Board of Health Meeting # 04-26

Public Health Sudbury & Districts

Thursday, May 21, 2026

1:30 p.m.

Boardroom

1300 Paris Street

Public Health
Santé publique
SUDBURY & DISTRICTS

AGENDA – FOURTH MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, LEVEL 3
THURSDAY, MAY 21, 2026 – 1:30 P.M.

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

4. DELEGATION/PRESENTATION

i) Community Drug Strategy for Greater Sudbury 2026 – Call to Action

- Josh Veilleux, Manager, Comprehensive Health Promotion, Health Promotion and Vaccine Preventable Diseases Division
- Brittany Pagnacco, Public Health Nurse, Comprehensive Health Promotion, Health Promotion and Vaccine Preventable Diseases Division

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Third Board of Health Meeting – April 16, 2026

ii) Business Arising From Minutes

iii) Report of Standing Committees

iv) Report of the Medical Officer of Health / Chief Executive Officer

a. MOH/CEO Report, May 2026

v) Correspondence

vi) Items of Information

a. Public Health Agency of Canada Statement Re: Andes to hantavirus situation — May 12, 2026

APPROVAL OF CONSENT AGENDA

MOTION:

THAT the Board of Health approve the consent agenda as distributed.

6. NEW BUSINESS

i) Administrative Changes to Part VIII of the Ontario Building Code: Transfer of Enforcement Authority for the Municipalities of St.-Charles, French River, Markstay-Warren, and Killarney

- Briefing Note from the Medical Officer of Health and Chief Executive Officer dated May 14, 2026

ii) Annual Service Plan – 2026-2027 One-Time Funding Requests

- Presentation by Renée Higgins, Director of Corporate Services

iii) Municipal Buy Ontario Procurement Directive - Phased Implementation Dates

- Briefing Note from the Medical Officer of Health and Chief Executive Officer dated May 14, 2026

iv) Association of Local Public Health Agencies (alPHa)

a. alPHa's 2026 Conference and Annual General Meeting, June 8-10, 2026

- Notice to Members of 2026 Annual General Meeting
- Draft Conference Program, draft as of April 7, 2026
- BOH Section Meeting Agenda dated May 12, 2026
- 2026 Resolutions for Consideration documents

2026 ALPHA ANNUAL GENERAL MEETING - VOTING DELEGATION

MOTION:

WHEREAS the Public Health Sudbury & Districts is allocated five votes* at the Association of Local Public Health Agencies Annual General Meeting Resolution Session;

THAT the following individuals are appointed as voting delegates for the Annual General Meeting:

1) **M. Mustafa Hirji ***
2) **Emily Groot**
3) **Robert Barclay ***

***Voting delegates are permitted one proxy vote per person, as required.**

7. ADDENDUM

ADDENDUM

MOTION:

THAT this Board of Health deals with the items on the Addendum.

8. IN CAMERA

IN CAMERA

MOTION:

THAT this Board of Health goes in camera to deal with advice that is subject to solicitor-client privilege, including communications necessary for that purpose. Time: _____

9. RISE AND REPORT

RISE AND REPORT

MOTION:

THAT this Board of Health rises and reports. Time: _____

10. ANNOUNCEMENTS

11. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time: ____

Public Health
Santé publique
SUDBURY & DISTRICTS

MINUTES – THIRD MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, LEVEL 3
THURSDAY, APRIL 16, 2026 – 1:30 P.M.

BOARD MEMBERS PRESENT

Robert Barclay	Ken Noland	Tom Trainor
Natalie Labbée	Mark Signoretti	
Amy Mazey	Natalie Tessier	

BOARD MEMBERS REGRET

Ryan Anderson	Abdullah Masood	Michel Parent
Michel Brabant	Renée Carrier	Angela Recollet

STAFF MEMBERS PRESENT

Kathy Dokis	M. Mustafa Hirji	Renée St Onge
Stacey Gilbeau	Stacey Laforest	Meredith McNeil
Renée Higgins	Rachel Quesnel, Recorder	

M. SIGNORETTI PRESIDING

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

The meeting was called to order at 1:30 p.m.

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

The agenda package was pre-circulated.

4. DELEGATION/PRESENTATION

i) Infection Prevention and Control Hub Program

- Stephanie Zakrocki, Manager, IPAC Hub, Health Protection Division
- Behnam Farhoudi, IPAC Practitioner, Health Protection Division

M.M. Hirji introduced the speakers noting that Infection Prevention and Control (IPAC) Hubs were established by the Ministry of Health in winter 2020/21 in response to many tragic deaths in long-term care homes and other congregate settings during the early days of COVID-19 pandemic; in March 2024 they were announced to become a permanent provincial program. The presentation outlined the background, purpose, and evolution of IPAC Hub since being established at Public Health Sudbury & Districts in 2021. The presenters described how the Hub's inspection and enforcement mandate has evolved to include mentorship, capacity building, and fostering sustainable IPAC practices across congregate living settings.

The presenters explained that the Hub operates under key principles including influence without authority, supporting those responsible for IPAC, evidence-informed practice, and building internal capacity rather than dependency. Services provided are tailored to the needs of each setting and include education and training, site visits and assessments, policy and program development, outbreak preparedness and management support, and ongoing coaching and mentoring. The Hub supports a wide range of congregate living environments, including long-term care homes, retirement homes, shelters, group homes, and other community settings.

In discussion, Board members asked questions about translating provincial guidance into local practice, the long-term sustainability of the IPAC Hub model, and how the Hub's supportive role differs from regulatory inspection and enforcement activities. It was clarified that, distinct from inspection and compliance processes, the IPAC Hub functions as a voluntary, supportive resource and works alongside facilities to improve IPAC knowledge and practices over time. Board members acknowledged the value of the Hub's work in strengthening infection prevention capacity across the region working towards *Healthier communities for all*. The presenters were thanked for their comprehensive overview and responses to questions.

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. First Meeting – February 19, 2026

ii) Business Arising from Minutes

iii) Report of Standing Committees

iv) Report of the Medical Officer of Health/Chief Executive Officer

a. MOH/CEO Report, April 2026

v) Correspondence

a. Alcohol Labelling

- Letter from Windsor-Essex County Board of Health to the Standing Senate Committee on Social Affairs, Science and Technology, The Senate of Canada, dated March 12, 2026

b. Protecting Workers from Growing Food Insecurity, Exacerbated by U.S. Tariffs

- Resolution passed by the Municipality of Killarney Council at their regular meeting held March 11, 2026
- Letter and Resolution from the Manitoulin-Sudbury District Services Board Chair dated February 24, 2026

c. Food Handler Training – Windsor Essex County Food Premises

- Resolution passed by the Windsor-Essex County Board of Health at their regular meeting held on February 5, 2026

d. Digital Dependence Support and Prevention in Pre-School and School Aged Children

- Resolution passed by Windsor-Essex County Board of Health at their regular meeting held on February 5, 2026

e. Canada's Chief Public Health Officer (effective April 1, 2026)

- Letter of welcome from the Association of Public Health Agencies to Dr. Joss Reimer, Chief Public Health Officer, dated April 1, 2026

f. Chief Medical Officer of Health for Ontario – Reappointment

- Letter from the Association of Public Health Agencies to Dr. Kieran Moore, Chief Medical Officer of Health, dated March 27, 2026

g. Protecting Children and Youth from Online Harms (Bill C-63)

- Letter from Windsor-Essex County Board of Health to the Minister of Canadian Heritage and the Minister of Justice and Attorney General of Canada, dated March 31, 2026
- Letter from Windsor-Essex County Board of Health to the Deputy Premier and Minister of Health and the Minister of Education, dated March 31, 2026

vi) Items of Information

a. alPHa's Workplace Health and Wellness Infographic *This Spring, Take the Active Route*

It was noted that, as discussed at the February Board meeting, the April 2026 Medical Officer of Health report represents the streamlined and strategic report to the Board which includes a link to a newly developed public-facing monthly indicators dashboard.

17-26 APPROVAL OF CONSENT AGENDA

MOVED BY TESSIER –BARCLAY: THAT the Board of Health approve the consent agenda as distributed.

CARRIED

6. NEW BUSINESS

i) Strengthening Critical Infrastructure Resilience in Public Health: Seeking Federal Partnership on Airborne Biological and Cyber Risk

- Briefing note from the Medical Officer of Health and Chief Executive Officer dated April 9, 2026

Recognizing the public health financial constraints, M.M. Hirji, noted that today's briefing note and motion outlines opportunities for Public Health Sudbury & Districts to support federal priorities related to national resilience, critical infrastructure, emergency preparedness, biosecurity/pandemic preparedness, and cybersecurity, in the context of expanded federal investments aligned with NATO defence and security-related spending targets.

Canada, alongside NATO allies, has adopted the goal to increase core defense spending by 2035 to 3.5% of GDP, plus an additional 1.5% of GDP for defense- and security-related spending. It is a challenge for the government to find meaningful areas to apply this spending such that expenditures can be ramped up at such a fast pace. M.M. Hirji indicated that opportunities for Public health agencies to help the federal government solve this challenge by presenting options for investment in areas of local public health focus: in biosecurity and pandemic preparedness, strengthening cybersecurity in critical public health infrastructure, and improving workforce resilience to biothreats that might disrupt critical civilian infrastructure, including access to critical minerals and supplies produced in the Greater Sudbury area.

It was noted that public health is not routinely positioned within federal resilience or critical infrastructure funding frameworks, creating a risk that local public health agencies may be overlooked despite their role in protecting population health, maintaining essential services during emergencies, and safeguarding sensitive data and systems. The proposed areas of investments in resilience, critical infrastructure, and community protection would support meeting Canada's NATO commitments, improve safety and security for all Canadians, and strengthen public health infrastructure in Canada.

Questions and comments were entertained, and Board members congratulated the Medical Officer of Health and team for this innovative initiative.

18-26 STRENGTHENING CRITICAL INFRASTRUCTURE RESILIENCE IN PUBLIC HEALTH: SEEKING FEDERAL PARTNERSHIP ON AIRBORNE BIOLOGICAL AND CYBER RISK

MOVED BY TESSIER - NOLAND: WHEREAS the federal government is seeking credible, evidence-based investments within defence and security-related spending that advance national resilience objectives and align with NATO defence-adjacent accounting frameworks; and

WHEREAS Public Health Sudbury & Districts can assist the federal government in identifying opportunities for investments such as maintaining essential health services during emergencies, safeguarding large volumes of sensitive health data, and supporting pandemic preparedness, biosecurity, and cybersecurity; and

WHEREAS public health is not routinely positioned as part of Canada's critical infrastructure or resilience ecosystem within current federal funding frameworks, creating a risk that the protection of public health may be overlooked for relevant defence-adjacent and resilience-focused investments;

THEREFORE BE IT RESOLVED THAT the Board of Health write to the Minister of National Defense, Minister of Health, Minister of Public Safety, President of the Treasury Board, and the Chief Public Health Officer of Canada to highlight the opportunity to leverage local public health to advance national resilience and cybersecurity priorities under national security-related funding programs;

AND FURTHER THAT the Board directs the Medical Officer of Health to issue a positioning letter to senior officials at Public Safety Canada, Treasury Board of Canada Secretariat, Shared Services Canada, and the Canadian Centre for Cyber Security, to signal the role of local public health within national resilience and cybersecurity priorities.

CARRIED UNANIMOULSY

ii) Support for Transitioning to the Combined DTaP-HB-IPV-Hib Vaccine into Ontario's Publicly Funded Immunization Schedule to Strengthen Early Protection against Hepatitis B

- Resolution passed by the Algoma Public Health Board of Health at their regular meeting held on February 25, 2026

The Medical Officer of Health and Chief Executive Officer noted today's proposed motion supports the Algoma Public Health's resolution advocating for the incorporation of the combined DTaP-HB-IPV-Hib vaccine into Ontario's publicly funded immunization schedule.

The Board was advised that hepatitis B infection when acquired in infancy and early childhood carries a significantly higher risk of becoming chronic, leading to serious long-

term health outcomes. Currently, hepatitis B immunization in Ontario is primarily delivered through a school-based Grade 7 program. A combined infant vaccine would provide earlier protection, improve equitable access, and increase vaccine coverage by integrating hepatitis B immunization into routine infant immunization schedules already delivered by public health.

It was noted that most Canadian jurisdictions, including British Columbia who has done so for over a decade, have implemented infant hepatitis B immunization programs using combination vaccines with no identified safety concerns. Members discussed that combining hepatitis B with existing childhood vaccines would reduce the burden on school-based immunization programs, lessen demands on public health nursing and school administration, and support more efficient delivery of immunization services.

It was also noted that Algoma Public Health is partnering with Simcoe Muskoka District Health Unit to advance this issue at the upcoming alPHa Annual General Meeting, with the goal of establishing this position as a collective local public health priority.

In response to questions, clarification was provided regarding vaccine safety, including that alternatives remain available for individuals with specific contraindications or allergies. Members expressed support for evidence from other provinces where infant hepatitis B programs have been successfully implemented.

19-26 COMBINED DTAP-HB-IPV-HIB VACCINE

MOVED BY LABBÉE – TRAINOR: WHEREAS Algoma Public Health has advocated for the transition to a combined DTaP-HB-IPV-Hib vaccine in Ontario's publicly funded immunization schedule to strengthen early protection against hepatitis B; and

WHEREAS delivering hepatitis B immunization in early childhood through a combination vaccine provides earlier protection, improves equitable access, increases vaccine coverage, and represents a cost-effective, evidence-informed approach aligned with other Canadian jurisdictions ; and

WHEREAS a combination vaccine offers long-term cost savings by reducing healthcare visits and in-school delivery, while continued school-based hepatitis B programs unnecessarily divert public health resources and create avoidable operational and financial pressures.

THEREFORE BE IT RESOLVED THAT the Board of Health endorses Algoma Public Health's position statement advocating for the incorporation of the combined DTaP-HB-IPV-Hib vaccine into Ontario's publicly funded immunization schedule as a measure to advance health equity and support cost-effective immunization delivery;

AND FURTHER THAT this endorsement be communicated to the Ontario Minister of Health, the Chief Medical Officer of Health, and other relevant stakeholders.

CARRIED UNANIMOUSLY

iii) Transition to a Departmental Model at NOSM University & Implications Resulting

- Briefing note from the Medical Officer of Health and Chief Executive Officer dated April 9, 2026

The Medical Officer of Health and Chief Executive Officer presented a briefing note regarding NOSM University's planned transition to a departmental academic structure and the potential implications for Public Health Sudbury & Districts.

The Medical Officer of Health highlighted that NOSM University has been a significant asset for nearly two decades, with Public Health representing a relatively small but longstanding component of the university's activities through in-kind contributions, teaching, and learner placements. As the institution matures, NOSM University is seeking to modernize how it is structured and governed academically. As part of NOSM University 2026–2030 Strategic Plan work and focus on strengthening the university's foundations to enable growth, it intends to develop and implement a departmental structure by 2028. Members were advised that NOSM University does not currently have an academic unit that supports public health research and education. Several potential models used by other Canadian medical schools were described.

A preferred approach being encouraged is a broader department of "community of health" that would integrate public health with other population-focused disciplines, such as dietetics and related health fields. The Medical Officer of Health noted that, if structured appropriately, a community of health model could be beneficial for public health by strengthening public health faculty presence, increasing teaching and research capacity, and supporting locally relevant research focused on population health challenges in Northern Ontario and other underserved areas.

NOSM University's transition presents an opportunity to establish an academic home for public health, potentially enhancing recruitment, training, and retention of public health professionals, as well as supporting applied research and evidence-informed practice. Board members expressed support for continued dialogue and engagement with NOSM University leadership. The Medical Officer of Health indicated that he would reach out to NOSM University to set up a meeting.

iv) Association of Local Public Health Agencies (alPHa)

a) alPHa's 2026 Conference and Annual General Meeting, June 8-10, 2026

- Pre-Notice to Members of 2026 Annual General Meeting
- Preliminary Conference Program
- BOH Section Meeting Agenda
- Call for Resolutions and for 2026 Distinguished Service Awards

Board members are invited to participate in alPHa's Conference and Annual General Meeting, from June 8 to 10, 2026. Interested Board members are asked to reach out to the R. Quesnel who will complete the registration. The costs of registration, accommodation, travel and meals would be covered in accordance with health unit policy.

7. ADDENDUM

20-26 ADDENDUM

MOVED BY MAZEY – NOLAND: THAT this Board of Health deals with the items on the Addendum.

CARRIED

DECLARATIONS OF CONFLICT OF INTEREST
There were no declarations of conflict of interest.

i) alPHa Boards of Health Section Election Meeting – May 5, 2026

- Email from alPHa dated April 15, 2026

M.M. Hirji noted that the Association of Local Public Health Agencies (alPHa), which is governed by a Board of Directors representing Boards of Health across the province, will be holding a Boards of Health Section Zoom election meeting on May 5, 2026, for the purpose of electing Boards of Health Regional Representatives to the alPHa Board of Directors. There are no elections for the North East region at this time; however, all Boards of Health Section members are eligible to participate and vote. Board members interested in attending were asked to advise R. Quesnel, Board Secretary, as Board participation must be registered through the Board office by April 30, 2026.

8. IN CAMERA

21-26 IN CAMERA

MOVED BY TRAINOR – BARCLAY: THAT this Board of Health goes in camera to deal with labour relations or employee negotiations and to deal with information explicitly

supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them. Time: 2:35 p.m.

CARRIED

9. RISE AND REPORT

22-26 RISE AND REPORT

MOVED BY MAZEY – TRAINOR: THAT this Board of Health rises and reports.
Time: 3:09 p.m.

CARRIED

It was reported that two matters were discussed to deal with labour relations or employee negotiations and to deal with information explicitly supplied in confidence to the local board by the province. The following motions emanated:

23-26 APPROVAL OF BOARD OF HEALTH INCAMERA MEETING NOTES

MOVED BY LABBÉE – NOLAND: THAT this Board of Health approve the meeting notes of the January 15, 2065, Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the Municipal Freedom of Information and Protection of Privacy Act.

CARRIED

24-26 CUPE BARGAINING MANDATE

MOVED BY TRAINOR – BARCLAY: THAT the Board of Health direct the Medical Officer of Health and Chief Executive Officer to enter into negotiations with CUPE seeking a settlement aligned with the recommendations in the CUPE Bargaining Mandate briefing note.

CARRIED

10. ANNOUNCEMENTS

- April 16, 2026, Board of Health meeting evaluation

Board members were invited to complete the evaluation for today's Board meeting.

- Next Board of Health Meeting

The next Bord of Health meeting will be held on Thursday, May 21, 2026, at 1:30 p.m.

11. ADJOURNMENT

25-26 ADJOURNMENT

MOVED BY TESSIER – MAZEY: THAT we do now adjourn. Time: 3:15 p.m.

CARRIED

_____ (Chair)

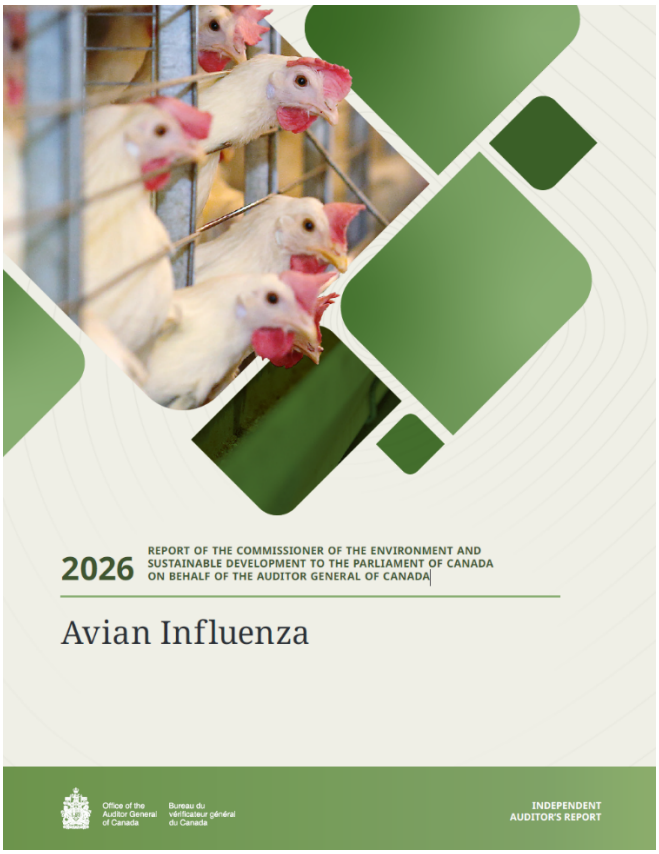
_____ (Secretary)

Public Health
Santé publique
SUDBURY & DISTRICTS

Medical Officer of Health/Chief Executive Officer Board of Health Report, May 2026

Words for thought

Avian Influenza: 2026 Report of the Commissioner of the Environment and Sustainable Development to the Parliament of Canada on Behalf of the Auditor General of Canada



Key facts and findings

- *Since December 2021, the avian influenza virus has been detected in every province and territory, including 43 bird species that are at risk at the federal or provincial level.*
- *Since December 2021, Environment and Climate Change Canada expanded its avian influenza surveillance program for migratory birds by increasing the numbers of samples tested and by including antibody testing in blood samples from wild birds and wild bird eggs.*
- *Between December 2021 and March 2026, approximately 17.3 million commercial birds either died or were culled due to the virus, costing about $360 million in compensation paid by the Canadian Food Inspection Agency.*
- *The Public Health Agency of Canada distributed 39,200 doses of the avian influenza vaccine to the provinces and territories and donated 2,300 doses to the research community.*

Highlights of our recommendations

- *Environment and Climate Change Canada should improve its surveillance methods for detecting highly pathogenic avian influenza in species at risk to understand which species at risk are most vulnerable and susceptible to the impacts of the virus, and to inform the management and conservation of these species.*

- *Given that the Public Health Agency of Canada obtained the financial approval to purchase more avian influenza vaccine doses if needed, the agency should support further procurement decisions based on updated risk assessments, a cost-benefit analysis, and an assessment of demand forecasting for the number of doses that may be needed.*

Date: Retrieved *May 6, 2026. https://www.canada.ca/en/auditor-general/our-work/audit-reports/commissioner-environment-sustainable-development-202605-avian-influenza.html*

Avian influenza is of great concern to human health because avian influenza strains have often found their way into becoming human pathogens, in several cases causing pandemics. Indeed, the original human influenza originated as an avian infection. When avian influenza strains gain the ability to spread more readily in animals, it is a warning sign that a potential new human pandemic virus may be emerging.

Each time a virus spreads, it has the opportunity to mutate. The more spread there is of a virus, the higher probability that a mutation will emerge that could give it pandemic potential.

Since the current strain of avian influenza emerged in December 2021, multiple poultry and wild bird outbreaks have occurred around the world. Several infections were identified in Canada. Like most countries, Canada culled bird populations infected with avian influenza to stop their spread, and prevent further mutation. Canda also delivered vaccinations for farm workers and laboratory workers who are the highest risk for infection. Public Health Sudbury and Districts executed that work locally.

However, the United States has struggled with containing avian influenza. In addition, the virus began to infect large numbers of cattle in the United States in a sustained way, showing a worrying jump from birds to mammals (mammals have been infected elsewhere in the world, but only sporadically). Since 2025, the United States has backed off monitoring the infection along side backing off responding to its spread in poultry and livestock. This has made us effectively blind to the epicentre of avian influenza spread and presumed mutation.

Canada continues to take the threat seriously, as evidenced by this report. Improving surveillance to detect new infections and mutations as well as remove barriers to acquiring more vaccine, if needed, are both sensible recommendations to better position Canada against this threat.

General Report

1. Boil Water Advisory in the City of Greater Sudbury

From May 6–8, the City of Greater Sudbury experienced a widespread boil water advisory, a very unusual incident for a large municipality with sophisticated water treatment. The boil

water advisory was prompted by four lab results demonstrating bacteria in the treated water. Fortunately, with three sets of lab results collected in the ensuing 36 hours showing no further evidence of bacterial contamination, the boil water advisory was lifted. As usual, regular water testing continues to take place to monitor for any risks in the drinking water.

The circumstances causing the bacteria in the lab results have not yet been identified, and Public Health continues to work with the City of Greater Sudbury and in consultation with provincial authorities to see if a definitive cause can be identified. A definitive cause would enable a solution that would provide greater confidence the situation will not recur.

The unusual nature of this incident posed novel communications challenges. The operator of an implicated water treatment plant, in this case the City of Greater Sudbury, has the responsibility to notify all residents. In municipalities who regularly experience boil water advisory, they will visit residents door-to-door. The City of Greater Sudbury faced the daunting task of communicating to over 90,000 residents which likely not possible door-to-door. As well, give such an incident had not occurred in living memory, communications and processes needed to be improvised de novo.

We recognize that both Public Health and the City have opportunities to learn from this incident, including around communications, and Public Health is organizing an after-action review to learn the lessons of this incident and better prepare for the future. High level findings from that review will be shared with the Board once completed later this year.

This incident also serves as a learning opportunity for everyone in terms of the importance of having a 72-hour emergency kit that includes drinking water. Public Health will be doing work to remind the public of this advice to capitalize on the real-world need for such a kit that was just experienced.

2. Hantavirus

Hantavirus is an infection mostly spread by rodents, though the Andes strain (which is the one currently in the news) has the ability to spread person-to-person. Approximately 35% to 50% of those infected will pass away.

Currently, hantavirus has been implicated with an outbreak on a cruise ship in the Atlantic Ocean, as well as linked air travel. As of May 13, there have been 11 people infected, with 3 deaths.

This incident is worrying, and many are concerned this could be a new pandemic like COVID-19. The parallel of a cruise ship outbreak that also kicked off the COVID-19 pandemic is bringing some déja-vu.

Fortunately, an pandemic here is extremely unlikely. COVID-19 was a brand-new virus that had never been seen before when it was identified in December 2019; hantavirus is a rare but vary

well-known virus. COVID-19 spread rapidly; hantavirus does not spread nearly as quickly. Indeed, the Diamond Princess Cruise Ship in February 2020 ended up with 712 infections of COVID-19. The MV Hondius cruise ship has had only 11 hantavirus infections as of May 13, 2026. Unlike COVID-19 which was a novel pathogen that rapidly infected many people; hantavirus is a well-known virus that spreads much more slowly. Current experience on the cruise ship is validating that understanding. Genetic analysis of the virus has also confirmed no major mutations have occurred.

The hantavirus outbreak should be suppressed with careful public health action, particularly isolation of infected persons and their contacts, cutting off opportunity for the virus to spread further. Our agency is coordinating with the province and our peers around the province and is ready to respond swiftly should anyone at risk be identified in our service area.

We wish the best to those who are infected or are contacts, and look forward to to the end of this incident.

3. Outcome Measurement

In alignment with our Strategic Priority of Excellence in Public Health Practice and our Medium-Term Priority to Orient Towards Impact and Outcome, we have launched an effort to define in concrete terms the health outcomes that Public Health achieves. Given we are measuring illnesses that didn't happen, and often illnesses that have been prevented through work done years earlier, this is not an easy task. However, we strive to do the best that can be done so that we can ensure we are increasing those outcomes over time, and so that we can demonstrate to the public and especially our provincial funders the value we bring to the public. We hope to report on the outcome of this work later in the year.

4. Community Drug Strategy of the City of Greater Sudbury: Call to Action

On May 12, 2026, the Community Drug Strategy of the City of Greater Sudbury launched a call to action that outlined priorities for the year, and sought to rally public alignment with those actions. In addition, it is hoped the concrete call to action with an end-of-year report card will bring greater transparency to the good work happening across the community on the substance use challenge.

Public Health is proud to be co-chair and a key partner in this Strategy, and the agency devotes significant in-kind resources to the work of the strategy. At this meeting, a presentation on the Calls ot Action will be shared with Board members for their increased awareness.

5. Measuring Ageism in Sudbury and districts

Public Health Sudbury & Districts has completed data collection for a community wide survey about ageism across different ages. Ageism can shape everyday experiences, such as access to services, feeling respected, and feeling included. These experiences are not just personal. They are shaped by policies, social norms, and community environments, which are important factors that influence health. As our population ages, understanding ageism is an important step toward creating fair and healthy communities for people of all ages.

This work supports the agency's priorities of equal opportunities for health and excellence in public health by strengthening evidence informed decision making. The survey provides local data that help better understand the conditions that support health across the lifespan. These findings support the Board of Health in setting direction, guiding priorities for investment, and strengthening informed advocacy and system leadership with municipal and community partners.

Community response was strong, with over 800 residents participating. Results will be used to guide future health promotion and system level actions to support more inclusive policies, services, and community environments for people of all ages.

6. Financial Report

As of March, cost-shared programs are slightly over budget, which is not unexpected at this point in the year for the approved budget, and improved from the previous month. Most of the reported shortfall ($364,370 or 77%) relates to planned investments in technology-driven efficiencies funded from reserves and reported on the financial statement as expenditures without offsetting revenue; the remaining operating variance ($106,411 or 23%) in part reflects several large purchases occurring early in the fiscal year, and delays in realizing provincial revenue. The 2026 Operating Budget included much smaller margins of error, reflecting that past budgets were overly-conservative, and these smaller margins of error make transient negative variances more likely. Financial performance will continue to be closely monitored and reported to the Board. Should the organization trend towards a deficit position, measures will be taken as appropriate.

7. MOH/CEO Performance Appraisal

Board of Health members and direct reports of MOH/CEO have been invited to provide feedback for the MOH/CEO performance appraisal. The Board of Health Executive Committee will meet to review the feedback before the Board Chair communicates the assessment to the MOH/CEO.

8. Northern MedTalks

Dr. Emily Groot, Associate Medical Officer of Health, was one of the speakers at Science North's Northern MedTalks this year. She spoke eloquently about the dangers of wildfire smoke, and how we protect the public from this health hazard.

9. Strengthening Automated Reporting and Information Governance for Public Health Activity Metrics

Aligned with the strategic direction to leverage technology and improve information management, staff from Knowledge and Strategic Services (KSS) supported the development and implementation of the new monthly *Activity metrics for Public Health* report. Staff centralized and standardized data collection, coordinated selection and definition of indicators, and automated data management processes. As a result, reporting is more efficient, reliable, and sustainable, while strengthening confidence in the metrics used for oversight and public transparency. Next steps will focus on fully automating data flows to further reduce manual data entry and support timely, scalable, and sustainable public reporting.

Activity Metrics for Public Health

Monthly and annually reported Activity Metrics for Public Health provide an overview of activities and showcase the breadth of the agency's work. The metrics highlight essential and routine efforts of Public Health that positively contribute to community well-being. Public Health's accountability monitoring and annual performance and financial reports provide additional information.

Respectfully submitted,

M. Mustafa Hirji, MD, MPH, FRCPC
Medical Officer of Health and Chief Executive Officer

Public Health Sudbury & Districts

STATEMENT OF REVENUE & EXPENDITURES

For The 3 Periods Ending March 31, 2026

Cost Shared Programs

	Adjusted BOH Approved Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over)/under	Balance Available
Revenue:					
MOH - General Program	18,910,969	4,727,742	4,680,948	46,794	14,230,021
MOH - Unorganized Territory	1,092,500	273,125	273,120	5	819,380
Municipal Levies	11,800,921	2,950,230	2,950,139	92	8,850,782
Interest Earned	225,000	56,250	51,998	4,252	173,002
Total Revenues:	$32,029,390	$8,007,347	$7,956,205	$51,143	$24,073,185
Expenditures:					
Corporate Services:					
Corporate Services	5,711,223	1,520,308	2,088,969	(568,661)	3,622,255
Office Admin.	104,350	26,088	19,263	6,824	85,087
Espanola	131,896	33,776	27,757	6,018	104,138
Manitoulin	136,962	35,061	30,936	4,125	106,027
Chapleau	139,335	35,636	32,438	3,198	106,897
Sudbury East	17,880	4,470	5,168	(699)	12,711
Intake	385,472	99,937	101,166	(1,229)	284,306
Facilities Management	792,033	198,008	182,141	15,867	609,892
Electronic Medical Records	149,907	38,865	224,661	(185,796)	(74,754)
Total Corporate Services:	$7,569,059	$1,992,147	$2,712,500	$(720,353)	$4,856,559
Health Protection:					
Environmental Health - General	1,341,750	338,198	329,166	9,031	1,012,583
Enviromental	2,915,324	757,219	691,699	65,520	2,223,624
Vector Borne Disease (VBD)	43,708	8,145	2,974	5,171	40,734
CID	1,688,503	437,676	453,636	(15,960)	1,234,866
Districts - Clinical	250,711	64,990	2,413	62,576	248,298
Risk Reduction	53,756	13,439	3,877	9,562	49,879
Sexual Health	1,580,939	410,947	436,465	(25,518)	1,144,474
SFO- Local Capacity Building: Prevention and Protect	274,327	66,709	62,925	3,784	211,402
Total Health Protection:	$8,149,017	$2,097,323	$1,983,158	$114,165	$6,165,860
Health Promotion and Vaccine Preventable					
Health Promotion and VPD- General	2,575,752	670,768	653,089	17,678	1,922,663
Comprehensive Health Promotion	4,061,800	1,044,821	971,154	73,667	3,090,646
Infant Feeding Clinic	645,413	167,021	165,094	1,927	480,319
Oral Health	540,421	139,797	133,082	6,714	407,339
Healthy Smiles Ontario - HSO	620,744	158,899	179,547	(20,648)	441,197
SFO- Tobacco Control Area Network	280,705	51,567	31,378	20,189	249,327
MOH - Harm Reduction Program Enhancement	191,822	49,678	13,275	36,404	178,547
VPD	2,614,472	677,752	638,634	39,118	1,975,839
MOH - Influenza	0	67	(260)	327	260
MOH - Meningittis	0	125	(3,825)	3,950	3,825
MOH - HPV	0	265	(3,715)	3,979	3,715
MOH - Northern Fruit & Vegetable Program	176,100	71,312	42,481	28,831	133,619
Total Health Promotion:	$11,707,231	$3,032,071	$2,820,048	$212,023	$8,887,184
Knowledge and Strategic Services:					
Knowledge and Strategic Services	3,457,368	887,276	900,516	(13,240)	2,556,852
Workplace Capacity Development	44,457	0	9,884	(9,884)	34,573
Health Equity Office	11,720	2,955	2,851	104	8,869
MOH - Special Nursing Initiative	557,232	144,467	145,855	(1,388)	411,376
Indigenous Public Health	407,705	104,704	105,399	(695)	302,305
MOH Local Model for Indigenous Public Health	125,601	32,563	32,935	(372)	92,666
Total Knowledge and Strategic Services:	$4,604,083	$1,171,966	$1,197,441	$(25,475)	$3,406,642
Total Expenditures:	$32,029,390	$8,293,508	$8,713,146	$(419,639)	$23,316,244
Net Surplus/(Deficit)	$(0)	$(286,160)	$(756,941)	$(470,781)	

Public Health Sudbury & Districts

Cost Shared Programs

STATEMENT OF REVENUE & EXPENDITURES
Summary By Expenditure Category
For The 3 Periods Ending March 31, 2026

	Adjusted BOH Approved Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:					
MOH Funding	32,029,390	8,007,347	7,940,427	66,921	24,088,963
Other Revenue/Transfers	493,475	123,369	267,582	(144,213)	225,893
Total Revenues & Expenditure Recoveries:	32,522,865	8,130,716	8,208,008	(77,292)	24,314,856
Expenditures:					
Salaries	19,814,870	5,139,532	5,642,703	(503,171)	14,172,167
Benefits	7,675,019	1,989,748	1,915,215	74,532	5,759,803
Travel	228,818	41,210	30,374	10,836	198,444
Program Expenses	570,624	148,388	103,099	45,288	467,525
Office Supplies	87,200	20,048	20,299	(251)	66,901
Postage & Courier Services	90,100	22,525	20,876	1,649	69,224
Photocopy Expenses	4,909	1,173	1,085	88	3,824
Telephone Expenses	61,530	15,383	18,582	(3,199)	42,948
Building Maintenance	562,416	140,604	129,341	11,264	433,076
Utilities	190,447	47,612	50,031	(2,420)	140,416
Rent	329,521	82,380	80,096	2,284	249,425
Insurance	125,000	89,250	77,182	12,068	47,818
Employee Assistance Program (EAP)	50,000	12,500	9,516	2,984	40,484
Memberships	51,900	19,275	10,297	8,978	41,603
Staff Development	158,203	22,187	16,755	5,432	141,448
Books & Subscriptions	10,395	3,419	2,038	1,380	8,357
Media & Advertising	55,214	7,554	3,079	4,475	52,136
Professional Fees	697,194	174,298	192,743	(18,444)	504,451
Translation	79,325	20,206	16,313	3,894	63,012
Furniture & Equipment	19,267	4,358	0	4,358	19,267
Information Technology	1,660,914	415,228	625,327	(210,099)	1,035,587
Total Expenditures	32,522,865	8,416,876	8,964,950	(548,073)	23,557,915
Net Surplus (Deficit)	(0)	(286,160)	(756,941)	(470,781)	

Sudbury & District Health Unit o/a Public Health Sudbury & Districts

SUMMARY OF REVENUE & EXPENDITURES

For the Period Ended March 31, 2026

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
100% Funded Programs							
Planet Youth Program	728	179,687	3,070	176,617	1.7%	*Mar 31/2026*	100.0%
LHIN - Falls Prevention Project & LHIN Screen	736	100,000	70,674	29,326	70.7%	*Mar 31/2026*	100.0%
Northern Fruit & Vegetable Program Expansion One-Time	746	152,350	143,165	9,185	94.0%	*Mar 31/2027*	100.0%
Healthy Babies Healthy Children	778	1,725,944	1,659,830	66,114	96.2%	*Mar 31/2026*	100.0%
IPAC Congregate CCM	780	932,250	903,272	28,978	96.9%	*Mar 31/2026*	100.0%
Ontario Senior Dental Care Program	786	1,315,000	238,414	1,076,586	18.1%	*Dec 31*	25.0%
Anonymous Testing	788	64,293	66,893	(2,600)	104.0%	*Mar 31/2026*	100.0%
Total		4,289,837	3,082,248	1,207,589			

Media update on Andes hantavirus situation

From: Public Health Agency of Canada

Statement

May 12, 2026 | Ottawa, ON

The Public Health Agency of Canada, along with other Government of Canada departments and agencies, continues to work closely with domestic and international partners, including the World Health Organization (WHO), to respond to the Andes hantavirus outbreak linked to passengers on the *MV Hondius*.

On May 10, 2026, four Canadian passengers arrived safely in British Columbia (BC). At several points on their return to Canada including on arrival, public health assessments took place, and the individuals were transferred to dedicated accommodations to complete a self-isolation period. All four travellers remain asymptomatic and are being actively monitored and supported by local public health authorities, in compliance with appropriate public health protocols.

The travellers are required to self-isolate for a minimum of 21 days, up to a maximum of 42 days. This period began on May 10, which is the last day that a confirmed case was aboard the ship.

There are currently five other individuals within Canada who are considered as having been **potentially exposed** to confirmed cases of Andes hantavirus: Two individuals who were aboard the *MV Hondius*, but disembarked on an earlier stop before the outbreak was first identified; and three individuals who were potentially exposed to a confirmed Andes hantavirus case on a flight. At this time, all potentially exposed individuals in Canada remain asymptomatic and are being monitored and supported by local public health authorities.

The current total number of high-risk contacts in Canada is nine. Please note that on May 8, 2026 when Dr. Reimer spoke, it was reported that there was a sixth person in Canada who was considered as potentially being exposed during a flight. Based on local public health assessment and the latest contact management guidance from the WHO, it was determined that the individual, living in Québec, is no longer considered to be a high-risk contact.

As the situation continues to evolve, the number of individuals for public health follow-up in Canada in the context of Andes hantavirus may change.

In accordance with WHO guidance, passengers and crew members who were on the affected vessel and individuals identified as high-risk contacts from a flight with a confirmed case should not travel. The Government of Canada is implementing temporary measures that will prevent any passenger and crew that have been aboard the *MV Hondius* since April 1, 2026 from boarding a

flight to Canada, working in collaboration with public health authorities, air carriers, and border officials.

The overall risk to the general population in Canada from the Andes hantavirus outbreak linked to the *MV Hondius* cruise ship remains low.

The Government of Canada will continue to monitor the situation closely and provide updates as needed.

Contacts

Media Relations
Public Health Agency of Canada
613-957-2983
media@hc-sc.gc.ca

Media Relations
Transport Canada
613-993-0055
media@tc.gc.ca

APPROVAL OF CONSENT AGENDA

MOTION: THAT the Board of Health approve the consent agenda as distributed.

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Board of Health for Public Health Sudbury & Districts

From: M.M. Hirji, Medical Officer of Health and Chief Executive Officer

Date: May 14, 2026

Re: Administrative changes to Part 8 of the Ontario Building Code – Transfer of enforcement authority for a geographical subset of on-site sewage systems effective November 1, 2026

☒ For Information ☐ For Discussion ☐ For a Decision

Purpose:

To update the Board of Health on a recent decision by the Ministry of Municipal Affairs and Housing regarding amendments to the Ontario Building Code that transfer authority for the administration and enforcement of Part 8 of the Code (on-site sewage systems) from Public Health Sudbury & Districts to the municipalities of French River, Markstay-Warren, Killarney, and St. Charles, and to outline the implications for Public Health Sudbury & Districts.

Background:

Public Health Sudbury & Districts has historically been deemed in provincial regulation as the principal authority for the administration and enforcement of Sewage Systems for all municipalities and unorganized territories within the Sudbury and Manitoulin Districts. This role includes plan review, permit issuance, inspections, enforcement, and complaint investigations.

In 2024, the municipalities of St.-Charles, French River, Markstay-Warren, and Killarney passed resolutions requesting that authority for Sewage Systems be transferred from Public Health Sudbury & Districts to those municipalities through a shared service arrangement. Public Health staff met with Ministry of Municipal Affairs and Housing representatives in September 2025 and subsequently provided written input outlining practical, legal, operational, financial, and governance considerations associated with such a transfer, based on Public Health Sudbury & Districts' experience as principal authority.

In our written submission, Public Health Sudbury & Districts highlighted several service continuity and risk considerations to support the Ministry's understanding of the potential implications for the affected municipalities. Based on Public Health Sudbury & Districts' experience administering Part 8 services across large geographic areas, economies of scale have historically supported technical expertise, staffing stability, workload variability from region-to-region, and consistent service levels. From this perspective, smaller municipal service areas assuming this responsibility may be more vulnerable to

staff turnover, workload variability, and service disruption, particularly where delivery depends on a limited number of specialized inspectors. The availability of qualified, Building Code Identification Number-certified sewage inspectors remains a province-wide challenge, and non-revenue activities such as complaints and enforcement can be resource-intensive while being essential to protecting health and the environment. In smaller communities, proximity between inspectors, contractors, elected officials, and residents can also create real or perceived conflicts of interest, with associated legal and reputational risks. Finally, if a municipal or shared service arrangement were to become unsustainable in the future, re-transferring authority could result in delays, service gaps, or uncertainty for regulated parties.

Ministry of Municipal Affairs and Housing Decision:

On April 20, 2026, Public Health Sudbury & Districts was formally notified that the Minister of Municipal Affairs and Housing will amend the administrative provisions of the Ontario Building Code to proceed with this transfer. As a result, effective November 1, 2026, enforcement authority for Part 8 of the Ontario Building Code (Sewage Systems) will transfer from the Board of Health for Public Health Sudbury & Districts to the municipalities of St.-Charles, French River, Markstay-Warren, and Killarney within these respective geographic areas. As of that date, those municipalities will be responsible for issuing sewage permits, conducting inspections, responding to complaints and malfunctions, and carrying out enforcement actions under the Building Code Act. Public Health Sudbury & Districts will remain designated with enforcement authority for all unorganized territories within its service area, as well as for all other municipalities across the Sudbury and Manitoulin Districts.

Operational Implications:

Public Health Sudbury & Districts' Sewage Systems enforcement workload will be reduced through the removal of permit, inspection, and enforcement activities in the four affected municipalities. In advance of the November 1, 2026, effective date, Public Health Sudbury & Districts must undertake a coordinated transition process, including the transfer of historical sewage system records, sharing high-level program information with the receiving municipalities, and coordinating external communications to ensure homeowners, contractors, and designers understand the change in enforcement authority.

The transition is administratively complex. Sewage system records span several decades and exist in both paper and electronic formats, with varying levels of completeness. In addition, there will be open or active files at different stages of the approval and inspection process at the time of transfer, such as permits issued but not yet finalized or inspections partially completed. Managing these files in a clear and defensible way will be a key focus of transition planning.

To support clarity and manage expectations, Public Health Sudbury & Districts is working toward the development of a Memorandum of Understanding with the affected municipalities that will outline responsibilities related to record transfer, information sharing, and communications, while clearly identifying activities that fall outside Public Health Sudbury & Districts' role following the transfer.

Financial Implications:
Public Health Sudbury & Districts will need to assess the staffing impacts associated with this reduction in workload, and the ensuing implications for future budgets. In addition, short-term transition costs, such as record preparation, administrative coordination, and staff time devoted to the transfer process, will need to be considered and tracked as part of implementation planning.

Sewage Systems programming is delivered on a cost-recovery basis, and so application fees are intended to recover the cost of ongoing service delivery. Therefore, the long-term net budget impact in future years is expected to be minimal.

However, the cost recovery nature of application fees do not consider the funds needed to support one-time transition activities driven by this Ministerial decision. Accordingly, once transition costs are better defined, Public Health Sudbury & Districts plans to request that the Ministry of Municipal Affairs and Housing provide funding to recoup reasonable and verifiable expenses associated with the transfer, in order to avoid those costs being born by the municipal levies of all other municipalities of our service area.

Ontario Public Health Standard: Not applicable. Sewage Systems programming is governed by the *Ontario Building Code Act* and the Ministry of Municipal Affairs and Housing.

Strategic Priority: This change is provincial direction and not aligned with any strategic priority.

Contact:
Stacey Laforest, Director, Health Protection Division

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Board of Health for Public Health Sudbury & Districts

From: M.M. Hirji, Medical Officer of Health/Chief Executive Officer

Date: May 14, 2026

Re: Buy Ontario Procurement directive –Implications for Public Health

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☒ For Information ☐ For Discussion ☐ For a Decision

Issue: To inform the Board of Health of the Province's phased implementation of the Municipal Buy Ontario Procurement Directive, which introduces procurement requirements related to fleet vehicles and capital infrastructure for local boards of health effective June 1, 2026. Public Health's anticipated impact is minimal, but changes to internal processes are being made to ensure alignment with the directive.

Recommended Action: That the Board of Health receive this briefing note for information.

Alternative Actions: None Recommended

Background: In Fall 2025, Ontario introduced and enacted the *Buy Ontario Act (Public Sector Procurement), 2025,* enabling the Province to issue procurement directives requiring public sector entities to prioritize Ontario/Canadian goods and services. This directive reflects the Province's broader objective to use public sector procurement to support Ontario and Canadian businesses, particularly in response to recent protectionist US trade policies. Municipalities, local boards (including boards of health), and municipal services corporations are prescribed as public sector entities under the *Act* and must comply with the Municipal Buy Ontario Procurement Directive.

The Province has advised that the effective date for local boards (including boards of health) to implement by Ontario/Canadian provisions is **June 1, 2026.** The Board of Health will be required to buy Ontario/Canadian for the Fleet Vehicles strategic category and Capital Infrastructure strategic category, as well as to maintain required documentation on these procurements.

Requirement #1 - General (documentation & reporting):
Municipal sector entities must retain documentation supporting procurements covered by the directive and must be able to provide information/data as requested by Supply Ontario and relevant ministries.

Public Health will ensure purchasing documentation demonstrates compliance with the directive and retain relevant documents.

Requirement #2 - Fleet Vehicles:
Applies to new procurements of new light-duty passenger fleet vehicles with Gross Vehicle Weight Rating (GVWR) ≤ 4,500 kg, regardless of procurement method/value. The directive sets a required prioritization sequence (Made-in-Ontario; then Ontario Vehicle Producer; then alternatives with documented rationale/approval). Exclusions include, among others, short-term leases up to 12 months, used vehicles, and physically modified/upfitted specialty vehicles (e.g., ambulances).

Public Health's impact is expected to remain minimal because Public Health does not have a fleet. Should future light-duty vehicle purchases occur, the directive's prioritization and documentation requirements would apply.

Requirement #3 - Capital Infrastructure:
Applies to new capital infrastructure procurements, defined to include construction (including repair/renovation) and fixtures/furniture/equipment incidental to construction and needed for operational readiness immediately following completion. The directive does not apply to procurement of medical equipment or information technology and generally does not apply to routine maintenance unless it involves repairing/renovating the physical structure.

For each in-scope capital infrastructure procurement, entities must include requirements such as a list of major goods/services and require vendors to submit a Domestic Supply Chain Plan, which must be evaluated/used via one of the permitted methods described in the directive. Where Public Health undertakes in-scope capital work, the impact is expected to be primarily administrative, including incorporating Domestic Supply Chain Plan requirements into procurement documents and applying the required evaluation approach.

Exemptions / limitations noted by the Province:
- The directive does not apply to procurements needed to address situations that are urgent and unforeseen (e.g., emergencies).
- The directive does not prevail over legislation.

Implications for Public Health (anticipated)
Public Health's anticipated impact is minimal, as we do not operate a fleet and rarely undertake capital infrastructure projects.

There is a minor increased compliance risk as failure to retain required documentation or apply Domestic Supply Chain Plan requirements to in-scope capital procurements could create compliance exposure if information is requested by Supply Ontario or ministries.

Financial Implications: At this time, there are no direct incremental costs identified solely from the directive. Potential indirect impacts relate to staff time for procurement documentation and ensuring bid documents contain required elements for in-scope capital procurements.

IT team and IT infrastructure implications: There are no significant IT team or IT infrastructure implications associated with the Municipal Buy Ontario Procurement Directive.

Minor, ad hoc involvement from IT may occur if procurement documentation is stored within shared digital repositories or if records are requested electronically by Supply Ontario or ministries; however, this is considered routine support and is not expected to result in additional workload, system changes, or resource pressures for the IT team.

Ontario Public Health Standard: Effective Public Health Practice

Strategic Priority: Excellence in Public Health Practice

Author: Renée Higgins, Director, Corporate Services

From: allhealthunits on behalf of alPHa communications
To: "allhealthunits@lists.alphaweb.org"
Cc: Board
Subject: [allhealthunits] 2026 Resolutions for Consideration | AGM & Conference Registration Reminder
Date: April 27, 2026 1:32:51 PM
Attachments: image001.jpg
image002.jpg

Dear alPHa Members,

The 2026 alPHa Annual General Meeting (AGM) and Conference is taking place in-person in Toronto at the Radisson Blu Toronto Downtown from June 8–10. Spots are filling quickly, and we encourage you to register as soon as possible. Thank you to the many Members who have already registered — we are pleased to see such strong engagement. **Please note that while conference registration remains open, the mobile workshop has sold out.**

This year's AGM and Conference marks the launch of alPHa's 40th Anniversary and provides a valuable opportunity to connect and engage on key public health priorities. alPHa would like to thank Northwestern Health Unit for co-hosting the event. We would also like to thank Platinum Sponsors The Personal, NaloxONE, GenWell, and Leaders for Leaders, and sponsor Mosey & Mosey for their generous event support.

New on the conference webpage are the 2026 Resolutions for Consideration documents (which are also attached to this e-mail), including:

- The voting registration list, which should be sent to Melanie Dziengo (communications@alphaweb.org) by 4:30 p.m. on Friday, May 29.

Important links:

- **Registration**
- **Draft Conference Program**
- **BOH Section Meeting Agenda**
- **Notice to Members of 2026 Annual General Meeting**
- **NEW! 2026 Resolutions for Consideration**
- **Sponsorship Prospectus**

Preliminary Program highlights include:

- Welcoming remarks from: Hon. Doug Ford, Premier of Ontario (invited), Hon. Sylvia Jones, Deputy Premier and Minister of Health (invited), Dr. Rebecca Hicks, President, Ontario Medical Association, and Doug Lawrance, Chair, Northwestern Health Unit Board of Health.
- The conference will be chaired by Dr. Hsiu-Li Wang, Chair, alPHa.
- Conference session speakers include (in order of appearance): Margaret Froh, President, Métis Nation of Ontario; Adalsteinn Brown, Dean, Dalla Lana School of Public Health, University of Toronto, and Dr. Na-Koshie Lamptey, Medical and

Scientific Support, Population Health, Public Health Ontario; Sabine Matheson, Principal, StrategyCorp; Cynthia St. John, Affiliate Representative, Board of Directors, alPHa, and Marilyn Herbacz, CEO, Northwestern Health Unit, and Dr. Kieran Moore, Chief Medical Officer of Health.

- The AGM and Resolutions Session Chair and Parliamentarian is Dr. Robert Kyle, Commissioner and Medical Officer of Health, Durham Region Health Department.
- Distinguished Service Awards and Board Recognition Luncheon Celebrating Leadership in Ontario Public Health.
- Connection sessions with Claudia Valle from Leaders for Leaders.

Stay tuned for more information and confirmation of additional speakers.

MOBILE WORKSHOP SOLD OUT AS OF TUESDAY, APRIL 7, 2026

Mobile Workshop highlights:

Join us for an engaging mobile workshop along Toronto's iconic waterfront where participants will explore how the built environment shapes the health and well-being of our communities. Participants will experience vibrant public spaces, innovative urban planning, and the evolving relationship between the City of Toronto and Lake Ontario. This interactive walking tour will feature HTO Park, the Music Garden, and Harbourfront, highlighting how these public spaces contribute to vibrant, inclusive, and resilient communities. Workshop Leaders: Hon Lu, Senior Project Manager, Toronto Region Conservation Authority, Dan Nicholson, Manager, Community Planning, City of Toronto, and Raconteur: Dr. Charles Gardner, COMOH Emeritus Member and longstanding built environment enthusiast! *Numbers are limited and all participants must be registered. Mobile workshop will take place rain or shine. The workshop will begin and end at the Radisson Blu.*

The BOH Section Meeting Agenda highlights include:

- *Setting the Stage: The Governance Moment Before Us*, Speaker: Loretta Ryan, Chief Executive Officer, alPHa
- *Appointments, Authorities & Accountability*, Presenters: James LeNoury, Principal, LeNoury Law/alPHa Legal Counsel in conversation with Adam Malek, Partner, Allen & Malek LLP
- *Walk the Talk: Embedding Health Promotion into Governance*, Facilitator: Shannon Robinson, alPHa Board of Directors, HPO Affiliate
- *Association of Municipalities of Ontario (AMO) Update*, Speaker: Alicia Neufeld, Associate Director, AMO
- *From Principle to Practice — Building High-Impact Skills-Based Boards*, Speakers: Jim Pine, MPA, Consultancy & Strategy, and Dr. Eileen de Villa, Senior Fellow, Dalla Lana School of Public Health & Consultant in Public Health

alPHa would like to thank Northwestern Health Unit and the members of the board of

directors who have generously taken on the moderator roles, including (in order of appearance): Dr. Kit Young Hoon, Medical Officer of Health, Northwestern Health Unit, Board of Directors, alPHa; Bernia Martin, Vice Chair, Board of Directors, alPHa, Dr. Pepi McTavish, COMOH Section Chair, Board of Directors, alPHa, and Trudy Sachowski, Board of Directors, alPHa.

Timeline and other key information:

June 8:

- Mobile Workshop - Toronto Waterfront - 2 p.m. to 4 p.m. EDT – **SOLD OUT AS OF APRIL 7, 2026**
- Opening Reception - 5 p.m. to 7 p.m. EDT

June 9:

- AGM & Conference - 8:15 a.m. to 4:30 p.m. EDT

June 10:

- BOH Section & COMOH Section Meetings - 9 a.m. to 12 p.m. EDT
- *Leading Change* Leadership Workshop with Tim Arnold from Leaders for Leaders – 1:30 p.m. to 4:30 p.m. EDT

  Participation is limited to one senior leader per public health unit.
  Details were shared in earlier/separate communication, and this workshop is not part of the conference registration process.

Accommodation and travel information:

- **Please note, the block of rooms at Radisson Blu is almost sold out. Once the block is full, accommodations may still be available at Radisson Blu at the regular rate or at Union Hotel. Attendees are encouraged to book sooner rather than later.**
- For a more budget-friendly option, attendees willing to walk (30+ minutes) or take the TTC may wish to consider George Brown Polytechnic's two-bedroom suites.
- alPHa Members are encouraged to use public transit. From Union Station, take the 509 Harbourfront streetcar westbound. If you're not carrying luggage, it's a pleasant 15–20-minute walk from Union Station. If you are driving, there is parking available at and near Radisson Blu.

We look forward to seeing you at the AGM and Conference.
Take Care,
Loretta

_____

Loretta Ryan, CAE, RPP
Chief Executive Officer
Association of Local Public Health Agencies (alPHa)
PO Box 73510, RPO Wychwood

Toronto, ON M6C 4A7
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loretta@alphaweb.org
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alPHa
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PUBLIC HEALTH
Agencies

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Providing leadership in public health management

NOTICE

2026 ANNUAL GENERAL MEETING

NOTICE is hereby given the 2026 Annual General Meeting of the ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES (alPHa) will be held in Toronto on Tuesday, June 9, 2026, at 10:15 a.m. Eastern Daylight Time during the 2026 Annual Conference.

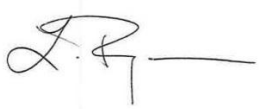
Member Representatives of the Association in good standing at the time of the meeting are entitled to vote.

The Annual General Meeting is being held for the following purposes:

1. To consider and approve the minutes of the 2025 Annual General Meeting;
2. To receive and adopt the annual reports from the Chair, Chief Executive Officer, Section Chairs, and others, as appropriate;
3. To consider and approve the Audited Financial Statements for the 2025–2026 fiscal year;
4. To appoint an auditor for the 2026–2027 fiscal year; and
5. To transact such other business as may properly be brought before the meeting.

DATED at Toronto, Ontario, Thursday, April 23, 2026.

BY ORDER OF THE BOARD OF DIRECTORS.



Loretta Ryan
Chief Executive Officer

Strengthening Public Health Leadership in a Changing Landscape

Preliminary Program

Draft as of April 7, 2026

June 8: Mobile Workshop 2 p.m. to 4 p.m. EDT

Opening Reception 5 p.m. to 7 p.m. EDT

June 9: AGM & Conference 8:15 a.m. to 4:30 p.m. EDT

June 10: BOH Section & COMOH Section Meetings 9 a.m. to 12 p.m. EDT

Radisson Blu, Toronto Downtown

249 Queens Quay W, Toronto, ON M5J 2N5

June 8	
Join us for an engaging mobile workshop along Toronto's iconic waterfront where participants will explore how the built environment shapes the health and well-being of our communities. Participants will experience vibrant public spaces, innovative urban planning, and the evolving relationship between the City of Toronto and Lake Ontario. This interactive walking tour will feature HTO Park, the Music Garden, and Harbourfront, highlighting how these public spaces contribute to vibrant, inclusive, and resilient communities. Workshop Leaders: Hon Lu, Senior Project Manager, Toronto Region Conservation Authority Dan Nicholson, Manager, Community Planning, City of Toronto Raconteur: Dr. Charles Gardner, COMOH Emeritus Member and longstanding built environment enthusiast! *Numbers are limited and all participants must be registered. The mobile workshop will take place rain or shine. The workshop will begin and end at the Radisson Blu.*	2:00 p.m. – 4:00 p.m.

Opening Reception You are cordially invited to join colleagues both familiar and new for a reception at the Radisson Blu Toronto Downtown, featuring spectacular views of the Toronto waterfront. The evening will include a cash bar and light refreshments. New for this year, GenWell's Founder, Pete Bombaci will be facilitating opportunities to connect and reconnect with colleagues and special guests.	5:00 p.m. – 7:00 p.m.
June 9	
Breakfast will be available from 7:30 a.m. to 8:15 a.m.	
Connection before Content We will start the day with Claudia Valle from Leaders for Leaders, and before we dive into the morning agenda, we will take a few minutes to connect and chat with each other — because the best conversations start with genuine connection.	8:00 a.m. – 8:15 a.m.
Call to Order, Remarks, and Land Acknowledgement Speakers: Dr. Hsiu-Li Wang, Chair, Board of Directors, alPHa **Welcoming Remarks** Hon. Doug Ford, Premier of Ontario *(invited)* Hon. Sylvia Jones, Deputy Premier and Minister of Health *(invited)* Dr. Rebecca Hicks, President, Ontario Medical Association Doug Lawrance, Chair, Northwestern Health Unit Board of Health The conference will open with a call to order, land acknowledgement, and welcoming remarks, setting the stage for the important conversations and collaboration ahead.	8:15 a.m. – 8:45 a.m.
Advancing Public Health Through Métis Leadership and Partnership in Ontario Speaker: Margaret Froh, President of the Métis Nation of Ontario (MNO) Margaret Froh will discuss the role of Métis leadership in advancing health equity and strengthening Ontario's local public health system. The session will highlight MNO's community-driven health initiatives, including the Chronic Disease Surveillance Program conducted with ICES, which has identified higher rates of chronic diseases among Métis people in Ontario. It will also explore opportunities for collaboration between the MNO and Ontario's public health system to support the health and well-being of Métis communities.	8:45 a.m. – 9:15 a.m.

Projected Patterns of Illness in Ontario Speaker: Adalsteinn Brown, Dean, Dalla Lana School of Public Health, University of Toronto and Dr. Na-Koshie Lamptey, Deputy Chief, Medical and Scientific Support, Population Health, Public Health Ontario Moderator: Dr. Kit Young Hoon, Board of Directors, alPHa Conducted in collaboration with the Ontario Hospital Association (OHA), the Dalla Lana School of Public Health recently released a study on the *Projected Patterns of Illness in Ontario*. The study examines the future burden of illness across the province and its implications for the health system. Region-specific data highlights the growing impact of chronic disease and multimorbidity and underscores the importance of targeted prevention and chronic disease management. These findings provide an important lens for system planning over the next two decades, including the need for a sustainable local public health system.	9:15 a.m. – 10:00 a.m.
Morning Break Network, connect, reconnect, and engage with colleagues as you enjoy refreshments in the foyer.	10:00 a.m. – 10:15 a.m.
Combined alPHa Business Meeting and Resolutions Session Speakers: Dr. Hsiu-Li Wang, Chair, Board of Directors, alPHa, and Loretta Ryan, Chief Executive Officer, alPHa Resolutions Chair and Parliamentarian: Dr. Robert Kyle, Commissioner and Medical Officer of Health, Durham Region Health Department This session will include the Association's annual business meeting and consideration of Resolutions submitted by members. Resolutions provide a mechanism for boards of health and public health leaders to identify emerging issues, establish policy positions, and guide alPHa's public policy positions on matters affecting Ontario's public health system. Members will review and vote on submitted Resolutions, which help shape the association's priorities and inform alPHa's engagement with provincial and municipal partners and decision-makers. **Final Reflection Activity** At the end of the session, we will take a moment to reflect and re-set for the afternoon, with Claudia Valle from Leaders for Leaders.	10:15 a.m. – 12:15 p.m.

Distinguished Service Awards and Board Recognition Luncheon **Celebrating Leadership in Ontario Public Health** Speakers: Dr. Hsiu-Li Wang, Chair, Board of Directors, alPHa, and Loretta Ryan, Chief Executive Officer, alPHa The Distinguished Service Award (DSA) is given by alPHa to individuals in recognition of their outstanding contributions to public health in Ontario by board of health members, health unit staff, and public health professionals. The Award is given to those individuals who have demonstrated exceptional qualities of leadership in their own milieu, achieved tangible results through long service or distinctive acts, and shown exemplary devotion to public health. alPHa will also recognize members of the Board of Directors whose leadership and service have strengthened the association and Ontario's local public health system.	12:15 p.m. – 1:45 p.m.
Navigating Ontario's Political Landscape in Increasingly Challenging Times Speaker: Sabine Matheson, Principal, StrategyCorp Moderator: Bernia Martin, Vice Chair, Board of Directors, alPHa Back by popular demand! We live in an increasingly uncertain world. The political landscape continues to change. Hear about what to expect regarding the public policy climate and key political issues impacting public health agencies and their local boards of health.	1:45 p.m. – 2:30 p.m.
Public Health Funding: What's on the Horizon Speakers: Cynthia St. John, Affiliate Representative, Board of Directors, alPHa, and Marilyn Herbacz, CEO, Northwestern Health Unit As Ontario's public health system continues to evolve, the funding landscape is shifting in ways that will shape local capacity, partnerships, and long-term sustainability. This session offers a forward-looking exploration of what may be ahead, acknowledging both the challenges and the opportunities emerging on the horizon. Cynthia St. John and Marilyn Herbacz will share insights on navigating uncertainty with clarity and collaboration, inviting participants to reflect on how we prepare—collectively and strategically—for the future of public health funding.	2:30 p.m. – 3:00 p.m.
Afternoon Break **Enjoy refreshments while networking with colleagues and continuing the day's conversations.**	3:00 p.m. – 3:30 p.m.
Update from the Chief Medical Officer of Health Speaker: Dr. Kieran Moore, Chief Medical Officer of Health Moderator: Dr. Pepi McTavish, COMOH Section Chair, Board of Directors, alPHa Dr. Kieran Moore, Ontario's Chief Medical Officer of Health, will provide an	3:30 p.m. – 4:25 p.m.

update on current priorities, emerging public health issues, and key provincial initiatives impacting local public health agencies.	
Closing Remarks, Door Prize and Adjournment Speakers: Dr. Hsiu-Li Wang, Chair, Board of Directors, alPHa, and Loretta Ryan, Chief Executive Officer, alPHa	4:25 p.m. – 4:30 p.m.
June 10	
Breakfast will be available starting at 8:00 a.m. **Section Meetings:** *Members of the alPHa BOH Section and Affiliates and alPHa COMOH Section will meet in the morning. There are separate agendas for these meetings.*	9:00 a.m. – 12:00 p.m.

This event is co-hosted by alPHa and Northwestern Health Unit

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With special thanks to:

DRYDEN FIBRE CANADA

Boards of Health (BOH) Section Meeting Agenda

June 10, 2026, from 9:00 a.m. to 12:00 p.m. EDT

Radisson Blu, Toronto Downtown

249 Queens Quay W, Toronto, ON M5J 2N5

Draft as of May 12, 2026

Breakfast will be available starting at 8:00 a.m.	8:00 a.m. – 9:00 a.m.
Call to Order, Opening Remarks, Land Acknowledgement, Section Business, and Approval of Minutes Speaker: Chair, BOH Section, alPHa (2026-2027) and Chair, Board of Directors alPHa	9:00 a.m. – 9:05 a.m.
Setting the Stage: The Governance Moment Before Us Speaker: Loretta Ryan, alPHa Chief Executive Officer This opening session sets the foundation for the day by highlighting the governance moment before us and the opportunities created by upcoming municipal and board transitions. This session includes alPHa's new products, transition resources, and tools launching in Fall 2026 to support boards from orientation through to optimization. This session prepares participants for a program designed to deepen readiness, strengthen leadership, and governance excellence across Ontario's public health system.	9:05 a.m. – 9:30 a.m.
Appointments, Authorities & Accountability Presenters: James LeNoury, Principal, LeNoury Law and alPHa Legal Counsel in conversation with Adam Malek, Partner, Allen & Malek LLP Reviewing legal frameworks for board appointments, authority, and accountability, with a focus on governance implications and risk mitigation.	9:30 a.m. – 10:00 a.m.

Walk the Talk: Embedding Health Promotion into Governance Facilitator: Shannon Robinson, alPHa Board of Directors, HPO Affiliate A practical demonstration of integrating health promotion principles into governance practice, including guided movement to illustrate how healthy meeting design supports focus, engagement, and leadership effectiveness.	10:00 a.m. – 10:10 a.m.
Networking Break Connect with colleagues and enjoy refreshments in the foyer.	10:10 a.m. – 10:30 a.m.
Association of Municipalities of Ontario (AMO) Update Speaker: Alicia Neufeld, Associate Director, AMO Moderator: Loretta Ryan, Chief Executive Officer, alPHa AMO works with Ontario's 444 municipalities to make municipal governments stronger and more effective. Participants will receive an update from AMO with a focus on their recent work.	10:30 a.m. – 11:00 a.m.
From Principle to Practice — Building High-Impact Skills-Based Boards Speakers: Jim Pine, MPA, Consultancy & Strategy and Dr. Eileen de Villa, Senior Fellow, Dalla Lana School of Public Health & Consultant in Public Health Moderator: Trudy Sachowski, Board of Directors, alPHa This session explores how Boards of Health can strengthen governance capacity within an appointments-based system. The discussion will focus on: • Lived governance experience from municipal and public health leadership perspectives • Practical governance tools such as skills matrices, board orientation, and ongoing education • The importance of board culture, leadership alignment, and intentional governance practices • Awareness of alPHa governance supports available to boards The conversation is designed to be story-driven, reflective, and practical, highlighting how boards can strengthen governance even when membership is appointed.	11:00 a.m. – 11:55 a.m.
Closing Remarks, Door Prize and Adjournment Chair, BOH Section, alPHa and Loretta Ryan, CEO, alPHa	11:55 a.m. – 12:00 p.m.

This event is co-hosted by alPHa and Northwestern Health Unit

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With special thanks to:

DRYDEN FIBRE CANADA

To:	Chairs and Members of Boards of Health Medical Officers of Health and Associate Medical Officers of Health Presidents of Affiliate Organizations
From:	Loretta Ryan, Chief Executive Officer
Subject:	alPHa Resolutions for Consideration at the June 9, 2026 Annual General Meeting
Date:	April 27, 2026

Please find enclosed a package of the resolutions to be considered at the Resolutions Session taking place following the 2026 Annual General Meeting (AGM) and important information on voting procedures.

Four (4) Resolutions were submitted for consideration. These have been reviewed by the alPHa Executive Committee and recommended for debate by the alPHa Membership at the Resolutions Session.

IMPORTANT NOTE FOR VOTING DELEGATES:

Members must register to vote at the Resolutions Session by filling out the attached registration form, wherein member Health Units must indicate who they are designating as voting delegates and which delegates will require a proxy vote.

Eligible voting delegates include Medical Officers of Health, Associate Medical Officers of Health, Acting Medical Officers of Health, members of a Board of Health and senior members in any of alPHa's Affiliate Member Organizations. Each delegate will be voting on behalf of their health unit and only one proxy vote is allowed per person, up to the maximum total allocated per health unit. (Please see the attached voter registration document that is in word format).

The completed registration form must be received by Melanie Dziengo (communications@alphaweb.org) no later than 4:30 pm on May 29, 2026.

If you have any questions on the above, please contact Loretta Ryan, Chief Executive Officer, loretta@alphaweb.org / 416-595-0006, x 222.

Enclosures:
Resolutions Voting Registration Form
Number of Resolutions Votes Allocated per Health Unit
2026 Resolutions for Consideration

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Agencies

Allocation of Votes: alPHa Resolutions Revised 2025		
Health Unit	**Population**	**Voting Delegates**
TORONTO*	2,794,356	**20**
POPULATION 1,000,000 and OVER **		**8**
Ottawa	1,017,449	
Peel	1,451,022	
York	1,173,334	
POPULATION OVER 400,000		**7**
Durham	696,992	
Halton	596,637	
Hamilton	569,353	
Middlesex-London	500,563	
Niagara	477,941	
Simcoe-Muskoka	599,843	
South East	558,292	
Waterloo	587,165	
Windsor Essex	422,860	
POPULATION 300,001 – 400,000		**6**
Lakelands	336,864	
Wellington-Dufferin-Guelph	307,283	
POPULATION 200,000 – 300,000		**5**
Eastern Ontario	210,276	
Grand Erie	261,643	
Southwestern	216,533	
Sudbury	202,431	
POPULATION UNDER 200,000		**4**
Algoma	112,764	
Chatham-Kent	104,316	
Grey Bruce	174,301	
Huron Perth	142,931	
Lambton	128,154	
North Bay-Parry Sound	129,362	
Northeastern	113,582	
Northwestern	77,338	
Renfrew	107,522	
Thunder Bay	152,885	

* total number of votes for Toronto endorsed by membership at 1998 Annual Conference
**new allocation category of population >1M endorsed by membership at 2023 Annual Conference

Health Unit population statistics taken from: Statistics Canada – 2021 Census Profiles – Sorted by Health Region

Resolutions for Consideration
2026

Resolutions Session
2026 Annual General Meeting
Tuesday, June 9, 2026

Resolution #	Title	Sponsor	Page
A26-01	**Strengthening Hepatitis B Prevention in Ontario Through Vaccination in the First Year of Life**	**The Board of Health for the District of Algoma Health Unit (Algoma Public Health); The Board of Health for the Simcoe Muskoka District Health Unit (Simcoe Muskoka District Health Unit)**	**5**

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) writes to the Ontario Minister of Health recommending a review in consultation with the Ontario Immunization Advisory Committee and/or the National Advisory Committee on Immunization regarding shifting universal HBV vaccination from Grade 7 to the first year of life, based on existing epidemiologic and economic evidence and programmatic considerations, in order to strengthen early protection against HBV, reduce preventable chronic infections, and advance health equity for children and families across Ontario;

AND FURTHER that alPHa recommends that the Minister of Health specifically considers the adoption of the combined DTaP-HB-IPV-Hib vaccine given at 2, 4, and 6 months of age as the preferred option for Ontario given its ability to seamlessly integrate into the existing vaccination schedule;

alPHa's long-standing position is that all vaccines licensed in Canada should be publicly funded and made available through Boards of Health for administration to the categories of individuals as recommended by the National Advisory Committee on Immunization (NACI). NACI has concluded that HBV vaccination in the first year of life provides long-lasting protection and that acceptable schedule options in the first year of life include either vaccination at birth or later in infancy

Staff Recommendation: Key Strategic Direction; include in package as submitted.

A26-02	**Strengthening Certified Public Health Inspector Capacity to Support Delivery of the Ontario Public Health Standards**	**ASPHIO**	**10**

THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies of Ontario (alPHa) respectfully request that the Province of Ontario, through the Ministry of Health:

1. Provide sustained, base funding to local public health agencies to support the hiring of up to 150 additional certified Public Health Inspectors across Ontario, to strengthen PHI staffing capacity and support consistent delivery of OPHS requirements. This estimate reflects anticipated provincial workforce gaps, emerging workload pressures, and replacement-rate forecasting for attrition and retirements; and
2. Undertake a provincial PHI workforce assessment and forecasting approach, aligned with the Ministry-led PHI Workforce Capacity Working Group, to identify current and projected workforce needs and to inform evidence-informed and equitable distribution of PHI resources; and
3. Continue to advance education, recruitment, and practicum capacity initiatives—including mentorship supports and standardized practicum approaches—in partnership with accredited

institutions, Boards of Health, ASPHIO, and the Canadian Institute of Public Health Inspectors (Ontario Branch); and

4. Support retention and professional sustainability strategies, including targeted approaches for northern and rural communities, and investments in professional development and mentorship to support early-career PHIs and succession planning; and
5. Recognize PHI capacity as essential health and economic system infrastructure requiring stable and predictable investment to support OPHS compliance, emergency readiness, and ongoing protection of Ontarians.

One of alPHa's central purposes is to ensure boards of health can deliver their basic mandated programs under the OPHS through government commitments to sustained and adequate resources (financial, human and supportive).

Staff Recommendation: Key Strategic Direction; include in package as submitted.

A26-03	**Mandatory and Regulated Alcohol Labelling on Alcohol Manufactured or Sold in Canada**	**Middlesex-London Health Unit (MLHU) and Toronto Public Health (TPH)**	**15**

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies call on the Federal Government to amend the *Food and Drugs Act* to mandate alcohol labelling including:

- Health Warnings: prominent, rotating warnings on all alcohol containers.
- Canada's Guidance on Alcohol and Health: providing guidance for preventing or reducing consumption-related health risks.
- Standard Drink Size: static standard drink information per container and per serving.

AND FURTHER that the Association of Local Public Health Agencies endorse the Statement from Provincial/Territorial Chief Medical Officers of Health on Labelling of Alcohol Products.
AND FURTHER that the Association of Local Public Health Agencies recommend Health Canada update their website to reflect Canada's current Guidance on Alcohol and Health.
AND FURTHER that the Association of Local Public Health Agencies advise all Ontario Boards of Health to recommend their local Members of Parliament to advocate that all alcohol manufactured or sold in Canada have mandatory, regulated labels including health warnings, Canada's Guidance on Alcohol and Health, and standard drink size information.

alPHa's stated position is that Public Health has an important mandate in key areas related to the use of alcohol and other drugs, including activities in chronic disease prevention, injury prevention, substance abuse prevention and harm reduction. Comprehensive strategies to address the potential harms of substance use can only succeed through a combination of interventions: education, prevention, harm reduction, treatment and enforcement.

Staff Recommendation: Key Strategic Direction; include in package as submitted.

A26-04	**Enhancing the Ontario Works Benefit**	**Middlesex-London Health Unit (MLHU), Huron Perth Public Health Unit (HPPH), Windsor-Essex County Health Unit (WECHU) and Oxford-Elgin-St. Thomas Public Health Unit (also known as**	**24**

		Southwestern Public Health Unit, SWPH)	

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies call on the Government of Ontario to increase the OW earned income exemption to align with ODSP exemption increases, and adjust the OW benefit reduction rate to align with ODSP reduction rates;

AND FURTHER that the Government of Ontario eliminate the three-month waiting period for the OW earned income exemption to ensure that exemptions apply immediately upon entry to assistance;

AND FURTHER that the Association of Local Public Health Agencies reaffirm and advance its previously adopted position in Resolution A23-05, *Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates,* calling for increases to Ontario Works base benefit rates and the indexation of those rates to inflation, and urge the Government of Ontario to implement these measures as foundational components of a sustained approach to income adequacy;

AND FURTHER that the Government of Ontario conduct periodic reviews of the OW earned income exemption to maintain alignment with labor market conditions and cost-of-living trends;

AND FURTHER that a copy of this resolution be sent to the Premier of Ontario, the Minister of Children, Community and Social Services, and local Members of Provincial Parliament.

alPHa has continually expressed clear positions on income-related determinants of health and this resolution builds upon these.

Staff recommendation: Key Strategic Direction; include in package as submitted.

DRAFT RESOLUTION A26-01

TITLE: **Strengthening Hepatitis B Prevention in Ontario Through Vaccination in the First Year of Life**

SPONSOR: **The Board of Health for the District of Algoma Health Unit (Algoma Public Health)**
The Board of Health for the Simcoe Muskoka District Health Unit (Simcoe Muskoka District Health Unit)

WHEREAS hepatitis B virus (HBV) infection causes a substantial burden of disease globally, with chronic infection leading to cirrhosis, liver failure, and liver cancer(1), noting that in 2021 alone, 3524 cases of HBV were reported in Canada(2); and

WHEREAS chronic HBV infection results in high lifetime healthcare utilization and substantial costs, with increased costs related to disease severity and for patients requiring liver transplantation(3); and

WHEREAS infants and young children who become infected with HBV are at the highest risk of developing chronic infection, with up to 90% of infected infants becoming chronic carriers compared with fewer than 5% of infected adults(4); and

WHEREAS Ontario currently administers HBV vaccine routinely in Grade 7, which leaves children susceptible to infection during their first 12 years of life when they are most vulnerable to developing chronic HBV infection(5); and

WHEREAS surveillance data from Public Health Ontario indicate that HBV infections continue to occur among children in Ontario prior to adolescence, including Canadian-born children (139 cases before age 12 between 2003 and 2013)(1), often due to missed prenatal screening for HBV, incomplete post-exposure prophylaxis, household exposure to undiagnosed carriers, travel, or immigration from regions of higher HBV prevalence(6); and

WHEREAS the National Advisory Committee on Immunization (NACI) has concluded that HBV vaccination in the first year of life provides long-lasting protection(4,6,7) and that acceptable schedule options in the first year of life include either vaccination at birth or later in infancy; and

WHEREAS birth dose HBV vaccination is safe and highly effective(3), and jurisdictions that implemented it decades ago now show lower adult HBV prevalence and reduced long‑term disease burden, supporting the population‑level benefits of early immunization(8); and

WHEREAS infant HBV vaccination at 2, 4, and 6 months of age is a well-studied safe and effective alternative to birth vaccination which has also been implemented in many jurisdictions in Canada and globally(9); and

WHEREAS a recent analysis modelling potential HBV immunization strategies for Ontario showed that providing 3 doses of the DTaP-HB-IPV-Hib vaccine (combination vaccine against 6 diseases) in infancy would lead to cost-savings compared to the current practice of

administering the DTaP-IPV-Hib vaccines (combination vaccine against 5 diseases) in infancy plus the HBV vaccines in grade 7, due to reduced costs related to averted visits to healthcare providers, treatment costs, and complication costs, and noting this is also more favorable from a cost perspective than introducing birth dose HBV vaccination(10); and

WHEREAS several other Canadian jurisdictions already provide universal HBV vaccination in infancy, including British Columbia, Quebec, PEI, and Yukon; and

WHEREAS altogether, considering cost, safety, effectiveness, feasibility to integrate into the current vaccination schedule, and likelihood of acceptability to parents and health care providers, adopting HBV vaccination in infancy (at 2, 4 and 6 months of age) may be preferred for Ontario over birth vaccination, with the benefits of this immunization strategy over the Grade 7 program sufficiently justifying the required catch-up efforts;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) writes to the Ontario Minister of Health recommending a review in consultation with the Ontario Immunization Advisory Committee and/or the National Advisory Committee on Immunization regarding shifting universal HBV vaccination from Grade 7 to the first year of life, based on existing epidemiologic and economic evidence and programmatic considerations, in order to strengthen early protection against HBV, reduce preventable chronic infections, and advance health equity for children and families across Ontario;

AND FURTHER that alPHa recommends that the Minister of Health specifically considers the adoption of the combined DTaP-HB-IPV-Hib vaccine given at 2, 4, and 6 months of age as the preferred option for Ontario given its ability to seamlessly integrate into the existing vaccination schedule;

AND FURTHER that the Chief Medical Officer of Health be so advised.

Background

Hepatitis B is a liver disease that can lead to complications such as cirrhosis, liver failure, liver cancer, disability, and premature death, especially when acquired at an early age. Hepatitis B virus is very infectious; the virus can survive on surfaces for up to 7 days. Globally, the highest risk of transmission in childhood occurs in infants exposed during birth to their mothers who are carriers of Hepatitis B, many of them being immigrants from hepatitis B endemic areas such as Africa and Asia(4)(11); in such cases, 70% of infected pregnant women will transmit the virus to their baby.(12)

Transmission in childhood is also possible via close household contact with infected individuals (horizontal transmission), the risk being as high as 54%(13). Although rare, horizontal transmission in daycare settings is also possible (14). One of the challenges with childhood transmission is that Hepatitis B infection at an early age is mostly asymptomatic, therefore, not all cases are identified. Despite the absence of symptoms, 90% of infants infected will develop Chronic hepatitis B, and one out of four individuals with Chronic HB will die prematurely of cirrhosis or hepatocellular carcinoma.(12)
There are various Hepatitis B-containing vaccines available in Canada, alone or in combination with other vaccines that are already part of the current vaccination schedule[1].

Canada's vaccination strategy varies by province, under the principle that circulation of hepatitis B in the country is low (less than 5% of Canadians have markers of past infection, and less than 0.5% are carriers).(4) However, between 2003 and 2013, there were six cases per every 1000 Canada-born children under age 12 (time at which they usually receive the vaccine in Ontario).(1) Infections in childhood may be more likely to be occur among racialized children.(15)

Currently, the National Advisory Committee on Immunizations (NACI) does not give a specific recommendation regarding the best age for Hepatitis B vaccination. Instead, they leave it up to the provinces to make updates based on local epidemiology and specific programmatic considerations.(7) Currently in Ontario, the Hepatitis B vaccine is routinely offered in Grade 7 (12 years of age) through the school immunization program, and a high-risk program is offered for younger age of vaccination for those most at risk. Immunization nurses visit schools twice a year to administer two doses at least 6 months apart.(5) With the current approach, most children remain unprotected from hepatitis B for the first 12 years of life.

There are two other approaches to Hepatitis B vaccination in Canada: vaccination at birth and vaccination in infancy.(11) Research shows that vaccinating children early in life is effective and safe.(4,16) Vaccination at birth[2] is done in New Brunswick, Northwestern Territories and Nunavut. WHO recommends universal vaccination at birth based on the evidence that mother to child transmission is the highest risk factor for Hepatitis B in childhood.(11) Vaccination in infancy[3] is routinely done in British Columbia, Yukon, PEI and Quebec. Countries in Europe and the Americas have too successfully included Hepatitis B vaccine into their immunization programs in infancy.(9)

Hepatitis B vaccine is safe. There is no information suggesting that administering the vaccine at an earlier age is associated with safety concerns, the only exception being an increased risk of side effects among premature babies under 1500 g birth weight.(4) Moreover, there is no evidence that hepatitis B interferes with the immune response to any other vaccine or vice versa.(11) Likewise, there are no clinically

[1] ENGERIX-B-Pediatric, INFARIX hexa (DTaP-HB-IPV-Hib), RECOMBIVAX HB-Pediatric and TWINRIX Junior.
[2] At birth, at 1 month of age and at 6 months.
[3] This can be achieved by giving a hepatitis B vaccine in addition to the current combination vaccine against five diseases (pentavalent vaccine + Hep B vaccine) or by giving one vaccine protecting against six diseases, including hepatitis B (hexavalent vaccine).

meaningful differences in the safety profile of combination vaccines with and without the hepatitis B component.(9)

Records from Public Health Ontario indicate that vaccination coverage achieved in infancy through the routine infant vaccination schedule is higher than what is achieved in adolescence through school-based programs. Immunization coverage in the first year is above 80%, higher than the 70% coverage of Hepatitis B vaccination offered in adolescence.(17) Shifting to vaccination in infancy would likely translate into a higher number of children protected from the infection.

An Irish study found universal vaccination in infancy using a combination vaccine cost effective when compared to selective vaccination to newborns at high risk.(18) In the Ontario case, switching from the current practice of vaccination in grade seven to vaccination at birth or in infancy would prevent 37-38% of acute hepatitis B cases and 30-31% of chronic hepatitis B cases. Furthermore, birth vaccination would be cost-effective and infant immunization -involving vaccinating with a combined vaccine at 2, 4 and 6 months of age- would be cost saving.(10) This study considered costs of each vaccination modality, healthcare costs of hepatitis B disease and complications, and costs of years lost due to premature death and due to disability resulting from complications of hepatitis B infection.
In conclusion, hepatitis B and its complications are preventable with vaccination. Giving the vaccine earlier in life is safe and effective. A shift to a schedule that includes starting hepatitis B vaccination in the first year of life in Ontario would protect our children earlier and provide long-term cost-savings.

A representative from both Algoma Public Health and Simcoe Muskoka District Health Unit will be present at the meeting to introduce, move, and answer questions about the resolution being presented and commits to undertaking actions as requested by alPHa for carrying out the strategy should the resolution pass.

References

1. Biondi MJ, Marchand-Austin A, Cronin K, Nanwa N, Ravirajan V, Mandel E, et al. Health services: Prenatal hepatitis b screening, and hepatitis b burden among children, in ontario: A descriptive study. CMAJ. 2020 Oct 26;192(43):E1299–305. doi:10.1503/cmaj.200290 PubMed PMID: 33106301.
2. Public Health Agency of Canada. Hepatitis B in Canada: 2021 surveillance data update. 2023.
3. Nanwa N, Kwong JC, Feld JJ, Fangyun Wu C, Sander B. The mean attributable health care costs associated with hepatitis B virus in Ontario, Canada: A matched cohort study. Can Liver J. 2022;5(3):339–61.
4. Public Health Agency of Canada. Hepatitis B vaccine: Canadian Immunization Guide [Internet]. 2024.
5. Government of Ontario. Publicly Funded Immunization Schedules for Ontario. 2022 Jun.
6. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Hepatitis B immunization. Toronto; 2017.
7. Public Health Agency of Canada. Update on the recommended use of hepatitis B vaccine. An Advisory Committee Statement (ACS). National Advisory Committee on Immunization (NACI). Ottawa: Public Health Agency of Canada; 2017. 54 p.
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DRAFT RESOLUTION A26-02

Title: **Strengthening Certified Public Health Inspector Capacity to Support Delivery of the Ontario Public Health Standards**

Sponsor: **Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO (Affiliate Member Organization)**

WHEREAS Certified Public Health Inspectors (PHIs) are essential to the delivery of mandatory programs and services under the Ontario Public Health Standards (OPHS), including, but not limited to: Food Safety; Safe Water; Health Hazard Prevention and Management; Infection Prevention and Control; Rabies Prevention and Control; Recreational Water; and Emergency Preparedness and Response; and

WHEREAS Certified PHIs have specialized training and regulatory authority under the Health Protection and Promotion Act (HPPA) and its regulations to conduct risk-based inspections, lead outbreak investigations, and make regulatory decisions that safeguard public health; and

WHEREAS local public health agencies are required under the HPPA to ensure the provision of these programs and services in accordance with the OPHS; and

WHEREAS PHI responsibilities have increased in scope and complexity in response to population growth, evolving regulatory requirements, emerging infectious diseases, climate-related health risks, and heightened expectations for infection prevention and control and timely response; and

WHEREAS The COVID-19 pandemic increased workload demands and exposed workforce vulnerabilities, contributing to recruitment and retention challenges and to service backlogs in routine OPHS programming; and

WHEREAS Strengthening public health inspection capacity is a prevention-focused approach that can help avoid outbreaks and infrastructure failures, reduce emergency health-care utilization, and mitigate workplace disruptions and business closures, thereby supporting fiscal sustainability and economic productivity; and

WHEREAS The Canadian Institute of Public Health Inspectors (CIPHI) Ontario Branch and the Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO) are actively collaborating to enhance recruitment pathways, including outreach to CIPHI-accredited post-secondary academic institutions, internationally educated professionals, and newcomers; and

WHEREAS The Ministry of Health has demonstrated leadership through the Ministry-led Public Health Inspector Workforce Capacity Working Group, established under the Office of the Chief Medical Officer of Health, to inform strategies that build PHI workforce capacity across recruitment, education pathways, practicums, mentorship, and retention;

THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies of Ontario (alPHa) respectfully request that the Province of Ontario, through the Ministry of Health:

1. Provide sustained, base funding to local public health agencies to support the hiring of up to 150 additional certified Public Health Inspectors across Ontario, to strengthen PHI staffing capacity and support consistent delivery of OPHS requirements. This estimate reflects anticipated provincial workforce gaps, emerging workload pressures, and replacement-rate forecasting for attrition and retirements; and
2. Undertake a provincial PHI workforce assessment and forecasting approach, aligned with the Ministry-led PHI Workforce Capacity Working Group, to identify current and projected workforce needs and to inform evidence-informed and equitable distribution of PHI resources; and
3. mentorship supports and standardized practicum approaches—in partnership with accredited institutions, Boards of Health, ASPHIO, and the Canadian Institute of Public Health Inspectors (Ontario Branch); and
4. Support retention and professional sustainability strategies, including targeted approaches for northern and rural communities, and investments in professional development and mentorship to support early-career PHIs and succession planning; and
5. Recognize PHI capacity as essential health and economic system infrastructure requiring stable and predictable investment to support OPHS compliance, emergency readiness, and ongoing protection of Ontarians.

AND FURTHER that alPHa circulate this resolution to the Minister of Health, the Chief Medical Officer of Health, the Association of Municipalities of Ontario (AMO), Ontario Boards of Health, the Canadian Institute of Public Health Inspectors (CIPHI), Canadian Institute of Public Health Inspectors (Ontario Branch), and CIPHI-accredited post-secondary academic institutions.

BACKGROUNDER: STRENGTHENING CERTIFIED PUBLIC HEALTH INSPECTOR CAPACITY TO SUPPORT ONTARIO'S PUBLIC HEALTH SYSTEM

Prepared by: Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO)
Dominique Bremner (ASPHIO Chair)
Heidi Pitfield (alPHa Affiliate Member Representative)
Peter Heywood (ASPHIO Member)
For: alPHa Annual General Meeting & Resolutions Session
Date: June 9, 2026

Purpose

This document provides background context to support an alPHa resolution requesting strengthened certified Public Health Inspector (PHI) staffing capacity in Ontario. It is intended to complement ongoing collaborative work led by the Ontario Ministry of Health to build capacity in the PHI workforce.

Background

1. Public Health Inspectors as essential public health system infrastructure

Certified Public Health Inspectors (PHIs) play a central role in delivering mandatory programs and services under the Ontario Public Health Standards (OPHS) and supporting Boards of Health in meeting requirements under the Health Protection and Promotion Act (HPPA). PHIs protect communities by preventing, identifying, and mitigating health hazards across multiple settings, including food premises, recreational water facilities, small drinking water systems, child care and congregate living settings, and other environments where preventable risks can have significant health and economic impacts. Certified PHIs have specialized education, practicum training, and national certification, with competencies in risk assessment, infection prevention and control (IPAC), outbreak management, environmental health sciences, regulatory interpretation and enforcement, and effective public communication. This specialized training and regulatory authority supports consistent, high-quality inspection services and timely, evidence-informed decision-making.

2. Growing and evolving service demands

In recent years, PHI responsibilities have expanded in scope and complexity due to population growth, evolving regulatory requirements, emerging and novel infectious diseases, climate-related health risks, heightened IPAC expectations, and increased public expectations for transparency and timely response. PHIs are also routinely called upon to respond to urgent and emergencies, consistent with OPHS requirements for 24/7 readiness.
3. Lessons from the COVID-19 response and the need to strengthen capacity
The ASPHIO White Paper (June 2023) documents the critical contributions of PHIs to Ontario's COVID-19 response, including outbreak management in long-term care and other congregate settings; IPAC assessments and guidance; support for enforcement and Section 22 orders; and surge support for

evolving public health priorities. At the same time, routine OPHS programming experienced service disruption and backlogs as PHIs were redeployed to pandemic response activities.
The White Paper also highlights workforce impacts that challenge sustainability, including burnout and mental distress, increased resignations, leaves of absence, and retirements, and reported incidents of harassment directed at PHIs. These pressures have compounded long-standing recruitment and retention challenges, particularly in northern and rural communities, and have reduced the availability of experienced staff to mentor and train new PHIs.

4. Value of prevention and the case for sustained investment

Preventive inspection and hazard prevention programs reduce the likelihood and severity of foodborne illness outbreaks, water contamination events, and IPAC lapses, and support continuity of operations for businesses and institutions. Strengthening PHI capacity helps Boards of Health deliver OPHS requirements, clear backlogs, address emerging local priorities, and maintain readiness for future public health emergencies.
Local public health agencies are currently facing challenges in meeting the required inspection frequencies outlined in the Ontario Public Health Standards (OPHS). This is primarily due to constraints in the staffing capacity of Public Health Inspectors (PHIs), which increases organizational risk for the Boards of Health that are responsible for statutory oversight. This situation highlights the critical need to address PHI staffing levels to improve compliance and support the Boards of Health in fulfilling their essential oversight responsibilities.
Further, strengthening public health inspection capacity is a prevention-focused approach that can help avoid outbreaks and infrastructure failures, reduce emergency health-care utilization, and mitigate workplace disruptions and business closures, thereby supporting fiscal sustainability and economic productivity.

5. Building on Ministry of Health leadership and collaboration

ASPHIO recognizes and appreciates the Ontario Ministry of Health's leadership in convening the Ministry-led Public Health Inspector Workforce Capacity Working Group. The Working Group—established under the Office of the Chief Medical Officer of Health—provides a collaborative forum to identify, assess, and prioritize PHI workforce capacity issues and opportunities, and to make recommendations to the Public Health Leadership Team.
The Working Group's Terms of Reference identify practical, professional pipeline (education – practicum - workforce) focused objectives, including: increasing enrolment in Ontario's accredited environmental health programs; exploring fast-track pathways; strengthening practicum quality and mentorship supports; partnering to attract internationally educated public health professionals; and considering targeted retention supports for northern and rural communities. This resolution is intended to complement this work by supporting timely, sustained staffing investments in PHI capacity.

6. Implementation considerations (for context)

As part of Ontario's 2026 budget consultation, the Canadian Institute of Public Health Inspectors (CIPHI), Ontario Branch, recommended a targeted provincial investment of $20 million to support the recruitment of 150 certified PHIs across Ontario, with a proposed cost-sharing approach in subsequent years (75% provincial / 25% municipal). This estimate reflects projected workforce gaps in the province identified through sector consultations, increasing inspection and compliance workloads, and forecasts of replacement rates due to attrition and anticipated retirements within the current PHI workforce.
The same submission recommended maintaining an annual investment of $435,000 to enhance the PHI practicum pipeline through local public health agencies and support future workforce development.

These figures are provided for background context only. The resolution below focuses on the core policy outcomes of sustained, base funding and coordinated workforce planning to support delivery of the OPHS province-wide. Any proposed increase in PHI capacity must adopt an evidence-informed and equitable distribution strategy. This strategy should take into account population growth trends, geographic size and remoteness, community risk profiles, and the practical challenges of serving diverse urban, suburban, rural, and northern populations.

Key message

A well-resourced certified public health inspector workforce is crucial for a strong public health system. Ongoing base funding to enhance PHI staffing capacity, combined with coordinated workforce assessments, education, and supply initiatives, will ensure equitable resource distribution. This approach will enable consistent delivery of Ontario's public health services and programs, improve emergency preparedness, and reduce organizational and compliance risks for Boards of Health tasked with fulfilling mandated public health responsibilities.

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DRAFT RESOLUTION A26-03

TITLE: **Mandatory and Regulated Alcohol Labelling on Alcohol Manufactured or Sold in Canada**

SPONSORS: **Middlesex-London Health Unit (MLHU) and Toronto Public Health (TPH)**

WHEREAS alcohol is a legal product with associated health harms and classified as a Group 1 carcinogen with a causal link to cancer (Babor, 2023; IARC, 1988; IARC, 2012; Paradis, 2023; Rumgay, 2021); and

WHEREAS alcohol caused an estimated 4,330 deaths, 22,009 hospitalizations, and 194,693 emergency department visits each year in people aged 15 and older in Ontario (Ontario Health and Ontario Agency for Health Protection and Promotion, 2023); and

WHEREAS 77% of Ontarians self-report alcohol use in the past 12 months and 33% report drinking alcohol at more than a low-risk level as per the *Canadian Guidance on Alcohol and Health* in the past week (Ontario Health and Ontario Agency for Health Protection and Promotion, 2023); and

WHEREAS the harms due to alcohol are disproportionally carried by individuals from lower socioeconomic groups, compared to those from higher socioeconomic groups, despite often drinking less alcohol; described as the alcohol harm paradox (Bloomfield, 2020; CIHI, 2017); and

WHEREAS many Canadians are unaware of:
-alcohol's relationship to cancer risk, especially at low levels of consumption,
-what a standard drink of alcohol contains, and
-guidance to reduce their alcohol risk (Government of Canada, 2024); and

WHEREAS alcohol containers in Canada lack comprehensive health warning labels to inform consumers of the risks or ways to reduce risks; and

WHEREAS labels are an effective tool to help consumers understand product risk (CCS, 2023; Hobin, 2022; Noar, 2016); and

WHEREAS the membership previously carried alPHa RESOLUTION A24-03: A Proposal for a Comprehensive Provincial Alcohol Strategy: Enhancing Public Health through Prevention, Education, Regulation and Treatment.

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies call on the Federal Government to amend the *Food and Drugs Act* to mandate alcohol labelling including:
Health Warnings: prominent, rotating warnings on all alcohol containers.
Canada's Guidance on Alcohol and Health: providing guidance for preventing or reducing consumption-related health risks.
Standard Drink Size: static standard drink information per container and per serving.

AND FURTHER that the Association of Local Public Health Agencies endorse the Statement from Provincial/Territorial Chief Medical Officers of Health on Labelling of Alcohol Products.

AND FURTHER that the Association of Local Public Health Agencies recommend Health Canada update their website to reflect Canada's current Guidance on Alcohol and Health.

AND FURTHER that the Association of Local Public Health Agencies advise all Ontario Boards of Health to recommend their local Members of Parliament to advocate that all alcohol manufactured or sold in Canada have mandatory, regulated labels including health warnings, Canada's Guidance on Alcohol and Health, and standard drink size information.

AND FURTHER that a copy of this resolution be sent to the Chief Medical Officer of Health of Ontario.

Statement of Sponsor Commitment
Dr. Alexander Summers and Dr. Michelle Murti, Medical Officers of Health for the Middlesex-London Health Unit and Toronto Public Health respectively, will be present at the 2026 Annual General Meeting to introduce, move, and answer questions about the resolution being presented and commit to undertaking actions as requested by the Association of Local Public Health Agencies should the resolution pass.

Background

Alcohol – No Ordinary Commodity

In Ontario and across Canada, alcohol availability has increased significantly over the past decade, while health protective regulations have not kept pace. Alcohol is normalized in our society as an ordinary consumer good used to celebrate, commiserate, and has even been seen as a rite of passage; however, alcohol is anything but an ordinary commodity. It is a leading risk factor for disease and injury, responsible for over 17,000 deaths and nearly 120,000 hospitalizations every year in Canada (CISUR/CCSA, 2023). Alcohol contributes to over 200 health conditions, including cancers, liver disease, cardiovascular conditions, mental health concerns, and fetal alcohol spectrum disorder (Babor, 2023; Paradis, 2023). In addition to these significant health harms, the economic and social implications of alcohol are substantial, costing Canadians $19.7 billion/year (CISUR/CCSA, 2023) which is more than the societal costs of tobacco and opioids combined.

In Ontario, 77% of residents identify themselves as current drinkers and 33% report drinking above what is considered a low-risk level based on the Canadian Guidance on Alcohol and Health (Ontario Health and Ontario Agency for Health Protection and Promotion, 2023). Since it is well established that individuals chronically underreport the amount of alcohol consumed, these percentages are likely to be even higher (Stockwell, 2023; Stockwell 2018). Current consumption levels account for 4.3% of deaths, 2.1% of hospitalizations, and 3.7% of emergency department visits each year in Ontario (Ontario Health and Ontario Agency for Health Protection and Promotion, 2023). The population health burden from alcohol exceeds available capacity on already overstretched healthcare and policing systems. Furthermore, alcohol can have profound secondary harms to communities through impaired driving, intimate partner violence, and public disturbances.

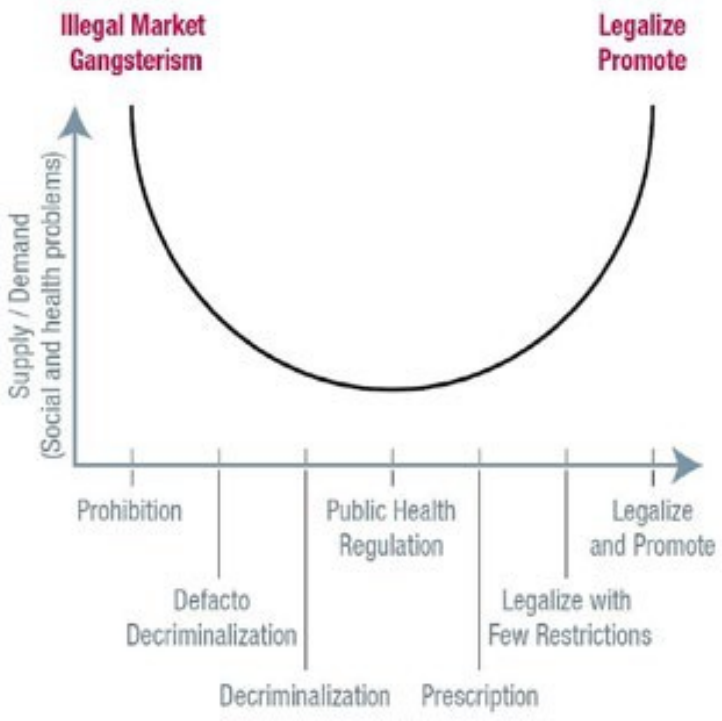
Public Health Approach to Preventing Harms from Alcohol

From a public health perspective, preventing harms from alcohol consumption requires a comprehensive, organized, and multi-sectoral approach that provides controlled access to a strictly regulated product, while removing the commercial and/or industry influence. A public health approach is anchored in social justice, human rights, equity, and the application of evidence-informed policy and practice (CPHA, 2017).

Since 2024, there have been significant changes to the alcohol retail market, expanding sales to many different retail settings in Ontario, including convenience stores and grocery stores. In a cross-sectional study from Ontario, alcohol outlet density was associated with higher alcohol-attributable emergency department visits; an association that had a larger impact in low compared to high socioeconomic status neighbourhoods (Forbes, 2024).

Figure 1, pictured below, shows the population health benefit to reducing health and social harms when there is a balance between alcohol availability and the enactment of measures to protect public health and safety**.** Through the implementation of strict public health regulations, including simple, evidence-based health warning labels on alcohol containers sold in Canada, the consumer would be informed about the health risks associated with alcohol, as well as better understand how much alcohol they are consuming, allowing for a more informed decision.

Figure 1. The Paradox of Prohibition – Adapted from Marks U-Shaped Curve (Health Officers Council of British Columbia, 2005)



Rationale

Alcohol Labelling Supports Informed Choice by Consumers

In Canada, other legalized substances like commercial tobacco products and non-medical cannabis are required to display standardized labels that include health warnings and product information to inform consumers about associated health risks and have standardized packaging designed to reduce product promotion and appeal (Government of Canada, 2023; Government of Canada, 2025). While tobacco's labelling evolution took significant public health efforts to move from small text warnings in the 1970s to graphic health warnings and the plain packaging requirements that we see in Canada today, evidence confirms that these warning labels have increased awareness of health risks, reduced product appeal, and contributed to declines in smoking rates (Noar, 2016; CCS, 2023). The benefits of these tobacco warning labels were significant enough to influence Canada's approach to packaging and labelling legalized, non-medical cannabis products in 2018, pictured below in Figure 2. Alcohol remains the outlier, as the only legalized substance that currently does not have a warning label.

Figure 2. Examples of tobacco and cannabis warning labels mandated by the government of Canada (CCS, 2023; Israel, 2019)

Evidence indicates that alcohol warning labels impact individuals' knowledge, awareness, behavioural intentions, and perceptual judgements (Babor, 2023; CAPE, 2022; Correia, 2024; Hobin, 2020; WHO, 2022). Labels can reach all consumers regardless of education, income, or whether living in large urban centres or remote rural communities (Hammond, 2011), and exposure to labels is highest among those consuming the highest volume of alcohol as messaging is at point of pour.

Canadians have the right to informed decision making, including the risks associated with alcohol consumption, accurate standard drink sizing descriptions, and up-to-date guidance to help reduce their risk. The "duty to warn" obligation under product liability law could reasonably be applied to the alcohol industry since "the basic underlying rationale for the duty to warn is that consumers rely on manufacturers to provide accurate information about the risks inherent in the use of their products" (Shelly, 2021, p.268). Drawing upon lessons learned from the regulation of commercial tobacco products, warning labels are an evidence-informed policy tool that have been proven to help educate the public about the health risks associated with smoking, and instrumental in building public support for strengthening tobacco control policies, including bans on marketing and tobacco tax increases (Hammond, 2011; Noar, 2016; PHO, 2017)

Canadians Are Unaware of Health Harms from Alcohol

Alcohol is a known carcinogen and has been classified by the International Agency for Research on Cancer (IARC, 1988; IARC, 2012) as a Group 1 carcinogen for over 35 years causing at least 7 kinds of cancers and was linked to nearly 7,000 new cancer cases in Canada in 2020 (Rumgay et al., 2021). Unfortunately, most Canadians are unaware of alcohol's relationship to cancer, especially at low levels of consumption. The Government of Canada's 2023 Public Awareness of Alcohol-related Harms Survey confirmed that less than one-third of Canadians believe that alcohol increases the risk for breast, throat, or mouth cancers. Additionally, only one-third of Canadians were familiar with the concept of a "standard drink" and just over half of respondents were aware of Canada's Guidance on Alcohol and Health, despite widespread promotion (Government of Canada, 2024).

The majority of Canadians agree that alcohol products should display or provide:

- the number of standard drinks;
- guidance to reduce health risks; and,
- health warnings.

Furthermore, most believe that health labelling of alcohol products would help them

- track their alcohol consumption;
- think more readily about alcohol-related harms; and,
- think about cutting back on drinking or talking to others about cutting back (Government of Canada, 2024).

Alcohol Labelling and Youth Prevention

Between 2015 and 2020, expansion of alcohol sales to approximately 450 grocery stores licensed to sell beer, wine, and cider led to increased alcohol product promotion and exposure to children and youth (Friesen, 2022). Drawing upon the lessons learned from comprehensive tobacco control, tobacco warning labels are especially effective in preventing youth initiation (Hammond, 2011; Francis, 2019). With the increased visibility of alcohol products in stores accessible to children and youth, alcohol labelling has the potential to reach them with messages that will counter industry-based advertising. The health warnings are visible to all consumers, including children and youth, on store shelves in their local convenience or grocery store. The labels also provide an opportunity for meaningful conversations between parents and their children regarding the health harms associated with alcohol.

Summary

To address complex societal problems with significant public health burden, cooperation and collaboration between local, municipal, provincial, and federal partners are required. Impacts of alcohol consumption remain a substantial population health burden, and one that exceeds social and health care system capacity. The Middlesex-London Health Unit and Toronto Public Health support mandatory and regulated alcohol labelling including health warnings, Canada's Guidance on Alcohol and Health, and standard drink size on all containers of alcohol manufactured and sold in Canada. It is a modest and evidence-informed policy that ensures that consumers are aware of the health harms associated with alcohol and is in alignment with Canada's approach to commercial tobacco products and the legalization of non-medical cannabis.

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DRAFT RESOLUTION A26-04

TITLE **Enhancing the Ontario Works Benefit**

SPONSORS **Middlesex-London Health Unit (MLHU), Huron Perth Public Health Unit (HPPH), Windsor-Essex County Health Unit (WECHU) and Oxford-Elgin-St. Thomas Public Health Unit (also known as Southwestern Public Health Unit, SWPH)**

WHEREAS household food insecurity (HFI), the inadequate or insecure access to food due to financial constraints, is a critical indicator of a household's financial situation, their ability to afford basic needs, and a highly sensitive measure of material deprivation;

WHEREAS HFI is an important social determinant of health, a strong predictor of poor health, and is associated with an increased risk of a wide range of physical and mental health challenges, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress;

WHEREAS poor diet quality costs Ontario an estimated $5.6 billion annually in direct healthcare costs and indirect costs (e.g., lost productively due to disability and premature mortality), with higher costs associated with more severe food insecurity;

WHEREAS from 2020 to 2024, Ontario's food insecurity rates have significantly increased from 1 in 6 households (17.1%) to 1 in 4 households (25.3%);

WHEREAS Ontario Works (OW) rates are inadequate for households to afford basic needs;

WHEREAS 67.2% of Ontario households reliant on OW or Ontario Disability Support Program (ODSP) were food insecure in 2021;

WHEREAS OW income plus all eligible family and tax benefit entitlements is $11,500-$23,500 below Canada's Official Poverty Line and $4,000-$11,500 below the Deep Income Poverty threshold for various household scenarios (e.g., single person household, single parent with one child, and couple with two children);

WHEREAS based on average provincial rent and food costs, Ontario households (e.g., single person, family of 4) receiving OW and all eligible family and tax benefit entitlements need an additional $333-$817 per month to afford rent and food, plus funds for all additional expenses, and a single parent with 2 children has only $447 remaining to pay for all additional expenses;

WHEREAS the OW earned income exemption of $200 per month after a 3-month waiting period, with benefits reduced by 50 cents for every additional dollar earned, was established to encourage workforce participation;

WHEREAS the OW earned income exemption has not increased since 2013 while minimum wage and the cost of living have greatly increased;

WHEREAS greater than 11.5 hours of minimum wage work per month results in a reduction in OW benefits, impacting the ability to afford the cost of living and creating a deterrent to workforce participation;

WHEREAS an increased OW earned income exemption would help households afford the cost of living and help support people working toward leaving the OW program;

WHEREAS the ODSP earned income exemption increased from $200 to $1,000 per month in 2023, with benefits reduced by 75 cents for every additional dollar earned and no waiting period;

WHEREAS ODSP rates are increased annually based on inflation, with the first inflation-based increase in 2025;

WHEREAS OW rate increases indexed to inflation are needed as part of OW enhancements and were previously supported by alPHa (A23-05);

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies call on the Government of Ontario to increase the OW earned income exemption to align with ODSP exemption increases, and adjust the OW benefit reduction rate to align with ODSP reduction rates;

AND FURTHER that the Government of Ontario eliminate the three-month waiting period for the OW earned income exemption to ensure that exemptions apply immediately upon entry to assistance;

AND FURTHER that the Association of Local Public Health Agencies reaffirm and advance its previously adopted position in Resolution A23-05, *Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates,* calling for increases to Ontario Works base benefit rates and the indexation of those rates to inflation, and urge the Government of Ontario to implement these measures as foundational components of a sustained approach to income adequacy;

AND FURTHER that the Government of Ontario conduct periodic reviews of the OW earned income exemption to maintain alignment with labor market conditions and cost-of-living trends;

AND FURTHER that a copy of this resolution be sent to the Premier of Ontario, the Minister of Children, Community and Social Services, and local Members of Provincial Parliament.

Statement of Sponsor Commitment
Drs. Alexander Summers, Miriam Klassen, Mehdi Aloosh and Ninh Tran, Medical Officers of Health for the endorsing health units, will be present at the 2026 Annual General Meeting to introduce, move, and answer questions about the resolution being presented and commit to undertaking actions as requested by the Association of Local Public Health Agencies should the resolution pass.

Background

alPHa previously endorsed various resolutions in support of social assistance reform and income-based solutions to household food insecurity including:

- A24-05: Early Childhood Food Insecurity: An Emerging Public Health Problem Requiring Urgent Action
- A23-05: Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates
- A18-02: Public Health Support for a Minimum Wage that is a Living Wage
- A18-04: Extending the Ontario Pregnancy and Breastfeeding Nutritional Allowance to 24 Months
- A15-04: Public Health Support for a Basic Income Guarantee
- A05-18: Adequate Nutrition for Ontario Works and Ontario Disability Support Program Participants and Low Wage Earners

Food Insecurity in Ontario

Household food insecurity (HFI) is the inadequate or insecure access to food due to financial constraints[1]. HFI is a critical indicator of a household's financial situation and their ability to afford basic needs, and a highly sensitive measure of material deprivation[1].

HFI is an important social determinant of health, a strong predictor of poor health, and is associated with an increased risk of a wide range of physical and mental health challenges, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress[1,2,3].

Poor diet quality costs Ontario an estimated $5.6 billion annually in direct healthcare and indirect costs (e.g., lost productively due to disability and premature mortality)[4], with higher costs associated with more severe food insecurity[5].

Current Situation

- From 2020 to 2024, Ontario's food insecurity rates significantly increased from 17.1% (1 in 6 households) to 25.3% (1 in 4 households)[6].
- In 2024, 4,055,000 people lived in a food insecure household in Ontario, including 33.3% of children under 18[7].
- From 2022 to 2024, Middlesex-London's food insecurity rates significantly increased from 17.5% (1 in 6 households) to 31.3% (1 in 3 households)[6].

Inadequacy of Ontario Works

Ontario Works (OW) rates are inadequate for households to afford basic needs and haven't increased since 2018.

- In 2021, 67.2% of Ontario households reliant on social assistance were food insecure[1].
- In 2024, Ontario Works income plus all eligible family and tax benefit entitlements was $11,504-$23,498 below Canada's Official Poverty Line (i.e., Market Basket Measure) and $4,171-$11,452 below the Deep Income Poverty threshold (i.e., Market Basket Measure – Deep Income Poverty) for various household scenarios (e.g., single person household, single parent with one child, and couple with two children)[8].
- Based on average provincial rent and food costs, Ontario households (e.g., single person, family of 4) receiving Ontario Works and all eligible family and tax benefit entitlements (e.g., Ontario Trillium Benefit, Canada Child Benefit) need an additional $333-$817 per month to afford rent and food, plus funds for all additional expenses, and a single parent with 2 children has only $447 remaining to pay for all additional expenses[2].

- Middlesex-London households receiving Ontario Works (e.g., single person, single parent with 2 children, family of 4) and all eligible family and tax benefit entitlements (e.g., Ontario Trillium Benefit, Canada Child Benefit) need an additional $7-$558 per month to afford rent and food, plus funds for all additional expenses[9].

Ontario Works Earned Income Exemption

Under current OW rules, the first $200 per month of (net) earned income is exempt from OW clawbacks, with benefits reduced by 50 cents for every additional dollar earned. The earned income exemption amount starts after a 3-month waiting period, meaning all earned income reduces benefits by 50 cents for every dollar earned in the first 3 months receiving assistance.

The earned income exemption was established in 2013 to encourage workforce participation[10]. However, the exemption has not increased since it started[11], while minimum wage in Ontario has increased from $10.25 to $17.60 per hour and cost of living, as measured by the Consumer Price Index in Ontario, has increased by 36.9% (121.3 to 166.1)[12].

In 2013, greater than 19.5 hours of minimum wage work per month resulted in a reduction in OW benefits ($10.25 x 19.5 = $199.88). In 2026, greater than 11.5 hours of minimum wage work per month results in a reduction in OW benefits ($17.60 x 11.5 = $202.40). Benefit reductions at the current level impact the ability to afford the cost of living and create a deterrent to workforce participation[13]. An increased earned income exemption would help households afford the cost of living and help support people working toward leaving the OW program.

The 3-month waiting period for the earned income exemption limits income at entry to assistance, where financial need is often greatest, and reduces the effectiveness of earned income exemptions as a work incentive. Removing the three-month waiting period would allow exemptions to apply immediately, improving income stability during the point of greatest vulnerability.

Comparison to Ontario Disability Support Program (ODSP)

Aligning select OW rules with ODSP rules would provide short-term and long-term improvements to the adequacy of OW rates.

- ODSP rates are increased annually based on inflation, with the first inflation-based increase in 2025[14].
- ODSP earned income exemption increased from $200 to $1,000 per month in 2023, with benefits reduced by 75 cents for every additional dollar earned[15]. There is no waiting period for the ODSP earned income exemption.
- Aligning OW earned income rules with those of ODSP would improve income adequacy and reduce inequities between social assistance programs.
- While the OW benefit reduction rate (50%) appears lower than ODSP's reduction rate (75%), the much lower OW earned income exemption ($200 vs. $1,000) means that OW recipients begin to lose benefits at far lower levels of earned income.
- As shown in Table 1, an individual receiving OW would need to earn approximately $2,600 per month before experiencing the same $1,200 reduction in benefits as an individual receiving ODSP. This level of earned income is unrealistic for most OW recipients, given that individuals typically qualify for OW due to significant barriers to employment, including unstable work, caregiving responsibilities, health challenges, or recent job loss.
- In practice, the current OW structure results in earlier and steeper benefit reductions, discouraging workforce participation and undermining income stability. Aligning OW earned

income exemptions and reduction rates with ODSP would allow individuals to increase earnings without immediate loss of essential income supports.

Table 1. Ontario Works and ODSP Earned Income Exemption Comparison

Earned Income (Monthly, Net)	Ontario Works $200 Exemption 50% Clawback		ODSP $1,000 Exemption 75% Clawback	
	$ Above Exemption	Reduction	$ Above Exemption	Reduction
$200	$0	$0	$0	$0
$500	$300	$150	$0	$0
$1,000	$800	$400	$0	$0
$1,500	$1,300	$650	$500	$375
$2,000	$1,800	$900	$1,000	$750
$2,600	$2,400	$1,200	$1,600	$1,200
$3,000	$2,800	$1,400	$2,000	$1,500

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2026 ALPHA ANNUAL GENERAL MEETING - VOTING DELEGATION

MOTION:

WHEREAS the Public Health Sudbury & Districts is allocated five votes* at the Association of Local Public Health Agencies Annual General Meeting Resolution Session;

THAT the following individuals are appointed as voting delegates for the Annual General Meeting:

1) **M. Mustafa Hirji ***
2) **Emily Groot**
3) **Robert Barclay ***

***Voting delegates are permitted one proxy vote per person, as required.**

ADDENDUM

MOTION: THAT this Board of Health deals with the items on the Addendum.

IN CAMERA

MOTION:

THAT this Board of Health goes in camera to deal with advice that is subject to solicitor-client privilege, including communications necessary for that purpose.
Time: _____

RISE AND REPORT

MOTION:

THAT this Board of Health rises and reports. Time: _____

ADJOURNMENT
MOTION: THAT we do now adjourn. Time: _____