

ISSUE 1 Fall 2016

HORIZONS



Resident physicians Dr. Shruti Sebastian and Dr. Hugh Guan (with Dr. Eva Purkey, centre) during a work break in Loikaw, Myanmar, January 2016

Welcome

Welcome to this premiere issue of *Horizons*, a three-times yearly newsletter designed to update faculty, residents and staff on what's going on in Global Health at the Queen's Department of Family Medicine (DFM) and in the broader community.

We at Queen's DFM are proud of our robust Global Health/Health Equity program. We believe in health for all, where persons can live to their full capacity, without distinction of any kind such as race, gender identity,

sexual orientation, language, religion, political or other opinion, national or social place of birth, socioeconomic status, ability or disability. As part of our mission, we are committed to addressing health disparities among persons and communities, and advocating for increased services to improve health outcomes for all.

We invite you to visit our **Global Health** website to learn more about our program and the many ways you can get involved.

We are always looking for new PGY1 residents to join our Global Health working group. If you are interested

in learning more, please email Dana Doll at dana.doll@dfm.queensu.ca or Dr. Eva Purkey at eva.purkey@dfm.queensu.ca.



Dr. Eva Purkey
Global Health Director
Department of Family Medicine
Queen's University

Global Health/Health Equity

at the Queen's Department of Family Medicine

Education

Innovations in our Global Health/Health Equity curriculum for the 2016 academic year included mandatory predeparture preparation and post-return debriefing for residents going on rotations in remote indigenous communities (particularly Moose Factory, but others also apply). Dr. Shayna Watson is leading this initiative, with support from the Queen's Four Directions Aboriginal Student Centre. All residents with rotations in Moose Factory are encouraged to contact Dr. Watson to ensure they have received the appropriate preparation.

Research

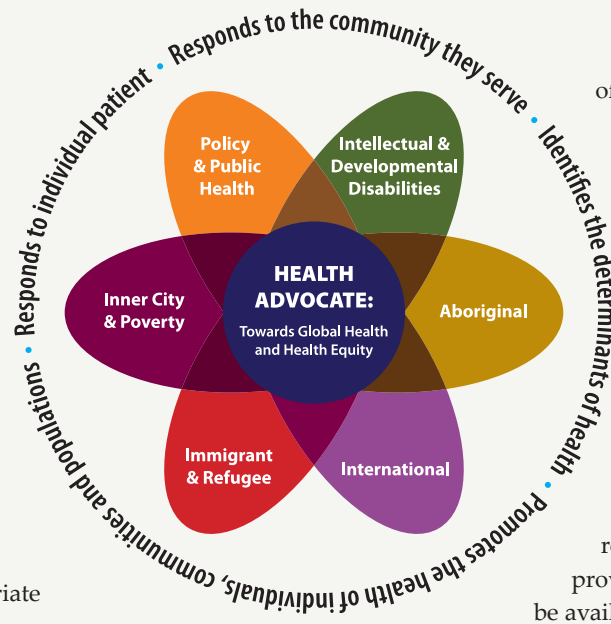
This year, several residents have indicated their interest in a global health focus for their resident research projects, with research questions related to new immigrants and refugees, the LGBTQ community, poverty in Kingston and the international health project launched last year in Loikaw, Myanmar.

Faculty members are also engaged in global health projects, including research with indigenous and international communities, and persons living in poverty within Kingston.

Residents interested in being involved in global health research are encouraged to visit the [Research](#) page on the Queen's Department of Family Medicine's [Global Health](#) website. Faculty members listed on the [Global Health](#) page of the department's Centre for Studies in Primary Care website will direct residents to others who can support their interest.

Refugee Health Initiative

The Queen's Family Health Team continues to be open to accepting incoming refugee clients arriving either through the government's mass resettlement program or through other sources. Kingston will be opening a Resettlement Assistance Program (RAP) centre shortly (visit the [KEYS Job Centre](#) website for more information), which will support the arrival of up to 120 new government-assisted refugees (GARs) per year in Kingston for a minimum of two years. This will present new challenges, as GARs are not provided the same level



of settlement support as privately sponsored refugees. We are excited to be part of the solution to their integration from a health-care perspective.

In partnership with the South East LHIN and Kingston Community Health Centres, the department has taken on the role of building a health resources web portal for newcomers and those who support them. The final product, which will provide valuable resources for newcomers, health-care providers and settlement agencies, will be available on our website's [Refugee Health Initiative](#) page by November 1.

Partnerships and Programming

The department hosted two exciting workshops in 2016 that were open to the community at large. The first, **Treating Poverty**, an Ontario College of Family Physicians workshop, was presented as part of an implementation study funded by a Queen's Office of Research Services Innovation Grant. This workshop has been presented throughout the province with great success, and we were happy to host it for primary care and pediatric colleagues.

The second workshop, **Transgendered Health**, was hosted courtesy of Rainbow Health Ontario. This session was very well attended, indicating that there are a number of primary-care physicians in Kingston who are interested in and willing to support patients who are transitioning.

Global Health/Health Equity in Canada

[Family Medicine Forum](#), Nov 9-12, 2016, Vancouver BC

Sessions on Global Health and Marginalized Populations

[Fourth Global Symposium on Health Systems Research](#), November 14-18, 2016, Vancouver, BC

[Annual Scientific Assembly](#), Nov 24-26, 2016, Toronto ON

Sessions on Poverty and Health, Remote First Nations Health, Transgendered Health, etc.

The Opioid Epidemic



The opioid epidemic continues to be a major public health concern, both on a local and national level. Canada has the most prescription opioid users per capita in the world, and no other province or territory has higher opioid dispensing than Ontario.^{1,2} The use of opioids to treat chronic non-cancer pain has been subject to much debate, since there is no evidence that these medications provide any therapeutic benefit when prescribed for long-term use.³ All physicians must work collectively to refine prescribing and reduce opioid-related deaths.

As rates of physician prescriptions for opioids have increased, so too have morbidity and mortality from opioid-related toxicity.⁴ Statistics from the Office of the Chief Coroner for Ontario confirm that the province's opioid problem is escalating. In fact, accidental deaths due to prescription opioid overdoses have more than tripled over the last decade. Since 2002, accidental opioid overdoses accounted for more than 5,000 premature deaths in Ontario.⁵ The cost of human life is staggering, and has detrimental effects on individuals, families and communities.

Fentanyl, a synthetic opioid that is 50 to 100 times more potent than morphine,⁶ is of particular concern in Ontario. Since OxyContin was removed from the formulary in 2012, fentanyl has become the opioid related to the most mortality in the province.⁵ According to the Ontario Association of Chiefs of Police, fentanyl is a drug of choice among young adults, and most fatalities can be linked to a legally obtained prescription.⁷ Indeed, there is a well-established link between prescribing

practices and opioid harms, and most addicts were first exposed to opioids by a doctor's prescription either directly or through diversion.⁸

A study by the Ontario Drug Policy Research Network correlated annualized opioid prescription rates and toxicity-related emergency department visits and hospital admissions across Ontario counties. The results not only show a strong link between prescription rates and negative health outcomes, but also identify differential severity across the province. Frontenac ranked as the seventh-highest opioid prescriber in the province from 2011 to 2013, and had among the highest rates of emergency department visits and hospital admissions.⁹ To gain a better understanding of the problem in their own community, physicians can use an [online interactive map](#) that colour-codes counties based on their rates of opioid prescribing and toxicity-related emergency department visits and hospital admissions.

The public health crisis of prescription opioid misuse has developed, in part, due to physician prescribing practices. The burden of disease of prescription opioid overdoses is high and concentrated in the young. From a local perspective, Frontenac has a particularly high rate of opioid prescribing and opioid-related mortality, highlighting the need for urgent action in our community. All physicians must take collective ownership and reflect on the role they can play to reduce negative health outcomes.

*Dr. Kieran Moore, Associate Medical Officer of Health,
KFL&A Public Health and Professor,
Queen's Department of Family Medicine*

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Take Home Naloxone as First Aid for Opioid Overdose



Photo: Allen McAvoy

A naloxone kit, above, resembles a hard-shelled sunglasses case. It contains alcohol swabs, latex-free gloves, a rescue breathing mask, two vials of naloxone, two syringes, a vial snapper, an identification card and steps for responding to an overdose.

Canada is now the leading consumer of prescription opioids.¹ Non-medical use of prescription drugs is one of the leading public health and safety concerns across North America.² Overdose deaths are at an epidemic level across Canada. In April 2016, British Columbia's provincial health officer declared a public health emergency because more than 200 people had died from fentanyl overdoses in the first three months of this year³. On June 3, 2016, the BC coroner reported that overdose deaths are up 75 per cent in 2016.⁴

In Ontario, opioid-related mortality increased 463 per cent from 2000 to 2013⁵. This represents one death every 14 hours. Preliminary figures from Ontario's Office of the Chief Coroner obtained by *The Globe and Mail* in February 2016 show that fentanyl overdoses accounted for one of every four opioid-related fatalities in 2014.⁶ We have had 13 years of increasing and record-setting opioid overdose fatalities that rank as the third-leading cause of accidental death, and more than double the number of drivers killed in motor vehicle collisions.⁷ The current rate of overdose deaths is likely far higher than this, as we have seen multiple communities across Ontario report a significant increase in opioid overdoses and deaths in the past year.

Take Home Naloxone Programs Save Lives

Take Home Naloxone programs have been available in most provinces for a few years. Naloxone, an opioid antagonist that is first aid for an opioid overdose, can reverse fatal respiratory depression. Communities that provide Take Home Naloxone and overdose-prevention training have lower opioid-related overdose fatalities.⁸

Eighty-five per cent of overdoses occur in the presence of another person.⁹ Naloxone injections for opioid overdoses, similar to epinephrine injections given for anaphylaxis, are most often given by bystanders.

How to Get Naloxone

There are two ways to obtain naloxone in Ontario:¹⁰

1) Ontario Naloxone Program (ONP)

Since October 2013, via the Ministry of Health and Long-Term Care (MOHLTC), eligible HCV treatment teams and public health needle syringe programs can distribute naloxone kits and training supplies.

SHOOPP: Street Health Centre Opioid Overdose Prevention Program

The Street Health Centre (SHC) has an opioid overdose prevention program through which staff members will meet with at-risk persons and provide training on preventing and responding to an opioid overdose. Patients may self-refer or be referred to SHC via a [Street Health Centre referral form](#).

There have been 25 successful opioid overdose reversals in the community since the program's inception.

2) Ontario Naloxone Pharmacy Program (ONPP)

The MOHLTC announced on May 18, 2016, that naloxone will be available free of charge at participating pharmacies. The program's first rollout will be through pharmacies that currently dispense methadone and buprenorphine/naloxone (Suboxone). The ministry has provided program information to these pharmacies to enable them to begin supplying naloxone kits to eligible persons if certain terms and conditions are met. On June 24, 2016, the National Association of Pharmacy

Regulatory Authorities (NAPRA) reclassified naloxone as a Schedule II drug when used in an emergency opioid overdose situation outside of hospital settings. This change was effective immediately in Ontario. As a result, naloxone can now be kept behind the counter in Ontario pharmacies, and the province's pharmacists can now provide training on how to safely administer the drug. *People at risk of an overdose (or their concerned family members or peers) will not need a prescription and will not pay anything when receiving naloxone.*

To find out which pharmacy in your area carries naloxone, visit www.drugstrategy.ca and click the tab "Find a Pharmacy Here."

Who Should Be Provided with Naloxone?

Evidence shows that doses higher than 50 mg morphine equivalents increase the risk of overdose or morbidity.¹¹ The Centers for Disease Control and Prevention (CDC) recommends offering naloxone kits to all patients being prescribed more than 50 mg of morphine equivalents per day. (See the CDC's [Calculating Total Daily Dose of Opioids for Safer Dosage.](#))

The Street Health Centre is aware of drug use in the context of "pill parties," where young people take pills from parents/grandparents/others and toss them into a bowl and then consume them. We believe that any home that has an opioid prescription presents as a risk for opioid overdose. It's recommended that a naloxone kit be kept on hand in much the same way an EpiPen is kept on hand in the home of someone with anaphylaxis history.



Hepatitis C outreach worker Justine McIsaac, left, and Dr. Meredith MacKenzie

The Importance of Calling 911

Opioid overdose is a medical emergency. Once naloxone is given, it lasts between 20 and 90 minutes. As these potent opioids can "outlast" naloxone, however, the overdose can recur, even if no further drug is used. Calling 911 is a crucial step to survival and a cornerstone of opioid overdose treatment. With the arrival of more potent opioids like powdered fentanyl and other fentanyl analogues across all communities in Canada, activating 911 is of particular importance. If 911 is not called, the risk of death is increased substantially.

The primary barrier to calling 911 has been identified as fear of criminal charges.¹² People have given testimony during Bill C-224 hearings, telling stories of how their children have died at parties because no one called 911. A Canadian study showed that only 46 per cent of those involved in an overdose will call 911.¹² This compares to more than 90 per cent of people who call 911 when experiencing a cardiac event. The best way to encourage people who have overdosed or have witnessed an overdose to seek help from 911 is to provide protection from charges for possession. Early evidence from the U.S. indicates that 88 per cent of people using opioids are more likely to call 911 after establishment of a Good Samaritan Law and being made aware of its existence.¹³

Samaritan Law and being made aware of its existence.¹³

Bill C-224 is before the Standing Committee on Health at the House of Commons.

For more information, contact Dr. Meredith MacKenzie at Street Health Centre at 613-549-1440.



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Dr. Susan Bartels

Dr. Susan Bartels, centre, works with research assistants as they role-play how to conduct an interview.



Vulnerable Women, Children Focus of Physician's Research

The emergency department at Kingston General Hospital may be a far cry from the Syrian refugee settlements of Lebanon or small villages in Sub-Saharan Africa, but Dr. Susan Bartels has made it her goal to be actively engaged across these disparate spaces.

Dr. Bartels completed medical school at Memorial University in Newfoundland, and her emergency medicine residency at Queen's. She completed a master of public health (MPH) degree at Harvard School of Public Health and a fellowship in international emergency medicine. Before returning to Queen's as a clinician scientist in 2014, she worked as a faculty member in Boston, where she was very active in global health and acquired extensive international experience as a researcher at the Harvard Humanitarian Initiative.

Dr. Bartels' research interests and activities span many continents, often focusing on the plight of women and children in conflict and post-conflict settings, where early marriage can be common and sexual violence is often used as a weapon of war. She has completed projects in the Democratic Republic of Congo looking at outcomes for women who have become pregnant or had children resulting from conflict-related sexual violence. These women are often highly stigmatized, and it is hoped that their health outcomes might be improved by bringing their voices to international attention, identifying their needs and advocating for their rights.

Whether it is in Africa, Asia or North America, Dr. Bartels looks for, and finds, resilience. While some people are deeply marred by their traumatic experiences, others find it in themselves to overcome these terrible events and grow. Part of her goal is to help individuals and communities identify and build on the characteristics, structures and systems that can help those who have experienced trauma to thrive.

Her current and most active project uses an innovative research tool called SenseMaker to explore the reasons for early marriage among Syrian refugee communities in Lebanon, where girls as young as 13 can be married off to men several times their age. The project, funded by the World Bank and the Sexual Violence Research Initiative, is being conducted in close partnership with a local partner, the ABAAD Resource Center for Gender Equality.

In May, Dr. Bartels travelled to Lebanon with Queen's faculty member Colleen Davison and Queen's MPH student Nour Bakhache to pilot the SenseMaker survey and to plan the study. Dr. Bartels returned to Lebanon in July to train 12 local interviewers and initiate data collection, which concluded in early September after a total of 1,425 stories were collected.

In addition to these projects she leads, Dr. Bartels has supported other global health activities at Queen's, including a project in Karenni State, Myanmar, supporting the prevention of maternal-to-child transmission of hepatitis B virus. She is an active member of a group of Queen's faculty members trying to build the profile of the university's global health research through engaging in joint projects throughout the world.

While much of Dr. Bartels' global health research has been international, she is also concerned about vulnerable women closer to home. These interests include women who have been involved in trafficking in Canada – a topic that is fortunately gaining more public attention of late – as well as how emergency departments in Canada can become more responsive to marginalized women.

Basic Income:

An Idea Whose Time Has Come



Opinion

No one knows better than health-care providers why income is such an important determinant of health. Without adequate income, people do without basic essentials such as healthy food, prescription medications, adequate housing and suitable clothing. Moreover, the stress of living in poverty contributes to mental illness and family dysfunction, and leads people to take up unhealthy coping practices. People who live in poverty lead shorter, sicker lives than those who are better off, and children who grow up in poverty suffer health consequences for the rest of their lives.

It is not surprising, then, that health professionals have been significant contributors to the new national campaign to implement a basic income in Canada. The Basic Income Canada Network is advocating a basic income that would ensure everyone has an income sufficient to meet basic needs, and lives with dignity, regardless of work status. The basic income we want would be like our health-care system. It would be unconditional, available to all who need it and simple to access. It would replace our current stigmatizing, intrusive and punitive welfare system, but would supplement other key components of the social safety net, such as affordable housing.

Ontario health-care providers have been particularly active in this campaign. Last summer, almost 200 Ontario physicians signed a letter addressed to Health Minister Eric Hoskins asking for his support of basic income as an intervention to improve the health of Ontarians. The Ontario Public Health Association, the Association of Local Public Health Agencies and the Ontario Society of Nutrition Professionals in Public Health have all passed resolutions calling for the government to implement a basic income. Several boards of health and municipal councils (of which Kingston was the first) have also endorsed basic income.

In the March 2016 budget, the Ontario government announced it would fund a basic income pilot project. In June, it announced that the Honourable Hugh Segal, former senator and longtime vocal proponent of basic income, will write an advisory report on the design of the pilot project, which will likely begin in March 2017.

This will not be Canada's first basic income pilot project. From 1974 to 1979, the Manitoba government and the federal government funded an experiment in Dauphin, MB, called MINCOME, which provided a guaranteed unconditional income to everyone who was eligible. There was no evaluation conducted of MINCOME until, in the early 2000s, University of Manitoba economist Evelyn Forget went looking for the

dusty boxes of records. Her analysis shows that during the experimental period, hospital visits dropped by 8.5 per cent, with lower rates of accidents and injuries, fewer mental health consultations and lower rates of psychiatric hospitalizations. Two groups of participants worked less than previously: new mothers stayed home longer with their infants, and teenagers stayed in school longer instead of dropping out to support their families.

These days, the idea of a basic income appeals to a broad audience because the nature of employment is shifting due to permanent, structural changes in the economy related to globalization and technology. More and more employment is precarious — short term without benefits — and minimum wages have not kept up with the cost of living. A basic income could help smooth the resulting income instability and inadequacy, and allow people more choice and freedom in deciding what type of work they will undertake. Moreover, a basic income rewards the unpaid, often invisible work that keeps society running, including unpaid care work and volunteering. Basic income could also support those who want to pursue a passion that is unpaid or poorly paid, such as the creative arts, activism or a new business.

While those of us in the Basic Income Canada Network want a basic income that would effectively tackle poverty and support the well-being of all Canadians, there are others who see basic income as a way to further reduce the size of government, cut services and supports to those who are living on low incomes, and reduce the amount of money provided through income security programs. This means that those living in poverty could be worse off. This “austerity” version of basic income will do nothing to improve the health of Canadians living in poverty.

Though the implementation of a basic income program, available to all who need it, still seems distant, those of us interested in improving population health must be vigilant to ensure that the basic income program we eventually get is one that effectively reduces poverty and substantially improves the lives of the most marginalized among us.

Elaine Power, Ph.D., is an associate professor in the Queen's School of Kinesiology & Health Studies, where she teaches HLTH 101, The Social Determinants of Health. She is the co-founder, with Toni Pickard, of the Kingston Action Group for a Basic Income Guarantee.

Our Social Experiences and their Effect on Health

Are women and men different when it comes to health?

Does it matter, and what's this got to do with global health?

Men and women share more than 99 per cent of their genetic material. In fact, humans share 57 per cent of their genome with the cabbage and 75 per cent with pumpkins. Perhaps, more than anything, this says that the answers to who we are lie outside our genes and, as epigenetic evidence increasingly demonstrates, outside our bodies.

It is the social experiences, opportunities and constraints we face that differentiate women and men and that have an enormous impact on health. Examples abound. In some countries, for every 100 boys born there are fewer than 85 girls. This is not because of biology; it arises from devaluing girls, availability of ultrasound to determine fetal sex and then sex-selective abortion.

In Canada, as in most countries, men's life expectancy is about 15 per cent shorter than women's, not because of some inherent weakness but more likely because men engage in more risk-taking behaviours. Even medical problems like chronic pain often have different or gendered significance in women, where abuse frequently exacerbates pain.

Does any of this matter for medical practice? If we truly accept Dr. David Sackett's definition of evidence-based practice (and he is the originator of the term so we should), then we must recognize that excellent care combines research evidence with physician experience and with an understanding of patients' realities and wishes. It's hard to practise evidence-based medicine if we know patients only by their diagnoses and not as people who happen to have an illness.



Dr. Susan Phillips, Program Director, Women's Health, Queen's Department of Family Medicine, and family medicine residents who completed a third-year program of specialized training in women's health celebrated their 2015-2016 program completion with a cake provided by a resident in the women's health seminar series.

And what has this got to do with global health? Everything. Global health takes into account characteristics of people, systems and structures that lead to inequities in health and health-care access. We seek to improve health and to achieve equity in health for all people worldwide. In many countries of the world, the most glaring inequity is between men and women.

Queen's Family Medicine residents who find these concepts interesting are invited to join the women's health seminar series. These participatory monthly seminars explore all this and much more.

For more information, contact Dr. Susan Phillips, Program Director, Women's Health, Queen's Department of Family Medicine.

CSWs' Role in Primary Care Focus of Conference Presentation

In October 2016, Queen's Family Health Team (QFHT) Nursing Manager Francine Janiuk will co-present Community Service Workers (CSW): Addressing an Equity Need in Primary Care Organizations at the annual **Association of Family Health Teams of Ontario (AFHTO)** conference. Linda Robb-Blenderman, Kingston Health Links co-ordinator, and Laura Cassidy, Quality Improvement Data Support co-ordinator for Kingston region family health teams, will co-present with Francine.

The presentation will address the extension of community partnerships to support and share the CSW resource across four different primary care models in an urban setting – and the benefits to patients. The results of a pilot project involving the **Upstream Risks Screening Tool and Guide**, devised to screen social determinants of health in the primary care setting, will also be discussed.

Community service workers have filled an important equity role in empowering our vulnerable patients with information and connections to resources and, quite simply, offering a helping hand to those most in need. The QFHT's Maria Sherwood, CSW, is currently accepting referrals from the team's clinicians. Patients may also benefit from a home visit and co-ordinated care plan prepared by Kayla Purdon, the QFHT's Health Links RN.



Dr. Ruth Wilson UWI External Examiner for Family Medicine

Dr. Ruth Wilson, third from right, poses with her family medicine colleagues at the University of the West Indies, School of Clinical Medicine and Research, The Bahamas.

Dr. Ruth Wilson has served as the external examiner for the University of the West Indies (UWI) family medicine specialty exams for the past two years. When she graduated from medical school in Canada, there was no requirement for specialty training in family medicine in order to practise as a GP; the situation is similar now in the English-speaking Caribbean. However, the UWI offers a high-quality four-year residency in family medicine that includes clinical rotations, course work and a resident research project at a master's level. The exams are similar to the CFPC exams, except the residents each do a written and verbal report on their completed research project after the written and OSCE portions of the exam are complete.

This year, Dr. Wilson examined in Jamaica and Trinidad in June. Jamaica was in the midst of a Zika virus outbreak,

with family physicians reporting seeing 15 to 20 cases a day. For most patients, it appeared to be a fairly mild illness characterized by rash, fever, conjunctivitis and some GI symptoms. The potential sequelae are worrisome, of course.

Queen's Department of Family Medicine has a long history of co-operation with the UWI. Dr. Tony Johnson, department head from 1981 to 1986 and Barbadian by birth, and Professor Emeritus Dr. Walter Rosser have also served as examiners.

The Caribbean College of Family Physicians is a member of WONCA North America, so in her role as regional president for WONCA, Dr. Wilson was particularly pleased to continue this connection with international colleagues.



Deb St. Amant, a Metis artist from Trenton, participates in a smudging ceremony to open the indigenous healing room at KGH

Indigenous Healing Room Opens at KGH

The South East Regional Cancer Program (SERCP), in partnership with Kingston General Hospital (KGH), recently invited indigenous community members from across the region to celebrate the hospital's newly opened indigenous all nations healing room.

The space, which opened in late June this year, was designed with input from indigenous patients who were asking for an area to perform culturally important ceremonies such as smudging, circle prayer and singing. Officially named "Mamawi," which means "Together," the room allows indigenous patients to gather with family members to perform traditional healing practices while in hospital. Located on level six of the Connell wing, the room is open to all KGH patients and their families at any time.

"Our goal is to improve the services we provide for our First Nations, Inuit and Métis patients in a way that honours the Aboriginal path of well-being," said Brenda Carter, Regional Vice-President, Cancer Services, South East Regional Cancer Program. "The opening of this room is a significant step in building cultural awareness by showing our support and respect for the health traditions of our Aboriginal community."

Aboriginal populations believe health is holistic, comprising emotional, mental, physical and spiritual well-being. Recognizing and embracing these cultural differences will provide a balance between the highly clinical world of a hospital and patients' spiritual health.

"It will make a huge difference for aboriginal patients to be welcome to incorporate traditional healing into what many feel is a daunting hospital setting," said Dionne Nolan, Aboriginal Patient Navigator, South East Regional Cancer Program. "We want to support patients on their journey to healing, so it is exciting to see that they will have a safe space, where traditional cultural values and beliefs can be practised."

The space was also gifted with the healing power of art, as local traditional artists Morris Blanchard, Deb St. Amant and Laura St. Amant unveiled paintings for the room to promote healing and well-being.

"Each piece represents one of our indigenous peoples, First Nations, Inuit and Métis," said Deb St. Amant, a Métis artist from Trenton. "These paintings are meant to be therapeutic, calming to the spirit, and we know this beautiful artwork will play a big part in creating a healing atmosphere in the new room."

For more information about Aboriginal cultural practices, or how this room can be used, please contact Dionne Nolan at 613-549-6666 (1-800-567-5722), Ext. 3851 or via email at noland@kgh.kari.net.

Podcast - <http://cancercaresoutheast.ca/resources-services/cancer-corner/cars-and-cancer-podcast-series>

Officially named "Mamawi," which means "Together," the room allows indigenous patients to gather with family members to perform traditional healing practices while in hospital.



Browse Services | Map Services



Shelter and Housing



Food



Clothing



Mental Health And Addiction Services



Health Care



Support Services



Legal Advice



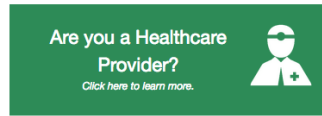
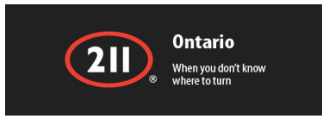
Community



Employment and Education



Income Supports



Community Blog

23 and 1/2 hours

Watch as Dr. Mike Evans describes the single best thing we can do for our health.

May 5th, 2016

Community Engagement

Upcoming Free Events

Movies in the Square - The Martian

September 1, 2016 08:30 pm - 10:30 pm @ Springer Market Square, Kingston

Facebook News

E-Communities Help

Resource Hubs Aim to Reduce Poverty's Impact on Health

Kingston Helps is an electronic community hub where local organizations and community members can come together to share their experiences with poverty, and provide links to resources and services available in the community. The **Kingston Helps** website was developed in 2013 as per the recommendations of the Poverty Reduction Health Working Group and other community partners including the City of Kingston, United Way, Kingston Community Health Centres and KFL&A Public Health. This initiative will enable communication, co-ordination and collaboration among organizations, the public and health-care providers in the hopes of reducing the impact poverty has on health.

Following the initial development of the Kingston Helps website, two sets of evaluations were conducted in order to improve the tool. The first round of improvements was based on recommendations made by focus groups of individuals living in poverty. The second round was based on feedback from qualitative interviews with clinicians and community stakeholders. The findings from these evaluations were used to inform the design of the **Lennox and Addington (L and A) Helps** website, which provides easily accessible information about resources and services specific to those in the Lennox and Addington area. The next step is to introduce a tool for the Frontenac area, and the Frontenac Helps website is currently being developed.

The websites include resources for various types of users, including community service providers, health-care providers and individuals living in poverty. Links direct those in need to services that can help them find shelter and housing, food, clothing, mental health and addiction services, health care, social support, legal advice, employment, education, and income supports. Individuals can also share personal experiences through the various social media platforms linked to the websites.

For suggestions or feedback on content, please contact Dr. Kieran Moore, Associate Medical Officer of Health, KFL&A Public Health, at kieran.moore@kflapublichealth.ca.