cent), and being under two years of age or over 65 years of age (44.0 per cent).
- Public Health is continuing to promote immunization for IPD among priority and high-risk individuals through health care providers.
Measles

Background

- Measles is a very contagious infection caused by the measles virus. It is easily spread from person to person by direct contact with nasal or throat secretions from an infected person. The infected person can spread the droplets while talking, coughing or sneezing.
- Symptoms can include fever, cough, runny nose and a rash that initially appears on the face and then spreads to the rest of the body. Complications of measles can involve ear infection, pneumonia (lung infection), and encephalitis (infection of the brain) which could lead to brain damage.
- All persons who have not had the disease or who have not been fully immunized are susceptible to acquiring the infection, particularly individuals who travel to measles endemic areas, young children, individuals with a chronic disease, and those with weakened immunity.

Local Picture

Figure 27. Age-standardized measles incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


1The Waterloo Region rate for 2009 is unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.
• There were no cases of measles in 2016 in Waterloo Region.
• Provincially, there were seven cases of measles in 2016 for a provincial age-adjusted incidence rate of 0.1 cases per 100,000.
• In general, most cases of measles are acquired through travel, or in individuals who came to Ontario from other jurisdictions.
• The increase in 2009 was due to a small local outbreak of measles in six unimmunized or inadequately immunized persons. The disease was imported from an unimmunized child who had travelled outside of Canada. Increased immunization and isolation measures implemented by Region of Waterloo Public Health prevented further spread of this highly infectious disease.
• Due to the small number of cases and resulting instability in rates, caution should be used when interpreting this data.
Mumps

Background
- Mumps is a viral infection caused by the mumps virus.
- Mumps is spread from person to person by coming in contact with an infected person’s saliva.
- Symptoms include fever, headache and swollen glands of the face. Complications can involve meningitis (infection of the lining of the brain), deafness and swollen testicles.
- All persons who have not had the disease or who have not been fully immunized are at risk of acquiring mumps.

Local Picture

Figure 28. Age-standardized mumps\(^1\) incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016\(^2\)


\(^1\) Includes both confirmed and probable mumps cases.

\(^2\) The Waterloo Region rates for 2006-2007, 2009-2012, 2014 and 2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.
In 2016, there was one case of mumps reported in Waterloo Region for an age-adjusted incidence rate of 0.2 cases per 100,000; this is similar to the previous five-year annual average incidence rate for 2011-2015 (0.3 cases per 100,000).

In Ontario in 2016, there were 40 cases of mumps (age-adjusted incidence rate of 0.3 cases per 100,000). Provincially over the last 10 years, the age-adjusted incidence rate of mumps has ranged from a low of 0.1 cases per 100,000 in 2006 and 2014, to a high of 0.8 cases per 100,000 in 2009.

With the exception of 2009, local incidence rates have remained similar to or lower than provincial rates.

In 2009, there was an increased incidence of mumps in Ontario and throughout Canada, mainly in university and college students. There were 12 cases in Waterloo Region; the cases were primarily young male university or college students and were in the cohort of individuals who would have been given only one dose of mumps vaccine.

Due to the small number of cases and resulting instability in rates, caution should be used when interpreting this data.
Pertussis

Background

- Pertussis or whooping cough is a respiratory infection caused by the *Bordetella pertussis* bacterium. The disease can affect people of any age but it is more severe in children less than one year of age.
- It is spread from person to person through direct contact of respiratory secretions (e.g., cough of an infected person).
- It initially causes cold-like symptoms such as a runny nose and a cough. The cough then worsens progressing into coughing spells which can be severe leading to vomiting, feeling short of breath, gagging, and a ‘whoop’ like sound when the person takes a breath. Complications can include seizures, brain damage and pneumonia (lung infection).
- Pertussis is preventable through immunization and is part of the routine childhood immunization schedule. A booster dose is given to adolescents and adults.
- Anyone can get whooping cough but unimmunized or inadequately immunized individuals and those people living in the same household as someone with whooping cough are at higher risk of acquiring pertussis.
Local Picture

Figure 29. Age-standardized pertussis\(^1\) incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016\(^2\)


\(^1\)Includes both confirmed and probable pertussis cases.

\(^2\)The Waterloo Region rates for 2008-2009, 2011, 2013-2014 and 2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016, there were 13 cases of pertussis in Waterloo Region (age-standardized incidence rate of 2.3 cases per 100,000). This rate is lower than the previous five-year average of 4.8 cases per 100,000.
- The local pertussis incidence rate in 2016 was lower than but not significantly different from the provincial rate (SRR = 0.67 [CI: 0.43-1.06]).
- In general, pertussis incidence declined with age. In 2016 in Waterloo Region, the youngest age groups had the highest age-specific incidence rates (19.3 cases per 100,000 among 0 to 4 year olds. There were no notable differences in the number of pertussis cases among males and females.
- There was a peak in incidence in 2012 both locally (incidence rate of 12.6 cases per 100,000) and across all of Ontario (incidence rate of 7.8 cases per 100,000). Pertussis is naturally cyclic in nature, with peaks in disease every three to five years. Local cases from 2012 were sporadic and not associated with an outbreak.
Varicella

Background

- Varicella infection (or chickenpox) is a common childhood illness caused by the varicella zoster virus. The virus can reactivate and cause a painful rash called shingles.
- Chickenpox can spread from person to person through the air by coughing or sneezing or by directly touching the rash (blisters). It is contagious from one to two days before the rash appears until the rash has scabbed over. The symptoms include fever, cough, sore throat, general aches, and a generalized itchy rash.
- Chickenpox usually gets better on its own without the use of any medication. Immunization is available for children who have not had chickenpox and there is also another vaccine for adults above the age of 50 (Zostavax), to prevent the occurrence of shingles. Beginning in the 2014-2015 school year, varicella was one of the immunizations added to the required vaccination list to attend school as per the Immunization of School Pupils Act (ISPA).
- All persons who have not had varicella or who have not been fully immunized are at risk of acquiring the virus.

Local Picture

Figure 30. Age-standardized varicella ambulatory care visit\(^1\) rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016

![Graph showing varicella rates per 100,000 from 2006 to 2016 for Waterloo Region and Ontario.]


1Varicella ambulatory care visits from IntelliHEALTH are reported as a proxy measure to determine severity of disease. They include both visits to emergency departments as well as hospital outpatient visits.

- Local and provincial varicella data was sourced from the National Ambulatory Care Reporting System (NACRS) rather than the integrated Public Health Reporting System for reportable diseases (iPHIS), as individual cases of varicella are generally underreported. As such, only cases of varicella that led to ambulatory care visits are captured in the following findings.
- In 2016, there were 53 ambulatory care visits for varicella in Waterloo Region (age-standardized visit rate of 9.5 cases per 100,000).
- Since 2010, the rate of varicella ambulatory care visits has generally declined both locally and provincially; in 2016, the ambulatory visit rate for varicella was lower than the previous five-year annual average for 2011-2015 (12.1 cases per 100,000).
- Since 2006, the local rates of varicella ambulatory care visits were similar to or lower than those of the province; in 2016, the local rate remained lower than that for Ontario, but this difference was not statistically significant (SRR = 0.82 [CI: 0.64-1.06]).
- In 2016, local varicella ambulatory care visits were generally evenly distributed among males and females.
- In 2016, the younger age groups had the highest proportion of varicella ambulatory care visits (rate of 58.2 visits per 100,000); 51.0 per cent of varicella visits occurred in individuals less than 15 years of age.
Other Infectious Diseases

Reportable diseases categorized into this section include:

- Encephalitis/meningitis
- Group A streptococcal disease, invasive (iGAS)
- Group B streptococcal disease (neonatal)
- Legionellosis
- Tuberculosis (TB) – active and latent

Table 6. Numbers and age-standardized incidence rates per 100,000 for other infectious diseases, Waterloo Region & Ontario, 2016 and 2011-2015 (five-year annual average)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Waterloo Region</th>
<th></th>
<th></th>
<th>Ontario</th>
<th></th>
<th></th>
<th>2016 Standardized rate ratio (95% confidence interval)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Cases in 2016</td>
<td>2016 Age-standardized rate per 100,000</td>
<td>5-year average rate per 100,000 (2011-2015)</td>
<td># Cases in 2016</td>
<td>2016 Age-standardized rate per 100,000</td>
<td>5-year average rate per 100,000 (2011-2015)</td>
<td>²</td>
</tr>
<tr>
<td>Tuberculosis (latent)</td>
<td>314</td>
<td>56.7</td>
<td>63.2</td>
<td>7,698</td>
<td>55.9</td>
<td>62.4¹</td>
<td>1.01 (0.90-1.14)</td>
</tr>
<tr>
<td>Group A streptococcal disease, invasive</td>
<td>22</td>
<td>4.1</td>
<td>5.0</td>
<td>715</td>
<td>5.0</td>
<td>4.7</td>
<td>0.8 (0.60-1.20)</td>
</tr>
<tr>
<td>Encephalitis/meningitis³</td>
<td>26</td>
<td>4.7</td>
<td>2.5</td>
<td>440</td>
<td>3.2</td>
<td>2.5</td>
<td>1.47 (0.92-2.36)</td>
</tr>
<tr>
<td>Tuberculosis (active)</td>
<td>11</td>
<td>2.0¹</td>
<td>2.0¹</td>
<td>635</td>
<td>4.4</td>
<td>4.5</td>
<td>0.46 (0.30-0.68)</td>
</tr>
<tr>
<td>Legionellosis</td>
<td>10</td>
<td>1.8¹</td>
<td>2.2¹</td>
<td>144</td>
<td>1.0</td>
<td>1.3</td>
<td>1.81 (0.79-4.16)</td>
</tr>
<tr>
<td>Group B streptococcal disease, neonatal</td>
<td>1</td>
<td>0.2¹</td>
<td>0.3¹</td>
<td>49</td>
<td>0.4</td>
<td>0.5</td>
<td>1.1 (0.25-4.84)</td>
</tr>
</tbody>
</table>


¹ Standardized rate ratio (SRR) refers to the ratio of the Waterloo Region age-standardized rate for 2015 compared to the Ontario age-standardized rate for 2015. The 95% confidence interval indicates the statistical significance of the SRR (if the 95% confidence interval contains 1.00, the two rates are not statistically different from one another). SRRs indicating significant differences between Ontario and Waterloo in 2016 are highlighted in yellow. ² Data for Ontario LTBI cases is not available prior to 2013, thus this is a 3 year average rate (2013-2015).
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Public Health Activities for Tuberculosis (TB)

Region of Waterloo Public Health:
- Provides accessible and effective tuberculosis (TB) clinic services in partnership with a local group of respirologists.
- Provides TB skin test clinic for medically indicated and third party testing.
- Manages all active TB cases reported to Region of Waterloo Public Health.
- Investigates and follows-up contacts of cases.
- Follows up on all immigrant notifications for medical surveillance.
- Provides early screening for populations at highest risk.
- Provides all medications for treatment of active or latent TB free of charge.
- Reports confirmed and probable cases of tuberculosis to the Ministry of Health and Long-Term Care.
- Conducts disease surveillance and provides timely updates on local disease status to area health care providers and other stakeholders.
- Provides health education (e.g., via website, brochures, site visits, forums) for health care providers, including family physicians, long-term care homes, and retirement homes.

Public Health Activities for Encephalitis/Meningitis, Group A Streptococcal Disease, Neonatal Group B Streptococcal Disease, Legionellosis

Region of Waterloo Public Health:
- Receives and investigates reports of these diseases from health care providers and laboratories.
- Investigates contacts of confirmed cases of these diseases and recommends prophylaxis (preventative medication) as required.
- Reports confirmed and probable cases of diseases to the Ministry of Health and Long-Term Care.
- Conducts disease surveillance and provide timely updates on local disease status to area health care providers and other stakeholders.

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3 Viral and bacterial cases of encephalitis and meningitis are combined since most reported cases were undifferentiated; includes encephalitis primary viral, encephalitis/meningitis, meningitis (bacterial), meningitis (viral). Bacterial meningitis from pneumococcal disease and meningococcal disease are reported separately.

4 Rates are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.
• Provides health education (e.g., via website, brochures, site visits, forums) for health care providers (physicians, hospitals, long-term care/retirement homes).
• In recent years, Region of Waterloo Public Health has distributed legionellosis information to hospitals, schools, long-term care homes, retirement homes, and other identified cooling tower operators within the Region. The information included information on the provincial and local legionellosis disease trends, and recommended best practices for cooling tower maintenance.
Encephalitis/Meningitis

Background

- Encephalitis refers to inflammation of the brain. Meningitis refers to inflammation of the meninges, which are membranes that surround the brain and spinal cord.
- These two conditions cause a range of symptoms including fever, headache, confusion, and/or muscle weakness. In severe cases, permanent brain damage or death may occur due to injury of nerve or brain cells.
- Meningitis and encephalitis may have a variety of infectious causes (viral, bacterial and fungal) and non-infectious causes (cancer, lupus, etc.). In many cases it is impossible to identify a reason for the inflammation.
- The causes and risk factors vary by case. Those at higher risk include people with a weakened immune system, the elderly, persons who recently had a neurosurgical procedure, and those in contact with an infected person.
- Bacterial meningitis due to pneumococcal and meningococcal disease are reported separately under invasive pneumococcal (IPD) and invasive meningococcal disease (IMD) respectively. All other infectious cases of bacterial, viral, or fungal meningitis or encephalitis are included here.
Local Picture

Figure 31. Age-standardized encephalitis and meningitis\(^1\) incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016\(^2\)


\(^1\)Viral and bacterial cases are combined since most reported cases were undifferentiated; includes encephalitis primary viral, encephalitis/meningitis, meningitis (bacterial), meningitis (viral).

\(^2\)The Waterloo Region rates for 2007 and 2009-2015 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016, there were 26 cases of encephalitis and meningitis in Waterloo Region with an age-standardized incidence rate of 4.7 cases per 100,000; this rate is higher than the previous five-year annual average rate for 2011-2015 (2.5 cases per 100,000).
- Local rates have fluctuated around the provincial rate over the last 10-year period; in 2016 the local rate was higher than Ontario’s rate, but this difference was not statistically significant (SRR = 1.47 [CI: 0.92-2.36]).
- In 2016, the highest age-specific rate was among children 0 to 4 years-old (32.1 cases per 100,000). There were no discernible trends in encephalitis and meningitis incidence between males and females.
- There was no marked seasonal trend in the incidence of encephalitis and meningitis in Waterloo Region in 2016.
- Variations in the incidence of encephalitis/meningitis are expected from year to year as the circulation of the causative organisms varies.
Group A Streptococcal Disease, Invasive (iGAS)

Background

- Group A streptococcal (GAS) bacteria are common causes of minor infections such as “strep throat,” cellulitis (bacterial infection below the skin), skin abscesses (boils) or impetigo (skin infection). Persons may also carry these bacteria on the skin or in their throat without any symptoms or illness.
- More serious or invasive group A streptococcal infections (iGAS) occur more rarely. These infections include necrotizing fasciitis (flesh eating disease), toxic shock syndrome (failure of all body systems) or sepsis (overwhelming infection of the blood stream).
- The symptoms of iGAS vary and depend on the affected area. They can include fever, sore throat, rash, or sores on the skin. In severe infections, the skin can be red, swollen, and very painful and can progress to blisters or necrosis (tissue death).
- Those most at risk for iGAS include the elderly, people with chronic disease (such as cancer, diabetes, kidney, heart and lung disease), those with skin lesions, adults with a history of alcohol abuse, injection drug use, and those taking some specific medications such as steroids. Children with chickenpox have a higher risk of developing skin infections from group A streptococcus.
- There is no vaccine to prevent iGAS infection; iGAS infection is treated with antibiotics.
- As part of the investigation of an iGAS case, Public Health identifies close contacts of the case that are at increased risk of infection and facilitates the provision of preventative antibiotics for contacts.
Local Picture

Figure 32. Age-standardized invasive Group A streptococcal disease incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


1The Waterloo Region rate for 2011 is unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016 there were 22 cases of iGAS in Waterloo Region, for an age-standardized incidence rate of 4.1 cases per 100,000. This rate is slightly lower than the previous five-year average annual rate for 2011-2015 (5.0 cases per 100,000).
- Local rates of iGAS have fluctuated around the provincial rate since 2006. In 2016, the local rate was similar to that of the province (SRR = 0.80 [CI: 0.60-1.20]).
- In Waterloo Region in 2016, there were more cases among females (N=15) than males (N=7). The average age-specific iGAS incidence rate for 2016 was highest among adults 65 years of age and older (12.7 cases per 100,000) in Waterloo Region. This is consistent with what is typically seen; the average age-specific rate for the last 5 years was also highest among adults 65 years and older (10.9 cases per 100,000)
• According to the previous five-year annual average rates, cases occur regularly throughout the year, with slight increases expected in winter and early spring (November to April).
• There were three deaths among iGAS cases in Waterloo Region in 2016 where the disease was the underlying or contributing cause.
• Among the 2016 Waterloo Region cases with risk factor information available (N=21), the most common self-reported risk factor was having a dermatological condition or wound causing a break in skin integrity (60.0 per cent), followed by having an underlying medical condition or chronic illness (40.0 per cent).
Group B Streptococcal Disease (Neonatal)

Background

- Group B Streptococcus (GBS) are common bacteria often found in the vagina, rectum or urinary bladder of women. It is estimated that 10 to 35 per cent of pregnant women will have GBS in their vagina and/or rectum at any time. The bacteria usually do not harm the mother, but it can be transmitted to the newborn during delivery.
- Prenatal screening is offered to all pregnant women by the clinician providing prenatal care. For women carrying GBS bacteria in the vagina, antibiotics are often provided at the onset and throughout labour to decrease infection of the newborn and associated complications.
- Reported cases of neonatal GBS infections have been low due to routine screening of pregnant women between the 35th and 37th weeks of pregnancy. Additionally, antibiotics given to GBS positive mothers during labour are effective in preventing transmission.
- Risk factors for having a baby with GBS infection include: having a positive GBS screening/urine test during pregnancy, delivering early (less than 37 weeks), having fever during labor, and previously having had a child with GBS infection.
In 2016 there was one case of neonatal GBS in Waterloo Region (age-standardized incidence rate of 0.2 cases per 100,000); this is similar to the previous five-year average rate for 2011-2015 (0.3 cases per 100,000).

In Ontario in 2016, there were 49 cases of neonatal GBS; the provincial incidence rate has remained relatively stable over the past 10-year period around 0.4 cases per 100,000.

Due to small numbers and the resulting instability in rates, caution should be used in interpreting this data.
Legionellosis

Background

- Legionellosis is an infection which is caused by the bacterium known as *Legionella pneumophila*. This bacterium is naturally found in the environment (in water, soil and dust). Outbreaks have often involved hot tubs, water tanks, water fountains and cooling towers. Legionellosis is comprised of two diseases caused by the same bacterium: The more severe form, known as Legionnaires’ Disease, and the milder illness known as Pontiac Fever.
- It is spread by people inhaling the bacteria when they breathe in contaminated droplets of water in air. The bacteria are not spread from person-to-person.
- Legionnaires’ disease can have symptoms related to pneumonia (lung infection) which include: fever, chills, cough, muscle aches and headache. Pontiac Fever is a milder infection which causes fever and muscle aches, but not pneumonia.
- Older adults (65 years or older), smokers, those with lung disease, weakened immune systems or kidney disease, and those with cancer are at higher risk of becoming infected.
Local Picture

Figure 34. Age-standardized legionellosis incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


The Waterloo Region rates for 2006-2007 and 2009-2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In Waterloo Region in 2016, there were 10 cases of legionellosis for an age-standardized incidence rate of 1.8 cases per 100,000. This rate is similar to the previous five-year annual average rate for 2011-2015 (2.2 cases per 100,000).
- Local rates of legionellosis have been remaining relatively stable since 2013, with local rates remaining statistically comparable to provincial rates.
- There were no discernible differences in rates for males and females in 2016. All cases occurred among adults 55 years of age or older; the highest age-specific rate occurred among adults 55-59 years old (10.8 cases per 100,000).
- Legionellosis follows a seasonal pattern, with the majority of cases occurring between June and October every year. In Waterloo Region in 2016, more than 50 per cent of cases occurred in September and October.
- There were no legionellosis outbreaks or clusters of cases with a known common exposure or epidemiological link identified in Waterloo Region or Ontario in 2016.
Among 2016 cases with risk factor information available, one was related to travel outside of the province. The most common self-reported risk factors among non-travel related cases were being a smoker, having an underlying medical condition, and having recent exposure to aerosolized water.

Due to small numbers and the resulting instability in rates, caution should be used in interpreting this data.
Tuberculosis

Background

- Tuberculosis (TB) is a curable infectious disease caused by the bacteria *mycobacterium tuberculosis*. TB disease usually affects the lungs (pulmonary or respiratory TB); however, the bacteria can travel through the blood and infect other parts of the body (extrapulmonary or non-respiratory TB).

- Active TB disease occurs when the body’s immune system is unable to stop the growth and spread of the bacteria after the individual becomes infected. Latent TB infection (LTBI), or inactive TB, occurs when a person is infected, but is neither ill nor contagious from the infection. Five to ten per cent of individuals with inactive TB later develop the active form of the disease.

- Risk factors for acquiring TB disease include:
  - Having lived or being born in an endemic country
  - Immunosuppression or underlying medical conditions (e.g., human immunodeficiency virus)
  - Close contact with an individual infected with respiratory TB
  - Inadequate treatment of a previous TB infection
  - Priority populations are at greater risk (e.g., person experiencing homelessness, the under-housed, persons who use substances, aboriginal persons)

- Latent TB infection (LTBI) is most likely to develop into active TB within the first two years of becoming infected. Risk factors that also increase the likelihood of LTBI developing into active TB include:
  - Immunosuppression or underlying medical conditions (e.g., human immunodeficiency virus, organ transplant)
  - Treatment with certain medications (e.g., glucocorticoids, tumour necrosis factor-alpha inhibitors)
  - Having diabetes
  - Being under weight
  - Being under five years of age when first infected
  - Smoking cigarettes daily
  - Heavy alcohol consumption

- Active and latent TB infections are treated with antibiotics; treatment of both active and latent TB infection can take six to 12 months.
Local Picture

Figure 35. Age-standardized active tuberculosis incidence rates per 100,000, by year, Waterloo Region & Ontario, 2006-2016


1 The Waterloo Region rates for 2006-2016 are unstable due to small numbers (Relative Standard Error [RSE] >23%) and should be interpreted with caution.

- In 2016 there were 11 cases of active TB in Waterloo Region with an age-standardized incidence rate of 2.0 cases per 100,000. This rate is very similar to the previous five-year annual average rate for 2011-2015 (2.0 per 100,000).
- Local rates of active TB have been significantly lower than those of the province since 2010, and this trend continued in 2016 (SRR = 0.46 [CI: 0.30-0.68]).
- In Waterloo Region in 2016, active TB was most common among 65 years of age and older (age-specific rate of 7.6 cases per 100,000), and cases were fairly equally distributed among males and females.
- There was one death among active TB cases in Waterloo Region in 2016 where the disease was the underlying or contributing cause.
• Of the 11 active TB cases in 2016, six had risk factor information available. Six of these cases reported living in an endemic area: three cases originated from Asia, two cases originated from Africa, and one case originated from the Middle East.
• Treatment for active TB requires taking medication for six to nine months or more; to date, six cases diagnosed in 2016 have completed treatment.
• All TB cases are tested for drug resistance. Of the cases with information available on drug resistance in 2016, one demonstrated resistance to one or more TB drugs.
• In Waterloo Region in 2016, there were 314 cases of latent TB infection (LTBI) for an annual age-standardized incidence rate of 56.7 cases per 100,000.
• In 2016, the local rate of LTBI was similar to the provincial rate (SRR = 1.01 [CI: 0.90-1.14]).
• In 2016, almost three-quarters (72.3 per cent) of LTBI cases were among females in Waterloo Region, and most cases occurred in people aged 15 years or older.
Outbreaks

Public Health Activities for Outbreaks

• Region of Waterloo Public Health and Emergency Services follows up on all enteric and respiratory outbreaks reported by child care centres, hospitals, residential/group homes, long-term care homes and retirement homes.

• The health unit supports community partners in investigating the source of the outbreak and implementing appropriate infection prevention and control practices to minimize the spread of illness as per Ministry of Health and Long-Term Care guidelines.

• Other activities that contribute to outbreak management including:
  o Consultation with individual facilities (e.g., long-term care homes, retirement homes);
  o Education sessions to increase health care worker immunization rates;
  o Hosting health education forums with staff from local facilities to provide skill enhancement training regarding infection prevention and control, and outbreak management.
Enteric Outbreaks

Local Picture

Table 7. Number of enteric outbreaks by season, Waterloo Region, 2011-2012 to 2016-2017\(^1\) and previous 5-season average\(^2\)

<table>
<thead>
<tr>
<th>Season</th>
<th>Number of Enteric Outbreaks</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2012</td>
<td>65</td>
</tr>
<tr>
<td>2012-2013</td>
<td>42</td>
</tr>
<tr>
<td>2013-2014</td>
<td>68</td>
</tr>
<tr>
<td>2014-2015</td>
<td>75</td>
</tr>
<tr>
<td>2015-2016</td>
<td>53</td>
</tr>
<tr>
<td>2016-2017(^1)</td>
<td>51</td>
</tr>
<tr>
<td>Previous 5-season average(^2)</td>
<td>60.6</td>
</tr>
</tbody>
</table>

\(^1\) Data for the 2016-2017 season is partial (from September 1, 2016 to April 30, 2017).
\(^2\) Previous 5-season average is the number of outbreaks for the previous 5 seasons (2011-2012 to 2015-2016 combined).
Figure 36. Number of enteric outbreaks by month and year, Waterloo Region, 2011-2012 to 2016-2017* and previous 5-season average**

*Data for the 2016-2017 season is partial (from September 1, 2016 to April 30, 2017).
**Previous 5-season average is the number of outbreaks for the previous 5 seasons (2011-2012 to 2015-2016 combined).
Table 8. Proportion of enteric outbreaks by exposure setting, Waterloo Region, 2016-2017\(^1\) and previous five-season average\(^2\)

<table>
<thead>
<tr>
<th>Exposure Setting</th>
<th>2016-2017(^1)</th>
<th>Previous 5-season average(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Outbreaks</td>
<td>Per cent of Total</td>
</tr>
<tr>
<td>Child Care Facility</td>
<td>33</td>
<td>64.7</td>
</tr>
<tr>
<td>Retirement Home</td>
<td>4</td>
<td>7.8</td>
</tr>
<tr>
<td>Group Home</td>
<td>4</td>
<td>7.8</td>
</tr>
<tr>
<td>Long Term Care Home</td>
<td>3</td>
<td>5.9</td>
</tr>
<tr>
<td>Hospital</td>
<td>2</td>
<td>3.9</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>9.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

\(^1\) Data for the 2016-2017 season is partial (from September 1, 2016 to April 30, 2017).
\(^2\) Previous 5-season average is the number of outbreaks for the previous 5 seasons (2011-2012 to 2015-2016 combined).

- In the 2016-2017 season (September 1, 2016 to April 30, 2017) there were 51 enteric outbreaks in Waterloo Region; this is slightly lower compared to the previous 5-season average of 60.6.
- In the 2016-2017 season, enteric outbreaks demonstrated a peak during the winter months with most outbreaks occurring between November through February. This seasonal trend is fairly typical for enteric outbreaks and has been observed in previous years.
- In the 2016-2017 season (September 1, 2016 to April 30, 2017), most institutional enteric outbreaks occurred in child care facilities (64.7 per cent), followed by retirement homes (7.8 per cent) and group homes (7.8 per cent).
- When a responsible organism could be identified, the most frequently detected agent was Norovirus.
Respiratory Outbreaks

Local Picture

Table 9. Number of non-influenza outbreaks by year, Waterloo Region, 2011-2012 to 2016-2017\(^1\) and previous 5-season average\(^2\)

<table>
<thead>
<tr>
<th>Season</th>
<th>Number of Outbreaks</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2012</td>
<td>18</td>
</tr>
<tr>
<td>2012-2013</td>
<td>27</td>
</tr>
<tr>
<td>2013-2014</td>
<td>17</td>
</tr>
<tr>
<td>2014-2015</td>
<td>16</td>
</tr>
<tr>
<td>2015-2016</td>
<td>27</td>
</tr>
<tr>
<td>2016-2017(^1)</td>
<td>25</td>
</tr>
<tr>
<td>Previous 5-season Average(^2)</td>
<td>21.7</td>
</tr>
</tbody>
</table>


\(^1\) Data for the 2016-2017 season is partial (from September 1, 2016 to April 30, 2017).

\(^2\) Previous 5-season average is the number of outbreaks for the previous 5 seasons (2011-2012 to 2015-2016 combined).
Figure 37. Number of non-influenza outbreaks by month and year, Waterloo Region, 2011-2012 to 2016-2017* and previous 5-season average**

*2016-2017 data is partial from September 1, 2016 to April 30, 2017.
**Previous 5-season average is the number of outbreaks for the previous 5 seasons (2011-2012 to 2015-2016 combined).
Table 10. Proportion of non-influenza outbreaks by exposure setting, Waterloo Region, 2016-2017\(^1\) and previous five-season average\(^2\)

<table>
<thead>
<tr>
<th>Exposure Setting</th>
<th>2016-2017(^1)</th>
<th>Previous 5-Season Average(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Outbreaks</td>
<td>Per cent of Total</td>
</tr>
<tr>
<td>Long-Term Care Home</td>
<td>13</td>
<td>52.0</td>
</tr>
<tr>
<td>Retirement Home</td>
<td>9</td>
<td>36.0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>12.0</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0</td>
</tr>
</tbody>
</table>


\(^1\) 2016-2017 data is partial from September 1, 2016 to April 30, 2017.

\(^2\) Previous five-season average is the number of outbreaks for the previous five seasons (2011-2012 to 2015-2016 combined).

- In the 2016-2017 season (September 1, 2016 to April 30, 2017), there were 25 non-influenza respiratory outbreaks caused by other respiratory pathogens (e.g., rhinovirus, RSV, coronavirus, etc.). This is slightly higher than the previous 5-season average of 21.7 outbreaks, but still within what can be expected due to normal variation in a typical season.
- There was an early peak in the number of non-influenza respiratory outbreaks in October, followed by another peak in January for the 2016-2017 season; this is consistent with previous years’ trends.
- In the 2016-2017 season (September 1, 2016 to April 30, 2017), most non-influenza institutional respiratory outbreaks occurred in long-term care homes (52.0 per cent) and retirement homes (36.0 per cent).
Table 11. Number of influenza outbreaks by year, Waterloo Region, 2011-2012 to 2016-2017\(^1\) and previous 5-season average\(^2\)

<table>
<thead>
<tr>
<th>Season</th>
<th>Number of Outbreaks</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2012</td>
<td>5</td>
</tr>
<tr>
<td>2012-2013</td>
<td>34</td>
</tr>
<tr>
<td>2013-2014</td>
<td>6</td>
</tr>
<tr>
<td>2014-2015</td>
<td>37</td>
</tr>
<tr>
<td>2015-2016</td>
<td>8</td>
</tr>
<tr>
<td>2016-2017</td>
<td>24</td>
</tr>
<tr>
<td>Previous 5-season Average</td>
<td>19.0</td>
</tr>
</tbody>
</table>

\(^1\) 2016-2017 data is partial from September 1, 2016 to April 30, 2017.
\(^2\) Previous five-season average is the number of outbreaks for the previous five seasons (2011-2012 to 2015-2016 combined).

Figure 38. Number of influenza outbreaks by month and year, Waterloo Region, 2011-2012 to 2016-2017* and previous 5-season average**

* 2016-2017 data is partial from September 1, 2016 to April 30, 2017.
** Previous five-season average is the number of outbreaks for the previous five seasons (2011-2012 to 2015-2016 combined).
Table 12. Proportion of influenza outbreaks by exposure setting, Waterloo Region, 2016-2017\(^1\) and previous five-season average\(^2\)

<table>
<thead>
<tr>
<th>Exposure Setting</th>
<th>2016-2017(^1)</th>
<th>Previous 5-Season Average(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Outbreaks</td>
<td>Per cent of Total</td>
</tr>
<tr>
<td>Long-Term Care Home</td>
<td>13</td>
<td>54.2</td>
</tr>
<tr>
<td>Retirement Home</td>
<td>10</td>
<td>41.7</td>
</tr>
<tr>
<td>Hospital</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>4.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

\(^1\) 2016-2017 data is partial from September 1, 2016 to April 30, 2017.
\(^2\) Previous five-season average is the number of outbreaks for the previous five seasons (2011-2012 to 2015-2016 combined).

- There were 24 influenza outbreaks in the 2016-2017 season (September 1, 2016 to April 30, 2017). This is slightly higher than the previous 5-season average of 19 outbreaks but still within what is expected in a normal influenza season due to the variations from year to year.
- The influenza outbreaks peaked in February in the 2016-2017 season which demonstrates similar seasonality to previous seasons as well.
- In the 2016-2017 season (September 1, 2016 to April 30, 2017), more than half of all institutional influenza outbreaks occurred in long-term care homes (54.2 per cent), followed by retirement homes (41.7 per cent).
References


Appendix A: Glossary of Terms

**Accurate Episode Date:** Accurate Episode Date corresponds to the earliest date on record for the case according to iPHIS hierarchy: Symptom Date > Clinical Diagnosis Date > Specimen Collection Date > Lab Test Date > Reported Date.

**Active Transmission:** The spread of an infectious agent from one person to another.

**Age Standardization:** A method of adjusting rates to minimize the effects that different age compositions have on populations. This method is used when comparing two or more populations with potentially different age distributions. For example, an older population would be more likely to have higher rates of chronic diseases compared to a younger population. Standardizing controls for these differences. For the purposes of this report, the standard 1991 Canadian population was used as the standard.

**Agent of Disease:** A factor whether microorganism, chemical substance, radiation or nutrient whose presence or absence is essential for the onset of disease. A disease may require more than one agent to develop.

**Asymptomatic:** A person infected with an illness or disease who does not exhibit any symptoms.

**Average:** See “Mean”.

**Burden of Disease:** The amount of ill health from a specific cause, such as disease or injury, in a population. It can be measured by financial cost, mortality, morbidity, or lost healthy years.

**Case:** A case is an individual with an episode of a reportable disease. For each reportable disease there is a case definition which outlines the criteria to confirm that episode of disease. Case definitions are determined by the Ministry of Health and Long-Term Care.

**Carrier:** A person or animal without evident clinical disease (signs or symptoms) who harbours an infectious agent and is able to transmit the agent to others.

**Co-infection:** Having two infections at the same time. The progression of both (or either) disease(s) may be more severe as a result of the infection with the other disease. A person with a co-infection is counted as two separate cases.
**Confidence Interval:** A calculated range of values in which the actual value (such as mean, proportion or rate) is contained with a certain degree of confidence. For the purposes of this report 95 per cent confidence intervals were used, meaning that there is a 95 per cent probability that the actual value falls within this range.

**Contact:** A person who may have acquired an infection from a case.

**Endemic:** The constant presence of a disease or infectious agent within a geographic area or population group. It may also refer to a disease that is usually present at a relatively high prevalence and incidence rate in comparison with other areas or populations.

**Immunocompromised:** Incapable of developing a normal immune response, usually as a result of disease (e.g., cancer), irradiation, malnutrition, or immunosuppressive medication.

**Incidence:** The number of new events (such as new cases of a disease) among a population within a specific point in time.

**Incidence Rate:** The rate at which new events, or new cases, occur in a specified time in a defined population that is “at risk” of experiencing the condition or event.

**Incubation Period:** The time from the moment of exposure to an infectious agent until signs and symptoms of the disease appear.

**Indirect Transmission:** The transmission of an infectious agent carried from a reservoir to a susceptible host by air particles or by living (vector) or non-living (vehicle) intermediaries.

**Infectious Disease:** An illness that results from the transmission of an infectious agent or its toxins from an infected person, animal, or reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector or inanimate objects.

**Mean:** The mean or average is the sum of all the individual values in a set of measurements divided by the total number of values in the set of measurements.

**Non-endemic:** A disease or infectious agent that is rarely observed within a geographic area or population group. It may also refer to a disease that is not usually present at a relatively high prevalence and incidence rate in comparison with other areas or populations.
**Outbreak:** When the occurrence of cases of a disease or condition is in excess of the expected number of cases in a localized area over a given period of time. There is no set number of cases required to declare an outbreak as it varies by disease and local conditions.

**Prevalence:** The number of individuals with a disease or condition in a specific population at a designated time.

**Proportion:** A proportion is a type of ratio in which the numerator is included in the denominator. A proportion is calculated by dividing the number of people with a common characteristic at a given time period by the total population that shares the same event in the same time period.

**Range:** The range describes the spread of scores. It often represents the difference between the largest and smallest items in a set of numerical values. In this report, it is used to describe the highest and lowest numerical values.

**Relative Standard Error (RSE):** A relative standard error is the standard error divided by the mean and expressed as a percentage. Rates with an RSE >23% are considered unstable and should be interpreted with caution.

**Reportable Disease:** A human disease that is required to be reported to public health authorities in Ontario according to Regulation 559/91 (Specification of Reportable Diseases) made under the *Health Protection and Promotion Act (HPPA)* (available at https://www.ontario.ca/laws/regulation/910558). Under this legislation, physicians, laboratories, hospital administrators, principals of schools and superintendents of institutions must notify local health units about the occurrence or suspected occurrence of these diseases.

**Risk Factor:** An aspect of someone’s behaviour or lifestyle, a characteristic that a person was born with, or an event that s/he has been exposed to that is associated with acquiring a disease.

**Risk Setting:** The place or environment where the case may have acquired the infection. Risk settings reported by cases include: hospital, long-term care home, residential facility, retirement home, child care facility and community setting.

**Socio-demographic:** A variety of individual characteristics that may influence health status. Socio-demographic factors include age, sex, ethnicity, marital status, socioeconomic status and others.

**Sporadic:** When a disease occurs infrequently and irregularly. This term is also used to refer to non-outbreak associated cases of disease.
**Standardized Rate Ratio (SRR):** An SRR is the ratio of the age-standardized rate of cases observed in one population compared to the age-standardized rate of cases that occurred in another population. The 95 per cent confidence interval indicates the statistical significance of the SRR. If the 95 per cent confidence interval contains one, the two rates are not statistically different from one another.

**Surveillance:** The ongoing, systematic collection, collation, analysis, and interpretation of data with prompt dissemination of the results to those who need to know, particularly those who are in a position to take action.

**Trends:** Trends are changes in frequencies, proportions or rates of a disease, or an event observed over time. Trends may be irregular, flat, or move in one direction.

**Travel-associated:** In this report, travel-associated refers to cases of disease that were acquired during travel outside of Canada.

**Vector-borne disease:** A class of miscellaneous diseases which are transmitted to humans by vectors, predominately insects (e.g., mosquito-borne diseases caused by viruses, bacteria, etc.).

**Vector:** A living creature, typically an animal, which carries an infectious pathogen to a susceptible host. It is an intermediary without evident clinical disease who harbours an infectious agent and is able to transmit the agent to others.

**Zoonotic pathogen:** An agent of disease (e.g., bacteria or virus) that can be transmitted between animals and humans.
Appendix B: Data Sources and Methodology

Data Sources
All information related to cases of infectious disease for Waterloo Region included in this report was collected by Region of Waterloo Public Health and Emergency Services under the authority of the Health Protection and Promotion Act (HPPA), which mandates health care practitioners to notify the Medical Officer of Health (MOH) where the patient resides of all confirmed and probable cases of reportable disease. Case reports are investigated by Public Health staff as part of their routine activities.

Cases are entered into a provincially-mandated information and surveillance (monitoring) system, the integrated Public Health Information System (iPHIS), maintained by Public Health Ontario (PHO) and the Public Health Protection and Prevention Branch of the Ontario Ministry of Health and Long-term Care (MOHLTC). The only data included in this report that was not extracted from iPHIS was ambulatory care visits for varicella which was sourced from the National Ambulatory Care Reporting System (NACRS) and obtained through the IntelliHEALTH Ontario portal.

Sporadic Cases
All sporadic infectious disease data for Waterloo Region with accurate episode dates between January 1, 2006 and December 31, 2016 (September 1, 2011 to April 30, 2017 for influenza) were extracted from iPHIS on June 21, 2017 (except for HIV which was extracted by encounter date, tuberculosis which was extracted by diagnosis date, and varicella ambulatory care visits which were extracted from IntelliHEALTH Ontario). Accurate Episode Date corresponds to the earliest date on record for the case according to iPHIS hierarchy: Symptom Date > Clinical Diagnosis Date > Specimen Collection Date > Lab Test Date > Reported Date.

Unless otherwise noted, all cases reported in this report are confirmed as described by the Infectious Diseases Protocol of the Ontario Public Health Standards (2015). However, with revisions to case definitions of all reportable diseases in 2009, some cases that had previously met the confirmed case definition were then required to be reported as probable cases. For amebiasis, Lyme disease, mumps, pertussis, and West Nile virus, the impact of the change was substantial. Thus, for this report, both confirmed and probable cases of the above-mentioned diseases are included in the analysis to ensure valid comparisons of historical trends in incidence.

Syphilis case classifications for infectious and other categories were taken from the December 2009 Provincial Epidemiological Infectious Diseases Summary on the Ontario Public Health Portal. Primary, secondary and early latent syphilis are all
considered infectious (includes early latent; primary genital; primary other sites; secondary of skin and mucous membranes; secondary, other; infectious neurosyphilis; and primary anal). Other syphilis includes all other types of syphilis such as late latent; neurosyphilis, non-infectious; or unspecified (the other category excludes early congenital syphilis).

Provincial case summaries are compiled by Public Health Ontario. Provincial data was downloaded from the Public Health Ontario Infectious Diseases Query on June 21, 2017 and includes all infectious diseases reported in the province of Ontario with an accurate episode date between January 1, 2006 and December 31, 2016 (September 1, 2011 to April 30, 2017 for influenza).

Information on past episodes of disease can be added or updated to the provincial reporting system at any time. The information summarized in this report represents what was known to Region of Waterloo Public Health and Emergency Services and the MOHLTC at the date of data extraction recorded with the stipulation that these data are provisional and subject to change.

Outbreaks
Outbreak data is included in this report for enteric and respiratory diseases, both influenza and non-influenza respiratory outbreaks. For every confirmed outbreak, staff in Public Health complete detailed outbreak summary reports that document information pertaining to the outbreak, including the aetiologic agent, duration of the outbreak, reporting information, exposure setting, control measures and specimen information if available. An outbreak is defined as the occurrence of two or more cases of illness linked to each other in terms of time, exposure to source, and most often location. All data were reviewed by Public Health staff to ensure that final counts and outbreak information were accurate.

For this report, outbreak data for Waterloo Region was extracted from the iPHIS database. All outbreak records (outbreaks with a reportable enteric or respiratory disease identified as the aetiologic agent) that met the provincial surveillance case definition and had a reported date between September 1, 2011 and April 30, 2017 were extracted. All outbreak data was analyzed by seasonal year (September 1st of any given year to August 31st of the following year) and is partial up to April 30, 2017 for the 2016-2017 season.

Exposure and Risk Factor Data
Exposure and risk factor information were included for diseases which demonstrated consistently higher rates than the province, diseases that demonstrated increasing local
rates, as well as diseases that caused a significant burden of disease in 2016. When reporting exposure or risk factor proportions, those that were lost to follow-up and did not have exposure or risk factor information available were excluded from the denominator. In addition, more than one risk factor can be reported by a case resulting in proportions that do not sum to 100 per cent.

For every case of infectious disease reported to Region of Waterloo Public Health and Emergency Services, detailed case follow-up is conducted by Public Health staff. A pre-defined set of exposure or risk factor information is collected and input into iPHIS. However, exposure and risk factor information can be missing for individuals that were lost to follow-up.

It is also important to note that risk factors in iPHIS are self-reported and may not necessarily reflect the true exposure history of the individual. In addition, the risk factor and exposure setting variables in iPHIS provide investigators with a pre-defined set of categories of risk factors from which to choose which may not be adequate or specific enough to represent all potential risk factors and exposures for a disease.

**Population Data**

Incidence rates were calculated using population estimates obtained from Statistics Canada. Population estimates for 2006 to 2016 are post-censal estimates based on the 2011 census counts adjusted for net under-coverage and changes in the population between Census Day and July 1. Census subdivision post-censal estimates are extrapolated by applying the growth rates by age and sex of each census division to the adjust census counts of each census subdivision. Population data for 2006-2015 used in this report was downloaded from the Community Data Program, Statistics Canada’s Estimates of population by age and sex, 2001-2015 (CANSIM Table 109-5355) on April 26, 2016 and reflect the latest population estimates at the time of this report. Population estimates for 2016 were extracted from Statistics Canada 2016 Census data and were extracted on June 3, 2017.

**Methodology**

All diseases were extracted from iPHIS by accurate episode date (except for HIV which was extracted from iPHIS by encounter date, tuberculosis which was extracted from iPHIS by diagnosis date, and varicella ambulatory care visits which were extracted from IntelliHEALTH Ontario). All reportable diseases with one or more cases reported in the last ten years in Waterloo Region were included in the analysis. Cases that resided in Waterloo Region and met the provincial surveillance case definition were included. All data were reviewed by Public Health staff to ensure final case counts were accurate.
Varicella ambulatory care visits were extracted for Waterloo Region and Ontario for 2006-2016 from IntelliHEALTH’s Ambulatory All Visit All Tables which is sourced from the National Ambulatory Care Reporting System (NACRS). Ambulatory care visits include emergency visits as well as other hospital-based outpatient clinics. Visits were filtered to include only unscheduled emergency visits (Ambulatory Case Type = EMG). Ambulatory care visits were used instead of iPHIS reportable disease counts because iPHIS reports varicella as aggregated case counts rather than individual cases. Additionally, monitoring ambulatory care visits rather than reported cases helps to determine which varicella cases are more severe in nature. It must be noted that ambulatory care visit rates are not comparable to the incidence rates reported for other reportable diseases and that varicella counts presented in this report are an underestimate of the true number of cases.

For each reportable infectious disease, data on the number of cases and incidence rates were presented. Where relevant, disease case counts and rates were further broken down by:

- Sex (male and female – analysis by gender does not include those with unknown, transgender or other genders)
- Age group (0-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64 and 65+ years)
- Seasonality (month)

Note that latent tuberculosis infection (LTBI) was the only exception to this standard method of analysis; LTBI cases were only reported for 2013 to 2016, due to an inability to confirm case counts through normal data quality assurance processes for cases from 2006 to 2012. LTBI case counts and rates were still broken down by sex, age group and seasonality as relevant.

As age can be a factor in whether a person acquires a disease and how the disease progresses, it is necessary to control for differences in age distribution when comparing two populations. Age-standardization is a technique that minimizes the effect of differences in age between populations so that findings can be attributed to factors other than age. For this report, when comparisons between Waterloo Region and Ontario were made, rates were directly age-standardized using the July 1, 2011 Canadian Standard population from Statistics Canada. Note that this is a change from previous years that the Waterloo Region Infectious Disease Report was produced. For previous reports, the 1991 Canadian Standard Population was used for age-standardization which will result in different age-standardized rates between the current and previous reports even if the annual count remains unchanged. For each disease,
age-standardized incidence rates were presented for Waterloo Region and Ontario on an annual basis and refer to the number of new cases of disease per 100,000 population. The age groups (in years) used for direct age-standardization were: 0-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, and 90+. Cases that had missing age were not included in the calculation of the age-standardized rates.

Standardized Rate Ratios (SRR) with 95 per cent confidence intervals were also calculated for all reportable diseases, where possible. The SRR reported is the ratio of the age-standardized rate of cases observed in Waterloo Region compared to the age-standardized rate of cases that occurred in Ontario. The 95 per cent confidence interval indicates the statistical significance of the SRR. If the 95 per cent confidence interval contains the value ‘one’ in its range, the two rates are not statistically different from one another.

A relative standard error (RSE) was also calculated for each rate. The RSE is simply the standard error divided by the mean number of cases and expressed as a percentage. Rates with an RSE >23 per cent are considered unstable and should be interpreted with caution.

Annual average rates for 2011 to 2015 were also calculated which were defined as the average of the age-standardized rates for each year from 2011 to 2015. Age-standardized rates for 2016 were compared to the previous five-year annual average rate for 2011 to 2015 (or the previous 5-season average for the 2011-2012 to 2015-2016 seasons for outbreaks) but these differences are not implied to be statistically different.

Proportions and rates were rounded to one decimal place. As much as possible, data were presented in a consistent format with a figure highlighting the age-standardized overall rates for Waterloo Region and Ontario. Select diseases were highlighted with further in-depth analysis (e.g., mortality, risk factors). These diseases were selected for a variety of reasons including: local rates were significantly different than provincial rates, there are emerging issues related to the disease such as a provincial or local campaign, or because Region of Waterloo Public Health and Emergency Services has undertaken specific measures related to the prevention or containment of the disease.

**Data Limitations**
The published literature reveals variation in infectious disease reporting completeness. According to a review of the literature by Doyle (2002), reporting completeness was significantly greater for TB, AIDS and sexually transmitted diseases as a group than for all other reportable diseases combined. Other studies estimate that for each reported
case of enteric illness, there are at least several hundred undiagnosed or unreported cases in the community (Majowicz, 2005). Individuals that experience less severe manifestations of a disease may not experience symptoms, or only mild symptoms and may not seek medical assistance or be tested for the presence of a disease. Disease reports rely on a passive surveillance system, wherein laboratories, physicians, other health care providers and institution administrators are entrusted to know the regulations, recognize a disease that is on the reportable disease list, and inform public health.

In some instances, the number of reported cases may change in subsequent years due to periodic data quality assurance checks and corrections that result in the reclassification of cases (i.e., case status). In addition, there may be a lag in reporting of some cases due to the time required to collect a specimen, carry out a diagnostic test and inform the local public health department and Ontario MOHLTC which could lead to future changes in the number of reported cases. Chance, as well as statistical artifacts, may also account for some of the variation in infectious disease incidence over time and for different geographic areas (within Ontario).

While the provincial case summaries allowed for local data comparisons with Ontario rates, comparisons with other health units can be problematic due to inconsistencies in data collection and reporting across health units. Also, some cases may be double-counted among people who move to other health units. This double-counting is not an issue with the provincial data due to regular efforts to resolve inter-health unit duplicate records.

It is important to note that the number of outbreaks does not necessarily reflect the magnitude of individual outbreak investigations or burden of outbreak-related illness. Institutional outbreaks are likely well reported compared with other outbreaks because institutions often have infection control staff on-site, there are usually a large number of persons affected, and the agent, most often a virus transmitted person-to-person, is relatively easy to diagnose. However, prior to 2012, only long-term care homes were required to report outbreaks to Public Health; retirement homes were not required to report outbreaks which thereby affected the comparison between 2012 and previous years. Similarly, community outbreaks are not required to be reported to Public Health. At times Public Health will become aware of them due to (voluntary) reports if a number of people become ill (e.g., group of people who ate a common meal or attended a common event). Therefore, the data presented in this report would reflect an underestimation of the true burden of community outbreaks.

For some diseases, case definitions have changed over time. As of April 28, 2009, new provincial case definitions for reportable diseases came into effect. The Ontario
MOHLTC released the new case definitions as an appendix to the Infectious Diseases Protocol, 2009 (Ontario Ministry of Health and Long-Term Care, 2009). Ontario's new case definitions were updated to reflect the changing epidemiology of infectious diseases and the use of newer laboratory technologies. These updates impacted the classification of cases for several diseases, and may influence the incidence of some diseases during the year 2009. Both confirmed and probable cases of amebiasis, Lyme disease, mumps, pertussis, and West Nile virus were included to adjust for these changes. However, for other diseases, an observed increase or decrease in disease incidence during this period may not reflect a true change in incidence.

Due to the unavailability of case level data for varicella in iPHIS, ambulatory care visits from IntelliHEALTH were used instead. However, incidence and ambulatory care visits cannot be compared directly since ambulatory care visits represent the more severe varicella cases, thus underestimating the true number of varicella cases occurring locally and provincially.

Finally, the data presented in this report only relate to data collected on cases residing in Waterloo Region. Therefore, caution should be used when attempting to generalize these results beyond Waterloo Region.
Appendix C: List of Reportable Diseases (2016)

The following specified Reportable Diseases (Ontario Regulations 559/91 and amendments under the Health Protection and Promotion Act) are to be reported to the local Medical Officer of Health:

Reportable Diseases 2016

The following specified Reportable Diseases (Ontario Regulations 559/91 and amendments under the Health Protection and Promotion Act) are to be reported to the local Medical Officer of Health:

Infectious Disease & Tuberculosis Control

- Acute Flaccid Paralysis
- Rabies
- Chickenpox (Varicella)
- Diphtheria
- Encephalitis*, including:
  1. primary, viral
  2. post-infectious
  3. vaccine-related
- V. parahaemolyticus gastroenteritis
- Tuberculosis
- Group A Streptococcal Disease, invasive
- Group B Streptococcal Disease, neonatal
- Group A Streptococcal Disease, invasive
- Hemorrhagic Fever*, including:
  1. Ebola virus disease
  2. Marburg virus disease
  3. Other viral causes
- Hepatitis A
- Influenza
- Leptospirosis
- Lyme Disease
- Malaria
- Measles*
- Meningitis, acute*
  1. bacterial

Health Protection and Investigation

- Amebiasis
- Anthrax*
- Botulism
- Brucellosis
- Campylobacter Enteritis
- Cholera
- Cryptosporidiosis
- Cystic Fibrosis
- Firefighters’ Disease
- Food Poisoning, all causes
- Gastroenteritis, institutional outbreaks
- Giardiasis, except asymptomatic cases
- Hantavirus Pulmonary Syndrome
- Lassa Fever
- Legionella
- Lyme Disease
- Paralytic Shellfish Poisoning*
- Paratyphoid Fever
- Plague*
- Psittacosis / Ornithosis
- Q Fever
- Rabies*
- Salmonellosis
- Shigellosis
- Trichinosis
- Tularaemia
- Typhoid Fever
- Yersiniosis – producing E. coli infection
  indicator conditions include Hemolytic Uremic Syndrome (HUS)*
  - Yersiniosis

Sexual Health and Harm Reduction

- Acquired Immunodeficiency Syndrome (AIDS)
- Chlamydia Trachomatis Infection
- Gonorrhea
- Hepatitis B
- Hepatitis C
- Syphilis

Note: diseases marked* (and respiratory infection and gastroenteritis outbreaks in institutions) should be immediately reported to the Medical Officer of Health. Other diseases are to be reported by the next business day.

Reporting Contact Numbers:
Infectious Diseases and Tuberculosis Control Program
1-877-730-4000 ext. 5276
Health Protection and Investigation
519-877-4400 ext. 5147
Sexual Health and Harm Reduction
519-877-2267
Fax: 519-893-224B
Emergency after hours/weekends/holidays call: 519-877-4400