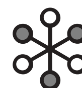
Sharing Public Health News & Views

Nexus



with the Health Care Community

Vol.1, No.2
October 2006

Introducing: Dr. Anne Carter, the new Medical Officer of Health for Leeds, Grenville and Lanark

Dear Colleagues

It gives me great pleasure to introduce myself to the health care providers of Leeds, Grenville and Lanark. I am delighted to have the privilege of serving this community as the Medical Officer of Health and look forward to a long and fruitful collaboration with its health care providers in the pursuit of improved health for all.

The essence of public health is prevention, and as such it tends to be invisible to the public and health care providers when done well. However, crises of recent years in Ontario have served to raise the profile of the role of Public Health and the importance of the health programs that we provide. I am sure you are all aware, for example, of the pandemic influenza plan that has been recently produced. However, these same crises have caused the public to focus on the need for protection from communicable diseases when the major burden of illness in our society is from chronic diseases such as heart disease and cancer, as well as injury. We must protect the community from communicable diseases but, at the same time, we must also work to prevent the chronic diseases and injuries, even if the public does not focus on these as intently.

The mandate of the Board of Health and the Health Unit is to protect and promote the health of the population of Leeds, Grenville and Lanark Counties as directed by the Ontario Health Protection and Promotion Act. In order to carry out our duties, we have a strategic plan, entitled *Moving Upstream*, which was recently developed to cover the years 2006-2010. The title refers to the need to move upstream from the actual disease state to prevent disease or, even further upstream, to prevent the factors that lead to disease. These factors are often called the determinants of health and include lifestyle choices, the physical and socioeconomic environment and health care services. The Health Unit has programs dealing with all of these issues.

Ultimately, public health is a team effort that succeeds only with cooperation between many people and organizations. The Health Unit staff and the Board of Health may be the prime movers in the public health sector but we could never succeed without our partner agencies and the broader community that we serve, particularly the health care providers in the community. In the next few months I will be going out to meet with many health care provider groups to cement relationships and explore new partnerships. I look forward to meeting you and to working with you to protect and promote the health of our community.

— Dr. Anne Carter

(See page 5 for interview with Dr. Carter)

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nexus (‘nek-sus) noun, *Latin: bond, tie; from nectere - to bind* : a connection or link between things, persons, or events esp. that is or is part of a chain of causation

Source: *Merriam-Webster’s Dictionary of Law, © 1996 Merriam-Webster, Inc.*

New Guidelines Available To Assist Medical Community In Fight Against CA-MRSA

— Bonnie Erwin, BScN, RN, Public Health Nurse,
on behalf of the Community and Hospital Infection Control Association (CHICA)

September 13, 2006 - Recognizing that the recent emergence of community-associated methicillin-resistant *Staphylococcus aureus* (CA-MRSA) has the potential to inflict significant impact in Canada, an expert panel of Canadian Infectious Disease, Infection Prevention and Control, and Public Health Specialists has developed guidelines to assist Canadian Health Care Practitioners. With a dramatic increase in the rate of methicillin resistance among community isolates of *Staphylococcus aureus* recently observed in the United States, experts here in Canada are warning that only vigilance and determined prevention and control efforts will stem the emergence of infection due to this strain in Canadian communities. As articles in the Canadian Medical Association Journal have been highlighting over the past few months, these guidelines come at a very critical time.

The Guidelines (*Guidelines for the Prevention and Management of Community-associated Methicillin-Resistant* Staphylococcus aureus *(CA-MRSA): A Perspective for Canadian Health Care Practioners)* will be published (in both English and French) in the September/ October edition of the *Canadian Journal of Infectious Diseases and Medical Microbiology* (CJIDMM) and the October issue of *Paediatrics and Child Health* through funding made available by the Public Health Agency of Canada (PHAC), the Canadian Committee on Antibiotic Resistance (CCAR), and the Ontario Ministry of Health and Long-Term Care (MOHLTC). A final draft version is being distributed over the next month through numerous websites and association membership advisory notices.

In addition to conveying basic information about the epidemiology and microbiology of CA-MRSA, the Guidelines provide recommendations related to the clinical management and prevention and control of CA-MRSA infections. "The goal of this document is to assist frontline physicians in the treatment of CA-MRSA infections but also highlight the preventative measures that can be implemented in a variety of settings - home, daycare centers and schools, sports settings, pet owners, prison and homeless shelters as well as neonatal care facilities," noted Dr. Michelle Barton-Forbes, who, along with Dr. Michael Hawkes, co-authored the report in conjunction with experts from across Canada and the U.S. "We are very pleased with the results of such a collaborative effort and we would like to thank all those who contributed. We feel the Guidelines will have a very positive impact in fighting CA-MRSA."

The Guidelines are the result of a year-long process, including a Working Group Meeting in October, 2005 in Toronto, Ontario, where 70 Canadian experts that included representatives from paediatric and adult infectious disease, infection prevention and control, microbiology and public health, as well as invited US experts in CA-MRSA from Texas and the Centers for Disease Prevention and Control. The PHAC, CCAR and MOHLTC coordinated and supported the process of development and distribution of the Guidelines.

In addition, the Guidelines were approved for publication by the Association of Medical Microbiology and Infectious Disease of Canada (AMMI Canada), the Canadian Paediatric Society (CPS) and Community and Hospital Infection Control Association-Canada (CHICA-Canada). The Guidelines will be reviewed annually by the CA-MRSA expert panel to ensure they are kept up to date.

A copy of the Guidelines can be obtained through *CJIDMM* (September/ October, 2006 issue) as well as *Paediatrics and Child Health* (October, 2006 issue) or via numerous websites, including:

www.ccar-ccra.org
www.ammi.ca
www.cmaj.ca and www.chica.org

Reprints can be requested through CCAR (jmcivor@ccar-ccra.org) after the publication date.

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Food Insecurity Increases the Risk of Disease

— Dianne Oickle, MSc, RD, Registered Dietitian/Public Health Nutritionist

Food insecurity occurs when an individual or family has an inadequate supply of food and/or is worried about access to food. Food insecurity can lead to poor dietary intake, inadequate amount of food and eating less expensive foods of inferior quality (Vozoris & Tarasuk, 2003). People with a low socioeconomic status as a result of income, education, and employment have a higher risk of premature morbidity and mortality (Knight, 2001). Low-income families find that receiving assistance from food banks and other food access points is insufficient to compensate for the lack of funds to buy adequate nutrition (Tarasuk, 2003).

Within Leeds, Grenville, and Lanark counties, a number of groups are at high risk of food insecurity. According to Statistics Canada 2001:

- 11.8% of children live in low income families
- 10% of the population lives below the low income cut-off point
- 8.2% of the population is unemployed
- 12.7% of families are headed by one parent
- 28% of seniors live alone
- 6.7% of the population has less than a grade 9 education

There are many families where one or both parents work but income is still inadequate to cover basic needs. As the price of gas, hydro, and food increases, family incomes are not increasing, making it harder for people to provide food for their family. Nutritious Food Basket data shows that the cost of food has increased more than 15% across the tri-county area over the past 8 years.

Statistics Canada 2001 data shows that, of the total population of Leeds, Grenville, and Lanark:

- 11.3% worried there would not be enough to eat because of a lack of money
- 6.4% did not have enough to eat because of a lack of money
- 13.8% did not eat the quality or variety of foods they wanted to eat because of a lack of money

The incidence of low income in private households across Ontario is 14.4%. Within Leeds, Grenville, and Lanark Counties, several communities have a higher poverty rate than the provincial rate (Brockville is just below). (Statistics Canada, 2001, 20% data sample)

Prescott	22.0%
Westport	18.5%
Smiths Falls	18.4%
Gananoque	15.0%
Perth	14.6%
Brockville	14.2%

If people do not have enough to eat, then why is the rate of obesity so high? An individual living in poverty who is also obese may be able to afford to consume sufficient calories to allow them to maintain or gain weight, but often the less expensive foods consumed have fewer nutrients. Although being overweight may create the appearance that someone has enough food to eat, they may not be consuming adequate vitamins and minerals, further increasing the risk of chronic disease already imposed by being overweight or obese.

For more information on food insecurity and determinants of health, contact the Leeds, Grenville, and Lanark District Health Unit's HealthACTION Line at 1-800-660-5853 (613-345-5685) and ask to speak with a Registered Dietitian.

References:

Knight, F. 2001. Building Bridges – Food Security and Heart Health. Ontario Public Health Association.

Tarasuk, V. 2003. Low income, welfare, and social vulnerability. JAMC; 168 (6): 709-710.

Vozoris, N and Tarasuk, V. 2003. Household food insufficiency is associated with poorer health. Journal of Nutrition; 133: 120-126.

Statistics Canada. Incidence of Low Income in 2000 of all Private Households. 2001 Census, 20% sample

SYNOPSIS

Safety of artificial sweeteners during pregnancy

— Krystal Taylor, BSc, RD, Public Health Dietitian

Evidence suggests that consumption of **aspartame** (Equal® and NutraSweet®) and **sucralose** (Splenda®) by pregnant women is safe and does not pose a health hazard. However, the Canadian Diabetes Association advises to avoid **Saccharin** and **Cyclamate** (Sugar Twin®, Sweet'N Low®, and Sucaryl®) during pregnancy, as their safety has not yet been proven.

Although proven safe, pregnant women should be cautioned against excessive consumption of products containing aspartame, sucralose, and Ace-K (acesulfame potassium) since such foods could be replacing nutrient-dense, energy-yielding foods.

References:

Health Canada. Nutrition for a Healthy Pregnancy: National Guidelines for the Childbearing Years. Ottawa: Minister of Public Works and Government Services Canada; 1999.

Health Canada. Comments on the Recent Study Relating to the Safety of Aspartame (5 May 2006). Available at http://www.hc-sc.gc.ca/fn-an/securit/facts-faits/aspartame/aspartame_statement_e.html Accessed September 11, 2006.

Canadian Diabetes Association. Sugars and Sweeteners (2004). Available at http://www.diabetes.ca/Section_Professionals/sugars_sweeteners.asp Accessed September 5, 2006.

Canadian STI Guidelines 2006

— Tammy Welk, BSc, RN, Public Health Nurse

Some of you may be aware that the Public Health Agency of Canada(PHAC) has released of some chapters from the **Canadian Guidelines on Sexually Transmitted Infections 2006 Edition.**

The completed guidelines are scheduled to be released this fall (2006) and will provide evidence-based recommendations for the prevention, diagnosis, treatment and management of STI's in Canada.

For more information:
http://www.phac-aspc.gc.ca/std-mts/sti_2006/sti_intro2006_e.html

Statistics Canada. Incidence of Low Income in 2000 of all Private Households. 2001 Census, 20% sample

Farewell Interview with Dr. Rani Tolton, Former Acting Medical Officer of Health

"It has broadened my view of the complexities of the issues that are dealt with and the other wider processes — financial, political, and social — that affect the work ... "

Nexus: *Thinking back to your first impressions of the Health Unit, how has your view of the work of Public Health changed in the 10 months that you have been the Acting Medical Officer of Health (MOH)?*

Dr. Tolton: It isn't so much that my view of the work of Public Health has changed as it has broadened my view of what happens at the Health Unit as well as the number of programmes that are administered by the Health Unit. It has broadened my view of the complexities of the issues that are dealt with and the other wider processes — financial, political, and social — that affect the work that is done by the Health Unit.

Nexus: *You came to the Acting MOH position having worked as a family physician. Is there anything that surprised you about the work/role of the Acting MOH that you had not anticipated?*

Dr. Tolton: I had not realized the number of after hours work that was required. I was thankful that I was not first on call. Even as second on call, one is on call 24/7. The expertise of the senior management group certainly made my calls less onerous and for that I am very thankful. Often I found that the Health Unit was used as a "whipping boy" whether intentionally or out of ignorance. Also it seems that often when persons do not know to whom to complain, they turn to the Health Unit. The Health Unit does not necessarily have the mandate to deal with all the issues that are sometimes presented to it.

Nexus: *Now that you've spent time on the 'inside' - do you see any ways that health care providers and the Health Unit could work together differently?*

Dr. Tolton: Respect and understanding for each other's jobs/careers in the various health fields is very crucial. It is normal for all of us to feel and think that our jobs are more important than someone else's. It is important to work together, learn about each other's health care roles, and respect the contributions made by each of these roles. One way of achieving this can be by meeting other health care providers in various situations and not necessarily when in the "authoritative role".

Nexus: *Is there anything memorable that you will take with you into your future practice, based on the experience you have had at the Health Unit?*

Dr. Tolton: I have learned a lot about infectious diseases and that knowledge will stay with me. Working through the bean sprout salmonella outbreak, boil water advisories, avian influenza, rabies, Smoke Free Ontario Act, farmers' markets, board meetings and media relations are some of the highlights/stresses that I guess you can say have been "memorable". It is not just the events themselves but also the people I met in association with these events.

Nexus: *What are you most looking forward to about being back in your former medical practice?*

Dr. Tolton: I have never really left my medical practice. I continued to work two days a week as a family physician and decreased my Emergency Department shifts to one per month from two throughout my time at the Health Unit. This meant longer week days and regularly some weekend and evening work.

I am looking forward to having more time with my children, more times to spend as a family on outings. We have already been doing more activities such as biking, walking and playing ping-pong (which my son loves).

I am most looking forward to not being reprimanded constantly by my kids about spending more time at work than with them. I am looking forward to not having to say 'Sorry, I'll make it up to you next time', to my kids. This has lead me to do a lot of soul searching and I have decided not to agree to more hours at the medical practice or to increase the hours too much at the emergency department.

Nexus: *Have you any other thoughts you want to share with our readers?*

Dr. Tolton: The Health Unit is a goldmine of information for the general public. The Health Unit and its Board could do a bit better job marketing itself.

The Health Unit for the first time opened its doors to medical students directly for example through ERMEP (*Eastern Region Medical Education Program*) and also through collaboration with community physicians. From what these first year and some third/fourth years students said, - they found their short visits eye opening about what public health is all about. It would be nice to see medical students continue to spend some time at the health unit during some of their rotations. It would also be nice to see family practice residents doing rotations at the Health Unit.

Again, I cannot emphasize enough that I would not have been able to do my job without the support of the staff who collectively are very dedicated to public health and to the community. ❊

Welcome Interview with Dr. Anne Carter, Medical Officer of Health

"...most of my patients ills were caused by factors that were far beyond their ability or my ability to control ... So I chose to go back to school to train as a community medicine physician. "

Nexus: *What is it that made you decide to go into the field of public health?*

Dr. Carter: I was a family physician, working the typical day to day grind of a family physician. It struck me that most of my patients ills were caused by factors that were far beyond their ability or my ability to control. Many smoked, were obese, and did not exercise. Many had family problems for which they did not have enough support. Many were lonely and unhappy. All of these problems led to symptoms that I would attempt to patch up. I felt frustrated and wanted to tackle the factors at a more basic level (move upstream if you will). So I chose to go back to school to train as a community medicine physician. Maybe I was idealistic and foolish because, despite 20 years in the field, all the problems I listed above still exist. In fact, some are worse today than when I trained. But I am very glad that I made that decision. I have had a very satisfying career in public health and enjoyed every minute of it.

Nexus: *What can you tell us about the career you have had so far in public health?*

Dr. Carter: Immediately after completing my residence program I went to Niagara to be the Associate Medical Officer of Health. Unfortunately, before I had even learned how to do my job, I became the acting Medical Officer of Health and was quickly overwhelmed by the responsibilities as I had a young family to attend to as well. So I decided to move to the federal level and took a demanding but more manageable position as the Chief of Disease Surveillance at the Laboratory Centre for Disease Control (now the Public Health Agency of Canada). After a number of satisfying years in that position I transferred to the non-governmental sphere by taking a position with the Canadian Medical Association as Director of Health Programs. This was also a very satisfying position as it let me work with physicians and other health care providers to improve the quality of care provided to patients. I also interacted with government bureaucrats (I was good at this as I had recently been one!!) to try to influence the drafting of policy, legislation and regulations in order to improve the health of Canadians.

After a number of years, I again got itchy feet and decided to move off-shore to the United Arab Emirates to teach at a medical school for the citizens of that country. In all of my previous positions I had maintained academic affiliations and had carried out research and teaching "in my spare time" so it was a great experience to finally do these activities as part of my job description. The experience of living and working in a completely foreign culture was exhilarating. However, after 5 years, the middle-east had turned from an area that was relatively peaceful to one at war. So I picked up again and moved to Barbados where I held a similar position at the University of the West Indies School of Clinical Medicine and Research. The opportunity to experience yet another culture was wonderful. However, after a total of 8 years abroad, I felt that my children were becoming strangers (if you have children who are just spreading their wings, try selling the house and moving half a world away if you really want to foster independence) and the rest of my family and friends were aging far too quickly.

So I have returned to Canada to renew my ties to my country, my community, my friends and my family and become the MOH of Leeds, Grenville and Lanark. It has been a wonderful homecoming and I am looking forward to the future and the challenges it will bring.

Nexus: *Can you tell us a bit about life outside of work?*

Dr. Carter: I am married to a family physician and have two sons in their early thirties. The entire family are Queen's grads, ranging from '67 to '99. No grandchildren yet! I try to live what I preach by exercising almost every day, eating a sensible diet and wearing my seat belt. We live on beautiful Upper Rideau Lake in the family cottage and love it there. I enjoy the 50-minute drive from the cottage to Brockville through the beautiful eastern Ontario landscape and I am looking forward to following the changing seasons as I drive. Activities that I enjoy include golfing, hiking, cross-country skiing, playing bridge and reading books as well as the Globe and Mail.

Nexus: *What values do you bring to your work as the CEO of the Health Unit?*

Dr. Carter: I believe in the principles of quality management. These include making decisions based on evidence, particularly locally collected data; believing that workers will try their best to do a good job and, if the results are less than desired, the assumption is that the problem is due to the system not the worker; involving the worker in data collection, interpretation and decision-making because the worker is the most familiar with their own work situation. Health care providers should embrace this philosophy because, in the health care system, they are the workers.

I also believe strongly in the principles of integrity, fairness, and consistency in management. Nothing disrupts the workplace more than wavering from these principles. I was delighted to see that, in its strategic planning process, the Health Unit has identified integrity and fairness as two of the values they see as part of the Health Unit identity.

Lyme Disease

— *Joan Mays, BAA(EH), CPHI(C), Supervisor, Health Protection*

It has now been established that Lyme Disease is endemic in the St. Lawrence Islands National Park area of Leeds and Grenville including some mainland sites. This summer, four lab-confirmed locally acquired cases were reported. These cases have sparked interest at the Ministry of Health and Long Term Care and Health Canada who, in co-operation with the Health Unit have coordinated field studies in this region to confirm the presence of the tick vector.

The blacklegged tick, Ixodes scapularis is the principal vector of Borrelia burgdorferi which causes a multi-systemic infection in humans known as Lyme Disease (Steere 1989; Wormser et al. 2000). Recent studies by the Zoonotic disease and Special Pathogens, National Microbiology Laboratory from Winnipeg concluded that the blacklegged tick population is likely established in the 1000 Islands Region of Eastern Ontario, and that an endemic cycle of pathogen transmission may be occurring (Lindsay, Dibernardo, Artsob, 2006).

Diagnosis of Lyme Disease can be made by evaluation of the patient's symptoms, especially the rash, erythema migrans, that occurs in approximately 70 to 80 % of cases. Blood work to determine the presence of antibodies to the bacteria should be ordered to assist in diagnosis. An acute and convalescent blood sample are recommended.

Lyme Disease can be treated by the use of antibiotics. Treatment is more effective when administered early in the course of the illness. If you remove a tick from a patient, or the patient has brought one into the office, please submit it to the Health Unit for testing.

References

Steere, A.C. Lyme disease. New England Journal of Medicine 1989; 321:586-96

Wormer, G.P., R.B. Nadelman, R.J. Dattwyler, et al. D.T. Dennis, E.D. Shapero, A.C. Steere, T.J. Rush, D.W. Rahn, P.K. Coule, D.H. Persing, D. Fish & B.J. Luft. Practice guidelines for the treatment of Lyme disease. 2000; Clin. Infect. Dis. 31: Suppl 1:1-14

Lindsay, L. Robbin - Dibernadro, Antonia - Artsob, Harvey. Unpublished interim report: Field studies on the establishment of the Lyme Disease vector tick, Ixodes scapularis, and associated zoonotic agents, in St. Lawrence Islands National Park, Ontario 2006; September 18

Cannabis Use of Concern in Breastfeeding Mothers

— *Lois Dewey, BScN, RN, IBCLC, Public Health Nurse*

Public health nurses in the Healthy Babies/Healthy Children program have identified marijuana use in breastfeeding mothers as an increasing issue in the tricounty area.

Marijuana is on the American Academy of Pediatrics Committee on Drugs (2001) list: *Drugs of Abuse for Which Adverse Effects on the Infant During Breastfeeding Have Been Reported.*

Marijuana is a crude preparation of leaves, stems and flowering tops of the *Cannabis sativa*. It is smoked, inhaled or ingested orally and is rapidly distributed to the brain and adipose tissue and is extensively bound to plasma proteins (97%). It is stored in fat tissues for long periods (weeks to months).

Infants exposed to marijuana via breast milk will test positive in urine screens for long periods (2-3 weeks). Long-term effects of marijuana exposure through breast milk are unknown.

Breast milk is the best food for babies. It contains appropriate amounts of carbohydrates, proteins, fats, minerals, vitamins, and hormones as well as maternal antibodies. Psychologically, breastfeeding facilitates bonding between mother and child. Advising mothers to discontinue breastfeeding if they cannot stop using cannabinoids must include warnings about the known risks of formula feeding. Referral to appropriate services for counseling may be efficacious.

Concerns:

- Marijuana in animals inhibits prolactin production and could inhibit lactation.
- Studies have shown significant absorption and metabolism in infants although long-term sequelae have not been shown.
- Marijuana may produce sedation and growth delay in a highly dose dependent relationship.
- Exposure to environmental marijuana smoke for both infant and the mother is hazardous.
- Marijuana use may affect a mother's mood and judgment, compromising her ability to care for her baby.
- Street drugs are rarely pure and marijuana may contain other substances.
- Analysis of breast milk in the chronic heavy user reveals an 8:1 milk to plasma ratio.

References:

American Academy of Pediatrics. The Transfer of Drugs and Other Chemicals Into Human Milk. *Pediatrics* 2001; 776-789

Hale T. *Medications and Mothers' Milk.* 11th Edition. Amarillo, Texas: Pharmasoft Publishing 2004, pp. 119-120.

Djulus, J. et al. Marijuana Use and Breastfeeding. *Canadian Family Physician* 2005; 51:349-350

New Promotional Campaign for Breast Cancer Awareness Month

—Bonnie Schnittker RN PHN

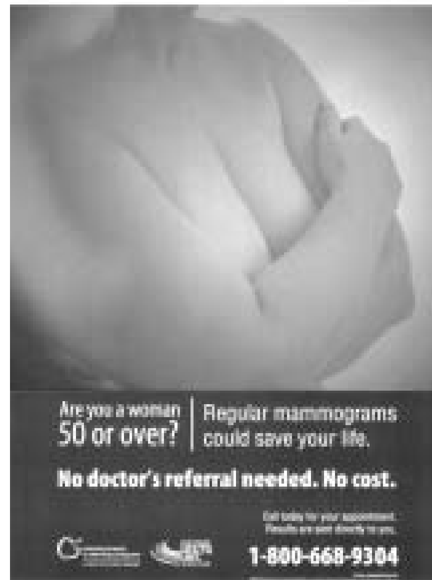
Adapted with permission of Brenda Bass, Regional Administrator, OBSP-Southeast Region

October is Breast Cancer Awareness Month and the Ontario Breast Screening Program (OBSP) is undertaking a special promotional campaign this month to make more women aware of the importance of the early detection of breast cancer.

Southeastern Ontario includes several counties that have been officially designated by the Ministry of Health and Long-Term Care of Ontario as under serviced by G.P.'s, including Leeds & Grenville County (19 vacancies). (Ministry of Health and Long-Term Care, 2006)

The Ontario Breast Screening Program (OBSP) has attempted to overcome this barrier by allowing eligible women to book their own appointments in the absence of a doctor's requisition. Despite the ability to self-refer to the program, OBSP statistics indicate that women without family doctors are under-represented in the program. This data is consistent with the known influence of family doctors in prompting women to attend screening services. Women without family doctors are missing this important motivator with respect to breast screening but may also be unaware of the fact that a family doctor is not required to make an appointment in the OBSP. They may also be unaware of their risk.

In an attempt to reach eligible women without family doctors, a poster campaign directed specifically at this group of women has been designed and will be implemented by the OBSP Public Health Network of Southeastern Ontario for Breast Cancer Awareness Month in October 2006.



The poster will be distributed across Southeastern Ontario in locations where women aged 50 and over are likely to see it – libraries, walk-in clinics, dress shops, community centres, beauty salons and pharmacies. ❄

Local Ontario Breast Screening Program (OBSP) sites:

Brockville	Brockville General Hospital (613) 345-8304
Kingston	OBSP Centre (613) 384-4284 1-800-465-8850
Winchester	Winchester District Memorial Hospital (613) 774-2422 ext. 5617
Ottawa	OBSP Centre (613) 728-0777 1-800-465-6226
Renfrew	Renfrew Victoria Hospital 613) 432-4851 1-800-916-6277

For more information about the OBSP call 1-800-668-9304.

For resources (brochures, posters) to promote the OBSP contact Bonnie Schnittker, Public Health Nurse at (613) 283-2740 or bonnie.schnittker@healthunit.org

Footnotes

Ministry of Health and Long-Term Care (2006), List of Areas Designated as Underserviced for General/Family Practitioners, April/May/June.

SYNOPSIS

Good Food for a Healthy Baby

Do you have patients who would benefit from a ***free Prenatal drop-in*** for pregnant women?

Through the Canada Prenatal Nutrition Program (CPNP), our partner agency, CONNECTIONS runs the *Good Food for a Healthy Baby* program in several locations across Leeds, Grenville & Lanark counties. The CPNP aims to reduce the incidence of low birth weight, improve the health of both infant and mother, and encourage breastfeeding.

Pregnant women can join the group prenatally & attend for up to three months postpartum.

They benefit from:

- Free food vouchers for milk products and produce (prenatal & up to 1 month postpartum)
- Nutrition counselling & education with a dietitian
- Free meals prepared with the dietitian
- Educational presentations
- A chance to meet & socialize with other mothers
- Access to a public health nurse to discuss health/infant concerns

Groups are held in:

- Carleton Place
- Smiths Falls
- Perth
- Brockville
- Prescott
- Kemptville

For more information, contact **CONNECTIONS**:

Lanark:
1-888-284-2204 or 613-257-2779

Leeds & Grenville:
1-877-901-5515 or 613-258-5212

FEED • BACK • FAX • BACK

Date: ______________________

From: ______________________

Fax to: **(613) 345-2879**

We value your opinion. Please feel free to send us your comments.

1. Comments/suggestions for the newsletter: ______________________

____

____

2. I would like to receive the newsletter:

❑ By mail ❑ By e-mail: e-mail address: ______________________

3. Can we provide information on specific topics? Please check all that interest you.

Clinical Services
- ❑ Infection Control
- ❑ Communicable Disease
- ❑ Immunization/Vaccine Preventable Diseases
- ❑ Sexual Health
  - ❑ STI/AIDS

Health Protection
- ❑ Rabies
- ❑ Food Safety
- ❑ Safe Water
- ❑ West Nile Virus
- ❑ Emergency Response
- ❑ Health Hazard Investigation

Health Promotion
- ❑ Cancer Prevention (Breast, Cervical & Skin)
- ❑ Dental Health
- ❑ Injury Prevention
- ❑ Substance Abuse Prevention
- ❑ Chronic Disease Prevention
  - ❑ Healthy Eating
  - ❑ Healthy Weights
  - ❑ Physical Activity
  - ❑ Tobacco-Free Living

Family Health
- ❑ Child Health
  - ❑ Growth & Development
  - ❑ Parenting
  - ❑ Breastfeeding
  - ❑ Nutrition for Infants, Toddlers & Preschoolers
  - ❑ Healthy Babies/Healthy Children program
  - ❑ Family Abuse Prevention
- ❑ Reproductive Health
  - ❑ Preconception Health
  - ❑ Pregnancy

Disease Surveillance
- ❑ Information on the health status/health risks in our community
- ❑ Information from local, provincial & national health surveys

Other? ______________________

____

4. Is there any change to your contact information?

Name: ______________________

Address: ______________________

Phone: ______________________

Fax: ______________________

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