What We Heard

Report on Public Health Professionals and the COVID-19 Pandemic Response

OPHA
Ontario Public Health Association
l'Association pour la santé publique de l'Ontario
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Table of Contents

EXECUTIVE SUMMARY

WHAT WE HEARD

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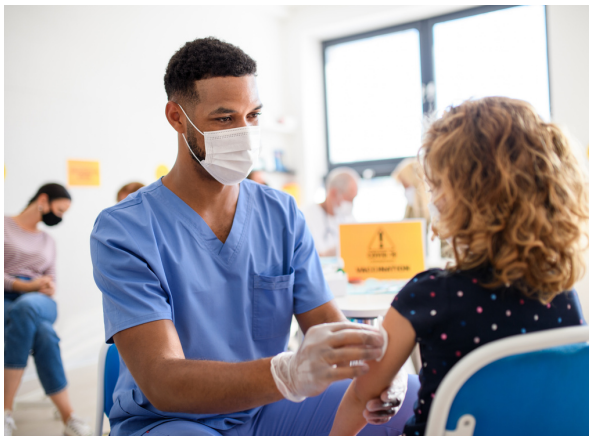


The years 2020-2021 will be remembered for many things COVID-19 related, not the least of which is the critical role of the public health sector. While the COVID-19 pandemic is not over, there is much to learn from those at the frontlines and behind the scenes of the public health response as we begin to rebuild public health in Ontario.

The Ontario Public Health Association (OPHA) invited its members, workgroups and constituent societies, working on the frontlines and behind the scenes of the public health pandemic response, to share their experiences responding to the COVID-19 pandemic.

We gathered input through small group discussions and an online survey. Participants were asked to share their perspectives on aspects of the pandemic response they felt worked well and would be important to build on, as well as vulnerabilities and recommendations that should be considered as the public health sector prepares to resume non-pandemic related activities.

The aim of this paper was to capture the perspectives of public and community health professionals across the province in responding to the COVID-19 pandemic. Their contributions to the pandemic response offer important insights for enhancing preparedness and for building a strong and resilient public health system and healthier communities in Ontario.

EXECUTIVE SUMMARY CONTINUED

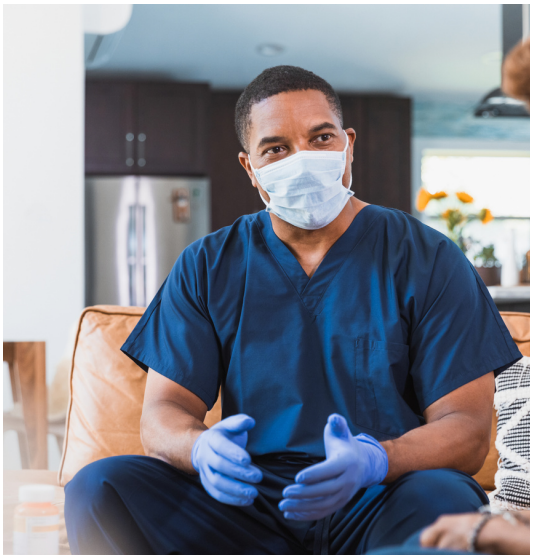
This report documents input from over 400 individuals who attended one of 16 virtual discussion sessions from October 18, 2021, to January 13, 2022 and from 128 individuals who responded to a short survey between December 27, 2021 and January 14, 2022. An advance draft of the report was provided to OPHA membership which garnered additional feedback from two groups and 12 individuals.

When asked which aspects of the pandemic response worked well and would be important to build on, seven key themes emerged, including: a skilled and responsive workforce, relationships with partners and stakeholders, technology and data analytics, leadership and governance, communication, local context, health equity and upstream approaches.

Most concerning were the negative impacts on the health of individuals and communities, especially the most vulnerable and marginalized, due to programs and services mandated by the Ontario Public Health Standards (OPHS)(1) that were paused or critically reduced.

Respondents identified several priority areas of action for creating a strong and resilient public health system and healthier communities in Ontario including: investment in human resources, technology and data analytics, enhanced collaboration and partnerships, commitment to health equity and upstream approaches, consistent funding, and strong leadership.

RECOMMENDATIONS



After hearing from our members, constituent societies, workgroups and others, OPHA urges the government of Ontario to consider building on and endorsing Canada's Chief Public Health Officer's four priority actions for public health renewal as well as two areas for strengthening community health in Ontario.

Specifically, OPHA calls on the Ontario Government to undertake the following priority actions for public health recovery and renewal and to strengthen community health in Ontario.

01 Foster excellence in the public health workforce through:

- A provincial human resources strategy that includes funding to support more regular opportunities for training, especially leadership training and supports the resiliency and recovery of the public health workforce
- The creation of new provincial and regional mechanisms to facilitate sharing of best practices, promote joint planning and communication among health units, with the province, other parts of the health system and other sectors impacting the determinants of health

02 Improve public health tools through:

- Updating technology and funding more and better sources for population health data, especially disaggregated data to better understand those communities that are often underserved and face significant barriers to optimal health
- Integration and linkage of provincial data systems
- Increased resourcing for epidemiology

03 Strengthen the mandate and public health's leadership role by:

- Ensuring public health expertise on boards of health and public health's independence
- Safeguarding autonomy for local/regional public health agencies to meet the needs of their communities
- Providing greater clarity on public health's role in relation to other parts of Ontario's health system
- Appealing to other sectors to adopt a health in all policies approach that creates shared goals and targets and identifies each agency's role and responsibilities for achieving them

04 Ensure stable and consistent funding by:

- Increasing the provincial percentage of funding in the public health cost sharing formula with municipalities
- Increasing investment in Ontario's 34 public health agencies beyond the less than 2% of the annual health care budget
- Increasing funding to Ontario public health units to strengthen their capacity to support local public health in the delivery of the Ontario Public Health Standards, even in the face of current and future pandemics

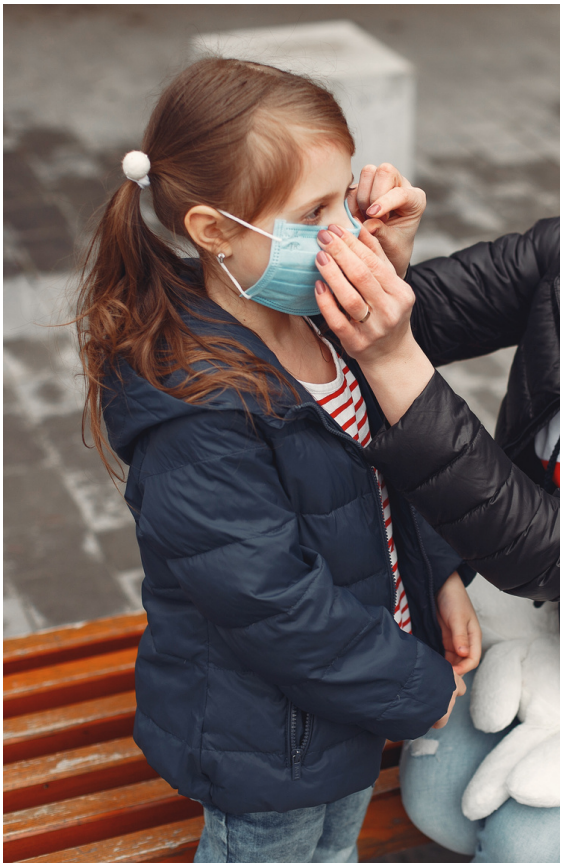
05 Prioritize upstream approaches and health equity by investing in health promotion and prevention strategies:

- In response to provincial and local needs (e.g. chronic disease prevention, substance misuse, maternal and child health, health and climate change, mental health promotion); especially for those communities that are often underserved and face barriers due to poverty, racism, oppression, discrimination and colonization

06 Accelerate a return to public health's mandated programs:

- Such as inspections, immunizations, health promotion and population health assessment

BACKGROUND



Local public health agencies have had a prominent role in the pandemic response, from case and contact management, outbreak management, enforcement of public health measures, surveillance, conveying credible advice to the public to leading the vaccination campaign. These efforts were possible due to the redeployment of staff from the many diverse program and service areas within each of Ontario's 34 public health agencies. This collective action saved lives, and reduced the spread of infection and hospitalizations.

However, the mandate of public health in Ontario is more than infection control and emergency response. According to the OPHS, public health must work through multiple channels and on multiple issues to have an impact on the health of the population. The work is diverse, including population health assessment, individual clinical service delivery, education, inspection, surveillance, and policy development, among other activities.

The COVID-19 pandemic has led to unprecedented challenges to public health, with far-reaching impacts on the public health workforce, individuals and communities (2). The aim of this paper was to hear from public health professionals across the province about these impacts and to hear their recommendations for building a strong and resilient public health system and healthier communities in Ontario.

WHAT WE HEARD

Three pre-determined questions were posed to virtual discussion session participants who were invited to contribute verbally and/or use a chat feature, and to respond to three poll questions. Questions one and three were the same for all groups, while question two varied slightly for each of the topic specific workgroups. The following is a summary of the responses to each of these questions.

01 What do you think worked well in terms of the public health response to the COVID-19 pandemic?

In response to this question, the following main themes emerged: skilled and responsive workforce, relationships with partners and stakeholders, local context, communication, technology and data analytics, leadership and governance, innovation and creativity, health equity and upstream approaches. A common thread throughout these themes was the “breaking down of silos” within and between public health units, partners and stakeholders, that enabled an effective, unified response.

Skilled and responsive workforce

At the start of the pandemic, certain public health professionals such as nurses, inspectors, dietitians/nutritionists, and communication specialists (and others) were assigned pandemic-related tasks. As the pandemic went on, the capacity of these groups could not meet the demand, necessitating the recruitment of additional public health personnel to the pandemic response. Instead of having a limited role, staff came together to tackle the response as a collective, regardless of their usual roles.

When redeployed to the COVID-19 response, public health's highly skilled workforce adapted quickly to new roles and technologies. Key public health skills and roles highlighted in the response include epidemiology, emergency preparedness, infection prevention and control (IPAC), case management, contact tracing, health communications, community engagement, and a focus on health equity implications of the pandemic. Critical core services continued to be offered during the pandemic.

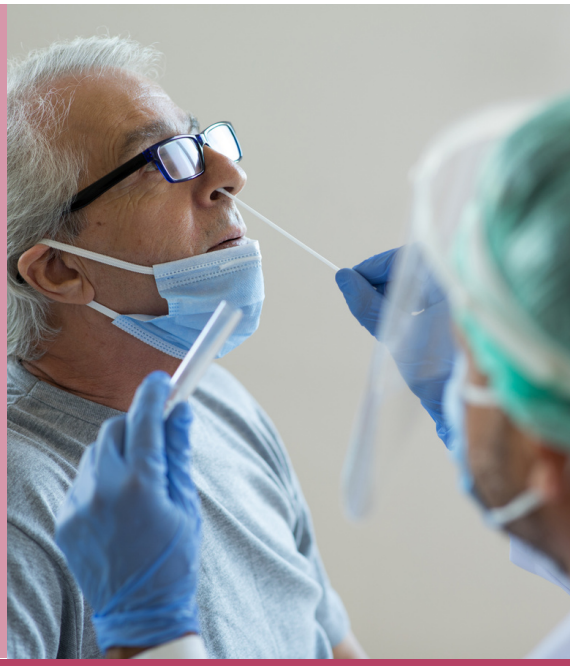
Staff adapted quickly and effectively to expanding interdisciplinary teams and practices along with a considerable shift in usual activities, including redeployment to clinical tasks. They successfully transitioned to working remotely from home and demonstrated flexibility with the changing pandemic landscape, while multi-tasking and problem solving on a regular basis.

Strong skills and a willingness to take on new roles proved to be instrumental in the pandemic response.

The multidisciplinary approach to the COVID-19 response has helped to strengthen relationships among different groups of public health professionals. It facilitated learning between groups and individuals, which allowed for better service delivery. Staff felt unified which helped ensure a "big picture" approach to the response.

"When there weren't enough nurses to do testing, particularly on vulnerable populations, others stepped up, showing bravery and courage – during a time with little knowledge and information."

Ontario Association of Public Health Dentistry member



Relationships with partners and stakeholders

Relationships with partners and stakeholders were essential to an effective COVID-19 pandemic response. While those relationships existed in the past, the pandemic heightened the need for collective action that was swift and effective.

Throughout the pandemic there was a strong urgency to work together. New collaborations were established between paramedics, primary care, public health, and hospitals. The pandemic highlighted the value in partnerships between hospitals and public health units in case investigation and contact tracing, epidemiology, and health communications.

Having invested in building strong relationships with community partners at the local level (e.g. social service, education, business, Indigenous service providers) as part of health promotion efforts pre-pandemic, proved beneficial in the pandemic response in providing isolation supports, vaccination, access to masks, surveillance data, health communications and equity supports. Public health staff were able to capitalize on those relationships as well as build new ones throughout the pandemic to reach underserved and vulnerable communities.

Bringing health units together, from the office of the Medical Officer of Health to manager levels proved beneficial as did inter-health unit collaboration (within departments). Health units shared resources with other health units. The pre-existing relationships with neighbouring health units facilitated getting those resources out quickly.

Strengthened connections were seen with various partners and agencies in the agri-food sector and enforcement partners. Relationships with schools and school boards were enhanced due to the provision of COVID-19 related services to schools.

Connections with long-term care homes, hospitals, group homes, childcare centres and recreational facilities enabled the sharing of essential information and robust communications.

Extremely strong connections were built with the Ministry of Labour, Training and Skills Development (MLTSD), which enabled public health to work collaboratively with them to complete outbreak inspections in occupational and congregate settings in a timely manner.

Relationships were built with different agencies and stakeholders at both the local and provincial level including:

- Ministry of Long-Term Care (MLTC)
- Retirement Homes Regulatory Authority (RHRA)
- Ministry of Children, Community and Social Services (MCCSS)
- Home and Community Care Support Services (HCCSS)
- Hospitals and congregate settings

Local boards of health tried coordinated enforcement activities through a multi-agency enforcement group. In some areas, weekly calls were coordinated with local police, bylaw, corporate security, as well as university campus police.

The pandemic raised the public's awareness and confidence in public health messaging that can be built upon.

Local context

The local context was identified as being extremely critical in the pandemic response, from working with local advocacy groups to planning and informing interventions for priority populations in the community. Having a solid understanding of local communities allowed the development of effective, targeted approaches, including reaching populations that had lower vaccination coverage.

Local knowledge and understanding of health systems planning informed the deployment of mobile clinics where they were most needed.

Public health was the point of contact for many members of their communities who were having difficulty getting their specific questions answered through regional, provincial or federal channels.

["The thought is that the province is looking to move health promotion activities up. It's probably the most vulnerable part of local public health. Whatever we do or whenever we go, I strongly recommend that we keep it local."]

OPHA Health Equity Workgroup member

Communication

Elements of internal and external communication worked well at different points throughout the pandemic. Due to their ability to understand regulations and how they apply, combined with risk assessment knowledge, experience communicating with the general public and local businesses, as well as conflict resolution skills, health units were well positioned to keep partners and communities apprised of the current and changing situation. Participants noted that health units and community agencies did well communicating the importance of wearing masks to mitigate the risk in the community.

Regular meetings with provincial partners who were all involved and heavily invested (Ontario School Health Managers Network, Ministry of Health, Ministry of Education, Public Health Ontario) were helpful in keeping public health units informed. Teleconferences held by the Ministry of Health provided an opportunity for more open dialogue between the ministry and public health.

Technology and data analytics

The amount of data collection and reporting required throughout the pandemic is far beyond anything ever experienced before by public health. Access to timely, local data was invaluable for public health decision making.

There were notable advancements in data management technology that helped support these data-related needs including:

- The launch of CCM (contact and tracing management system) and other technologies (COVAX) increased efficiencies and shortened response timelines.
- Health units quickly adapted to new technology - Zoom, Microsoft Teams, working remotely.
- The province introduced new technology (CCM, COVAX) at a pace that has have never seen before.
- Rapid quality improvement was employed more than ever (surveys and pre-registration data used to improve practice)

Leadership and governance

Aspects of leadership and governance worked well during the pandemic at both the local level and the provincial level.

Local level

- Boards of health created a “runway for management and staff” to deal with situations.
- Internal policies and approaches (e.g. work from home), were implemented quickly.
- Decisions were made using a comprehensive approach (e.g. considering the unintended consequences of closing beaches for those who have limited access to outdoor spaces).
- Partnerships were leveraged on a variety of fronts (e.g. immunization, enforcement, implementation of public health measures, accessing personal protective equipment).
- Others were drawn in to assist where possible (e.g. paramedics, pharmacists).

Provincial level

- Vaccine rollout guidelines kept health units across the province “on the same page”.
- Similar and consistent information went out around the province.
- Some of the resource development was centralized, reducing duplication.
- The provincial workforce (PWF) for CCM was beneficial to free up local public health staff.

"Participation of Ontario Health Tables have allowed us to get a better sense of how public health may fit with the larger system transformation and where there will be overlap/ability to share data going forward to look at population health from different aspects, and help integrate some PH initiatives in the past that have relied on community providers that helped us implement and see changes."

Ontario Association of Public Health Nursing Leaders member

Innovation and creativity

Participants shared examples of innovation and creativity that took place throughout the pandemic response, including leveraging the skills of non-public health staff and systematic use of geographic information systems (GIS) technologies, data analysis and information technologies (IT).

There were efforts and creativity that went into outreach in the community for vaccination, testing and public health measures including using buses and going to shelters or faith communities. A targeted outreach approach was needed, as mass vaccination sites did not reach the most vulnerable populations. There was agreement about the need to be creative to increase access for vulnerable populations which should continue in the future.

Health equity and upstream approaches

The application of equity-based approaches that respect diversity and inclusiveness was recognized as a positive element in the pandemic response in many health units. This included early recognition of racialized communities, deliberate and targeted outreach and advocacy for provincial collection of race-based data.

Attention to the social determinants of health (SDOH), and upstream issues and solutions have increased in many cases. Recognizing the critical role played by the SDOH, public health has been using disaggregated data in meaningful ways, including going on site to do case investigation rather than over phone.

Health promotion brought certain issues to the forefront during the pandemic, such as mental health, social isolation, the need for people to get outside, food insecurity, alcohol use, eating disorders and the opioid crisis. It raised awareness of the need to think about the broader health impacts of the virus and of public health measures.

QUESTION 1 POLL RESULTS

Participants were asked to identify what worked well in terms of the public health response to the pandemic from a list of seven options. Increased collaboration across sectors was selected most, followed by the ability to work remotely, ability of the workforce to adjust to changing demands and sharing of effective practices and lessons learned. Poll results can be found in Appendix A.

02 What problems or gaps did you see emerge from the COVID-19 pandemic response?

Problems related to the pandemic response were identified in the areas of communication, coordination, technology and data analytics, relationships and human resources. There were notable negative impacts of pausing or reducing usual public health programs and services, as public health staff were redeployed to the COVID-19 pandemic response.

Communication

COVID-19 information and guidance were evolving at a fast pace. Health units had to respond to new information that was constantly changing. Sometimes there were multiple new messages in a day. Provincial COVID-19 announcements were often made on Friday afternoons which meant that staff worked into the weekend in order to update communications internally and to partners, stakeholders and community members who were waiting for the information.

It was difficult at times to keep up with the phone calls from community members and businesses, especially after the province's updates. An added challenge was that staff needed time to understand new rules before drafting the updated communications. Internal communications continued around the clock; especially once vaccination clinics opened.

In some instances, the timing of communications from the province resulted in a duplication of efforts. A key example was the vaccine booking system. Health units developed their own systems while waiting for the provincial one. Also, time and effort were invested in developing communication tools and resources with general messaging when a universal (centralized) approach would have sufficed. For example, videos, social media posts and other communications with province-wide public health messages, such as how to properly wear a face covering, could have been developed at the provincial level and shared/re-posted by local public health units. This would have freed staff time for pandemic related activities requiring local or regional approaches, such as strategies for reaching under-served communities, as well as non-pandemic activities that had been reduced or put on hold.

Coordination

There was a desire to help support the public health response from a variety of organizations not typically involved public health, but it meant that roles and responsibilities could be unclear. At times, this led to duplication of efforts and sometimes mixed messages going to the public. While there was an urgency to collaborate with community partners, it was a rush to get agreements in place to work together.

Regulations, laws and bylaws were being interpreted differently in various health unit areas. There were also frequent changes which meant additional time spent re-interpreting the regulations. A lot of time was spent connecting with other health units to determine best practices.

Obtaining consistency across the province with respect to enforcement was and continues to be a challenge for public health. Interpretation in one jurisdiction would often not apply to a neighbouring one. At times, the expectation was that local public health would be expected to enforce the Reopening Ontario Act (ROA) and associated legislation as police did not always take the lead. This was challenging due to limited capacity.

Many respondents felt that Ontario's emergency response model is narrowly focused on command and control and not well suited for public health emergencies. Being designed for emergency response, the model was seen as working well for rapid, technical decision making, but resulted in pushing the secondary impacts of the pandemic, such as health promotion and well-being issues to the margins.

There was some confusion in the delivery of testing, monitoring, and response to congregate settings and migrant farm workers and logistics for handling samples, when COVID-19 was not identified. At times, trying to identify the pathogen and dealing with the outbreak were hindered.

"Additional consultation (by decision-makers during the pandemic) with local epidemiologists would have helped to ensure that the foundational standards of public health (as per the OPHS) would have been accounted for and thus secondary harms (e.g. disproportionate harms to those in certain socio-demographic groups) could have been mitigated to some degree."

Respondent

Technology and data analytics

Data can be the driver for good decision-making, yet data and epidemiology have often been overlooked or under-recognized during the pandemic. The demand for accountability by the public pushed public health units to share large volumes of data and to develop many new tools and systems (e.g. dashboards). Yet, the infrastructure to support and maintain such tools and systems and ensure data integrity remains limited.

The desire for comprehensive and rapid reporting on the pandemic's trajectory and public health response highlighted the importance of data stewardship and data sharing, yet these remain ongoing challenges with many unlinked provincial data systems. These challenges highlight concerns of insufficient capacity, duplication of effort, misalignment between public health and other sectors, and inconsistent priority setting in reporting. For example, transferring to new public health applications (e.g. CCM, COVAX) in the middle of the pandemic created additional workload on an already strained public health system, burdened the small analytical workforce, and required re-training of staff across the province to maintain continuous reporting.

Similarly, utilizing a multitude of datasets made coordination of reporting difficult and highlighted the degree to which data systems remain fragmented across the province. If these challenges remain, efficiencies and a fully integrated public health approach will remain out of reach.

The collection of SDOH data throughout the pandemic, and especially in COVAX gives few insights into differential impacts in communities. For example, there was limited access to and sometimes low quality of Indigenous population data.

Relationships

While relationships with businesses and the public were generally positive, participants felt that some relationships suffered and will need to be rebuilt. At times operators expressed frustration over the changing regulations as well as differences in regulatory requirements across the province. In establishments where there were strong relationships with public health, frequent staff turnover meant forging new relationships.

Relationships with the public posed challenges as they looked to public health for information and advice that was constantly changing and difficult to keep up with. For those who displayed hesitancy and reluctance regarding COVID-19 transmission, public health measures and vaccination, extra time and effort was required for education and reassurance.

Human resources

Public health staff were at the forefront of the pandemic response. They worked long hours, in unpredictable situations and were impacted by concerns of infection for themselves and their loved ones. The demands of the pandemic response have had a significant impact on public health personnel. Health units were not sufficiently resourced to respond through each of the stages and waves of the pandemic and hiring of additional staff posed several challenges. The capacity to recruit, hire and train new staff was limited and there were negative impacts on current staff, limiting their capacity.

While staff generally adapted well to working remotely, there were some challenges with technology, family members working and learning from home and a sense of isolation from colleagues. In some cases, there was a perception that staff were being compensated differently for the same work, which created a sense of inequality.

Numbers of experienced public health professionals diminished as people took extended leaves to support their well-being, care for loved ones or choose alternate employment. As many staff had never worked in communicable disease control, this sometimes resulted in confusion around the roles and functions of the various teams.

There were challenges to work-life balance as staff would respond to emails and phone calls on their days off. While proactive mental health supports for staff existed prior to the pandemic, their level of availability varied throughout the pandemic. As the pandemic continued, with no clear end in sight, the mental health and well-being of many employees worsened to the point of some describing their situation as being “burned out”.

"While staff felt unified initially, resiliency through the last two waves have started to visibly wear on cohesion among staff at health units."

Respondent

Regular programming halted or reduced

While public health has been receiving a lot of attention throughout the pandemic, it has been predominantly about COVID-19 and not the valuable public health programs and services that help keep individuals and communities healthy and well on an ongoing basis.

Prior to the pandemic, substance misuse and mental health promotion were a high priority. Sadly, the combination of stressors related to the pandemic and fewer supports available has led to a worsening of these and other issues affecting quality of life of individuals and communities.

Many respondents raised the issue of a "shadow pandemic" that has emerged related to the absence of programs and services focused on prevention and health promotion. For example, in the case of opioid-related deaths, they surpass deaths attributable to COVID-19 in some jurisdictions.

Other non-COVID-19 related impacts include:

Increases in:

- Racism
- Mental health conditions
- Food insecurity
- Syphilis and chlamydia infections
- Alcohol consumption and alcohol related harms
- Opioid overdoses
- Eating disorders (and disordered eating)
- Intakes of low nutritional value foods and beverages
- Oral infections
- Screen time
- Wait times for almost all programs and services

Decreases in:

- Physical activity
- Dental screening for children
- Vision screening for children
- Routine school immunizations (Hepatitis B/HPV)
- Dental services for low-income older adults
- Food safety inspections
- Home visits of new parents
- Food literacy initiatives

Concern was expressed that these issues have not garnered enough attention and that there will not be adequate resources in the coming months and year to address them; even as evidence emerges linking healthier lifestyles to improved outcomes from COVID-19 infections. More than that, some fear there may be reluctance from public health leaders to resume many of these upstream, prevention-focused activities due to lack of resources.

"What I would like to be resumed is our health promotion work, particularly the community engagement piece. We have had to engage with our partners related to COVID but a lot of our partners we had related to chronic disease prevention, climate change, etc., hasn't happened. A lot of partners have also had to refocus."

OPHA Built Environment Workgroup member

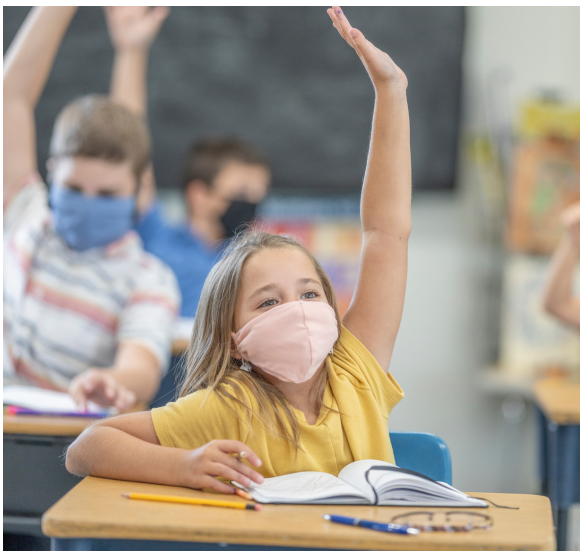
QUESTION 2 POLL RESULTS

Participants were asked to identify the top three OPHS requirements for programs, services, and accountability they think should be prioritized in the post-pandemic period. Substance use, injury prevention, chronic disease prevention and well-being were selected most often. Additionally, population health assessment and surveillance and health equity were identified as a vital component of all the program standards. Further, a focus on local context was identified as critical.

"Public health units have been really important in speaking to the important role of prevention of health impacts and think that prevention work has been hurt during COVID. But highlighting the important role of prevention and not only treatment and the important role of investing more in prevention needs to be ramped up and invested in again."

OPHA Environmental Health Workgroup member

03 What is needed for a strong and resilient public health system and healthier communities in Ontario?



The following main themes emerged in response to this question: investment in human resources, structures and new approaches, collaboration and partnerships, health equity and upstream approaches, technology and data analytics, and funding.

Investment in human resources

Many participants felt that there is a need to strengthen the public health workforce through training, knowledge, and skills development; and that the public health system requires a multidisciplinary approach. They identified a need to enhance capacity and hire staff with the full range of public health competencies as well as with specialized expertise and skillsets. The Public Health Agency of *Canada's Building the Public Health Workforce for the 21st Century, A Pan-Canadian framework for Public Health Human Resources Planning* could be utilized for human resources planning as we move into a recovery phase.

Recruitment and retention challenges experienced by some smaller, more remote health units may need different approaches to help alleviate movement in and out of positions.

"An ethics framework is necessary to ensure that impacts - particularly impacts on vulnerable populations - are considered and mitigated to the best of our ability as we respond to successive waves of COVID-19, future pandemics or other catastrophic events."

Respondent

Structures and new approaches

The issues public health is dealing with are increasingly complex and require a comprehensive, multidisciplinary, collaborative response. There is no one-size-fits-all solution to ensuring a strong and resilient public health system, however, suggestions for new approaches include:

Governance and structures

- Local boards of health that are autonomous from municipal governance structures
- Board of health members with greater expertise in public health issues
- Multidisciplinary public health representation within the provincial government and possibly the federal level (e.g. nursing, inspectors)
- Recruitment for senior leadership positions focused more on leadership skills
- More open communication between provincial and local organizations

Policy and mandate

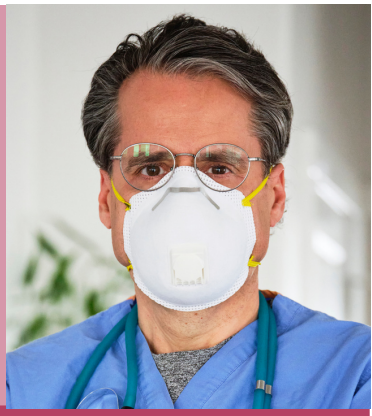
- Stronger chronic disease prevention policies (provincial)
- More policy around healthy eating in schools (provincial)
- Greater involvement of frontline staff in planning and decision-making
- More application of consistent approaches across health units
- Prioritizing and applying adequate resources to health promotion
- Clearer and more accountable organizational standards

Emergency preparedness

- Expanded and strengthened relationships with community partners and stakeholders (e.g. hospitals, Ministry of Labour, enforcement)
- Clearly identified and communicated roles and responsibilities
- Increased education and attention to risk-based emergency preparedness focused on resiliency to help minimize the impact of any emergency

"We can remember the shortage of N95 masks to protect hospital and LTC staff. This needs to be addressed within the public health preparedness framework with some combination of reserves and scalable local manufacturing capability. For such a critical item, we should not be entirely dependent upon other jurisdictions who may need all they can produce for their own populations."

Ontario Association of Public Health Dentistry member



Collaboration and partnerships

Collaboration and partnerships at the local level were key to successful dissemination of public health messaging, case and contact management and vaccination rollout. These relationships could be leveraged in innovative and creative ways to amplify the impact of efforts; in particular, when addressing health and social inequities. Collaboration with local partners could include collaborative data sharing, analysis, reporting and service delivery.

Health equity and upstream approaches

While public health work is diverse, what unifies public health action is its focus on prevention, upstream interventions and societal factors that influence health (1). Participants felt that population health assessment and health equity need to be prioritized, resourced and coordinated at all levels within public health to address the persistent health and social inequities that have resulted in disproportionate impacts of COVID-19 on some populations (2).

Participants expressed that the public health sector must address inequities – this is what public health is about. This involves more than resources; it requires greater expertise in SDOH and community development, involvement of ethno-cultural leaders, such as Indigenous leaders, and an openness to new approaches. Public health needs to consistently act on indisputable evidence of health inequities drawing on the latest research (e.g. from Dr. Dennis Raphael and others). There is a need for a standardized provincial software design documentation (SDD) suite, and engagement with community groups on the collection, use and reporting of data.

Many participants emphasized the habit of looking upstream to the causes-of-the-causes of poor health, is needed for policy change, and for action toward an upstream shift (3). Meaningful efforts should be made to decolonize public health anchored in the principles of Indigenous self-determination, leadership and knowledge (4). There needs to be more intersectional thinking; both in terms of people and infectious disease. It is important to consider both social and ecological determinants of health.

"When government was setting out priority populations, some populations felt they were left behind. When it came to offering vaccinations to populations that are precariously housed or food insecure, they were hesitant because there was a lot of information circulating that were not factual. Lead to vaccine hesitancy and vaccine refusal. Opioid death rates have sky rocketed and it doesn't seem to be public knowledge."

OPHA Health Equity Workgroup member

Technology and data analytics

The COVID-19 pandemic has highlighted the importance of epidemiology and data analytics in monitoring and responding to key public health issues. Data and epidemiology have supported, and at times, driven the public health response to the pandemic. Through local epidemiological analysis and expertise, the context and interpretation of regional data supported public communications and local decision-makers. Public health unit epidemiologists became indispensable in their abilities to describe and interpret population health data in the context of the diverse communities that each public health unit serves, which has been especially critical given the number of systematic limitations related to data and data infrastructure.

Surveillance of key indicators and trends allows public health units to respond effectively and allot resources appropriately, which require strong data management systems that are applied in a consistent way. Epidemiologists should be consulted when systems are being developed so that the right adjustments can be made to ensure they meet their needs.

Systems and strengthened data collection of SDOH and socio-economic status (SES) data at the local level are needed as health units often need to rely on older, regional-level data (i.e. Census 2016). Leveraging and developing more open-source tools for enhanced interoperability, integration and sustainability keeps health units from duplicating tasks, but keeps analysis and flexibility at the local level. R is a statistical software package that has been around since the 1980's. It's open source and very flexible, however, few analysts have been trained in how to use it. Data analysis skills should be developed across the province in open-source platforms. This also makes processes more standardized across public health units.

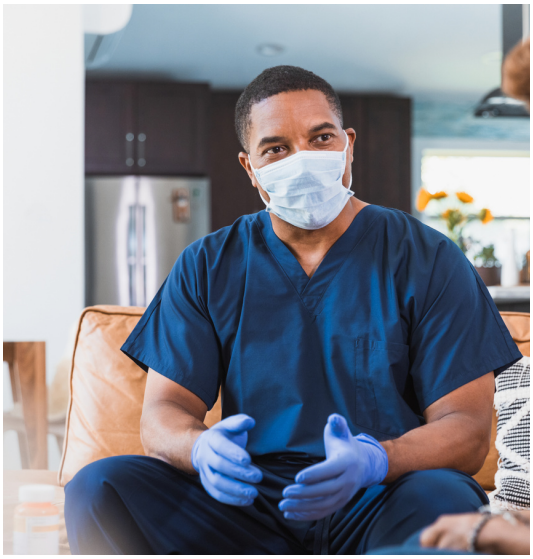
QUESTION 3 POLL RESULTS

Participants were asked to rank their top three choices from a list of eight items which they think offer the most impactful solutions for the future of public health.

Funding was selected most often and had the highest ranking. Examples include investing in:

- SDOH to tackle underlying health issues
- Build better data systems using good design principles
- Local level research
- Meaningful collaboration

RECOMMENDATIONS



After hearing from our members, constituent societies, workgroups and others, OPHA urges the government of Ontario to consider building on and endorsing Canada's Chief Public Health Officer's four priority actions for public health renewal as well as two areas for strengthening community health in Ontario.

Specifically, OPHA calls on the Ontario Government to undertake the following priority actions for public health recovery and renewal and to strengthen community health in Ontario.

01 Foster excellence in the public health workforce through:

- A provincial human resources strategy that includes funding to support more regular opportunities for training, especially leadership training and supports the resiliency and recovery of the public health workforce
- The creation of new provincial and regional mechanisms to facilitate sharing of best practices, promote joint planning and communication among health units, with the province, other parts of the health system and other sectors impacting the determinants of health

02 Improve public health tools through:

- Updating technology and funding more and better sources for population health data, especially disaggregated data to better understand those communities that are often underserved and face significant barriers to optimal health
- Integration and linkage of provincial data systems
- Increased resourcing for epidemiology

03 Strengthen the mandate and public health's leadership role by:

- Ensuring public health expertise on boards of health and public health's independence
- Safeguarding autonomy for local/regional public health agencies to meet the needs of their communities
- Providing greater clarity on public health's role in relation to other parts of Ontario's health system
- Appealing to other sectors to adopt a health in all policies approach that creates shared goals and targets and identifies each agency's role and responsibilities for achieving them

04 Ensure stable and consistent funding by:

- Increasing the provincial percentage of funding in the public health cost sharing formula with municipalities
- Increasing investment in Ontario's 34 public health agencies beyond the less than 2% of the annual health care budget
- Increasing funding to Ontario public health units to strengthen their capacity to support local public health in the delivery of the Ontario Public Health Standards, even in the face of current and future pandemics

05 Prioritize upstream approaches and health equity by investing in health promotion and prevention strategies:

- In response to provincial and local needs (e.g. chronic disease prevention, substance misuse, maternal and child health, health and climate change, mental health promotion); especially for those communities that are often underserved and face barriers due to poverty, racism, oppression, discrimination and colonization

06 Accelerate a return to public health's mandated programs:

- Such as inspections, immunizations, health promotion and population health assessment

CONCLUSION

This project revealed important insights and lessons for the future of public health as Ontario continues to deal with the COVID-19 pandemic. Many of these insights reinforce what has been reported by others, including in the 2003 SARS report: Renewal of Public Health in Canada – Report of the National Advisory Committee on SARS and Public Health (the Naylor Report), the 2021 Canadian Institutes of Health Research (CIHR) report: Building Public Health Systems for the Future, the 2021 report from the Chief Public Health Officer of Canada: A Vision to transform Canada's Public Health System and others.

As noted in the CIHR report, the COVID-19 pandemic made obvious "persistent financing, governance, workforce and information system shortcomings" of Canada's public health system, emphasizing the urgent need to more fully address structural drivers of health such as racism, colonialization, classism and ableism (5). It is critical that the government of Ontario take action in these areas.

With unprecedented attention on the public health system, there is a new opportunity to invest and rebuild public health in Ontario, to achieve optimal health for all.

OPHA is grateful to its members, constituent societies and workgroups for their time and willingness to share their perspectives responding to the COVID-19 pandemic and their hopes for the future of public health in Ontario.

APPENDIX A

Methodology

This report reflects the feedback collected by over 400 public and community health professionals through a series of discussion sessions and a survey. These discussion sessions took place over two phases.

Phase one

In August 2021, OPHA invited their 10 constituent societies to participate in an hour-long discussion session to share their perspectives responding to the COVID-19 pandemic. Constituent societies were invited through their representative on the OPHA Board of Directors. The nine constituent societies who participated were:

- Alliance for Healthier Communities
- Association of Public Health Epidemiologists in Ontario
- Association of Supervisors of Public Health Inspectors of Ontario
- Canadian Institute of Public Health Inspectors – Ontario
- Community Health Nurses' Initiatives Group – Registered Nurses' Association of Ontario
- Health Promotion Ontario
- Ontario Association of Public Health Dentistry
- Ontario Society of Physical Activity Promoters in Public Health
- Ontario Association of Public Health Nursing Leaders

Each discussion session was approximately one hour in duration and used the Zoom platform. Participants were invited to participate verbally or through the chat function. There were a series of three discussion questions, followed by three poll questions. In a few instances, poll questions were omitted due to lack of time, and one discussion session did not have any poll questions. In some cases, constituent society representatives slightly customized the questions for their group.

Most discussion sessions were open to all members of their respective society, however some representatives opted to invite a smaller, specific group of members. Eight of these discussion sessions took place from October – November 2021. The Alliance for Healthier Communities' discussion session took place in January 2022.

OPHA's Anti-Racism Task Group was invited to a discussion session that took place on October 26, 2021. All members of OPHA were invited to a members' forum, where they were guided through the three discussion questions and respective poll questions. This took place on November 3, 2021.

OPHA's Executive Director facilitated each discussion session, and one or more members of the OPHA team took notes. The sessions were recorded for the purpose of reviewing the notes for accuracy. The OPHA team collated the notes, chat messages, and poll results, and then deleted the recordings.

Phase two

In this phase of the project, the active OPHA workgroups were invited to a discussion session. The workgroups were invited through their chair(s). The discussion sessions who participated were:

- Alcohol Workgroup
- Reproductive Health Workgroup
- Built Environment Workgroup
- Health Equity Workgroup
- Environmental Health Workgroup

OPHA workgroups are voluntarily comprised groups of OPHA members who share an interest in a particular public health issue. The Health Equity Workgroup is shared between OPHA and the Association of Local Public Health Agencies (aLPHa). At these discussion sessions, three questions were posed that were slightly different from the phase one questions as they were modified to reflect the workgroup topic. Additionally, some chairs slightly customized the questions further for their group.

Poll questions were sometimes omitted due to lack of time and one discussion session did not include any poll questions. These sessions took place in November 2021 and summary notes were made using the same method as phase one. Over 400 individuals participated in the discussion sessions between phase one and two.

Survey and analysis

Following the discussion sessions, the OPHA team reviewed the session notes, recordings, and poll results to identify themes which were translated into eight potential actions that could help ensure a strong and resilient public health system and healthy communities in Ontario.

An anonymous survey was created using Survey Monkey in which participants were asked to use a sliding scale to identify the importance of each potential action, from 'not important' to 'very important'. The survey included an option to provide other potential actions participants considered as very important. A link to the survey was sent to OPHA members via email and was open between December 27, 2021 and January 14, 2022. A total of 128 participants completed the survey.

The OPHA team then reviewed the summary notes from the discussion sessions, the poll results, survey results and supporting documents from stakeholders. Responses were themed and summarized. Recommendations were drafted based on the themes identified and considered along with stakeholder reports and previous OPHA recommendations for building a strong and resilient public health system and healthy communities in Ontario.

OPHA would like to thank all those that participated in the discussion sessions and survey, and those who sent emails with additional feedback and comments.

Discussion questions

OPHA member and constituent society discussion session questions

1. What do you think worked well in terms of the public health response to the COVID-19 pandemic?

Poll: What specifically do you think worked well in terms of the public health response to the pandemic? Select all that apply:

- Application of quality improvement strategies
- Increased collaboration across sectors
- Sharing of effective practices & lessons learned
- Increased investment of resources from the provincial government
- Ability of the workforce to adjust to changing demands
- Collecting and reporting data
- Ability to work remotely
- Other (write in chat box)

2. What problems or gaps did you see emerge from the COVID-19 pandemic response?

Poll: Which of the following Ontario Public Health program standards do you think should be prioritized in the post-pandemic period? Pick your top three:

- Chronic disease prevention and well-being
- Food safety
- Healthy environments
- Healthy growth and development
- Immunization
- Infectious and communicable diseases prevention and control
- Safe water
- School health
- Substance use and injury prevention
- Other areas (write in chat box)

3. What do you think is needed to create a strong and resilient public health system and healthier communities in Ontario?

Poll: Which areas do you think to offer the most impactful solutions for the future of public health? Pick your top three:

- Funding
- Workforce
- Mandate/standards
- Structures
- Leadership
- Provincial direction
- Innovation/technology
- Quality improvement

Workgroup discussion session questions

1. What was public health doing well in the area [workgroup topic] prior to COVID-19 that has since paused or reduced?

Poll: What was public health doing well in the area of [workgroup topic] prior to COVID-19? Select all that apply:

- Strengthening community action
- Developing personal skills
- Building healthy public policy
- Creating supportive environments
- Reorienting health services
- Ensuring safe environments
- Undertaking population health assessment
- Other

2. What specific impacts did COVID-19 have on [workgroup topic]?

3. What role do you think public health should have in addressing these impacts post-pandemic?

Poll: Which areas do you think offer the most impactful solutions for public health to address [workgroup topic]? Pick your top 3:

- Funding
- Capacity
- Mandate/standards
- Local leadership
- Provincial policy
- Technology and innovation
- Partnerships
- Other (write in chat box)

APPENDIX B

Survey questions and results

Questions 1 – 8: Please slide to indicate your ranking (0 to 100) of the importance of each of the potential interventions/actions to help ensure a strong and resilient public health system and healthy communities in Ontario.

Responses (average ranking):

1. Invest in prevention, upstream approaches, and social determinants of health (SDOH) to optimize outcomes. (92)
2. Ensure a health-in-all-policies approach to local and provincial policy development. (84)
3. Prioritize collaborative action through workgroups, partnerships, and associations to increase capacity and reduce duplicated efforts. (82)
4. Identify and implement what is needed to heal and support public health staff to ensure their recovery and resilience moving forward. (81)
5. Increase funding for research on SDOH outcomes and needs of marginalized and racialized groups to better target services and policies. (78)
6. Consider new and innovative approaches to the structure and mandate of public health to ensure optimal efficiency and impact. (78)
7. Educate the general public and other sectors about the work/mandate of public health to help build trust and increase collaboration. (77)
8. Increase diversity and representation within the public health workforce (including leadership roles) to ensure equity and representation of the communities we serve. (76)

Question 9: Please include any potential actions you see as very important to help ensure a strong and resilient public health system and healthy communities in Ontario.

Responses:

- Advocate for basic income programs for those in need of income to support basic needs and promote health. Advocate for health coverage/benefits for those that have employment but remain close or below the poverty line for income. Consider research into a universal school lunch program.

- Reinstate the basic income pilot or advocate for a living wage proper and stable funding of the public health care system - resources, programs and staffing. Funding and valuing upstream programs/strategies. Continue to fund and support work related to nutrition, for example healthy eating environments, school nutrition programs, food security strategies, prenatal nutrition programs, breastfeeding support. Fund and support better technology options in public health and for municipalities, for example websites, EMR systems, virtual care technology, program databases, etc. Look at a bigger healthcare systems approach to connect public health with primary care and other allied health care professional services, to share resources, services, key messages, documentation, etc. Thank you!
- Development of a pan-northern Ontario health human resource strategy (skilled recruitment and retention in northern, rural, and remote locations). Annualized IPAC hub funding to support LTC and congregate settings - Increase to base funding for public health to adequately deliver mandated programs and services in addition to ongoing COVID response/immunization needs - public health resource drive sharing cross Ontario PHUs to allow for open resource adaptation and sharing to prevent duplication (i.e. load all final workable products - media, public reports, etc.).
- Integrate the system and reduce waste. Educate public on what services are found at what levels of the health system.
- A more user-friendly platform that replaces iPHIS for better surveillance and tracking of infectious disease trends across the province. A platform that is used consistently in the same way by all public health units (e.g. if the COVID-19 case and contact management platform in Salesforce could be adapted and used for all infectious diseases.
- Adequate funding to implement these strategies
- Adequate, stable funding
- Adopt a Trauma informed framework within OPHA on all levels
- Amalgamation of the 34 health units, more like the BC model
- Clarification is needed about what you mean "increase diversity and representation within the public health workforce (including leadership roles) to ensure equity and representation of the communities we serve". It should also include having the skills, knowledge, abilities, education and experience to do the job. If that is present, diversity should be considered as well. I would say it is more of a balance between ability to the work/having the qualifications and diversity than just increasing diversity.
- Continue to provide funding for peer education programs to prevent chronic disease. Support community nutrition programming for young children to help establish healthy eating habits.
- Clearly articulate to the public and sectors of our government and community to help them understand what public health can do for them and to encourage these groups to link up with public health. I feel that outside our general clinical work and specific community tasks we do... we are known as the "professional meeting go'ers", but aren't sure of what our work comprises (unless of course, you have worked with us, but the lines of what we do and don't do is often part of a grey zone). I have also heard a few times that community groups aren't aware of when to bring us in and when not to. It's so great to see collaboration at the govt level, such as public health and the ministry of education speaking regularly, these types of partnerships are amazing!
- Continuous sustainable funding in public health

- Cross training for any services that can be completed by those that aren't public health nurses to increase efficiency reduce costs
- Decolonize health standards to be more inclusive
- Designating chief medical officers of health as fully independent officers of the legislature to serve as the public's health watchdog. It's time to designate chief health officers as independent officers of the legislature, serving a watchdog role comparable to that of provincial auditors, with their reports being made public documents. Politicians in power still remain free to make decisions based on balancing competing interests, but at least citizens then understand the tradeoffs that their leaders have made and can hold them accountable at the voting booth.
- Distinguish public health from political leaders/current government. Despite being funded by government, goals and methods are different. PH receives government dollars to turn around and lobby them.
- Ensure alignment with CMO and regional PHU (communication). Increase collaboration and operational/integrated planning with regional health teams.
- Expose health and public health spending so that the public can grasp the huge job public health has had with few resources. Then maybe people will see that the individuals working in the field are not supported and cannot possibly do what is expected of them.
- Fewer medical officers of health. Fewer health promoters and more nurses and PHIs to do critical tasks in public health.
- For number 8, I think it is important. I am not sure if it is the mandate of OPHA.
- Funding
- Hire people to do covid work (ccm, hotline, clinics), so the rest of us can do our regular jobs
- I have judged the above to all be close to very important. work on the above is enough
- I think these potential actions are heading in the right direction but miss the overall foundational priority for public health in regards to addressing health inequities. We have the research (e.g. Dr. Dennis Raphael and others). We have been working on promoting public awareness of public health for the last 20+ years but we haven't seen changes in fundamental, universal socio-political policies that address the root causes of health (e.g. income, housing, etc.) and address the reasons why health inequities are increasing vs decreasing (e.g. increasing gap in income levels where the rich are getting richer). This needs to be the focus; otherwise, we will continue to "spin our wheels" while falsely believing we are making progress. A "health-in-all policy" approach is one small piece of the puzzle but not the key element.
- I'd like to emphasize points 7 and 9 as being paramount in our effort to move forward after this pandemic. Our world is increasingly polarized. We need to communicate with the public effectively, and we need our public health staff well-rested and up to the next challenge.
- Important for public to follow it's model and not the medical model
- Improvement in financial support for the public (e.g. paid sick days, better pay for nurses, PSWs) and small businesses and well-established action plan in the event of future pandemics (e.g. Available PPEs, frameworks).
- Increase health care budget to health departments post pandemic recovery and beyond
- Increased focus on addressing climate change and a green economy

- Intersectional thinking, both in terms of people and infectious disease - SDH - ecological determinants of health. Also shared governance with communities throughout.
- Invest in research re best practice interventions/initiatives that address public health needs. For example - mental health promotion is an essential public health role, however, there is little to no evidence to support 'what' interventions are the most effective and impactful.
- More investment in research to assess long term cost benefit analysis of health promotion policy development
- More of a link between the local Municipal Public Health Units with the local/regional Home & Community Care Support Services (HCCSS)
- Ontario should also advocate for public health needs and objectives at the federal level and coordinate with federal initiatives. Evaluation is key to ensure that the most effective public health policies and programs are implemented. Ensure the link is made between prevention and outcomes in primary care.
- PAY NURSES BETTER
- Priority item should be the health and capacity of the frontline - without which everything else on the list cannot be achieved
- Much more focus and funding on primary prevention efforts for NCDs!!!!! Including getting general check ups, cancer screening, bloodwork going again - immediately for those over 40 years old especially with already existing comorbidities. A significant increase in salary for all RNs in ON working during the pandemic, permanently. Donation of many more covid vaccines designated for those under 30 years of age in ON to low income countries to ease vaccine inequity - immediately. Emergency pandemic plans actually being researched and planned, before the next pandemic, including emergency stockpiling of necessary medical equipment and physical beds, rapid covid tests. Huge campaign for healthy lifestyle promotion - healthy eating, exercise, weight loss, healthy habits - promoted by mass media to start immediately. To decrease residual risk of covid in population. More efforts should be focused on getting children, high school students, and university students back to in person learning - as their mental health is immensely suffering including suicide. More awareness of overdose deaths, suicide, mental health suffering of those created by lock down on mass media - media reporting should be balanced in the benefits/harms of lockdowns and several other factors that are suffering. Increase in spaces for medical students and nursing students in ON schools as part of future emergency pandemic plans.
- More public health education added to public and private school curriculums for improved student information
- Properly fund programs providing services for communicable diseases
- Public health needs to be separate from political structures. We have seen decision making based on politics and NOT on science and best for health.
- Public health staff are burnt out. I really hope that we are valued after this and the public and government work together to make sure that systems are in place to make public health a stronger part of the health care system.
- Raise the profile of all public health workers at the local level - they are invisible
- Reduce financial burden on municipalities to help foster stronger partnerships between public health and the municipalities they serve

- Public health staff in long term care facilities that are unable to complete their current duties due to illness should be replaced ASAP with equally experienced staff that are immunized and familiar with the residents they need to support. In additional to replacement staff, new hires should also be hired to support the remaining current staff. Numbers of staff should be increased more than usual during an upcoming outbreak and support for residents should not be decreased due to lack of healthy staff. When times where "surveillance" and "outbreaks" occur family members are also impacted with assisting their loved ones, and provide support the creates additional stress on family members. Also supporting family members should be immunized at the same time as the residents to provide additional precaution for resident and family member
- The Importance of upstream, primordial, primary, secondary, prevention. Instead of waiting until developing disease
- Sustainable funding to public health
- The ability to change specific policies or change actions dependent on the specific needs of the population providing services to. Further, promotion and prevention at all levels will be more effective. In addition, having more clear information across all organizations will be key to provide accurate information to all populations.
- The modernization (amalgamation) of some public health units needs to move forward to gain efficiencies, which in turn will reduce duplication of work, lead to improved focus on public health priorities. Having one central body would be to drastic and not beneficial, however, the previous idea of some regions amalgamating makes sense.
- The most important thing right now is to assess the health/wellness of staff before moving forward with more change - COVID has been all about change and staff are weary
- The pandemic has highlighted the important role that public health nurses play in our communities. In an effort to recover from this pandemic and ensure adequate staffing moving forward, consideration should be given to creating new public health nurse roles.
- Throw directly into the garbage can, the ridiculous plan to reduce 36 health units into 10. If you can't tell by now, public health is important, and should not be part of ill advised cost cutting measure.
- To save the health care system it is crucial that public health promotion and illness prevention programing is funded appropriately, not less than 1% of the total health care budget! Currently we have a illness care system, not a health care system. Also have the hospitals funded for acute care and leave the health promotion and illness prevention to the Public Health agencies to reduce duplication. Also the community health centers (CHCs) need to work together with public health to provide programming that is accessible to the at risk and marginalized community members (not putting on programs at locations that are not accessible to those who have no transportation). Public health professionals are masters of collaborating and working with key community members with a population based model and approach. Family health teams are also duplicating public health programming. Fund public health so more upstream strategies can be done to reduce the number of people that end up in hospital (costing so much more). Supporting our seniors homes and LTC homes with an on site nurse practitioner to PREVENT costly trips to the hospitals. So many conditions can be caught and treated early improving the seniors quality of life! These are only a few actions that are Extremely important...I could go on but may run out of room...

Phase 3

The draft report was circulated to each of the groups that participated in the discussion sessions as well as group members and OPHA members who had not participated. Twelve individuals and two groups (Timiskaming Heath Unit, Association of Public Health Epidemiologists in Ontario) provided feedback which was reviewed and incorporated where appropriate.

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About OPHA

Created in 1949, the Ontario Public Health Association (OPHA) is a non-partisan, non-profit organization that brings together a broad spectrum of groups and individuals concerned about people's health. OPHA's members come from various backgrounds and sectors – from the various disciplines in public health, health care, academic, non-profit to the private sector.

They are united by OPHA's mission of providing leadership on issues affecting the public's health and strengthening the impact of people who are active in public and community health throughout Ontario. This mission is achieved through professional development, information and analysis on issues effecting community and public health, access to multidisciplinary networks, advocacy on health public policy and the provision of expertise and consultation.