Board of Health Meeting # 06-25

Public Health Sudbury & Districts

Thursday, September 18, 2025

1:30 p.m. (BOH group photo at 12:25 p.m., followed by lunch)

Boardroom

1300 Paris Street

Public Health
Santé publique
SUDBURY & DISTRICTS

AGENDA – SIXTH MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, LEVEL 3
THURSDAY, SEPTEMBER 18, 2025 – 1:30 P.M.

SEPTEMBER 18

Reminder:
A professional Board of Health group photo is scheduled for Thursday, September 18, 2025. Board of Health members are asked to arrive at 12:20 p.m.

Light lunch will follow

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

4. DELEGATION/PRESENTATION

i) Measles Preparedness and Outbreak Response

- Christina Baier, Manager, Health Protection Division
- Afzaa Rajabali, Health Promoter, Health Protection Division

ii) Unlearning and Undoing White Supremacy & Racism Project – Foundational Obligations to Indigenous Peoples: Reports of the Truth and Reconciliation Commission of Canada

- Alicia Boston, Health Promoter, Indigenous Public Health
- Sarah Rice, Manager, Indigenous Public Health

5. CONSENT AGENDA

i) Minutes of Previous Board of Health Meeting

a. Fifth Meeting – June 12, 2025

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, September 2025

v) Correspondence

a. Opioid Crisis

- Resolution Letter from Windsor-Essex County Health Unit Board of Health Chair to Minister of Health, dated August 26, 2025

b. Food Insecurity and Food Affordability in Ontario

- Resolution re Primer for municipalities from Middlesex-London Health Unit to Boards of Health dated July 24, 2025

c. 2024 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario, “Protecting Tomorrow: The Future of Immunization in Ontario”

vi) Items of Information

a. 2025 alPHa Conference, Annual General Meeting and Board Section Meeting

b. alPHa Fall Symposium November 5-7, 2025

APPROVAL OF CONSENT AGENDA

MOTION:

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

6. NEW BUSINESS

i) Public Health Sudbury & Districts’ 2024 Annual Financial Report

- 2024 Financial Report (English and French)

ii) Endorsing CIHPHI & ASPHIO Joint Statement: Implementation of Recommendations from the Auditor General's 2025 Report on Non-Municipal Drinking Water Safety

- Briefing Note from the Acting Medical Officer of Health and Chief Executive Officer dated September 11, 2025, and appendices

ENDORSING CIPHI & ASPHIO JOINT STATEMENT: IMPLEMENTATION OF RECOMMENDATIONS FROM THE AUDITOR GENERAL'S 2025 REPORT ON NON-MUNICIPAL DRINKING WATER SAFETY

MOTION:

WHEREAS the *Health Protection & Promotion Act* mandates the Board of Health to prevent water-borne illness related to drinking water, including non-municipal drinking water;

AND WHEREAS the Auditor General's 2025 performance audit on non-municipal drinking water safety made 17 recommendations, including 10 to the Ministry of Health for improvement;

AND WHEREAS the Canadian Institute of Public Health Inspectors (CIPHI) and the Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO) have endorsed these recommendations and offered their support the Ministry of Health to implement the recommendations;

AND WHEREAS the recommendations of the Auditor General, CIPHI, and ASPHIO align strongly with addressing challenges observed and experienced by Public Health Sudbury & Districts;

THEREFORE BE IT RESOLVED THAT this Board of Health endorses and supports the "Joint Statement from CIPHI and ASPHIO: Supporting the Implementation of Recommendations from the Auditor General's 2025 Report on Non-Municipal Drinking Water Safety, 2025".

iii) Communications between the Chief Medical Officer of Health and the Grey Bruce Board of Health, & Governance Implications for Public Health Sudbury & Districts

- Briefing Note from the Acting Medical Officer of Health and Chief Executive Officer dated September 11, 2025, and appendices

COMMUNICATIONS BETWEEN THE CHIEF MEDICAL OFFICER OF HEALTH AND THE GREY BRUCE BOARD OF HEALTH, & GOVERNANCE IMPLICATIONS FOR PUBLIC HEALTH SUDBURY & DISTRICTS

MOTION:

WHEREAS the Ministry of Health has intervened with Boards of Health in response to governance issues in 2006 with the Muskoka-Parry Sound Health Unit, in 2015 with Algoma Public Health, and now in 2025 with Grey Bruce Health Unit;

AND WHEREAS the 2006 Capacity Review Committee recommended skills-based boards of health, which have not been realized;

AND WHEREAS the Chief Medical Officer of Health has recommended to Grey Bruce Health Unit the development of a "skills matrix" for board of health members as a consequence of this most recent incident, in order to establish a skills-based board of health there;

AND WHEREAS Public Health Sudbury & Districts has a long history and strong reputation for excellence in governance practices and financial oversight;

AND WHEREAS Public Health Sudbury & Districts has been a leader in the province around governance improvements, most recently establishing the inclusion of Indigenous membership on the Board of Health;

THAT the Board of Health receive the communications between the Chief Medical Officer of Health and the Chair of the Grey Bruce Health Unit Board of Health for information;

AND THAT the Board of Health recommit to vigilance around its governance practices, including its ongoing work to strengthen governance training, its financial oversight work, and its efforts to ensure municipal politics do not impact Board discussions; this includes that all Board members set aside any considerations of or loyalties to other organizations in order to exercise their fiduciary duty as Board members;

AND THAT the Board of Health direct the Acting Medical Officer of Health & CEO to build on the recent request to municipalities to include an Indigenous person on the Board of Health, to now broaden that and recommend a comprehensive skills-matrix to guide municipalities and the Public Appointments Secretariat in future Board of Health appointments.

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 a personal matter about an identifiable individual, including municipal or local board employees. Time: _____

9. RISE AND REPORT

RISE AND REPORT

MOTION:

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

10. ANNOUNCEMENTS

i) September 18, 2025, Board of Health meeting survey

ii) Annual Board of Health self-evaluation survey for 2025

iii) Mandatory annual emergency preparedness training for Board of Health members

11. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time: ____

MINUTES – FIFTH MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, SECOND FLOOR
THURSDAY, JUNE 12, 2025 – 1:30 P.M.

BOARD MEMBERS PRESENT

Robert Barclay	Ken Noland	Mark Signoretti
Renée Carrier	Michel Parent	
Amy Mazey	Angela Recollet	

BOARD MEMBERS REGRET

Ryan Anderson	Natalie Labbée	Natalie Tessier
Michel Brabant	Abdullah Masood	

STAFF MEMBERS PRESENT

Grace Bowie	Sandra Laclé	Blessing Odia
Kathy Dokis	Stacey Gilbeau	Rachel Quesnel
M. Mustafa Hirji	Stacey Laforest	Renée St Onge

M. SIGNORETTI PRESIDING

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

The meeting was called to order at 1:40 p.m.

The Board Chair highlighted that June is National Indigenous History Month and the Board of Health continues its journey of learning about Indigenous history, and Unlearning of social imprinting of bias through continued participation in the Unlearning Club. He added that June 21 is National Indigenous Peoples Day, and N'Swakamok Indigenous Friendship Centre will be holding their annual Pow Wow at Bell Park in Sudbury starting at 11 a.m. This is an opportunity for Board members to attend an Indigenous-led community event and further build relationships as per our ReconciliAction Framework.

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

The agenda package was pre-circulated. There were no declarations of conflict of interest.

4. DELEGATION/PRESENTATION

i) Preliminary Insights: Positive Space Evaluation

- Ginette Demers, Manager, Health Equity, Knowledge and Strategic Services
- Geneviève Projean, Public Health Nurse, Health Equity, Knowledge and Strategic Services

G. Demers and G. Projean were invited to present on the evolution of the Positive Space initiative at Public Health Sudbury & Districts and to share work that is underway to help make Public Health more welcoming to Two-Spirit, lesbian, gay, bisexual, trans, queer, asexual and other gender and sexually diverse people (2SLGBQIA+).

In 2019, Public Health Sudbury & Districts collaborated with Laurentian University to conduct a study around how Public Health can better engage and support the 2SLGBTQIA+ population in the service area. Based on the study findings, and following further consultation with subject matter experts, the Positive Space initiative was launched in June 2023.

With the Positive Space initiative having been in place for nearly two years, a process and outcome evaluation is being conducted in two phases. The current phase focuses on assessing the implementation of key actions and measuring their effects on clients and staff. Although the analysis is not yet complete, early insights from the process and outcome components of the evaluation were shared. These include that most staff who responded to the survey (97%) felt supported with implementing a Positive Space and many clients surveyed (88%) agreed they were treated in a safe and respectful manner by staff during their most recent Public Health visit. Initial recommendations for improvement of the Positive Space efforts include

- Enhancing partnerships and collaborations with 2SLGBTQIA+ people and service providers
- Working on enhancement of positive, inclusive, and safer spaces through Public Health services in the community
- Providing additional staff development as well as routine training opportunities to ensure Positive Space efforts are continuously actioned

Next steps include finalizing a report of the findings from this first part of our evaluation. Recommendations will then inform a second phase of evaluation.

In addition, planning is underway for the collection of socio-demographic data pertaining to gender identity and sexual orientation across program areas. Further, additional staff development and training opportunities are being explored and will be implemented while feedback from staff and clients continues to be monitored.

Over the next year, we will work with partners and people with lived and living experience to explore the assets, needs, and priorities of 2SLGBTQIA+ communities in our service area, and we will engage in knowledge mobilization of community surveillance data and past research findings. We have partnered with the University of Toronto on a new research project to explore how intergenerational connections between 2SLGBTQIA+ youth and older adults can strengthen wellbeing and shape inclusive community programs. This work builds on our previous study and will help Public Health improve outreach, build partnerships, and design more responsive, community-informed supports.

Questions and comments were entertained and presenters thanked.

ii) Unlearning & Undoing White Supremacy and Racism Project Unlearning Club – United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)

- Sarah Rice, Manager, Indigenous Public Health
- Alicia Boston, Health Promoter, Indigenous Public Health

S. Rice and A. Boston were invited to present on the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) which serves as a critical international framework that has significantly shaped global conversations on Indigenous rights. For the Board of Health, which is engaged in the Unlearning & Undoing White Supremacy and Racism Project, UNDRIP is a foundational document that supports Public Health Sudbury & Districts' commitment to addressing systemic racism and advancing justice. Understanding and applying these principles is essential in efforts to dismantle colonial structures and promote equity for Indigenous communities. A historical overview was provided regarding the slow timeline to the eventual legislative incorporation of UNDRIP's recommendations in 2021.

UNDRIP aligns closely with the Public Health Sudbury & Districts' Indigenous Engagement Strategy and Governance ReconciliAction Framework. These local commitments reflect our ongoing dedication to reconciliation and building respectful, meaningful relationships with Indigenous communities. UNDRIP provides a foundational framework to guide and deepen these efforts, helping address historic injustices and systemic inequities faced by Indigenous peoples in our region. It affirms the right of Indigenous peoples to self-govern their own health services and programs. This supports our shift from viewing Indigenous health solely through an equity lens, to recognizing Indigenous peoples as rights holders with authority

over their own health and wellness. This shift is crucial to improving health outcomes and building meaningful relationships based on respect and shared decision-making.

UNDRIP recognizes and validates traditional healing practices and the importance of cultural safety in health care. This aligns with our efforts to integrate Indigenous knowledge systems into our approaches, to ensure that our programs and services are culturally safe, respectful, and effective. Finally, UNDRIP grounds ethical and inclusive decision-making in health governance and reminds us that policies and programs must be co-developed with Indigenous partners, ensuring their voices are meaningfully engaged at every stage. This collaborative approach is embedded in our Governance ReconciliAction Framework and essential to fostering trust and respect. It was concluded that UNDRIP is a vital tool for Public Health Sudbury & Districts to lead in advancing Indigenous health rights, equity, and reconciliation in our community.

Comments and questions were entertained and presenters thanked for their presentation and work at ensuring Indigenous peoples continue to have their rights respected and protected.

Due to the risk of losing quorum for the meeting, consensus was reached to deal with the 2024 Audited Financial Statements before the consent agenda.

NEW BUSINESS

i) 2024 Audited Financial Statements

- Public Health Sudbury & Districts Audited Financial Statements for 2024

M.M. Hirji noted the requirement to provide Audited Financial Statements every year.

M. Parent, Chair of the Board of Health Finance Standing Committee, was invited to present the 2024 Audited Financial Statements. He shared that the Finance Standing Committee met on June 2, 2025, and reviewed the 2024 draft audited financial statements.
Derek D'Angelo, Audit Partner at KPMG virtually joined the Finance meeting to review the audit processes and present the audit findings report. Based on the auditor's report, the financial statements present fairly, in all material respects, the financial position of Public Health Sudbury & Districts as of December 31, 2024. The auditors did not identify any material misstatements, illegal acts or fraud and no internal control issues.

As such, the auditors propose to issue an unqualified report on the financial statements subject to the approval today of the draft statements. The financial statements for 2024 are presented with the Board Finance Standing Committee's recommendation for approval of the 2024 audited financial statements.

With respect to the content of what is reported in the financial statements, highlights discussed by the Finance Committee were outlined, including that 2024 was a year of significant change where the agency completed its ramp down COVID-19 activities, refocused on Public Health priorities and addressed the backlog that occurred over the pandemic. In 2024, the Ministry ceased to provide local Public Health with extraordinary funding for COVID-19 expenses as of March 31, 2024. The Ministry also did not provide local public health agencies with the opportunity to apply for one-time funded programs on the 2024 Annual Service Plan. Notwithstanding this, the province did ultimately provide small unsolicited and unplanned one-time funding grants for COVID-19 vaccines, for Public Health Inspector Practicums, and for a new RSV (Respiratory Syncytial Virus) vaccination program.

Major capital/infrastructure projects in 2024 were summarized.

The 2024 Audited Financial Statements reflect these major events, and the variances observed on the financial statements are attributable primarily to the reduction in one time funding opportunities from the Ministry.

Dr. Hirji and the Corporate Services Finance Team under Interim Director, Sandra Laclé and Manager, Keeley O'Neill, were recognized for their thorough, accurate, and careful stewardship of the organization's finances that has led to the auditor's making an unqualified assessment around the accuracy of the financial statements.

29-25 ADOPTION OF THE 2024 AUDITED FINANCIAL STATEMENTS

MOVED BY PARENT – NOLAND: WHEREAS the Board of Health Finance Standing Committee recommends that the Board of Health for the Sudbury and District Health Unit adopt the 2024 audited financial statements, as reviewed by the Finance Standing Committee at its meeting of June 2, 2025;

THEREFORE BE IT RESOLVED THAT the 2024 audited financial statements be approved as distributed.

CARRIED

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Fourth Meeting – May 15, 2025

ii) Business Arising from Minutes

iii) Report of Standing Committees

a. Unapproved Board of Health Finance Standing Committee minutes dated June 2, 2025

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

a. MOH/CEO Report, May 2025

v) Correspondence

- None

vi) Items of Information

a. 2025 alPHa Conference, Annual General Meeting and Board Section Meeting
- Conference Program – draft dated June 3
- Board of Health Section Agenda – draft dated May 23
- 2025 alPHa Resolutions for Consideration

b. Statement from the Chief Medical Officer of Health dated June 5, 2025

In response to inquiries regarding the MOH/CEO report to the Board, clarification was provided regarding the Province's proposal to amend Section 22, as well as surveillance of waste water for COVID-19, influenza, and other viruses. Additional information will be provided to Board of Health members regarding the Icelandic Prevention Model and consideration will be given for a presentation to focus this topic at a future Board of Health meeting.

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

CARRIED

6. NEW BUSINESS

i) 2024 Audited Financial Statements

- Public Health Sudbury & Districts Audited Financial Statements for 2024

Dealt with prior to Consent Agenda.

ii) Organizational Risk Management

- Briefing Note from the Acting Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated June 5, 2025
- 2024 Risk Management Annual Report
- 2026–2028 Risk Management Plan – Engagement Strategy

In October 2016, the Board of Health proactively approved an organization-wide risk management framework, policy, procedure, and a risk management plan which prescribes quarterly reporting for Senior Management Executive Committee and annual roll-up of all

data for Board of Health review. The 2024 Risk Management Annual Report is included in today's Board of Health agenda package.

M.M. Hirji provided an overview of the risk management framework and risk prioritization matrix heat map which visually represents and prioritizes risks based on their likelihood of occurrence and potential impact. It was noted that commentary is provided within the report for each risk. It was noted that the quarterly report shows that the risks have remained stable overtime. It was noted that the risks are largely external in nature and risks that cannot be completely eliminated; however, putting mitigation strategies in place help reduce their potential impact.

This is the final year of the current 2023–2025 Risk Management Plan. Planning is underway for the development of the next iteration of the risk management plan for the 3-year period of 2026–2028. The engagement strategy, shared with the Board of Health for awareness, will begin in the fall with workshops for the Senior Management Executive Committee in September 2025 and Board of Health in October 2025 for final approval by the Board of Health in the January 2026.

The Board of Health 3-hour workshop will be to identify and assess new risks to Public Heath for the 2026–2028 risk management plan. Board members are asked to pencil in the morning of Thursday, October 16, 2025, in their calendars. Following the workshop, lunch will be provided before the October 16, 2025, Board of Health meeting.

31-25 RISK MANAGEMENT

MOVED BY RECOLLET - CARRIER: BE IT RESOLVED THAT the Board of Health receive the 2024 Annual Risk Management Report; and

FURTHER THAT the Board of Health receive an update on the engagement strategy for the development of its 2026–2028 Risk Management Plan.

CARRIED

7. ADDENDUM

None

8. ANNOUNCEMENT

Board members were invited to complete the June Board of Health meeting evaluation following the meeting.

Ken Noland was presented with a service pin for reaching a 20-year milestone as a Board of Health member.

There are no regularly scheduled Board of Health meetings for July and August. The next regular Board of Health meeting is Thursday, September 18, 2025. Board of Health members were reminded that the Board of Health group photo will be held prior to the September 18, 2025, Board of Health meeting.

Also, following today's meeting, Board members are asked stay for the Unlearning Club session.

9. ADJOURNMENT

32-25 ADJOURNMENT

MOVED BY PARENT – BARCLAY: THAT we do now adjourn. Time: 2:40 p.m.

CARRIED

_____ (Chair)

_____ (Secretary)

Public Health
Santé publique
SUDBURY & DISTRICTS

Medical Officer of Health/Chief Executive Officer Board of Health Report, September 2025

Words for thought

Improving Vaccination Programs in a Time of Continental Backlash

2024 ANNUAL REPORT
Of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario

Key Recommendations:

- Build a centralized provincial immunization information system to make it easier for people to check their immunization history.
- Advocate for a national immunization information system and harmonized vaccine schedule to ensure consistency and equity across Canada.
- Address inconsistencies in access by supporting community-led strategies and improving access to primary care.
- Strengthen vaccine confidence through trusted relationships with healthcare providers and community ambassadors.
- Strengthen surveillance systems to monitor vaccine safety and effectiveness in real time.
- Invest in innovation and preparedness, including domestic vaccine development and manufacturing; using new technologies to tackle emerging threats.

Figure 2: Comparison of case counts in Canada for six vaccine-preventable diseases before and after introducing each vaccine

Cases before the introduction of vaccine*	Disease	Percent reduction in cases	Cases after the introduction of vaccine**
17,777	Whooping Cough (Pertussis)	87% ↓	2,340
36,101	Mumps	98% ↓	737
53,584	Measles	99% ↓	37
8,142	Diphtheria	99% ↓	5
14,974	Rubella	99% ↓	1
2,545	Polio	100% ↓	0

*Cases before the introduction of vaccine are average annual case counts in Canada during the five years before routine vaccine or closest possible five years where stable reporting was occurring.

**Cases after the introduction of the vaccine is the average annual case count in Canada 2016-2020. Canada has held endemic measles elimination status since 1998. Given global circulation, outbreaks still occur in Canada because of imported cases.

Source: *Protecting Tomorrow: The Future of Immunization in Ontario.* 2024 Annual Report Of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario. August 2025.

Date: August 29, 2025

The Chief Medical Officer of Health (CMOH) has released his latest annual report, highlighting the incredible achievements of vaccinations, and his advice on how Ontario can strengthen vaccination programs. This comes at a time when vaccination programs are under assault in North America.

Most high profile has been in the United States where the US government, under Donald Trump and Robert F. Kennedy Jr., fired the scientists on its vaccine science advisory committee and replaced them with non-experts, removed the recommendation that most adults and children be vaccinated for COVID-19, removed recommendations for many (though not all) influenza vaccines, and cancelled research into new vaccinations[1]. Kennedy has also hinted strongly that he will soon be releasing a report linking vaccines to autism[2], a claim that has been thoroughly studied over 25 years and consistently debunked. Indeed, Kennedy recently attempted to bully a medical journal to retract the latest study that once again debunked this conspiracy[3].

Emboldened by this, the State of Florida announced it is eliminating all vaccine requirements, including in schools[4]. And the Province of Alberta has cited changing US guidance to change its COVID-19 vaccine program: persons must now pre-order vaccines in August or September if they are to then be eligible to book a vaccine appointment later in the fall. Most Albertans must also pay out-of-pocket for the vaccine and cannot get the vaccine through their primary care provide or a pharmacy, making access more difficult. The government initially intended to deny health care workers access to publicly-funded vaccines but they relented under intense pressure[5].

It is therefore heartening in this context to see the Ontario government's decision to expand its RSV vaccination program[6].

Moving forward, the CMOH highlights the importance of improved vaccine data systems (which this Board endorsed in February 2025), improved community engagement, better understanding the sociodeographics of those getting vaccinated and those experiencing barriers to getting vaccinated, and working to strengthen vaccine confidence. These are areas of ongoing work for Public Health Sudbury & Districts, and we hope to share some details on progress on these in the future.

[1] RFK Jr. faced tough hearing on vaccines, CDC changes : Shots - Health News : NPR
[2] RFK Jr. demands scrutiny of vaccines and autism in latest 'Make America Healthy Again' report - The Globe and Mail
[3] RFK Jr demanded a vaccine study be retracted — the journal said no
[4] 'Reckless and dangerous': Florida to eliminate childhood vaccine mandates in schools | CBC News
[5] Alberta to cover COVID vaccines for health-care workers after all | CBC News
[6] Ontario Expanding RSV Immunization to Protect More Seniors This Fall | Ontario Newsroom

Report Highlights

1. Director of Corporate Service Recruitment

As discussed in more detail below, after a year-long recruitment process, Renée Higgins has been hired as the new Director to start on October 1, 2025. Renée comes to us from the City of Greater Sudbury and will be a strong addition to our leadership team.

2. Multi-Jurisdictional Measles Outbreak

Ontario has seen a significant decline in measles infections since the last report in June. In most weeks recently, Ontario has been reporting only one new infection. The measles outbreak has affected 26 of 29 public health jurisdictions in Ontario.

Unfortunately, Public Health Sudbury & Districts was impacted by this outbreak over the summer with 44 infections identified locally. Thanks to a detailed investigation, further spread was contained, and transmission has ceased. All infections in our service area were in persons who were not vaccinated against measles. This is consistent with the provincial trend of 95.4% of infections being in persons without a complete measles vaccine record.

While Ontario's measles' outbreak is almost under control now, the broader outbreak to which it is linked spans other parts of Canada and the US, and many other jurisdictions are continuing to see infections. In particular, Alberta continues to see infections in Canada. As a consequence, it is likely that Canada will lose its measles elimination status, something it has held since 1998.

3. IT & HR Reviews

Pursuant to the 2025 Budget, reviews of the agency's human resources strategy and information technology set-up are underway and nearing completion. These efforts are critical to adapt to budgets that are shrinking in inflation-adjusted terms. Technology will help us maintain services as the organization contracts, while a human resources strategy will maximize recruitment and retention, staff resilience and engagement through these difficult times. Findings of these reviews will inform the 2026 Budget proposal to the Board of Health in November.

4. Substance Use Efforts

I will be participating in several meetings this fall around the substance use issue in our community as we try to strengthen community action. The Community Drug Strategy is also working to define clearer objectives and outcomes that it can share with the community.

5. Building Renovations

As discussed below in the report, renovations to our offices to improve engagement and moral, as well as better adapt to hybrid work, are nearing completion. I had the opportunity to see the renovations in Chapleau, Mindemoya, and Espanola recently on visits to those communities. Our staff are very appreciative for the remediations completed and look forward to be able to align with our current branding.

6. Indigenous Engagement

I have had the opportunity to meet with several Indigenous partners in recent weeks and am seeking to meet with others this fall. This will support our ongoing Indigenous Public Health work, as well as discuss a particular gap in communicable disease prevention where we have identified a jurisdictional gap. Work around skill-building to dismantle colonial structures internally continues with the Unlearning Club, and some of the materials are now going to be shared with the wider community.

7. Engagement with Primary Care & Ontario Health Team

As the Ontario government seeks to have every resident in the province attached to primary care, we are meeting with our partners to see how we can fit in. Public Health delivers primary care services around vaccinations, sexual health, and, even to some extent, in early childhood. Having observed the challenges of prevention work when someone does not have a primary care provider, we strive to be part of the solution for our community.

8. Revamped Planning

Work has been underway to revamp our planning processes with new more efficient systems and a greater focus on measuring outcomes and impact. The hope is that this can lead our strong programs to deliver an incrementally even greater benefit to our community. We also hope that strong metrics of impact will facilitate more effective advocacy to the provincial government and other partners around funding.

9. Electronic Medical Record Implementation

As an investment in the 2025 Operating Budget, Public Health is beginning the transition to an electronic medical record (EMR). It is hoped that an EMR will both improve efficiency of documentation but also facilitate access to data to improve care to our clients. More details are discussed below. Further updates will be shared in the coming months with the Board, particularly around the 2026 Budget discussions as we seek to ensure the sustainability of this new infrastructure.

General Report

1. Board of Health

Board of Health Group Photo

A professional photo of the Board of Health will be taken on Thursday, September 18, 2025. Board members are asked to arrive at 1300 Paris Street at 12:20 p.m. on September 18, 2025. Weather permitting, the photo may be taken outside. Otherwise, the group photo will be taken inside at 1300 Paris Street. Wearing business casual in neutral or light colours is recommended rather than bright colours or bold patterns. The group photo will be posted on phsd.ca. We hope every Board member will be able to be present for the September 18 group photo.

A light lunch will be provided following the group photo and prior to the 1:30 p.m. Board of Health meeting.

Risk Management Workshop for Board of Health

Board members are reminded of the Risk Management workshop scheduled for Thursday, October 16, 2025, from 9 a.m. to noon in Public Health Sudbury & Districts' Ramsey Room at 1300 Paris Street. A warm lunch will be served following the workshop. The regular Board of Health meeting will follow on October 16, 2025, at 1:30 p.m. in the Boardroom.

Board of Health Annual Self-Evaluation Survey – 2025

As part of the Board of Health's commitment to good governance and continuous quality improvement, in compliance with provincial requirements, and in accordance with Board of Health Manual policy C-I-12 and C-I-14, the Board of Health annual self-evaluation of its governance practices and outcomes is now available.

Board of Health members are asked to complete the *2025 Board of Health Annual Self-Evaluation Survey* in BoardEffect (under the Board of Health workroom – Collaborate – Surveys) by Friday, October 17, 2025. Results of the annual Board of Health member self-evaluation of performance evaluation will be presented at the November Board meeting.

2. Annual mandatory training for Board of Health members

Emergency preparedness

The *Ontario Public Health Standards* require that boards of health effectively prepare for emergencies to ensure 24/7 timely, integrated, safe, and effective response to and recovery from emergencies with public health impacts in accordance with ministry policy and guidelines. A key component of emergency preparedness is training of Board of Health members and staff.

The emergency preparedness PowerPoint is linked to the September 18, 2025, Board of Health meeting in BoardEffect event and can also be found in BoardEffect under Libraries – Board of Health – Annual Mandatory Training: Emergency Preparedness Training for Board Members. Once you have reviewed the Power Point presentation, please email quesnelr@phsd.ca to confirm completion of the annual mandatory emergency preparedness training.

3. Human Resources

I am delighted to share that after a year-long process, we have completed our recruitment for the Director of Corporate Services and have hired Renée Higgins to be our new Director. Renée's first day with us will be Wednesday, October 1, 2025. Renée comes to us from the City of Greater Sudbury where she has most recently been the Director of Data, Analytics, and Change within their Corporate Services Department. Renée has previously worked in leadership roles for the City in IT, in customer service, and within the CAO's office leading a major City-wide quality improvement and budget efficiency project. Given the importance of this position, we have taken the necessary time to find the right candidate for this leadership role. Renée brings emotional intelligence, leadership skills, and values that align very well with this agency and our goals.

I hope you will join me in looking forward to welcoming Renée in October!

I am pleased to share that Sandra Laclé will remain with Public Health Sudbury & Districts until December 12, 2025. This will allow a smooth transition and help advance some key initiatives that are scheduled for this fall. Our thanks to Sandra for her contributions in recent months as Interim Director of Corporate Services.

4. Local and Provincial Meetings

I, along with Board of Health Chair, Mark Signoretti, Board member, Robert Barclay, Acting Associate Medical Officer of Health Emily Groot (for part), and Director of Indigenous Public Health, Kathy Dokis, attended the alPHa AGM and Conference from June 18 to 20, 2025. A brief oral update will be provided at the September 18, 2025, Board of Health meeting.

An offsite retreat was held with members of the Senior Management Executive Committee team on June 23, 2025, where the team discussed organizational priorities as we prepare for the 2026 budget.

I continued to meet with community partners over the summer including the City of Greater Sudbury CAO, Chief of Police, Township of Chapleau, First Nation partners, and Manitoulin Health Centre. I will continue to meet with partners as well as Public Health Sudbury & Districts staff this fall.

On June 19, 2025, the Ministry of Health announced the creation of a new French Language Health Planning Centre that will support system-wide coordination by identifying and advising on Francophone health needs across all sectors, including public health, through regional engagement aligned with Ontario Health regions. Congratulations have been extended to Sudbury's own Natalie Aubin on being named the Chief Executive Officer of this new French Language Health Planning Centre.

5. Electronical Medical Records (EMR)

Progress continues to be made on the EMR implementation project. Specifically, the contract with our selected vendor is nearing finalization. This milestone will secure the partnership and set the foundation for implementation. On September 11, the agency planned for its project kick-off meeting with the vendor and internal stakeholders. The purpose of this session was to introduce the project scope, objectives, and roles, and mark the official launch. Recruitment for one core project team position is still underway. Filling this role is a priority, as this team will provide the specialized expertise required for successful implementation.

We are currently in the initiation and planning phases of the project, which has focused on governance, communications, and preparation for project delivery. The next major activity is the Program Discovery Phase. During this stage, we will work closely with program teams and the vendor to map current workflows, identify requirements, and ensure the system design aligns with both clinical and organizational needs.

6. Supplementary Infrastructure Modernization Projects

The Supplementary Infrastructure Modernization projects, approved at the February meeting, are progressing well and remain on schedule.

- District Offices: Painting and flooring replacement have been completed in the Mindemoya and Espanola offices. In Chapleau, all required painting and flooring repairs are also complete. Procurement is underway for updated signage at the Mindemoya Espanola and Sudbury East offices to reflect current branding.

- 1300 Paris Street: The project remains on track for October 2025 completion. Key components of this project include:
    - Addition of meeting rooms to support collaborative and hybrid work
    - Enclosure of the cultural area with ventilation to support smudging
    - Increase in accessible space
    - Additional offices, including for the Associate Medical Officer(s) of Health
- Drywall installation is complete, and painting is complete. Glass partitions have been ordered and are anticipated to arrive in the near future. Mechanical modifications have been roofed in and are progressing as scheduled, alongside ongoing electrical work.

7. Financial Report

The financial statements ending July 2025 show positive budget variance of $1,503,945 in the cost-shared programs. This reflects the timing of some expenditures that are scheduled later in the year, as well as ongoing challenges with recruiting to fill staff vacancies.

8. Quarterly Compliance Report

The agency is compliant with the terms and conditions of our provincial Public Health Funding and Accountability Agreement. Procedures are in place to uphold the Ontario Public Health Accountability Framework and Organizational Requirements, to provide for the effective management of our funding, and to enable the timely identification and management of risks. Public Health Sudbury & Districts has disbursed all payable remittances for employee income tax deductions, Canada Pension Plan, and Employment Insurance premiums as required by law to August 29, 2025, on September 2, 2025. The Employer Health Tax has been paid, as required by law, to July 31, 2025, with an online payment date of August 12, 2025. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to July 31, 2025. There are no outstanding issues regarding compliance with the *Occupational Health and Safety Act* or the *Employment Standards Act*. However, there is one order from the Ministry of Labour and one associated matter currently before the Ontario Human Rights Tribunal. No new matters have come forward pursuant to the *Accessibility for Ontarians with Disabilities Act*.

9. Accountability Monitoring Plan

The accountability monitoring reports demonstrate how we have achieved provincial mandates and local commitments. A mid-year check-in report was done in June to demonstrate our progress in fulfilling the priorities set out in our strategic plan, our requirements under the Foundational and Program Standards within the *Ontario Public Health Standards*, and our commitments to Organizational Requirements. The Senior Management Executive Committee has reviewed the mid-year report and provided recommendations for further dialogue in the fall with staff and managers related to the strategic priority performance measures. The year-end report data collection will begin in Q4 with a plan to have a Joint Board of Health working group meeting in January to review the draft of the 2025 annual report.

10. 2024 Financial Report

The 2024 Public Health Sudbury & Districts Financial Report has been prepared and is included in the Board of Health package. The report promotes clear communication, transparency, and documents Public Health's various revenue sources (including provincial and municipal contributions) as well as the agency's operating expenses. Throughout 2024, Public Health fostered strong partnerships, as well as meaningful relationships with First Nations and Indigenous communities in our vast service area. This work is highlighted in Public Health's

2024 Year-in-review: Connecting the Dots report. Once received by the Board, the financial report will also be posted to the website and shared with the community.

Following are the divisional program highlights.

Health Promotion and Vaccine Preventable Diseases Division

1. Chronic Disease Prevention and Well-Being

Physical activity and sedentary behaviour

Public Health staff met with SportLink, the Greater Sudbury Sport Council's Board of Directors, to discuss the development of a community-wide sport policy focused on enhancing access, equity, and alignment across local sport organizations. Work is underway to inform this policy through a survey distributed to local coaches and sport organizations. Following the survey, staff will collaborate with SportLink to develop a meaningful policy that reflects diverse perspectives and supports SportLink's vision and mission while strengthening access, equity, and alignment within the local sport organizations.

Oral Health

Over the summer, staff provided comprehensive dental care at the Seniors Dental Care Clinic at Elm Place, including restorative, diagnostic, and preventive services. Staff also provided referrals to contracted community providers for emergency, restorative, and prosthodontic services, as well as enrollment assistance to low-income seniors eligible for the Ontario Seniors Dental Care Program (OSDCP).

To expand service capacity in the districts, letters were sent to dental providers in the Manitoulin and Sudbury districts, inviting them to participate in the OSDCP through service partnership agreements with Public Health.

On June 9, 2025, a media release informed Espanola residents that fluoride levels in the municipal water supply had returned to normal following repairs, and acknowledged the Town of Espanola for its ongoing investment in fluoridation.

2. Healthy Growth and Development

Infant feeding

From June to August, staff provided 304 clinic appointments to parents at the main office, and at the Val Caron, Espanola, and Manitoulin locations. These services support parents in making informed infant feeding decisions, including breastfeeding and formula feeding. Parents also

learn skills that promote, protect, and support breastfeeding and had the opportunity to ask questions about other feeding options.

The nurse conducting these visits also screens for potential concerns, such as insufficient milk supply and monitors the infant weight gain and growth to ensure they are within expected parameters.

Growth and development

In June, Healthy Families staff welcomed Northern Ontario School of Medicine (NOSM) pediatric resident learners to Public Health Sudbury & Districts for a mock learning experience as part of NOSM's Amazing Race challenge. This activity required learners to navigate the community and complete real-world tasks, highlighting barriers families often face, such as applying for housing, attending appointments at the Children's Treatment Centre, or buying groceries on a limited budget.

At the main office, learners worked through a case study on infant feeding, which involved calculating the cost of specialized formula for a four-month-old with nutritional sensitivities. They also completed a task to book a mock vaccine appointment for a family of four children with varying needs and vaccination statuses.

This experiential learning opportunity helped future pediatricians better understand the challenges families encounter in accessing services, and the important role public health plays in supporting equitable health outcomes.

Additional activities included mailing 124 reminder postcards to parents encouraging them to book their child's 18-month well-baby visit. Additional activities included mailing 124 reminder postcards to parents encouraging them to book their child's 18-month well-baby visit. The intervention aims to increase early developmental screening and timely referrals, as needed. Between June and August, staff also conducted 394 48-hour follow-up calls to parents of newborns, addressing infant feeding, post-partum care, and community resources. These calls resulted in 49 referrals to the infant feeding clinic.

Health Information Line

The Health Information Line fielded 272 calls on topics including infant feeding, healthy pregnancies, parenting, communicable diseases (such as measles), healthy growth and development, mental health services, and locating a nearby family physician.

Healthy Babies Healthy Children

From June to August, staff supported 194 families through 3 326 interactions. Public health dietitians also provided nutrition support to families identified as being at high nutritional risk.

Healthy pregnancies

From June to August, 89 individuals registered for Public Health's online prenatal course. This free, self-directed program provides information on pregnancy and fetal development, healthy lifestyles, labour and delivery, the early hours after birth, caring for a newborn, infant feeding and safety, postpartum recovery, mental health, and adjustment to parenthood. The course also offers tools and local resources to help parents navigate pregnancy and transition to parenthood with confidence.

Preparation for parenting

In June, staff delivered a *Prep 4 Parenting* class to nine participants. Topics included preparing for parenthood, attachment and bonding, communication, roles and responsibilities, caring for a newborn, postpartum mood disorder (PPMD), and infant mental health. This program supports the strategic priority of *Addressing Equal Opportunities for Health* by ensuring inclusive programs and services informed by diverse community voices, needs, and priorities.

Positive parenting

Staff co-chaired the Parenting Programming Advisory Committee, which works to identify community needs and coordinate parenting services to reduce duplication. A sub-committee was also formed to update the parenting4me.com website to improve usability, enhance accessibility features, and expand language options. Participation on this committee supports the strategic priority of *Impactful Relationships*, reflecting staff's commitment to strengthening partnerships and collaborating to provide evidence-based positive parenting programs for families in need.

3. School Health

Oral Health

Over the summer months, staff provided preventive oral health services at the Paris Street office for children enrolled in the Healthy Smiles Ontario (HSO) Program, assisted families with enrollment, and conducted case management follow-ups for children with urgent dental care needs. Preventive services were also offered to HSO clients at the Sudbury East office in early June. On June 6, staff hosted a drop-in dental screening clinic at the Paris Street office on a school professional activity day. Of the 65 children and youth screened, 16 (25%) were identified as having urgent dental care needs requiring treatment.

To support navigation and referrals for HSO clients, staff surveyed local dental offices to determine whether they accept the HSO program and could be included on a referral list. In addition, staff met with Indigenous partners in Chapleau and Wikwemikong in June to explore opportunities for collaboration in promoting children's oral health.

4. Substance Use and Injury Prevention

Substance Use

Continuing efforts to reduce substance-related harms, the Community Drug Strategy (CDS) for the City Greater Sudbury held a Health Promotion Stream meeting, as well as Steering and Executive Committee meetings in June. On July 25, Public Health staff co-chaired the Northern Ontario Toxic Drug Crisis Response Community of Practice (CoP) meeting.

On August 11, 2025, a drug warning was issued in response to an increase in drug poisonings (overdoses) and unexpected reactions to substances in the Sudbury and Manitoulin districts. Timely alerts and coordinated responses to drug events remain critical to protecting public health and reducing harm.

In response to the increasingly complex overdoses, Public Health participated in several media interviews in June and August to share harm reduction messaging and raise awareness. In June, staff completed three interviews: Two with CBC and CTV on naloxone use and overdose response amid an increasingly toxic drug supply, and a third with CTV highlighting drug toxicity surveillance data on the Community Drug Strategy website. In August, staff completed two additional media interviews with Radio Canada, one on recent surveillance data and another on Radio Canada TV (at the 14 minute mark) addressing the drug warning issued on August 11.

Harm reduction – Naloxone

In collaboration with community partners, Public Health distributed 1718 naloxone doses and trained 710 individuals on its use in May. In June, 2240 naloxone doses were distributed, and 924 individuals were trained, followed by 2174 naloxone doses distributed, and 851 individuals trained in July. These efforts are part of ongoing harm reduction initiatives to equip community members with the tools and knowledge to safely respond to drug poisonings and reduce the harms of opioid use.

Public Health also participated in several community events to expand naloxone training and harm reduction outreach. In May, staff hosted a booth at the White River First Nation Safety Summit. In June and July, Public Health partnered with the North Bay Regional Health Centre to train staff and attended the Noojmowin-Teg Health Centre's Annual Addiction Recovery Breakfast on June 18 to provide training, distribute harm reduction supplies, and share valuable resources. These events facilitated meaningful conversations with people who use drugs, their families and friends, and created opportunities to strengthen partnerships with fellow service providers.

Building on discussions from a fall 2024 meeting with the Killarney Health Centre, Public Health collaborated with local partners to install a yellow kiosk bin for sharps disposal in Killarney in June—the first in the community. With this addition, the Sudbury East area now has two kiosk bins, one in Killarney, and one in St. Charles.

Smoke Free Ontario Strategy

This summer, Health Promotion and Health Protection staff collaborated with Sudbury East municipalities to raise awareness of smoke- and vape-free outdoor areas, including sports fields, playgrounds, and spectator areas.

Activities included site visits and consultations by tobacco enforcement officers to assess signage needs, supporting the installation of *Smoke-Free Ontario Act* (SFOA) decals and metal signs in public and recreational areas such as dumps, sports fields, and playgrounds, providing comprehensive online resources for social media, municipal websites, and newsletters, and developing a letter template for key municipal contacts to share with sport field users to support local SFOA implementation.

Public Health will continue working with Sudbury East municipalities to update and create SFOA bylaws.

5. Vaccine Preventable Diseases

Immunization information line

Between June and August, Public Health staff responded to approximately 1100 calls through the immunization information line. Most enquiries related to the *Immunization of School Pupils Act* (ISPA) or the *Child Care and Early Years Act* (CCEYA), assisting in accessing immunization records, and general immunization questions. Other topics included school-based clinics, respiratory season vaccines, travel-related immunizations, adverse events following immunization, and the submission of foreign immunization records.

Publicly funded immunization programs

Staff completed the second round of Grade 7 school-based clinics, offering publicly funded vaccines against Hepatitis B, Human Papillomavirus (HPV), and meningococcal disease to students at 53 schools.

In alignment with Ontario's Human Vaccines Against Avian Influenza program, Public Health offered the avian flu vaccine (Arepanrix™ H5N1) to eligible high-risk populations, including individuals working with potentially infected birds and those handling live avian virus in a lab setting. As the vaccine requires a two-dose series, clinics were held in July and August, with 10 individuals completing the series.

In July and August, the Vaccine Preventable Diseases team supported response efforts related to local measles cases. Vaccination clinics were offered in affected communities, and staff provided guidance to health care providers as needed.

Education, partnerships and engagement

Public Health responded to three media requests related to student vaccines, immunization awareness, and the expansion of fall Respiratory Syncytial Virus (RSV) eligibility. Staff also provided information and key messages to support media coverage on measles.

Immunization of School Pupils Act (ISPA) and Child Care and Early Years Act (CCEYA)

Public Health completed its annual review of immunization records for elementary and secondary students under the *Immunization of School Pupils Act (ISPA)*. Initial notices were sent to 5740 students with incomplete records, followed by 4545 second notices. A total of 1211 suspensions were applied. To support families in updating immunizations, Public Health offered daily drop-in clinics and weekly evening appointments at the 1300 Paris Street location, as well as additional opportunities in Mindemoya, Espanola, and Chapleau.

In June, Public Health also began its annual review of immunization records for children attending licensed child care settings in accordance with the *Child Care and Early Years Act (CCEYA*). 79 centres were included in the review. Of 2700 enrolled children, 1300 were overdue or had incomplete records. Parents received a letter with a deadline to respond, after which Public Health notified centres of families who had not complied. As child care centres are required to maintain up-to-date records, they were responsible for follow-up. Public Health continues to support centres through consultations and resources.

Cold chain inspections

In July and August, public health nurses conducted 188 cold chain inspections across the service area. Results were submitted to the Ministry in preparation for the fall seasonal vaccine campaign. At the time of submission, 98 sites received a pass, two received a conditional pass, and two failed inspections.

Health Protection

1. Control of Infectious Diseases (CID)

In the months of June, July, and August, staff investigated 210 sporadic reports of communicable diseases. During this timeframe, 16 respiratory outbreaks were declared. The causative organisms for the respiratory outbreaks were identified to be rhinovirus (6), parainfluenza (3), human coronavirus (1), COVID-19 (1), enterovirus (1), and metapneumovirus (1). The causative organism for the remaining respiratory outbreak was not identified.

During this time, an institutional invasive group A streptococcus outbreak was declared. Further, a local measles infection was reported with a subsequent identification of a total of 44 infections. This measles cluster was linked to the ongoing provincial outbreak. Staff responded in alignment with the agency's measles response plan.

Staff continue to monitor all reports of enteric and respiratory diseases in institutions, as well as sporadic communicable diseases.

During the months of June, July, and August, six infection control complaints were received and investigated, and 24 requests for service were addressed.

Staff issued eight special event animal exhibit permits to various organizations during the months of June, July and August.

Infection Prevention and Control Hub

The Infection Prevention and Control Hub provided 59 services and supports to congregate living settings in June, July, and August. These included proactive IPAC assessments, education sessions, feedback on facility policies, and supporting congregate living settings in developing and strengthening IPAC programs and practices, to ensure that effective measures were in place to prevent transmission of infectious agents.

In July, the IPAC Hub launched the Congregate Living Setting (CLS) Participatory Approach Project. The CLS Participatory approach was designed to assist facilities with developing and implementing new policies and procedures. The response from various CLS partners has been very positive, and we look forward to continuing this collaboration.

2. Food Safety

During the months of June, July, and August, public health inspectors issued one Closure Order to a food premises due to unsanitary conditions. The Closure Order has since been rescinded following corrective action, and the premises was allowed to reopen. Public health inspectors also issued an Order to Cease Operation to an occupant of a rental unit stopping the sale of meat from an uninspected food premises.

Public health inspectors issued one charge to a food premises for an infraction identified under the *Food Premises Regulation*.

Staff issued 429 special event food service and non-exempt farmers' market permits to various organizations.

3. Health Hazard

In June, July, and August, 60 health hazard complaints were received and investigated. Further, staff provided 61 consultations in response to health hazards that are not part of the public health mandate and redirected clients to the most appropriate lead agency for investigative follow-up.

Several media releases were issued in June, July, and August in response to high temperatures (heat warnings) and poor air quality due to wildfire smoke. The releases provided information concerning symptoms and actions to take as well as measures to reduce risk of exposure.

Meetings were held with Glencore and Vale with the Ministry of Environment, Conservation and Parks regarding 2024 emissions from the smelters. Additionally, staff attended an open house held by Glencore regarding their Nickel Site Specific Standard Renewal application and a meeting with Vale regarding the demolition of the Super Stack.

4. Ontario Building Code

In June, July, and August, 127 sewage system permits, 42 renovation applications, and 10 consent applications were received.

5. Rabies Prevention and Control

In June, July, and August, 160 rabies-related investigations were conducted. Three specimens were submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis. Two results were reported as negative, and one result (a bat) was reported as positive. As a result of the positive bat, two individuals are currently receiving rabies post-exposure prophylaxis.

Over the summer months, a total of 34 individuals received rabies post-exposure prophylaxis following an exposure to wild or stray animals.

One animal owner was charged for failing to immunize their dog against rabies.

6. Safe Water

During June, July, and August, 203 residents were contacted regarding adverse private drinking water samples. Additionally, public health inspectors investigated 29 regulated adverse water sample results.

Eight boil water orders were issued over the summer months due to adverse water sample results or inadequate primary or secondary disinfection. Eight boil water orders were subsequently rescinded during this time.

Nine drinking water orders were issued in the months of June, July, and August, due to a loss of pressure in the drinking water systems. 10 drinking water orders were rescinded following corrective actions.

In July, one blue-green algae bloom capable of producing toxins was identified in a local waterway and health protective measures were communicated to the public.

In August, public health inspectors issued one closure order to a seasonal outdoor swimming pool due to several infractions, which included failure to notify public health of intent to operate, adverse water chemistry, and lack of prescribed signage.

7. Smoke Free Ontario Act, 2017 Enforcement

In June, July, and August, *Smoke Free Ontario Act* inspectors charged one individual for smoking in an enclosed workplace and two individuals for smoking on hospital property. Additionally, two warning letters were issued for vaping on school property.

Furthermore, *Smoke-Free Ontario Act* inspectors charged four retail employees for selling tobacco to a person who is less than 19 years of age, four retail employees or owners for selling e-cigarettes to a person who is less than 19 years of age, and one business owner for failing to ensure compliance with section 15(a) of the act.

8. Vector Borne Diseases

In June, July, and August, 26 ticks were submitted to the Public Health Ontario Laboratory for identification, six of which were identified as Ixodes scapularis, commonly known as the blacklegged tick or deer tick. Infected blacklegged ticks are vectors of Lyme disease and other tick-borne diseases.

On July 17, a media release was issued in response to an American Crow having tested positive for West Nile virus in our service area. The last infected bird reported was in 2024. The media release reminded the public that although the overall risk of becoming infected with West Nile virus is considered low, the virus is present in our area, and it is important to take precautions to protect ourselves and our families.

9. Emergency Preparedness & Response

During June, July, and August, staff attended municipal emergency planning meetings at Sables-Spanish Rivers, Assiginack, and Greater Sudbury. Discussions regarding municipal cooling centers were held with the City of Greater Sudbury and the Manitoulin-Sudbury District Services Board. Staff were also involved with on-site assessments of potential emergency reception areas and shelters in Espanola.

Staff provided a presentation on Emergency Food Plan Preparation to the Sudbury Food Insecurity Network, and co-presented with the City of Greater Sudbury to the Municipal Exchange Inservice on From Heatwaves to Action, Municipal Planning for Extreme Heat in Ontario, outlining the CGS *Hot Weather Response Plan*. Additionally, staff participated in the Hydro One Powering Preparedness Workshop in Little Current.

10. Needle/Syringe Program

In May, June, and July, harm reduction supplies were distributed, and services received through 8752 client visits across our service area. Public Health Sudbury & Districts and community partners distributed a total of 99 471 syringes for injection, 199 633 foils, 47 327 straight stems, and 17 647 bowl pipes for inhalation through both our fixed site at Elm Place and outreach harm reduction programs.

In May, approximately 20 217 used syringes were returned, which represents a 98% return ratio of the needles and syringes distributed in the month of April. In June, approximately 39 466 used syringes were returned, which represents a 92% return ratio of the needles and syringes distributed in the month of May. In July, approximately 18 782 used syringes were returned, which represents a 91% return ratio of the needles and syringes distributed in the month of June.

11. Sexual Health/Sexually Transmitted Infections (STI) including HIV and other Blood Borne Infections

Sexual health clinic

In June, July, and August, there were 361 drop-in visits to the Elm Place site related to sexually transmitted infections, blood-borne infections, and pregnancy counselling. As well, the Elm Place site completed a total of 1083 telephone assessments related to STIs, blood-borne infections, and pregnancy counselling in June, July and August, resulting in 485 onsite visits.

Knowledge and Strategic Services

1. Health Equity

Over the summer, the Health Equity team hosted two community sessions with newcomers on a Public Health resource designed to support individuals new to Canada understand and access public health services across Sudbury and districts. An English-language session was held on June 18, in collaboration with the Afro Women & Youth Foundation, and a French-language session was held on July 3, in partnership with the Centre de santé communautaire du Grand Sudbury. A total of 34 participants provided feedback to help make the *Newcomer Guide* more relevant and useful. A final version of the Guide is anticipated early in the fall.

As part of the Positive Space initiative, the Health Equity team hosted the first Pride at Public Health Social staff event on July 9, 2025. During this gathering, an update on the Positive Space evaluation was shared along with insightful information about the hard-won rights and challenges experienced by 2SLGBTQIA+ people in Canada. Pride-filled moments were recalled among participants, and reflections on why Pride continues to be both a celebration and a

protest were brought to light. Staff shared lunch together while participating in a friendly game of trivia.

Over the summer, a Public Health report, *Building Bridges: A community dialogue on public health access and equity for Black communities* was made public. The report highlights key themes heard during consultations held in December 2024 and supports Public Health's ongoing commitment to advancing racial equity.

2. Indigenous Public Health

One of the Health Promoters in Indigenous Public Health joined the Medical Officer of Health and the Assistant Medical Officer of Health as they visited Chapleau and met with the Chiefs and Health Directors of Brunswick House First Nation and Chapleau Cree First Nation. The purpose of the visit was to strengthen relationships, listen to community-identified health priorities, and explore opportunities for collaboration in public health initiatives.

Two team members attended the Chiefs of Ontario 2025 First Nations Community Wellness Conference in Toronto. The event provided valuable opportunities to connect with First Nation health leaders and learn about the priorities of First Nations community wellness across the province.

The team played an active role in supporting a culturally respectful public health response to the recent measles outbreak on Manitoulin Island. Engagement included an open meeting to the Health Directors and chiefs of the First Nations in the service area, from which three First Nations communities attended. The goal was to share information, discuss response strategies, and support communities in pursuing their self-determined public health goals.

In June, the Director of Indigenous Public Health presented an alPHa resolution about Indigenous Representation on all Boards of Health that was tabled.

The Unlearning Club was put on pause over the summer, and the team has been actively working on reports and materials. The Unlearning Club resumes in September and the team is re-engaging participants and reminding them of the work ahead. The team has also been preparing for fall events, like the Fall Harvest Feast.

3. Population Health Assessment and Surveillance

Between June and August, the Population Health Assessment and Surveillance team responded to 30 requests, including routine surveillance and reporting, media requests, and other internal and external requests for data, information, and consultation. This included 3 project-related requests (for example, dashboard development, database, report development, and process improvement projects).

The team supported the management of the measles outbreak through the provision of a contact tracing tool and the provision of outbreak statistics and measles vaccine coverage in our region.

Public Health has been piloting a relationship with BlueDot, a provider of curated infectious diseases monitoring and risk assessment data by subscription. The team developed an internal dashboard to present regionally-tailored data from this resource. This is particularly relevant as the primary free resource for global infectious diseases monitoring was paywalled this year.

In collaboration with the Vaccine Preventable Diseases team, the Population Health Assessment and Surveillance team supported a pilot project for the annual immunization assessment under the *Child Care Early Years Act* (CCEYA). The pilot's objectives were to increase the efficiencies by using technology to automate the generation of letters, as well as the validation of data. This work was completed in collaboration with Wellington Dufferin Guelph Public Health.

4. Effective Public Health Practice

The agency has partnered with Sandbox Software Solutions to develop an online program planning tool to increase planning efficiency, streamline data collection and support ministry and accountability reporting. A core team of staff and managers are working with the service provider to customize the tool. Project completion and implementation of the tool is anticipated in late fall 2025 to plan for 2026 programs and services.

5. Student Placement

There are currently seven confirmed learner placements starting in September. This includes learners from Laurentian University and Cambrian College from nursing and social work programs, and from NOSM University for the dietetics program. In addition, there will be short-term observations arranged for four dental hygiene and four second year BScN learners, all from College Boréal.

6. Communications

Throughout the summer months, the Communications team provided support to inform the community about a drinking water advisory, heat warnings, drug alerts, air quality concerns, West Nile virus, and blue-green algae. Significant support was also provided to prepare for and respond to the appearance of measles cases locally. Media interest and requests for information in recent months also covered topics such as overdoses and deaths due to opioid use, the Community Drug Strategy, and improving self-esteem. Social media promotions continue, which include broad recruitment efforts for vacant positions as well as for other public health topics such as beach safety, our client service standards, and local Pride events. The website redevelopment project is ongoing. With insights gained from an initial needs

assessment, the current focus is now on auditing and developing content strategies and working to identify a potentially qualified vendor to develop, deploy, and offer ongoing support for the agency's new website.

Respectfully submitted,

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

Public Health Sudbury & Districts

STATEMENT OF REVENUE & EXPENDITURES

For The 7 Periods Ending July 31, 2025

Cost Shared Programs

	Adjusted BOH Approved Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over)/under	Balance Available
Revenue:					
MOH - General Program	18,723,731	10,922,176	10,922,222	(46)	7,801,509
MOH - Unorganized Territory	826,000	481,833	481,847	(14)	344,153
Municipal Levies	11,186,768	6,525,614	6,525,760	(145)	4,661,008
Interest Earned	300,000	175,000	220,736	(45,736)	79,264
Total Revenues:	$31,036,499	$18,104,624	$18,150,564	$(45,940)	$12,885,935
Expenditures:					
Corporate Services:					
Corporate Services	6,320,175	3,932,306	3,771,928	160,378	2,548,248
Office Admin.	104,350	60,871	35,938	24,933	68,412
Espanola	131,102	75,950	72,999	2,951	58,103
Manitoulin	141,746	82,107	73,294	8,813	68,452
Chapleau	140,300	81,301	69,268	12,034	71,033
Sudbury East	19,530	11,393	11,605	(212)	7,925
Intake	372,587	214,954	195,879	19,075	176,708
Facilities Management	744,668	439,307	508,675	(69,368)	235,993
Volunteer Resources	3,850	2,246	0	2,246	3,850
Total Corporate Services:	$7,978,309	$4,900,434	$4,739,585	$160,849	$3,238,724
Health Protection:					
Environmental Health - General	1,272,898	733,365	730,590	2,775	542,308
Enviromental	2,824,889	1,631,738	1,426,888	204,850	1,398,001
Vector Borne Disease (VBD)	42,914	26,745	15,684	11,061	27,230
CID	1,528,164	881,691	830,408	51,283	697,756
Districts - Clinical	236,444	136,416	138,454	(2,038)	97,990
Risk Reduction	53,756	30,566	8,594	21,972	45,162
Sexual Health	1,508,238	869,338	903,591	(34,252)	604,648
SFO: E-Cigarettes, Protection and Enforcement	257,027	145,294	127,519	17,774	129,508
Total Health Protection:	$7,724,330	$4,455,153	$4,181,729	$273,425	$3,542,601
Health Promotion and Vaccine Preventable Diseases:					
Health Promotion and VPD- General	1,865,620	1,072,796	910,563	162,233	955,057
Districts - Espanola / Manitoulin	376,553	217,242	192,051	25,191	184,502
Nutrition & Physical Activity	1,533,704	891,606	738,138	153,468	795,565
Districts - Chapleau / Sudbury East	432,484	249,510	240,618	8,892	191,866
Comprehensive Substance Use (Tobacco, Vaping, Car	970,307	568,159	441,917	126,242	528,390
Family Health	1,491,508	857,924	738,639	119,285	752,869
Community Drug Safety & Toxic Drug Crisis & Ment	966,457	544,744	439,259	105,485	527,199
Oral Health	524,052	302,555	312,245	(9,689)	211,807
Healthy Smiles Ontario	667,047	386,741	369,818	16,923	297,229
SFO: TCAN Coordination and Prevention	505,286	266,052	224,961	41,090	280,325
Harm Reduction Program Enhancement	198,465	114,535	94,876	19,660	103,589
COVID Vaccines	111,689	64,436	12,542	51,894	99,147
VPD	1,656,646	948,065	717,243	230,822	939,402
MOHLTC - Influenza	(0)	(313)	0	(313)	(0)
MOHLTC - Meningittis	0	(87)	(68)	(19)	68
MOHLTC - HPV	0	(120)	(391)	271	391
Total Health Promotion:	$11,299,817	$6,483,845	$5,432,411	$1,051,435	$5,867,407
Knowledge and Strategic Services:					
Knowledge and Strategic Services	3,048,643	1,756,497	1,776,626	(20,129)	1,272,017
Workplace Capacity Development	43,507	4,753	38,770	(34,017)	4,737
Health Equity Office	10,970	6,358	13,115	(6,757)	(2,145)
Nursing Initiatives: CNO, ICPHN, SDoH PHN	516,126	297,765	289,231	8,533	226,895
Indigenous Engagement	414,797	239,368	214,703	24,666	200,095
Total Knowledge and Strategic Services:	$4,034,043	$2,304,741	$2,332,444	$(27,704)	$1,701,599
Total Expenditures:	$31,036,499	$18,144,173	$16,686,168	$1,458,004	$14,350,331
Net Surplus/(Deficit)	$(0)	$(39,549)	$1,464,396	$1,503,945	

Public Health Sudbury & Districts

Cost Shared Programs
STATEMENT OF REVENUE & EXPENDITURES
Summary By Expenditure Category
For The 7 Periods Ending July 31, 2025

		Adjusted BOH Approved Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:						
	MOH Funding	31,036,499	18,104,624	18,231,559	(126,934)	12,804,940
	Other Revenue/Transfers	657,147	368,496	520,396	(151,900)	136,751
	Total Revenues & Expenditure Recoveries:	31,693,646	18,473,120	18,751,954	(278,835)	12,941,691
Expenditures:						
	Salaries	19,341,764	11,158,654	10,831,888	326,766	8,509,876
	Benefits	6,978,499	4,026,104	3,669,748	356,356	3,308,751
	Travel	256,343	149,021	96,138	52,882	160,205
	Program Expenses	747,366	396,845	238,233	158,611	509,132
	Office Supplies	88,150	50,994	13,055	37,939	75,095
	Postage & Courier Services	90,100	52,558	40,692	11,866	49,408
	Photocopy Expenses	5,030	2,934	380	2,554	4,650
	Telephone Expenses	72,960	42,560	43,206	(646)	29,754
	Building Maintenance	528,488	313,202	394,306	(81,104)	134,183
	Utilities	190,605	111,186	102,921	8,265	87,684
	Rent	329,758	192,359	185,538	6,821	144,220
	Insurance	147,768	145,685	98,602	47,083	49,166
	Employee Assistance Program (EAP)	37,000	18,500	40,164	(21,664)	(3,164)
	Memberships	52,250	42,552	42,496	56	9,754
	Staff Development	151,201	55,981	114,445	(58,464)	36,756
	Books & Subscriptions	7,045	4,220	4,304	(85)	2,740
	Media & Advertising	111,147	60,979	14,374	46,606	96,773
	Professional Fees	967,511	573,061	360,307	212,754	607,204
	Translation	67,679	39,622	52,793	(13,171)	14,885
	Furniture & Equipment	18,370	13,259	34,067	(20,808)	(15,697)
	Information Technology	1,504,612	1,062,394	909,901	152,494	594,711
	Total Expenditures	31,693,646	18,512,668	17,287,558	1,225,110	14,406,087
	Net Surplus (Deficit)	(0)	(39,549)	1,464,396	1,503,945	

	C-S Programs	
Gapped Salaries & Benefits	683,121	45.42%
Gapped Operating and Oth	820,824	54.58%
Total gapped funding at Jul	**1,503,945**	

Sudbury & District Health Unit o/a Public Health Sudbury & Districts
SUMMARY OF REVENUE & EXPENDITURES
For the Period Ended July 31, 2025

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
100% Funded Programs							
Indigenous Communities	703	90,400	68,670	21,730	76.0%	*Dec 31*	58.3%
LHIN - Falls Prevention Project & LHIN Screen	736	100,000	17,932	82,068	17.9%	***Mar 31/2026***	33.3%
Northern Fruit and Vegetable Program	743	176,100	118,847	57,253	67.5%	*Dec 31*	58.3%
Healthy Babies Healthy Children	778	1,725,944	485,807	1,240,137	28.1%	***Mar 31/2026***	33.3%
IPAC Congregate CCM	780	930,100	241,956	688,144	26.0%	***Mar 31/2026***	33.3%
Ontario Senior Dental Care Program	786	1,315,000	568,036	746,964	43.2%	*Dec 31*	58.3%
Anonymous Testing	788	64,293	21,428	42,865	33.3%	***Mar 31/2026***	33.3%
Total		4,401,837	1,522,676	2,879,161			

WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | wechu.org |

1005 Ouellette Avenue, Windsor, ON N9A 4J8 | 33 Princess Street, Leamington, ON N8H 5C5

August 26, 2025

The Honourable Marjorie Michel
Minister of Health
House of Commons
Ottawa, ON
K1A 0A6

Dear Minister Michel

The Windsor-Essex County Health Unit's Board of Health has a longstanding history of supporting progressive approaches to system changes. On June 26, 2026, the Board of Health continued this support by passing a resolution to address the escalating opioid crisis in Windsor-Essex County (WEC) through coordinated, comprehensive and innovative client support and substance prevention strategies.

The resolution states:

WHEREAS, the Windsor-Essex County has been consistently ranked among the areas in Ontario with the highest rates of opioid overdoses presenting in Emergency Departments, as well as significantly higher rates of opioid-related deaths.

WHEREAS, new and unrecognizable compounds and substances have entered the drug supply, worsening the substance use crisis.

WHEREAS, Windsor-Essex County's alcohol-related ED visits and hospitalizations are significantly higher than the provincial average, with emergency department visits rising among youth and young adults, particularly those 24 and under.

WHEREAS, the Public Health Agency of Canada's Youth Substance Use Prevention Program has previously opened opportunities for community-based funding program that focuses on implementing upstream prevention models for local community agencies.

NOW THEREFORE BE IT RESOLVED that the Windsor-Essex County Board of Health endorses the prioritization of communities which are experiencing disproportionately high overdose rates like Windsor-Essex for the allocation of funding from all levels of government for both upstream (e.g., youth prevention) and downstream services.

FURTHER, the Windsor-Essex County Board of Health supports work of the Windsor-Essex County Health Unit to explore new partnership opportunities with local agencies to implement novel drug testing solutions to support enhanced data collection, surveillance, and harm reduction services for people who use drugs.

FURTHER, the Windsor-Essex County Board of Health encourages the Public Health Agency of Canada for continued commitment to opening funding streams through one-time grants for Public Health Units and other community agencies in the most impacted regions to support local evidence-based substance use prevention models.

Given the escalating health impacts of opioids and other substances, it is critical to implement solutions that are sustainable in both the short and long term. In Windsor-Essex County, the severity of the opioid crisis has placed significant strain on local health system resources and has adversely impacted population health outcomes at a rate higher than the provincial average. In 2024, the region saw 519 Emergency Department (ED) visits due to opioid overdoses, more than double the 258 ED visits recorded in 2019. In 2024, WEC's opioid overdose rate was 11.09 per 10,000 residents, significantly higher than the provincial average of 7.76 per 10,000 (Public Health Ontario, 2024). Opioid-related deaths in WEC have also been on the rise, with 127 fatalities reported in 2023, equivalent to a rate of 28.9 deaths per 100,000 residents, significantly higher than the provincial average of 16.8 per 100,000 (Public Health Ontario, 2024). This underscores the need for accessible, well-resourced, and integrated substance use prevention and other strategies that not only address urgent needs but also promote conditions that protect and sustain population health and well-being.

Upstream and downstream prevention efforts are complementary, evidence-based strategies that address the root causes of substance use while supporting individuals who are actively using substances. Innovative drug checking tools help reduce overdose risk by enabling safer choices and ultimately better health outcomes (Vickers-Smith et al., 2025). In contrast, youth prevention programs that take a comprehensive, community-based approach have shown a reduction in adolescent substance use (Kristjansson et al., 2010). Since early substance use is a strong predictor of later addiction, mental health challenges, and risky behaviors, sustained investment in both approaches is essential to improving long-term outcomes in our communities (Clark, 2017).

The Board of Health for Windsor-Essex County commends the Federal government for investing in the Youth Substance Use Prevention Program (YSUPP), which supports efforts to prevent substance use and related harms among youth. However, limited funding availability places communities like Windsor-Essex, where youth substance use and related harms are on the rise, at a disadvantage. With Ontario public health units responsible for prevention activities, the Federal government has a significant opportunity to expand support for both upstream and downstream interventions. This would help mitigate current substance-related harms while fostering environments that support youth health, development, and resilience—especially amid the growing prevalence of vaping (from 28% in 2018 to 39% in 2023; Hammond et al., 2024) and the early onset of alcohol use, with an average initiation age of 13 (Drug Free Kids Canada, 2025).

Hence, continuing forward, we call on the Federal government to expand funding opportunities for public health units and community agencies to deliver sustainable and scalable evidence-based

prevention programs, such as Planet Youth. Without adequate support, communities may lack the capacity to deliver comprehensive strategies, leaving vulnerable youth at greater risk of substance use.

Yous truly,

Joe Bachetti, Chair
Windsor-Essex County Board of Health

Cc: Hon Francois-Philippe Champagne, Minister of Finance
Hon. Sylvia Jones, Ontario Minister of Health
Andrew Dowie, Member of Provincial Parliament
Lisa Gretzky, Member of Provincial Parliament
Anthony Leardi, Member of Provincial Parliament
Kathy Borelli, Member of Parliament
Harb Gill, Member of Parliament
Chris Lewis, Member of Parliament
Steve Vlachodimos, City Clerk, Windsor
Katherine Hebert, County Clerk, Essex

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 48-25

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2025 July 24

HOUSEHOLD FOOD INSECURITY: A PRIMER FOR MUNICIPALITIES

Recommendation

It is recommended that the Board of Health:

1) *Receive Report No. 48-25 re: "Household Food Insecurity: A Primer for Municipalities" for information; and*
2) *Direct the Clerk to send Report No. 48-25 (including Appendix A) to the City of London, Middlesex County, lower tier municipalities within the County of Middlesex and all Ontario Boards of Health.*

Report Highlights

- In 2023, 1 in 4 households in Middlesex-London were food insecure. This is a statistically significant increase from 2022.
- Food insecurity has a pervasive impact on health; and there is a need for income-based solutions.
- "Household Food Insecurity: A Primer for Municipalities" (Appendix A) provides a range of income-based strategies that London and Middlesex County can implement to help reduce food insecurity. The primer also includes affordability-based strategies, which can help reduce financial strain and contribute to more inclusive, resilient and healthy communities.

Background

Household food insecurity is defined as inadequate or insecure access to food due to financial constraints[1]. Food insecurity negatively impacts health and community well-being (e.g., increased barriers to employment and increased social isolation)[1-3].

The financial impact of food insecurity is broad and extends across all levels of government. For example, households with food insecurity have 23%-121% higher annual health care costs[4]. While health care funding primarily falls under provincial and federal jurisdictions, municipalities also shoulder significant costs. As reported by the Association of Municipalities in Ontario (AMO), in 2017, Ontario municipal governments contributed $2.1 billion for health care costs[5].

While food programs, such as community gardens and community meals, can offer temporary relief from hunger, they do not address the root cause. Research consistently shows that food insecurity is most effectively reduced through income-based solutions[1,2].

Food Insecurity in Middlesex-London

In 2023, one in four households in Middlesex-London were food insecure[6] - the highest rate reported in Middlesex-London since the Canadian Income Survey started measuring food insecurity in 2019. This marked a statistically significant increase from 2022, with an estimated 151,477 residents living in food insecure households in 2023, compared to 107,835 residents in 2022.[6,7]

As reported to the Board of Health in Q4 2024, the 2024 local Nutritious Food Basket results demonstrate decreased food affordability and inadequate income to afford basic needs for many Middlesex-London residents[8]. A single person receiving Ontario Works needs an additional $522 monthly to afford local rent and food costs, plus additional funds for all other expenses[8]. Report No. 82-24 includes additional household and income scenarios.

Municipal Strategies to Address Food Insecurity

MLHU established and chaired a provincial work group in partnership with the Ontario Dietitians in Public Health to develop resources and messaging aimed at reducing household food insecurity. The resulting municipal primer, adapted by MLHU for local municipalities, outlines strategies to address household food insecurity (Appendix A). Municipal governments are important partners in addressing food insecurity, and the primer provides a range of income-based strategies that London and Middlesex County can implement. The primer also includes affordability-based strategies, which can help reduce financial strain and contribute to more inclusive, resilient and healthy communities.

References are affixed as Appendix B.

Next Steps

It is recommended that the Board of Health direct Health Unit staff to share “Household Food Insecurity: A Primer for Municipalities” (Appendix A) with the City of London, Middlesex County, lower tier municipalities within the County of Middlesex, and Ontario Boards of Health.

The Health Unit will continue to monitor food affordability as mandated by the Ontario Public Health Standards in the Population Health Assessment and Surveillance Protocol, 2018. The 2025 surveillance data will be reported to the Board of Health in Q4 2025.

This report was written by the Municipal and Community Health Promotion Team of the Family and Community Health Division.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Population Health Assessment and Surveillance Protocol, 2018; and the Chronic Disease Prevention and Well-Being and Healthy Growth and Development standards, as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
    - Our public health programs are effective, grounded in evidence and equity

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically recommendations:

Anti-Black Racism Plan Recommendation #37: Lead and/or actively participate in healthy public policy initiatives focused on mitigating and addressing, at an upstream level, the negative and inequitable impacts of the social determinants of health which are priority for local ACB communities and ensure the policy approaches take an anti-Black racism lens.

Taking Action for Reconciliation Supportive Environments: Establish and implement policies to sustain a supportive environment, as required, related to the identified recommendations.

Household Food Insecurity: A Primer for Municipalities

Household food insecurity refers to inadequate or insecure access to food due to financial constraints.[1] For simplicity, household food insecurity will be referred to as food insecurity in this primer.

While food programs, such as community gardens and community meals, can offer temporary relief from hunger, they do not address the root cause. Research consistently shows that food insecurity is most effectively reduced through income-based solutions.[1]

Food insecurity and poverty are pressing issues that municipalities can help address.

This resource provides a range of income-based strategies that municipalities can implement to make a meaningful impact in their communities. It also includes affordability-focused strategies, which can help reduce financial strain and contribute to more inclusive, resilient communities.

Adapted from:
"Food Insecurity: A Primer for Municipalities" developed by the Ontario Dietitians in Public Health (ODPH) Food Insecurity Workgroup (www.odph.ca).

Adapted by:
Middlesex-London Health Unit

For more information, contact us:
Middlesex-London Health Unit
Phone: 519-663-5317
Email: health@mlhu.on.ca

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Food Insecurity: A Primer for Municipalities

Household Food Insecurity in Middlesex-London

Food insecurity means not having enough money for food.[1]

In 2023, 25% of Middlesex-London households were food insecure.[2]

1 in 4

Food Affordability

After rent and food, many don't have enough left for all other monthly expenses.[3]

Single parent of 2 on Ontario Works

$257

Single person on Ontario Works

-$522

Wages

Having a job does not guarantee food security.

In 2022, over half (58.6%) of food-insecure households in Ontario depended on employment income.[1]

Food Insecurity Takes a Toll on our Community

Physical and Mental Health

- risk of diabetes and heart disease [1]
- risk of depression, anxiety, and mood disorders [1]

Health Care Costs

23%-121% higher health care costs [4]

In 2017, Ontario municipal governments contributed **$2.1 billion** for health care costs[5]

Community Well-Being

- barriers to employment[6]
- social isolation[6]

impede people's ability to advance in life[6]

Solutions

Food insecurity is an income problem that requires income solutions.

Municipalities can support policies and initiatives that improve the finances of households with low incomes and advocate for a stronger social safety net.

For information on local data, health impacts, and to work together on strategies to reduce local food insecurity, email Middlesex-London Health Unit at health@mlhu.on.ca.

Income-Based Strategies

1. Support living wage certification

Ontario's minimum wage is less than a living wage. A living wage is the hourly pay a worker must earn to afford their basic needs and engage in their community based on regional living costs.[7] Paying a living wage benefits employers (e.g., employee retention), employees (e.g., afford housing and food), and the community (e.g., money spent locally).[8,9]

The minimal annual employer certification fee helps support the Ontario Living Wage Network to calculate the living wage and advance the living wage movement.

- Become a Living Wage employer and recertify annually (e.g., Township of Blandford-Blenheim, City of Waterloo, Corporation of the City of St. Catharines, The County of Huron, The Municipality of North Perth).
- Encourage local businesses to become Living Wage employers (e.g., provide education and awareness, incentives like public recognition of local Living Wage employers, community engagement and support).
- Provide support for local businesses to become certified (e.g., practical guidance, marketing incentives, and policy support).

Resource: Living Wage Certification Process

2. Support free income tax filing clinics for households with lower incomes

Filing income taxes is essential to be eligible for subsidized housing and receiving federal government benefits and credits. In 2023, nearly $44 million was received in refunds, credits, and benefits entitlements by 11,070 individuals through free tax clinics in London, Ontario through the Community Volunteer Income Tax Program.[10]

- Promote clinics and help to recruit volunteers (e.g., London tax clinics, Strathroy tax clinics).
- Provide subsidized transportation to clinics (e.g., transportation vouchers).
- Provide community spaces for clinics at no cost.
- Support systems navigation at clinics (e.g., promote community resources and governmental benefits, and make referrals to community resources).
- Coordinate existing income tax clinics and improve client support at tax clinics by offering more super clinics in the community.
- Advocate for policies that simplify tax filing for community members living with a low income (e.g., automated system using existing information).
- Explore the promotion of virtual tax-filing in partnership with local organizations and Prosper Canada.

Resource: Guide to Hosting an Enhanced Free Community Volunteer Income Tax Program (CVITP)

3. Work with the provincial and federal governments to advance income-based policies and income support programs

The current income support system in Ontario is not adequate for households to cover their basic needs and live with dignity.[1]

- Support the advocacy work of local partnerships (e.g., endorse advocacy letters sent to the provincial and federal governments by local partnerships) (e.g., United Way Elgin Middlesex).

- Advocate to the provincial government to:
  a. Raise the minimum wage to be on par with the cost of living (living wage).
  b. Increase social assistance rates to reflect the real cost of living (e.g., Middlesex-London Board of Health, 2023; Prince Edward-Lennox & Addington, 2025; Niagara Region, 2024; Prince Edward County, 2024; Simcoe-Muskoka District Health Unit, 2025)
  c. Index Ontario Works (OW) rates to inflation and increase the amount of income exempt from reduction of benefits to better support those working toward leaving the OW program (e.g., Orangeville, 2023; AMO, 2024)
  d. Commit to not reduce or claw back any provincial assistance related to the implementation of the Canada Disability Benefit (e.g., London, 2025).
- Advocate to the federal government to:
  a. Expand the Canada Child Benefit (CCB) by increasing the amount for lowest income households and equalizing the benefit for families with children over 6 years old (e.g., Peterborough Public Health, 2024; PROOF, 2023).
  b. Enhance the Canada Disability Benefit (CDB) by increasing the benefit amount and simplifying the application process by working with provinces and territories to automatically enroll recipients of provincial and territorial disability support programs (e.g., Community Food Centres Canada, 2024).
- Endorse basic income (e.g., Municipality of Chatham-Kent Council, 2024; Ottawa City Council, 2024; numerous Ontario municipalities) and advocate for the provincial and federal governments to collaborate to implement a basic income (e.g., Kitchener City Council, 2024; Region of Waterloo, 2023; Halton Region, 2023; Hamilton City Council, 2023).

Resource: PROOF – Identifying Policy Options to Reduce Household Food Insecurity in Canada

4. Raise awareness within the community about food insecurity and its connection to income

- Utilize reports from public health units to obtain local data on food insecurity and food affordability (e.g., Middlesex-London Health Unit, 2024)
- Engage with community partners to promote the need for long-term solutions to food insecurity (e.g., fund a forum)
- Communicate about food insecurity from a poverty reduction perspective (e.g., need for income-based solutions), and not as an issue of food access or food literacy (e.g., more food banks or food literacy programs)
- Declare food insecurity an emergency (e.g., City of Kingston Council, 2025; Mississauga, 2024; Toronto City Council, 2024; City of Brantford, 2025)

Resource: Position Statement and Recommendations on Responses to Food Insecurity

5. Create and support a municipal poverty reduction strategy

Municipal poverty reduction strategies address specific challenges and action plans tailored to the municipality complementing provincial and federal level strategies (e.g., London (2017); Ottawa (2025-2029); Toronto (2019-2022).[11]

- Provide funds to implement action(s) from a Poverty Reduction Strategy.
- Allocate higher amounts of funding towards food and housing insecurity.
- Actively engage people who have lived and/or have living experience of food insecurity and/or poverty.

Resource: Tamarack Institute Ending Poverty Network for Change

6. Provide leadership and support to local partnerships working to reduce food insecurity and/or poverty (e.g., Age Friendly London Network and Child & Youth Network, Middlesex-London Food Policy Council, Basic Income London)

- Explore forming a local partnership, if not already operating.
- Support the advocacy work of local partnerships (e.g., endorsing advocacy letters).
- Collaborate with community partners to determine local priorities for action to address food insecurity and poverty.
- Become a member of a local partnership.
- Provide funding (e.g., supporting a specific action item).

Resource: Food Systems Planning in Canada: A toolkit of priority practices for planners

Affordability-Based Strategies

7. Support affordable housing

Encouraging an adequate supply of affordable housing is critical to ensuring households can afford other basic necessities, such as food. Municipalities and regional governments play a critical role in shaping housing affordability through land use planning, investment, and policy advocacy.

Affordable housing is a priority for the City of London and Middlesex County (e.g., Health & Homelessness in London, Ontario: A Whole of Community System Response (2023)
The Housing Stability Action Plan for the City of London (2019-2024); Middlesex County's Homeless Prevention and Housing Plan (2019-2024).

8. Improve the affordability and accessibility of local public programs and services

- Invest in accessible and affordable transportation by providing subsidized transportation passes or subsidizing rural transportation services (e.g., London, Toronto, Waterloo).
- Offer childcare subsidies to eligible families, prioritizing individuals who are most financially in need (e.g., London-Middlesex (2024-2028), Middlesex County, London, Kingston).
- Provide discounted and/or subsidized recreation programs at municipal facilities (e.g., Middlesex County, London, Toronto, Hamilton, Kingston).
- Support and promote local financial literacy and counselling programs (e.g., CPA Canada, London, Toronto).
- Implement Community Connector and Community Navigator roles in municipalities, libraries, and other community organizations to support residents with applications to housing programs, social assistance, free income tax clinics, and other necessary supports (e.g., Middlesex County Libraries, London Family Centres, Durham, Huron Perth).

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Protecting Tomorrow

The Future of Immunization in Ontario

Ontario

2024 ANNUAL REPORT

Of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario

Dedication

This report is dedicated to Ontarians, and to the health care workers, local public health partners and community leaders whose unwavering commitment to providing immunizations to their communities has saved the lives of many.

ISBN 978-1-4868-9191-7 (PDF) August 2025

Land Acknowledgement

Contributors to this report respectfully acknowledge that the lands on which this work was developed are the traditional and enduring homelands of First Nations, Inuit, and Métis Peoples, who have cared for and stewarded these territories since time immemorial. Specifically, this report was prepared in the following traditional territories:

- In Toronto, also known as Tkaronto, the traditional territory of many nations, including the Mississaugas of the Credit, the Anishnaabeg, the Chippewa, the Haudenosaunee, and the Wendat peoples. Toronto is covered by Treaty 13 with the Mississaugas of the Credit and is now home to many diverse urban First Nations, Inuit, and Métis Peoples. Toronto is within the lands protected by the Dish with One Spoon Wampum Belt Covenant, an agreement between the Haudenosaunee and Anishnaabeg and allied nations to peaceably share and care for the resources around the Great Lakes.
- In Ottawa, also known as Adawe, on the traditional unceded and unsurrendered territory of the Algonquin People, members of the Anishnabek Nation Governance Agreement.
- In London, on the traditional lands of the Anishnaabek, Haudenosaunee, Lūnaapéewak and Chonnonton Nations, on lands connected with London Township and Sombra Treaties of 1796 and the Dish with One Spoon Covenant Wampum.
- In Hamilton, on the traditional territories of the Mississauga and Haudenosaunee nations, and within the lands protected by the Dish with One Spoon Wampum agreement.
- In Durham Region, on the traditional territory of the Mississaugas of Scugog Island First Nation, covered under the Williams Treaties, and the traditional lands of the Anishinaabe, Haudenosaunee, and Huron-Wendat peoples.

We understand that land acknowledgements alone are not enough. We recognize that our presence on these lands comes with responsibilities, not only to the people of these lands, but to the land itself. This acknowledgement comes with a commitment to ongoing learning, care for the land and support for Indigenous leadership in stewardship and decision making. We also recognize that stewardship is not ownership, it is a shared responsibility rooted in respect, humility, and accountability. We recognize colonial structures, including public health spaces, continue to produce inequities, and we are committed to working together to ameliorate these disparities and improve the health of all Ontarians. We are guided by First Nations, Inuit, and Métis partners in shaping health equity strategies, prioritizing Indigenous ways of knowing and being, and fostering Indigenous health in Indigenous hands.

Letter from Dr. Moore

Dear Mr. Speaker,

I am pleased to share with you my 2024 Annual Report, "Protecting Tomorrow: The Future of Immunization in Ontario," in fulfillment of the requirements of the independent Chief Medical Officer of Health for Ontario, and as outlined in section 81(4) of the *Health Protection and Promotion Act, 1990*.

This report celebrates the profound and lasting impact of immunization in Ontario. It highlights the leadership and dedication of policymakers and clinicians who have worked tirelessly to dramatically reduce or eliminate the spread of once-devastating diseases, like smallpox, polio, and rubella.

Protecting Tomorrow demonstrates the vital role provincial investment has played in increasing access to immunization. By expanding the number of registered health care providers, including pharmacists and midwives, who can administer vaccines, and in strengthening connections with primary care, more Ontarians can now receive timely immunizations. Additionally, new digital tools are starting to give people easy access to their health records which will enable people to track their vaccinations, as well as those of their children and family members.

To ensure continued progress on the investments made to date, Ontario must address remaining gaps in its immunization system. The absence of a centralized immunization information system makes it challenging to identify and respond to coverage gaps across the province.

While routine vaccines have saved the lives of thousands of children, access remains uneven in some communities. At the same time, misinformation and vaccine fatigue continue to erode public trust in the safety and importance of immunization. Tackling these issues head-on will strengthen Ontario's ability to protect all residents from preventable diseases today and in the years to come.

Strong relationships between health care providers and communities must be at the heart of Ontario's immunization strategy. I dedicate much of the report to highlighting the success of community-led initiatives because we know this is how trust is built.

This report presents a practical and forward-looking vision for Ontario's immunization system – one that includes a centralized provincial immunization information system, broader access to life-saving vaccines, enhanced surveillance, greater public confidence in vaccination and sustained investment in preparedness and innovation.

I wish to extend my deepest thanks and appreciation to those who contributed to this report, including the External Advisory Committee and internal review teams at the Ontario Ministry of Health.

Yours truly,

Dr. Kieran Moore

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Executive Summary

The Power and Promise of Immunization

Immunization is one of the most effective public health interventions in history. Globally, vaccines prevent up to 5 million deaths each year. In Ontario, immunization has helped eliminate diseases like polio and rubella, and drastically reduced others such as whooping cough. Beyond saving lives, vaccines also deliver major economic benefits. Adult immunizations alone save Canada an estimated $2.5 billion each year in decreased healthcare costs and productivity gains.

Ontario's immunization programs have expanded significantly over the years, now covering 29 vaccines that protect against 23 diseases. Since 2014, public investment in these programs has grown by over 400%. New additions include Respiratory Syncytial Virus (RSV) vaccines for infants and high-risk seniors, and broader pneumococcal protection for children and older adults. These developments highlight the growing recognition of immunization as a vital tool, not only in preventing infectious disease and cancer but also in managing chronic conditions.

Investments in Prevention

Provincial investments have played a vital role in expanding access to immunization across the province. By expanding the number of registered health care providers, such as pharmacists and midwives, who can administer vaccines and through strengthening connections to primary care, more Ontarians can now receive timely immunizations. Additionally, new digital tools that give people easy access to their health records will offer convenience and the opportunity to improve access to their immunization history.

Preparing for the Future

To ensure continued progress, Ontario must address remaining gaps in its immunization system. The absence of a centralized immunization information system makes it extremely challenging to identify and respond to coverage gaps across the province. Although routine vaccines have saved the lives of thousands of children, access remains uneven in some communities. At the same time, misinformation and vaccine fatigue continue to erode public trust in the safety and importance of immunization. Tackling these issues head-on will strengthen Ontario's ability to protect all residents from preventable diseases today and in the years to come.

Protecting Tomorrow

To strengthen Ontario's immunization programs for the future, this year's report outlines a practical, achievable vision.

A province-wide digital immunization information system would consolidate records, enable real-time monitoring, and support improved outbreak response. It would also link to sociodemographic data to identify and address access issues.

Relationships in the community must be at the heart of Ontario's immunization strategy. Community-led initiatives like the mpox Awareness Campaign, the Black Scientists' Task Force Town Halls, and the Na-Me-Res Vaccine Pow Wow show how culturally informed, locally driven approaches can build trust and improve access.

Strengthening vaccine confidence is equally critical. Healthcare providers remain the most trusted source of vaccine information and ensuring they have access to the best available resources is essential to increasing public confidence. A centralized Immunization Resource Centre would support both providers and the public with accurate, accessible information. Community ambassadors, trusted messengers within their own communities, can also play a powerful role in countering misinformation.

Ontario must also be ready for emerging threats—from outbreaks of infectious diseases, such as measles, to future pandemics. This means investing in domestic vaccine development and manufacturing, and supporting innovations to tackle antimicrobial resistance and prevent cancer.

Key Recommendations:

Build a centralized provincial immunization information system to make it easier for people to check their immunization history.

Advocate for a national immunization information system and harmonized vaccine schedule to ensure consistency and equity across Canada.

Address inconsistencies in access by supporting community-led strategies and improving access to primary care.

Strengthen vaccine confidence through trusted relationships with healthcare providers and community ambassadors.

Strengthen surveillance systems to monitor vaccine safety and effectiveness in real time.

Invest in innovation and preparedness, including domestic vaccine development and manufacturing; using new technologies to tackle emerging threats.

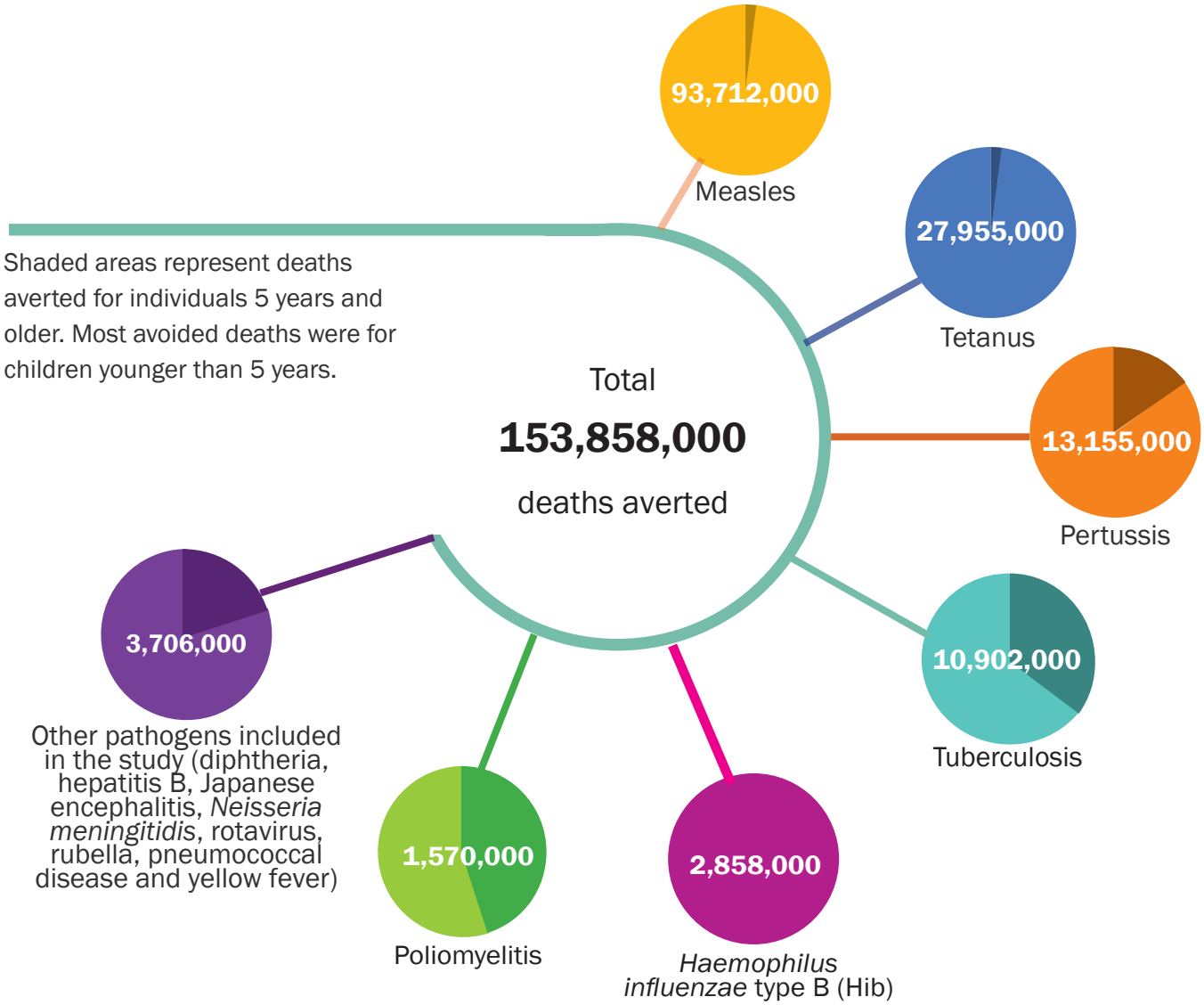
Section 1. Introduction

Immunization Saves Lives

Immunization is one of the most effective public health interventions in history. It prevents the spread of infectious disease, reduces infant mortality and has increased life expectancy on a global scale.[1]

The World Health Organization (WHO) estimates that between 3.5 - 5 million lives are saved each year through routine immunizations alone which prevent diseases like diphtheria, tetanus, pertussis, influenza and measles.[1] In the past fifty years, an estimated 154 million deaths have been prevented worldwide by immunizations – over 100 million of which were those of children under the age of one.[2]

Figure 1.Total number of deaths averted globally due to vaccines, 1974-2024



Source: Adapted from Shattock AJ, Johnson HC, Sim SY, et al. Contribution of vaccination to improved survival and health: modelling 50 years of the Expanded Programme on Immunization. The Lancet. 2024;403(10441):2307-2316.

Immunizations have made many once-feared diseases preventable and, in one case, eradicated. In 1967, WHO announced a vaccination program to eradicate smallpox, a disease which caused death, disfigurement and blindness. Thanks to a global effort, smallpox was eradicated in 1980, marking a historic public health achievement. While smallpox is the only disease that has been eradicated on a global scale, immunization has led to the elimination of diseases like polio, endemic measles, and rubella in Canada.

Universal immunization programs have also drastically reduced the incidence of diseases like whooping cough, mumps, measles, diphtheria and rubella in Canada (see Figure 2).

Figure 2: Comparison of case counts in Canada for six vaccine-preventable diseases before and after introducing each vaccine

Cases before the introduction of vaccine*	Disease		Percent reduction in cases		Cases after the introduction of vaccine**
17,777	Whooping Cough (Pertussis)		87%	↓	2,340
36,101	Mumps		98%	↓	737
53,584	Measles		99%	↓	37
8,142	Diphtheria		99%	↓	5
14,974	Rubella		99%	↓	1
2,545	Polio		100%	↓	0

*Cases before the introduction of vaccine are average annual case counts in Canada during the five years before routine vaccine or closest possible five years where stable reporting was occurring.

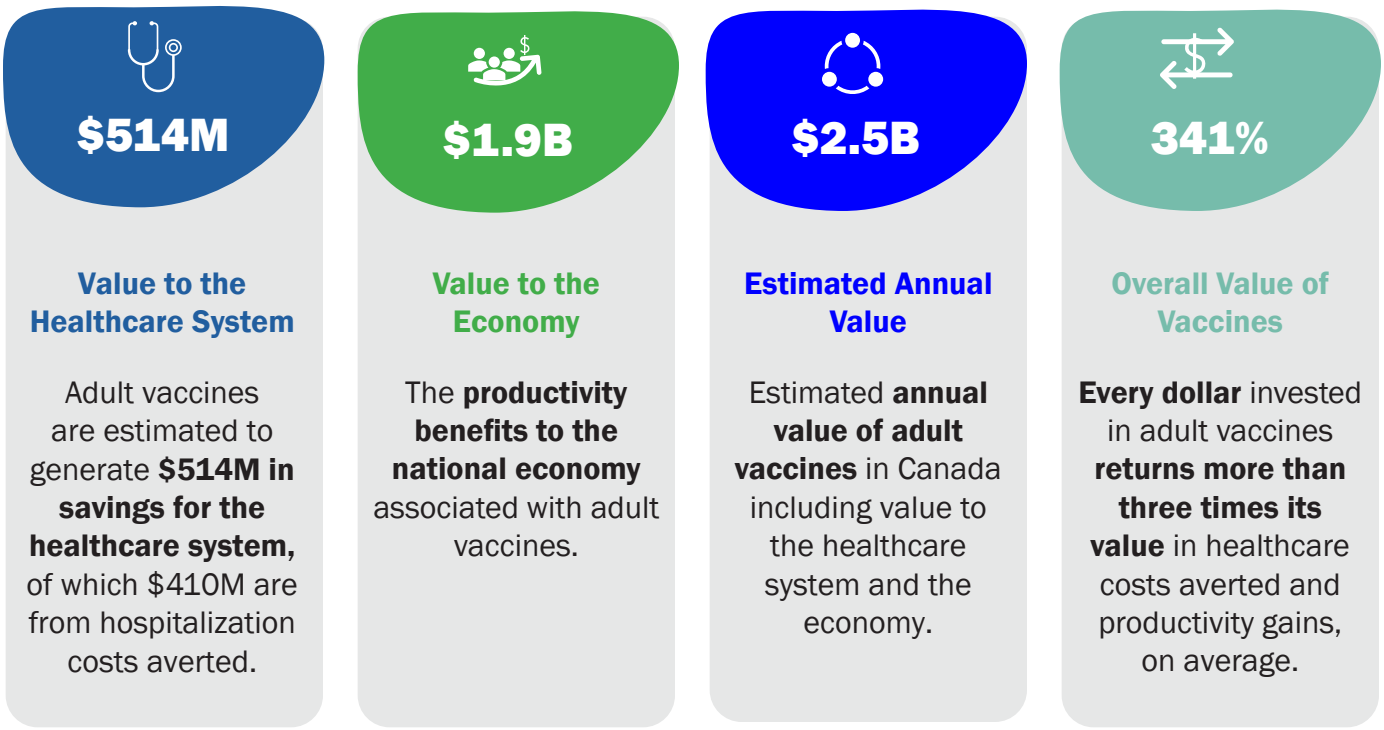
**Cases after the introduction of the vaccine is the average annual case count in Canada 2016-2020. Canada has held endemic measles elimination status since 1998. Given global circulation, outbreaks still occur in Canada because of imported cases.

An Investment in Prevention

In addition to reducing morbidity and mortality, immunization is also a significant source of cost savings for the health care system, reducing emergency room visits, hospitalizations and intensive care unit admissions.

A recent report commissioned by the Adult Vaccine Alliance and 19 to Zero estimates that in Canada adult vaccines result in cost savings of **$2.5 billion annually,** including **$514 million** in health care savings and **$1.9 billion** in economic benefits.[3] These savings come from fewer hospitalizations and increased productivity.

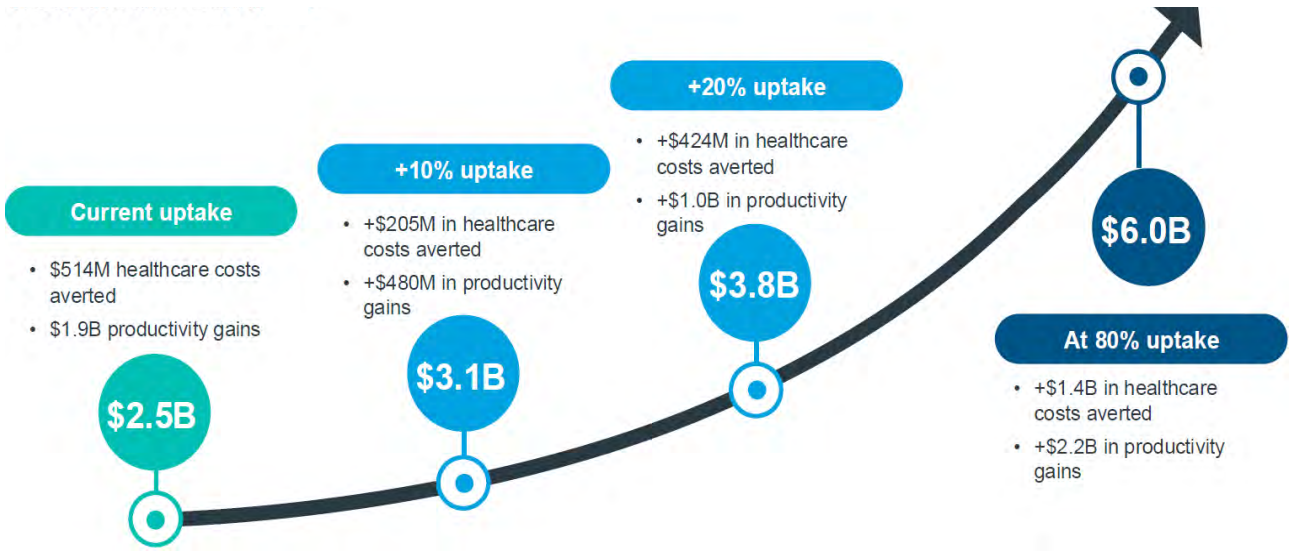
Figure 3. Value of adult vaccines in Canada



Source: IQVIA Solutions. The Unmet Value of Vaccines in Canada - IQVIA Study. Adult Vaccine Alliance; 2024.

Still, immunization holds the potential for even greater cost savings if more people receive vaccinations. Increasing adult uptake of the shingles, Respiratory Syncytial Virus (RSV), pneumococcal, Human Papillomavirus (HPV), COVID-19 and influenza (flu) vaccines by even 20% could add **$1 billion** in productivity gains nationally.[3] If 80% of adults were to receive these vaccines, the total annual value of adult vaccines in Canada could reach **$6 billion.**[3]

Figure 4. Increases in the uptake of adult vaccines would lead to economic and health care savings



Source: IQVIA Solutions. The Unmet Value of Vaccines in Canada - IQVIA Study. Adult Vaccine Alliance; 2024.

Section 2. Current Immunization Landscape in Ontario

Ontario's Publicly Funded Immunization Programs

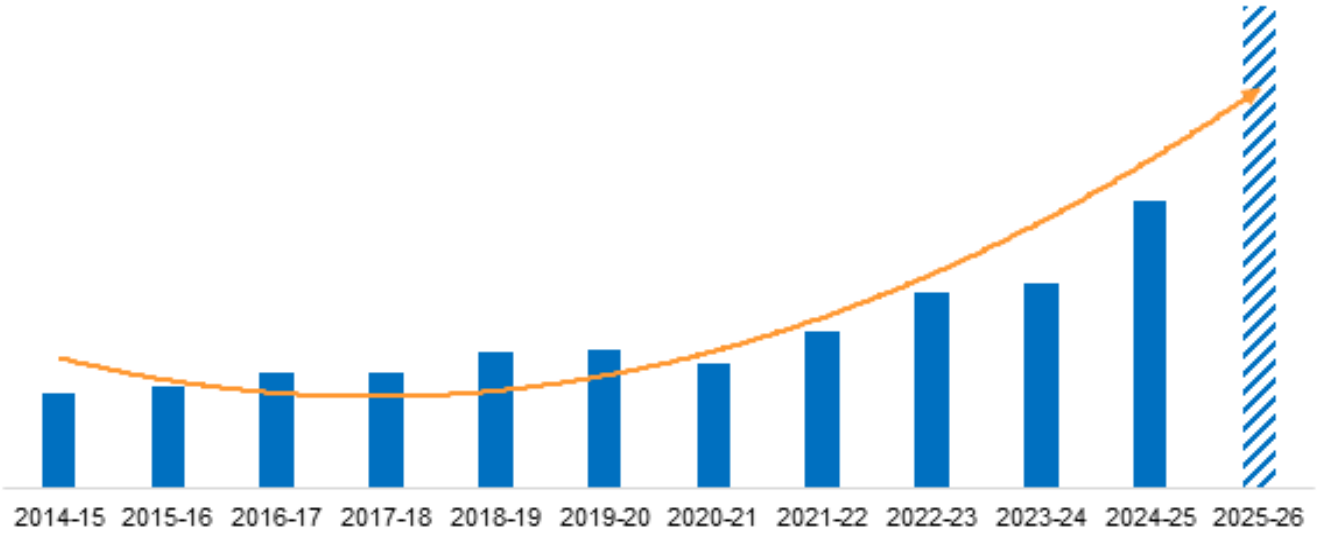
Immunizations protect against life-threatening infectious diseases across the lifespan, including those that can lead to cancer and other serious complications. They also play a critical role in the management of chronic diseases by preventing serious complications and secondary infections.

With projections showing that 1 in 4 Ontarians will be diagnosed with a chronic disease by 2040,[4] immunization will become increasingly vital to improving health across the province.

Investment in Immunization

Ontario's publicly funded immunization programs have expanded in scope in recent years to include 29 unique immunization products which protect against 23 different diseases. Between 2014 and 2025, investment in publicly funded immunization in Ontario has increased by over 400% (see Figure 5).

Figure 5. Ontario immunization programs: Year over year spending, 2014-2025



Source: Ministry of Health, 2025

Since 2023, Ontario has introduced new vaccines to better protect people at higher risk from serious illnesses such as:

Respiratory Syncytial Virus (RSV)

High-risk older adult program, introduced fall/ winter 2023-24

Universal infant program, introduced fall/winter 2024-25

Invasive Pneumococcal Disease (IPD)

Prevnar 15 (for children and high- risk adults) and Prevnar 20 (for seniors) vaccines, introduced summer 2024

For over a decade, Ontario has led the way in early childhood immunization programs. In 2011, Ontario was one of the first jurisdictions in Canada to offer the rotavirus vaccine to all infants. Then in September 2024, Ontario became one of only three provinces to offer the RSV vaccine to all infants.

Continued investment in research and new vaccine technologies will help create more ways to protect people from vaccine-preventable diseases.

Spotlight: A National Harmonized Immunization Schedule in Canada

Since 1997, the Canadian Paediatric Society has advocated for a harmonized immunization schedule.[5] Unlike countries including the United States, Australia, and the United Kingdom - where a single, standardized schedule is used nationwide - Canada relies on a fragmented system. Each province and territory set its own vaccine schedule, determining the timing, eligibility and availability of immunizations for children.

This patchwork approach can lead to confusion when families move between provinces, increasing the risk of missed or delayed vaccinations. It also raises an equity issue, as children in some regions may receive critical vaccines later, or not at all, compared to others.

Beyond improving access and consistency, a national schedule could offer economic advantages. Centralized procurement by the federal government would likely reduce costs through bulk purchasing, compared to separate provincial agreements. With Canada's National Pharmacare Strategy already in development, the infrastructure to support coordinated federal vaccine purchasing is already taking shape.

Figure 6. Immunizations across the lifespan in Ontario

Pregnancy

Vaccines to protect against tetanus, diphtheria, pertussis, influenza, and COVID-19 are offered during pregnancy to protect newborns in the first few months of life.

Children

Vaccines that protect against 12 serious infections, including diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, varicella, Hib, pneumococcal disease, RSV and rotavirus are offered at well-child visits.

Adolescents

Grade 7 students are offered HPV, hepatitis B, and meningitis vaccines through school-based clinics.

Seniors

Vaccines for pneumococcal disease and shingles are offered to seniors and beginning in 2023, RSV is offered for high-risk seniors.

Seasonal Vaccines

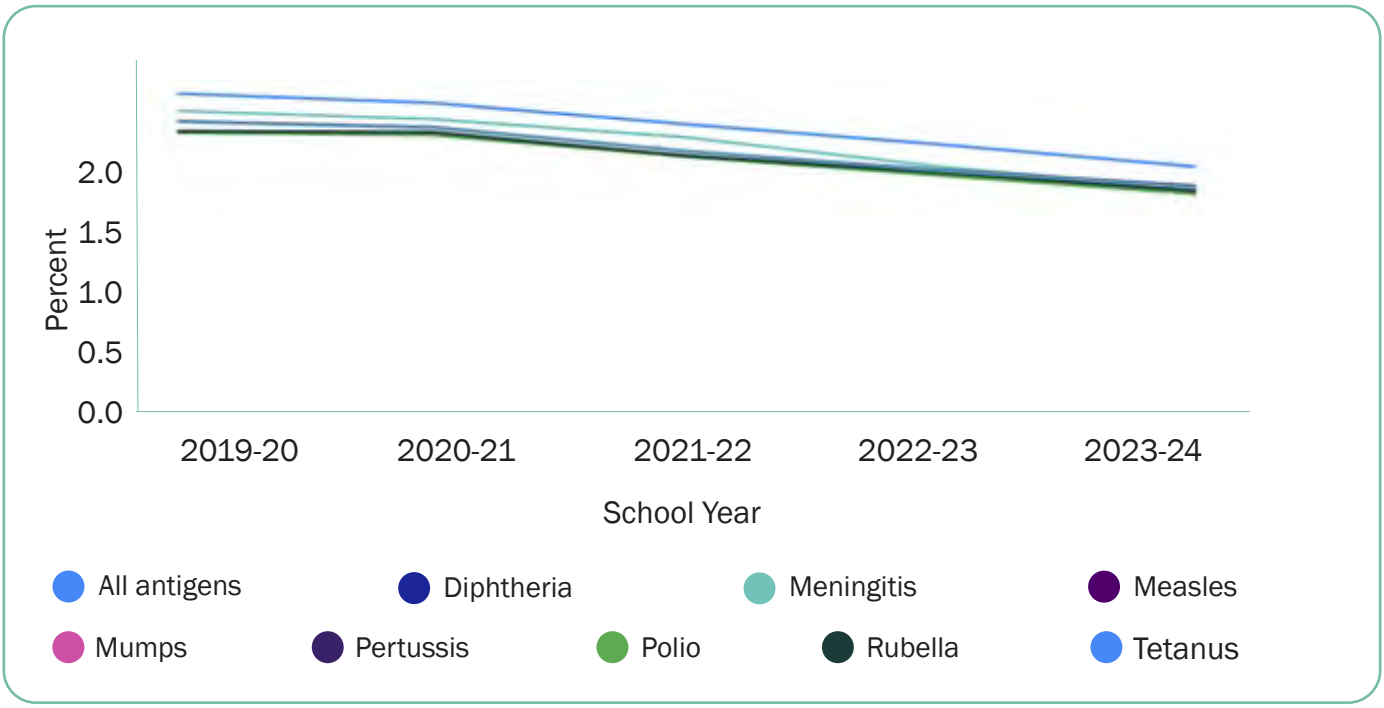
Flu and COVID-19 vaccines are available to everyone, but they are especially important for people at high risk of developing severe illness like seniors and those living in long term care settings.

Immunization Legislation and Workplace Requirements

The Immunization of School Pupils Act (ISPA) requires students to submit proof of vaccination against nine diseases or have a valid exemption.

Valid exemptions permitted under the ISPA fall into two categories: medical exemptions (contraindication or prior immunity) and non-medical exemptions (conscience or religious belief). The percentage of children with non-medical exemptions in Ontario has remained stable since 2019 at 2%.[6]

Figure 7. Non-medical exemptions for selected antigens among 17 year olds in Ontario, 2019-2020 to 2023-24 school year



Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Non-medical exemptions for selected antigens in Ontario. 2025.

The Child Care and Early Years Act (CCEYA) mandates proof of immunization for child care enrollment against disease specified by the local Medical Officer of Health.

Workplace policies require vaccines for child care operators, emergency medical attendants, and paramedics to keep these settings safe from infectious diseases.

Figure 8. How vaccines are given in Ontario

In Ontario, many health care providers offer vaccines to help make them easily accessible.

Figure 9. Ontario's publicly-funded immunization schedule

These vaccines are free for eligible individuals as part of Ontario's publicly funded immunization program.

6 Month & Older: Influenza vaccine (every fall) and COVID-19 vaccine (every fall).

PREGNANCY

- ✓Tetanus, diphtheria, & pertussis

NEWBORN

- ✓Respiratory syncytial virus

2 MONTHS

- ✓Pertussis, polio & Haemophilus influenzae type b (Hib)
- ✓Pneumococcal
- ✓Rotavirus

4 MONTHS

- ✓Diphtheria, tetanus, pertussis, polio & Haemophilus influenzae type b (Hib)
- ✓Pneumococcal
- ✓Rotavirus

6 MONTHS

- ✓Diphtheria, tetanus, pertussis, polio & Haemophilus influenzae type b (Hib)

12 MONTHS

- ✓Measles, mumps & rubella
- ✓Meningococcal
- ✓Pneumococcal

15 MONTHS

- ✓Varicella

18 MONTHS

- ✓Diphtheria, tetanus, pertussis, polio & Haemophilus influenzae type b (Hib)

4-6 YEARS

- ✓Tetanus, diphtheria, pertussis & polio
- ✓Measles, mumps, rubella & varicella

GRADE 7

- ✓Hepatitis B
- ✓Meningococcal
- ✓Human papillomavirus

14-16 YEARS

- ✓Tetanus, diphtheria & pertussis

18-64 YEARS

- ✓Tetanus, diphtheria & pertussis (at 24-26 years)
- ✓Tetanus & diphtheria (every 10 years after the above dose)

65 YEARS & OLDER

- ✓Pneumococcal (at 65 years)
- ✓Shingles (65 to 70 years)
- ✓Tetanus & diphtheria (every 10 years)

Adapted from: Ministry of Health. Immunization through the lifespan. 2024.

Spotlight on MMR: Early Childhood Immunization

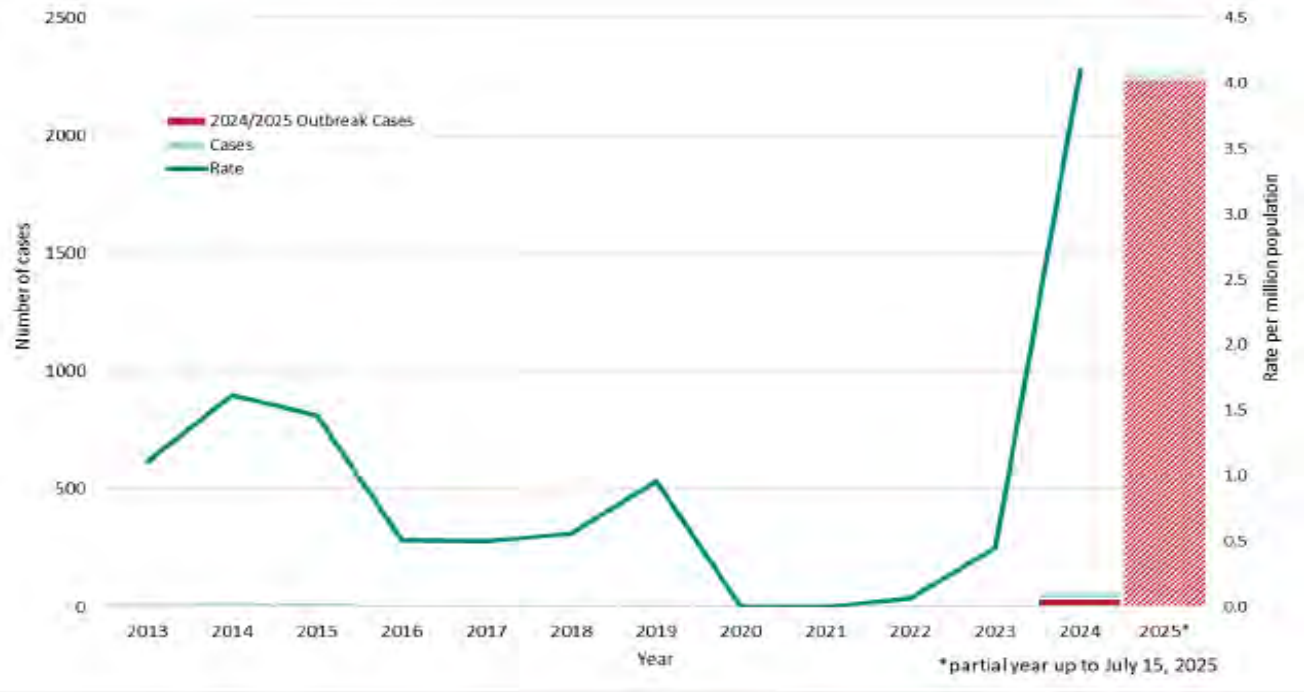
Measles, mumps, and rubella are serious diseases which can cause severe complications, especially in young children. Measles can lead to pneumonia, encephalitis and meningitis, while rubella, if contracted during pregnancy, can cause miscarriage, stillbirth and severe birth defects. To protect against these diseases, the MMR vaccine is given to children after 12 months, with a second dose using MMRV (with addition of chickenpox antigen) at four to six years to provide protection across the lifespan.

The vaccine is highly effective: **nearly 100%** for measles, **95%** for mumps, and **97%** for rubella after two doses following the immunization schedule. High vaccine coverage is crucial because measles is highly contagious, with a 90% infection rate among those without immunity. Even small gaps in coverage within the population can lead to outbreaks.

Ontario's Measles Outbreak 2024-25

In October 2024, Ontario began its largest measles outbreak in nearly thirty years with transmission primarily occurring within pockets of unimmunized communities. As of July 2, 2025, this multi-jurisdictional outbreak originating from a travel-related case has resulted in 2,223 cases, 150 hospitalizations and 12 ICU admissions in Ontario since the start of the outbreak. Recent epidemiological data as of July 2025 indicate that cases counts have stabilized in Ontario.

Figure 10. Number of measles cases and incidence rate per million population: Ontario, January 1, 2013- July 2, 2025

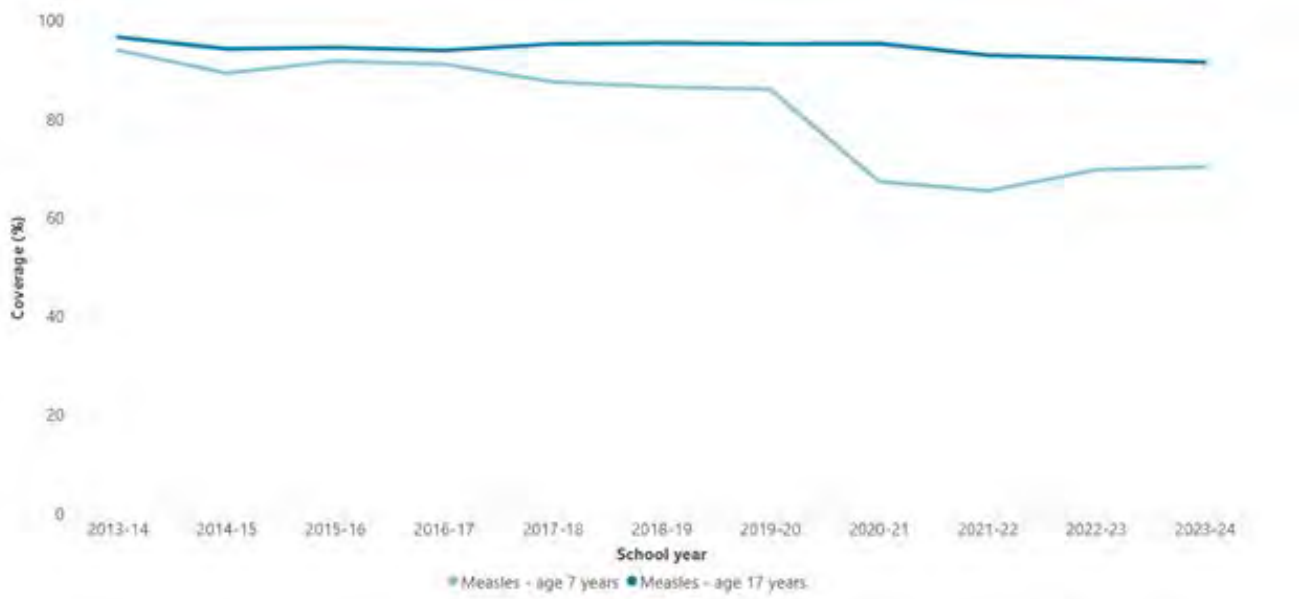


Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Measles in Ontario. Toronto, ON: King's Printer for Ontario; 2025.

Twenty-six public health units have been affected by the outbreak with the majority of cases occurring in western Ontario. Given the effectiveness of the vaccine in preventing disease, the vast majority of measles cases associated with the outbreak have occurred among those who are unimmunized or who have unknown immunization status.

Given the very high transmissibility of the measles virus, an immunization coverage rate of at least 95% at the population level is recommended to prevent outbreaks. In Ontario, disruptions to the delivery of primary care during the COVID-19 pandemic resulted in decreases in coverage. Although delays in immunization coverage assessment may underestimate true coverage rates, currently available data indicates that measles immunization coverage among seven-year-olds fell from 86% in 2019-20 to 70% in 2023-24 in Ontario.[7]

Figure 11. Measles immunization coverage in Ontario 2013-14 to 2023-24



Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Immunization Data Tool. Public Health Ontario. 2025.

The measles outbreak in Ontario has taken a significant toll on families, communities, emergency departments, hospitals, and intensive care units. Local public health authorities continue to play a pivotal role in outbreak response - conducting case and contact management investigations, reporting and running catch-up immunization clinics.

Spotlight on HPV Vaccine: Adolescent Immunization

Human papillomavirus (HPV) is transmitted through intimate contact and an estimated 80% of individuals will be infected with HPV in their lifetime. Strains of HPV can cause genital warts while others can lead to cancers including cervical, throat, penile and anal cancers. Vaccination before exposure is crucial for cancer prevention.

In Ontario, the rate of oropharynx cancers increased by 13% annually between 1993 and 2010, a finding that is linked to the rise in HPV infections seen in Canada, the United States and Europe.[8] HPV subtype 16 is the cause of 70% of oropharyngeal cancers, which are nearly four times more likely to be diagnosed in men.[9]

Virtually all cases of cervical cancer are caused by persistent HPV infections, and therefore are almost entirely preventable through a combination of immunization and early screening. While cervical cancers can be treated if detected early, treatment is invasive and costly. Vaccination before exposure provides 90% protection from cervical cancer and can prevent more invasive procedures.

Figure 12. The cost of primary and secondary prevention compared to treatment of invasive cervical cancer

Primary Prevention

HPV Immunization - **$200 per dose**

Secondary Prevention

$70 - $1000

- Routine screening (HPV test)
- Follow-up and treatment of precancerous lesions
  - o Colposcopy/ biopsy
  - o LEEP/LLETZ
  - o cold coagulation
  - o cone biopsy

Treatment of invasive cancer

- Surgery
- Radiation therapy
- Chemotherapy

$79,500
for five years of treatment

Expanding cervical cancer screening and HPV immunization has lowered the number of cervical cancer cases in Canada. However, it remains the third most common cancer among women aged 20-40 with 400 deaths in Canada each year.[10] With improvements in immunization uptake to 90% in addition to routine screening, it is estimated that over 6,000 cases of cervical cancer in Canada could be avoided by 2050.[11] As Ontario adopts HPV testing for cervical cancer screening, improvements in immunization data infrastructure will help evaluate and measure the impact of HPV immunization on cancer rates.

Spotlight on Pneumococcal: Immunization for Seniors

Streptococcus pneumoniae is a common cause of respiratory infections like pneumonia and ear infections. It can also lead to more severe infections of the blood (bacteremia) or brain (meningitis), which are known as invasive pneumococcal disease (IPD). There are routine and high-risk immunization programs to protect those most at-risk for IPD, which includes seniors and adults with underlying medical conditions that predispose them to severe outcomes.

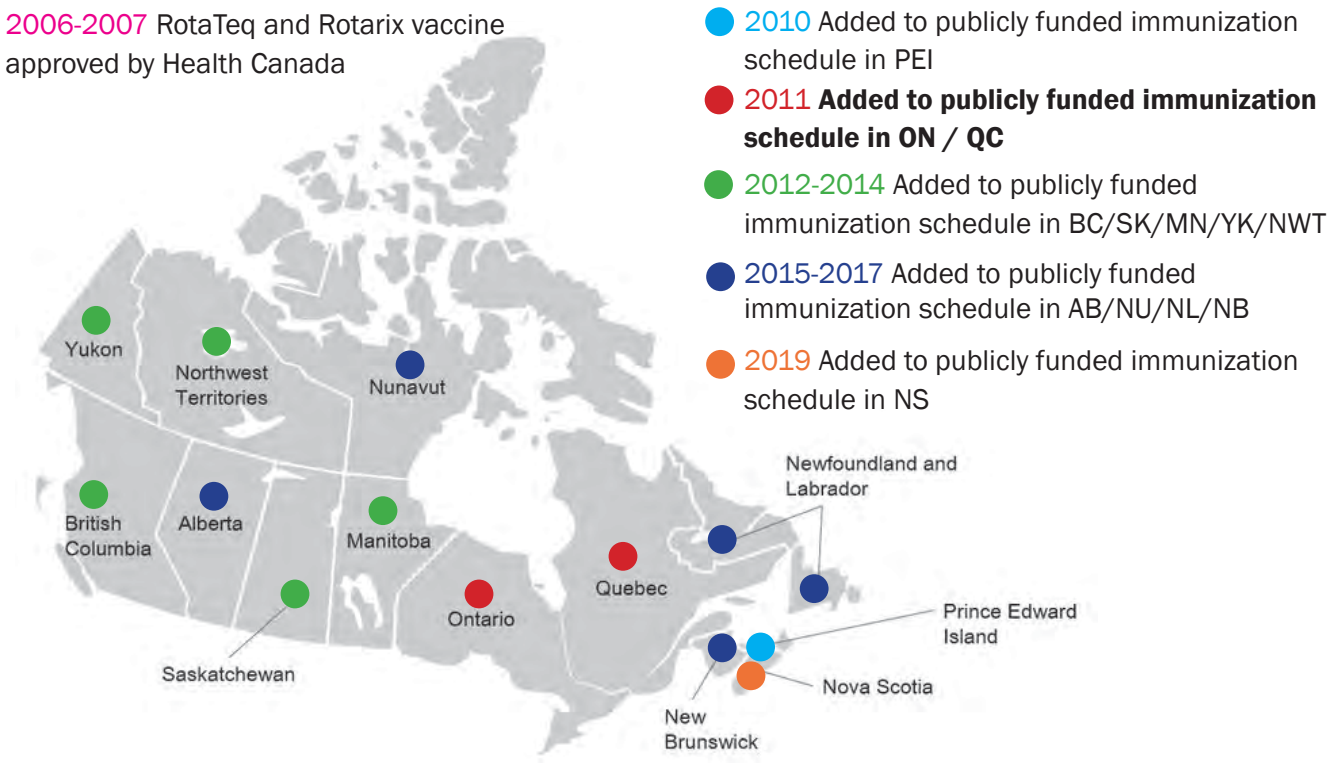
The introduction of the pneumococcal vaccine program for seniors (aged 65 years and older) and high-risk individuals in 1996 reduced IPD infections by 49%.[12] The 2005 introduction of the PCV7 vaccine for children further decreased IPD incidence among older adults due to herd immunity.[13]

As of July 2024, Ontario introduced a new vaccine Prevnar20 for seniors and high-risk individuals. This vaccine provides broader and longer-term protection. This update follows Health Canada approval and NACI recommendations examining the burden of pneumococcal disease in older adults.

Spotlight on Rotavirus: An Ontario Success Story

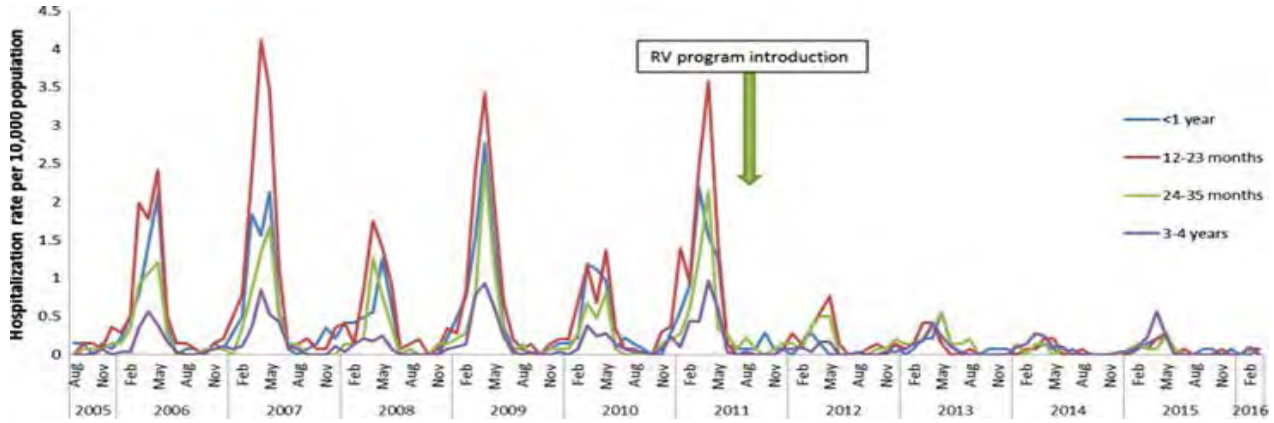
Rotavirus is a common infectious disease that causes gastrointestinal symptoms in children. Before vaccines, most children were infected by the age of five. While infections are usually mild in healthy children, they can cause severe dehydration and death in immunocompromised children. In Canada, two vaccines, RotaTeq and Rotarix, have been approved by Health Canada. The National Advisory Committee on Immunization (NACI) recommended these vaccines for healthy infants in 2008 and 2010 respectively, but their addition to publicly funded immunization schedules was staggered across provinces and territories (see Figure 13).

Figure 13. Rotavirus immunization implementation in Canada 2008-2019



In August 2011, Ontario became the second province in Canada to publicly fund the rotavirus vaccine. Before the vaccine, rotavirus infections were highest among children one to two years, and severe outcomes requiring hospitalization were disproportionality experienced by children living in the most disadvantaged neighborhoods.[14] Post-vaccine, hospitalizations dropped by 86% and emergency department visits by 89% in this age group, and differences in hospitalization rates by neighborhood disappeared, effectively eliminating disparities in disease outcomes.[14]

Figure 14. Hospitalizations for RV-AGE (Rotavirus acute gastroenteritis) among children <5 years of age per 10,000 population, by month, and year, August 2005-March 31, 2016: Ontario, Canada



Source: Wilson SE, Rosella LC, Wang J, et al. Equity and impact: Ontario's infant rotavirus immunization program five years following implementation. A population-based cohort study. Vaccine. 2019;37(17):2408-2414.

Section 3. Current Challenges

Despite these successes, Ontario faces challenges that could increase health inequities, reduce vaccination rates and put more pressure on the health care system if not addressed.

To ensure all Ontarians can live longer, healthier lives and receive the full benefit of immunization, three central issues must be addressed:

1. Gaps in immunization data
2. Disparities in access and uptake
3. Declining vaccine confidence

Resolving Gaps In Immunization Data

Immunization data in Ontario are spread across multiple record systems, making it difficult to check if individuals are up to date, to provide efficient clinical services and to determine vaccination coverage for communities and regions. The lack of a comprehensive, province-wide immunization data system presents several challenges including:

For Patients and Families

- Confusion about vaccine eligibility and prior immunizations;
- Inconvenience of a paper-based immunization record ("yellow card");
- Difficulty in tracking and communicating vaccine history and adverse reactions to multiple providers, increasing the risk of errors in vaccination and gaps in protection; and
- Challenges in providing proof of vaccination for school, work, travel, or relocation.

For Health Care Providers

- Difficulty accessing patients' comprehensive immunization history, increasing the potential for errors or inadequate protection; and
- Inability to efficiently assess practice-level vaccine coverage in real-time to make infection prevention and control decisions for patients.

For Public Health

- Lack the tools to conduct systematic real-time immunization coverage assessment of people living in Ontario (like during the COVID-19 pandemic which guided the response and provided reassurance of protection);
- Inability to detect and monitor inequities in vaccine access among sociodemographic groups;
- Relying on periodic national surveys and public health assessments to estimate vaccine coverage;
- Difficulty in assessing community risk and planning targeted interventions to improve equitable vaccine uptake;
- Complicates assessments of vaccine effectiveness and the ongoing monitoring of safety due to the lack of a unified information system linked to primary care, hospital and laboratory data; and
- Reliance on parents or providers to report immunizations, which is neither timely nor comprehensive.

For Health Care System

- Duplicate or missed vaccinations due to multiple record systems;
- Inefficient use of time as providers and patients piece together immunization records from various sources;
- Safety concerns if information related to contraindications or previous adverse reactions are not communicated to all health care providers within the individual's circle of care; and
- Product wastage due to challenges in inventory assessment.

Addressing Disparities In Access And Uptake

Disparities are driven by structural and systemic factors that create barriers to vaccine access as well as beliefs and attitudes that can impact confidence.

- Contextual factors may prevent attendance at immunization appointments, e.g., work, transportation, or childcare issues.[15] Mobility issues[16] and language barriers also impede access and uptake.[17]
- Historical and ongoing discrimination within health care settings and more broadly in society can also impact attitudes towards immunization. Black and Indigenous communities face intergenerational trauma and mistrust of institutions due to stigma and mistreatment.[18,19] 2SLGBTQIA+ communities may fear misgendering or emotional violence in health care settings leading to medical mistrust.[20] This mistrust can lower vaccine uptake and widen health inequities.[21]

The 2021 childhood National Immunization Coverage Survey, conducted by the Public Health Agency of Canada, reported lower immunization coverage for routine early childhood immunizations among[22]:

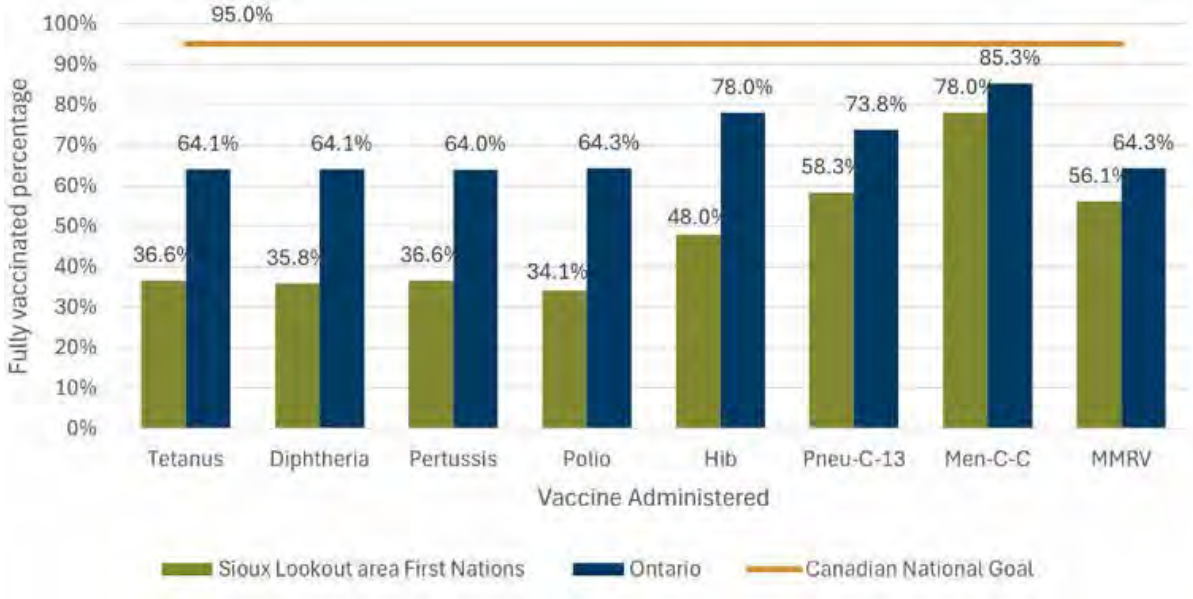
- Children identifying as Black;
- Children living in remote areas;
- Children living in households with lower household income; and
- Children living in households with a parent or guardian with lower educational attainment.

Ontario does not have consistent data to track vaccine uptake among different sociodemographic groups, making it challenging to identify and address gaps.

National surveys and local data suggest that some groups in Ontario face greater barriers to vaccination, leading to unfair differences in health outcomes.

For example, childhood immunization coverage among seven-year-old children in Sioux Lookout First Nation Health Authority was found to be substantially lower compared to coverage in the rest of Ontario[23] (see Figure 15).

Figure 15. Immunization coverage among seven-year-olds by type of vaccine, 2024



Source: © Sioux Lookout First Nations Health Authority (SLFNHA), 2024. Reproduced with permission.

Reversing Declining Vaccine Confidence

Vaccine confidence is a critical component to vaccine uptake.[24]

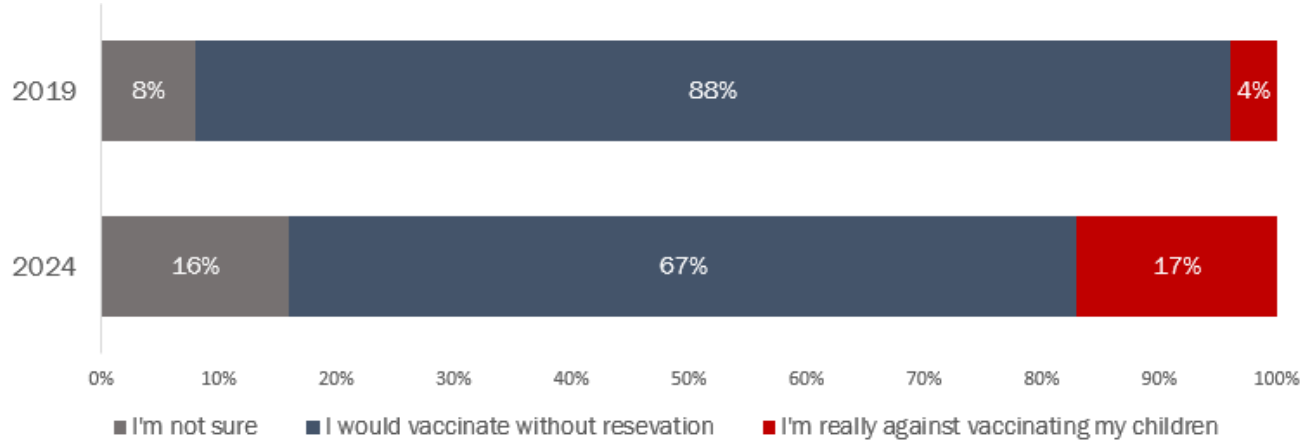
In 2019, prior to the COVID-19 pandemic, the WHO warned about the pressing global threat of vaccine hesitancy.[25] With the proliferation of misinformation through social media, which was exacerbated during the COVID-19 pandemic, vaccine confidence declined in Canada and globally. In Canada, parental skepticism about routine immunizations doubled between 2019 and 2024.

Decrease In Vaccine Confidence

Key Concerns:

- **Parental Confidence:** Only 67% of Canadian parents in 2024 would vaccinate their children without hesitation, down from 88% in 2019.[26]
- **Skepticism and Side Effects:** 29% are skeptical about vaccine science, and 34% worry about side effects.[26]
- **Economic Impact:** Misinformation delayed COVID-19 vaccine uptake for 2.3 million Canadians, costing the health care system $300 million in 2021.[27]

Figure 16. Vaccine attitudes among Canadian parents with children under age 18

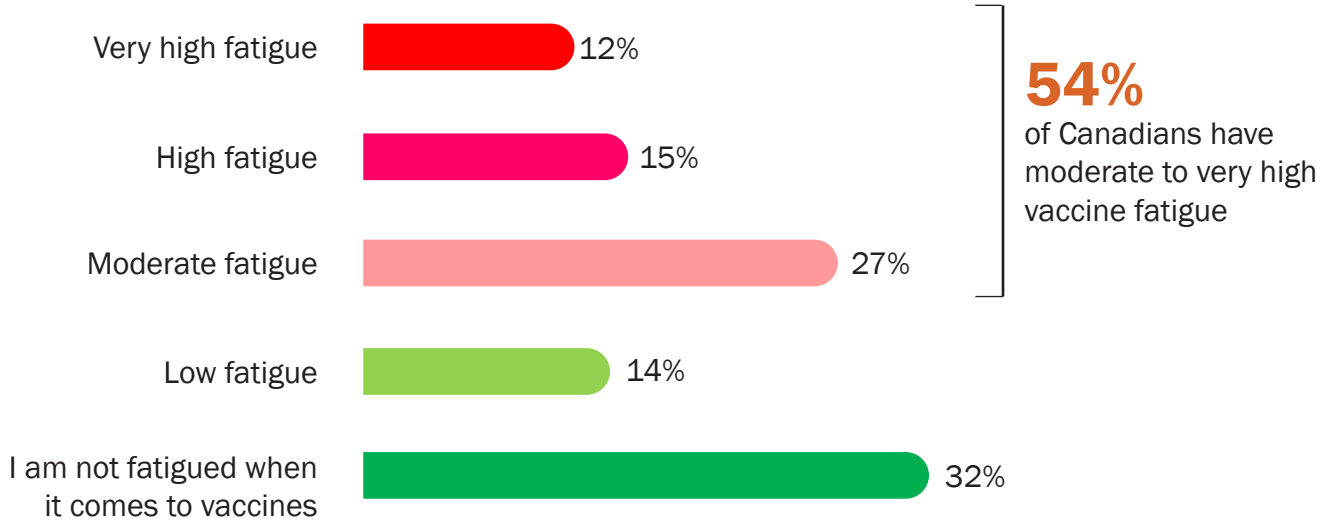


Source: Angus Reid Institute. Parental Opposition to Childhood Vaccination Grows as Canadians Worry about Harms of Anti-Vax Movement, 2024.

Vaccine Fatigue

Following the COVID-19 pandemic, there has been an increase in vaccine fatigue, defined as “inaction towards vaccine information due to perceived burden or burnout”.[28] Fifty-four percent of Canadians report moderate to high vaccine fatigue, especially those under age 45.[29] This fatigue can fuel a loss of confidence in the value of vaccines, especially among young and healthy individuals, and can decrease uptake.

Figure 17. Vaccine fatigue reported by Canadians, August 2023

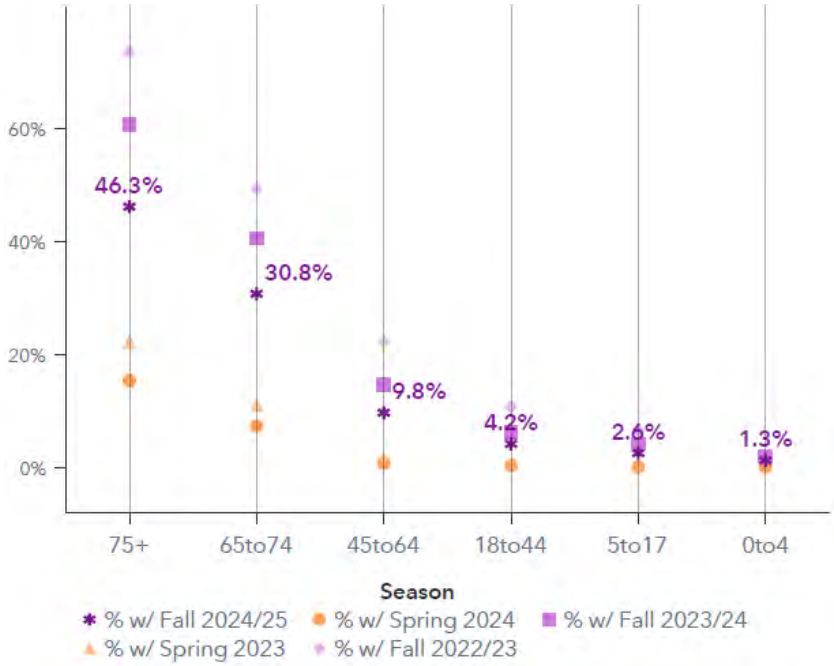


Source: Canadian Pharmacists Association. Canadians' level of vaccine fatigue has pharmacists worried heading into cold and flu season – English 2023.

Seasonal vaccines, which require annual or biannual boosters to maintain protection, are particularly likely to be impacted by vaccine fatigue.

In Ontario, the impact of vaccine fatigue is increasingly evident in the uptake of COVID-19 vaccines, even among seniors. In 2022, 73.7% of people aged 75 and older received a COVID-19 vaccine compared to only 46.3% in Fall 2024.[30] This is particularly concerning as older adults are at higher risk of severe disease if infected.

Figure 18. Seasonal COVID-19 immunization coverage by age in Ontario, 2022-2025



Source: Ministry of Health. Seasonal COVID-19 immunization coverage by age in Ontario, 2022-2025.

Section 4. Strengthening Ontario's Immunization Programs

Figure 19. One immunization record for all Ontarians

Protection across the lifespan

Pregnancy

Infancy and early years

Childhood and adolescence

Adulthood

Older adulthood

Up-to-date Protection:	Ensures up-to-date immunizations throughout lifespan, with reminders for annual and routine vaccines.
Comprehensive Records:	Allows individuals to accurately monitor their vaccination history across their lifespan.
Accessibility:	Easy submission of vaccionation records for school, work, and travel.
Health Management:	Facilitates better health management and proactive healthcare decisions.
Public Health:	Enhances public health efforts by ensuring high immunization coverage and timely outbreak response.

A Vision for the Future of Immunization in Ontario

Vaccination programs should be based on an efficient, comprehensive immunization information system that captures all immunizations from all providers across the lifespan. This interconnected provincial immunization information system would provide real-time data to everyone, including patients and health care providers, significantly improving vaccine program monitoring and evaluation. The vision for the future includes:

Digital Immunization Records:

- Every Ontarian would have a single digital record of all their immunizations, whether publicly funded or privately purchased, linked to their digital medical record.
- This record would be accessible to both the individual/family and their health care providers.
- People would be automatically informed if they are up-to-date and when they are eligible to receive their next immunization.

Comprehensive Data:

- The record would include information about each vaccine dose, such as product details, any adverse reactions, contraindications, consent and exemptions.
- Compatibility across systems will allow data collection from all providers, including electronic medical records, hospital records and systems from other provinces to allow for seamless information sharing.
- All vaccinators will be required to enter immunization records into the information system.

Unique Identifier:

- Each person's unique immunization record will be linked with other provincial health data, such as clinical care, hospital and ICU records, ensuring integration across the health system and across the patient's circle of care.

Enhanced Monitoring and Surveillance:

- The linked data will allow public health authorities to better monitor vaccine effectiveness, immunization coverage, safety, and program performance.
- Immunization linked to sociodemographic data will allow detection and monitoring of inequities in vaccine uptake, informing strategies to improve access and confidence.
- Mandatory data entry of all vaccines administered will ensure every individual's immunization record was complete and up to date.

The Vision for a National Immunization Information System in Canada

For over 20 years, individuals, families, health care providers and public health experts have emphasized the need for a national immunization data system. This system would improve tracking of vaccine coverage and facilitate record transfers across provinces and territories. It would also support monitoring of disease prevalence, vaccine effectiveness and safety at the national level.[31–34]

The Public Health Agency of Canada is working with provinces and territories on a proof-of-concept to connect immunization registries and improve data access. The goal is to enable individual record portability across jurisdictions, creating comprehensive records for public health assessment to ensure people across Canada are protected, regardless of where in the country they live.

Lessons from SARS

- The 2003 SARS outbreak highlighted the need for a unified public health surveillance system to manage national responses to disease outbreaks.
- The National Advisory Committee on SARS recommended a national system to track immunizations in real-time.

Panorama System

- The Federal Government funded Canada Health Infoway to work with federal, provincial and territorial partners on the implementation of Panorama, a public health surveillance system that is used in many provinces and territories.
- Despite this, comprehensive and standardized data collection and interoperability between provincial systems have remained a challenge.

Interoperability Efforts

- In 2020, the Pan-Canadian Health Data Strategy Expert Group recommended common principles for health data use, sharing, and management to enhance system compatibility.
- Federal, provincial, and territorial (FPT) governments committed to developing standardized health data policies and tools.

Recent Investments

- The 2023 Federal budget included nearly $200 billion over ten years to modernize health care, including standardized health data and digital tools.
- The FPT Action Plan on Health Data and Digital Health, signed by all provincial and territorial Ministers of Health, was announced in October 2023 to improve health data management and transparency.

Enabling A National Harmonized Immunization Schedule

- A national immunization information system would enable a national harmonized immunization schedule for all Canadians, enhancing equity in access across jurisdictions.
- A Canada-wide immunization schedule would facilitate greater efficiencies in vaccine procurement including bulk purchasing, domestic production, and risk-managed contracts.

Addressing Challenge #1:
Resolving Gaps in Immunization Data

Modern immunization programs require comprehensive immunization data registries.[35]

As investment in publicly funded immunization programs continues to grow in Ontario, a comprehensive immunization information system is needed to ensure Ontarians have access to their own health information, providers have the information to inform clinical services, and public health resources are managed efficiently and effectively.

Currently in Ontario there are three separate places where immunization data is kept:

1. **Panorama:**
   For school and childcare immunizations.
2. **COVaxON:**
   For COVID-19 immunizations.
3. **Administrative datasets:**
   Includes Ontario Health Insurance Plan (OHIP) billing claims and electronic medical records for immunizations administered in physician offices or community pharmacies.

Ontario's disparate immunization records system presents significant data access issues:

- Immunization coverage is assessed in different places. (i.e., through Panorama for school-age children and COVaxON for COVID-19 vaccines).
- Reporting by health care providers and parents is not mandatory, leading to incomplete records in Panorama.
- There are significant time lags and high administrative burden for public health authorities in assessing vaccine coverage.
- Adult immunizations are recorded in electronic medical records, which are not centralized, or only available as OHIP billing claims for immunizations administered in pharmacies
- There is no mechanism to assess coverage for adult non-COVID-19 immunizations.

Currently, Ontario lags behind other provinces like British Columbia, Quebec, Alberta, Manitoba and Nova Scotia, who continue to expand their digital solutions for immunization records.

A recent position statement by the Ontario Immunization Advisory Committee (OIAC) reinforced the pressing need for a central immunization information system to improve the delivery of Ontario's immunization programs and ensure more efficient use of health care resources.[36]

Because the province does not have a central repository for all immunization data across a person's lifespan, individuals (and parents/caregivers) must take on the role of central record keepers.

The 2022 Office of the Auditor General of Ontario report highlighted that the lack of a centralized COVID-19 immunization information system early in the pandemic hindered coverage assessment and equity monitoring, leading to some high-risk groups being overlooked.[37]

Figure 20. Characteristics of Ontario's current immunization data systems

Characteristic	Digital Health Immunization Repository (Panorama)	COVID-19 Immunization Registry (COVaxON)	Administrative Data (e.g., OHIP provider billing data)
Vaccine Programs Captured	• Routine publicly funded (child and adolescent) and school-based vaccines • Not comprehensive (relies on parent and/or health care provider reporting to public health for routine vaccines) • Limited to school-aged children and those in licensed child care	• All COVID-19 vaccines administered in Ontario or to residents of Ontario (i.e., vaccine doses administered out of province) across the lifespan	• Routine publicly-funded vaccines (infant to older adult) administered in primary care • Not comprehensive (e.g., very limited capture of vaccines without OHIP vaccine-specific billing codes, does not capture doses administered by non-fee-for-service providers [e.g., nurse practitioners])
Reminder - Recall	• Send notices to remind parents/guardians about recommended vaccines (to school aged children and those in licensed child care only) • Can forecast when the child is due for a vaccine (used for ISPA and school-based clinics)	• Send notices to remind individuals about recommended vaccines • Can forecast when an individual is due for a vaccine	• N/A
Access to Immunization Records	• Access limited to public health unit staff • Online portal (ICON) for parent/guardian reporting of childhood immunizations (relies on parent/guardian to provide immunization information)	• Access for authorized health care providers/ immunizers through web-based platform and viewing via Ontario's Digital Health Drug Repository • Patient can access their own COVID-19 vaccination record/ certificate	• Access to de-identified OHIP billing data is limited and with significant time lags
Entry of Immunization Records	• Retrospective entry of individual-level immunization data driven by ISPA activities (routine vaccines)	• Real-time and retrospective entry (e.g., out-of-province doses) of individual-level immunization data	• Retrospective entry of individual-level immunization data via OHIP-billing data

Characteristic	Digital Health Immunization Repository (Panorama)	COVID-19 Immunization Registry (COVaxON)	Administrative Data (e.g., OHIP provider billing data)
Data Elements & Terminology	• Standardized data elements, required data elements	• Standardized data elements, terminology and required data elements	• Generic and vaccine-specific OHIP billing codes
Support for Vaccine Programs	• Local public health unit inventory management • Mass immunization clinic set up • Mobile tool for clinics (m-Imms)	• Inventory management • Mass immunization clinics set up • Linkages with scheduling/booking system	• N/A
Monitoring and Evaluation	• Individual-level immunization data for retrospective assessments of immunization coverage and program impact	• Individual-level immunization data with routine linkages to other provincial databases to support near real-time immunization program monitoring and evaluation (including immunization coverage)	• Numerator for retrospective assessments of immunization coverage and program impact
Limitations	• Reliance on parent and/or health care provider reporting • Only captures immunization data for some vaccines for school-aged children and those in licensed childcare • Limited/incomplete reporting and capture of immunizations delivered outside public health unit setting • Long delays in data entry (retrospective) • Very limited record validation • Not accessible to health care providers outside the local public health unit	• Limited to COVID-19 vaccines • Administrative burden of data entry on health care provider/immunizer/public health	• Comprehensiveness is limited • Data are not available in real-time • No OHIP vaccine-specific billing codes for some publicly funded vaccines • Doses administered by non-fee-for-service providers and/or unbilled doses are not captured • Access generally limited to researchers

Adapted from: Ontario Agency for Health Protection and Promotion (Public Health Ontario), Ontario Immunization Advisory Committee. Position Statement: A Provincial Immunization Registry for Ontario.; 2024.

Implementing A Provincial Immunization Information System

Benefits for people living in Ontario include:

Easy Access:

Provide individuals/families with on-demand immunization data for school, work, travel, or relocation.

Reminders:

Reminders to ensure immunizations are not missed to support optimized protection.

Streamlined Care:

Help health care providers access full immunization records, improving clinical care and avoiding unnecessary revaccination and invalid schedules.

Better Monitoring:

Improve vaccine coverage monitoring and identified unimmunized individuals, especially during outbreaks, ensuring we build community immunity against common diseases. Detect rare safety signals earlier, improving outcomes.

System Efficiency:

Allow for better vaccine inventory management and distribution, minimizing wastage and maximizing effectiveness of the provincial investment in immunization. Enhances supply chain efficiency, optimizing health care spending.

Enhanced Evidence:

Support vaccine program performance monitoring, including safety and effectiveness and duration of protection.

Improved Confidence:

Provide precise information on vaccine effectiveness and safety, so Ontarians can feel confident regarding vaccine safety.

Addressing Disparities:

Identify gaps in vaccine coverage by region and sociodemographic groups, allowing for tailored interventions.

Balancing User Benefit and Privacy

While the benefits are significant, privacy and data access must be carefully managed. A provincial immunization information system needs clear data governance guidelines to regulate who can access immunization data and when.

These frameworks must specify how the data will be used and how to ensure privacy and confidentiality are protected.

Using Sociodemographic Data to Detect Gaps in Vaccine Coverage

Identifying and monitoring differences in health care access is a critical first step to addressing disparities. Without reliable and timely data to detect and track differences in vaccine uptake by sociodemographic groups at a population level, it is difficult to design, implement or evaluate interventions that promote access and reduce gaps in coverage. The collection of sociodemographic data linked to health data for the purpose of identifying disparities is an approach supported by both The Ontario Human Rights Commission (OHRC) and the Anti-Racism Directorate.[38,39] During COVID-19, individual- and neighbourhood-level sociodemographic data guided Ontario's High Priority Communities Strategy, which led to better resource allocation in neighbourhoods that were shown to have higher infection rates and more severe outcomes.[40]

Spotlight: High Priority Communities Strategy

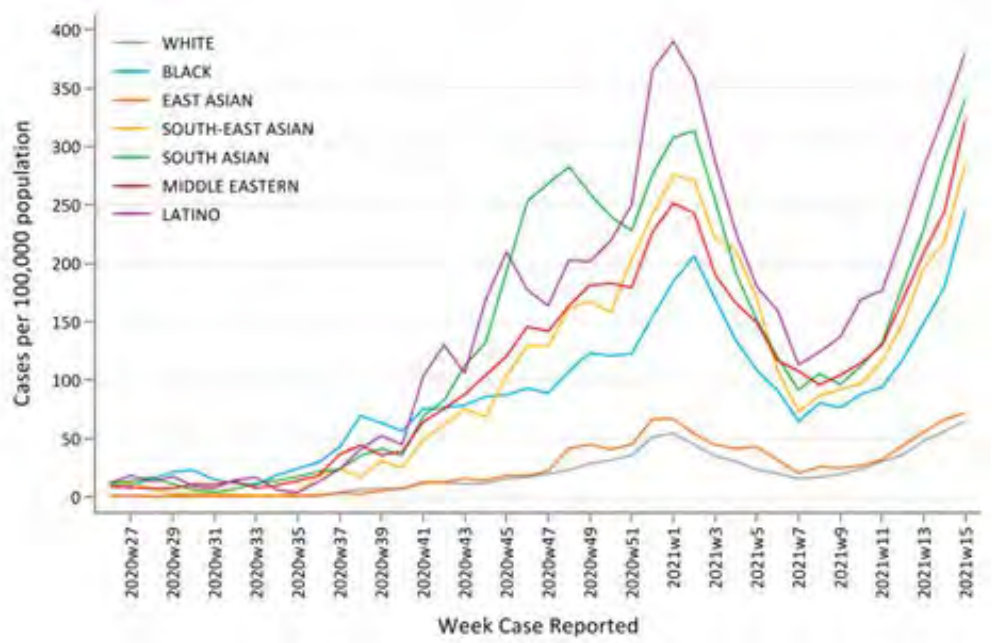
The High-Priority Communities Strategy supported 15 high-needs communities in Ontario, including Durham, Peel, Toronto, York and Ottawa, which were identified due to COVID-19 infection rates, low testing rates and barriers to testing or self-isolation. The strategy funded local agencies to work with Ontario Health and community partners to deliver key interventions.

Actions included door-to-door outreach by community ambassadors, culturally appropriate communications, increased testing locations with transportation assistance, and wraparound supports like groceries and emergency financial assistance. This approach enhanced service awareness, countered misinformation and addressed barriers to testing and self-isolation.

Previous outbreaks, such as the 2009 H1N1 pandemic, revealed significant disparities in disease outcomes. In Manitoba, First Nations children experienced infection rates five times higher and the rate of hospitalization was 22 times higher than non-First Nations children.[41]

During the COVID-19 pandemic, beginning in April 2020, public health units in Peel, Middlesex-London and Toronto started collecting sociodemographic data among those who tested positive for COVID-19. By June 2020, this was required by the province through the *Health Protection and Promotion Act,* Despite challenges in getting complete data, it was evident that COVID-19 infection rates were 4.6, 7.1, and 6.7 times higher among Black, Latino and South Asian Ontarians, respectively, compared to white Ontarians.[42]

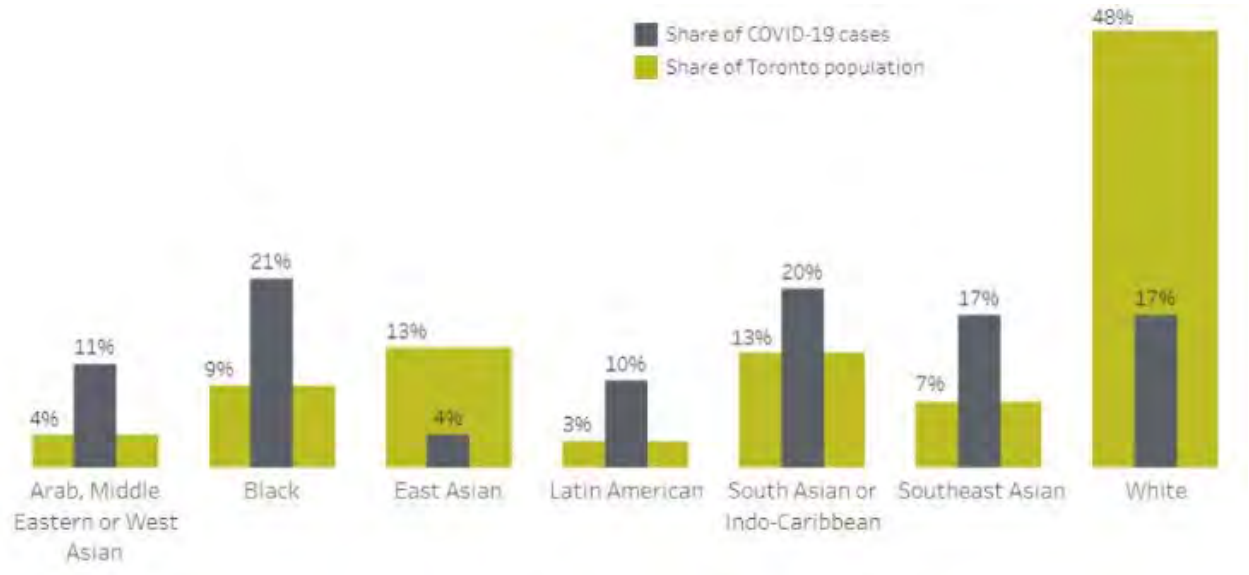
Figure 21. Weekly COVID-19 case counts per capita by race in Ontario (June 2020-April 2021)



Source: McKenzie K, Dube S, Petersen S, Equity, Inclusion, Diversity and Anti-Racism Team, Ontario Health. Tracking COVID-19 through Race-Based Data. Ontario Health, Wellesley Institute; 2025.

Local public health units used data on infection rates among specific populations to focus efforts on those at highest risk of COVID-19. Toronto Public Health found that Black Torontonians and other non-white populations made up 83% of all COVID-19 infections but only 50% of the population of Toronto. Households with five or more people were also overrepresented among those infected. The availability of this data led to targeted testing, improved community communication and increased social support.[40]

Figure 22. COVID-19 cases among ethno-racial groups compared to the share of people living in Toronto, with valid date up to July 16th, 2020



Source: COVID-19: Ethno-racial identity & income. City of Toronto. 2021.

Voluntary collection of sociodemographic data for people receiving the COVID-19 vaccine at vaccination sites began in March 2021. The goal was to support the development and delivery of an equitable vaccination strategy.[43,44] As it was not mandated, sociodemographic data was only recorded for 4.9% of the 12.7 million people who received vaccines.[44] The low percentage of individuals with available sociodemographic data was likely due to a combination of people not being asked or not wanting to provide this information.[44]

Nonetheless, survey data, such as the Canadian Community Health Survey (2021-22), indicated higher rates of non-vaccination among off-reserve First Nations and Black people compared to white Canadians.[45] However, the lack of comprehensive real-time provincial immunization data made assessment of vaccine coverage among specific groups difficult.

Surveys help but are time-consuming and results are delayed, hindering real-time evaluation and intervention. **A provincial immunization information system and improved data collection would enable ongoing monitoring and improve access.**

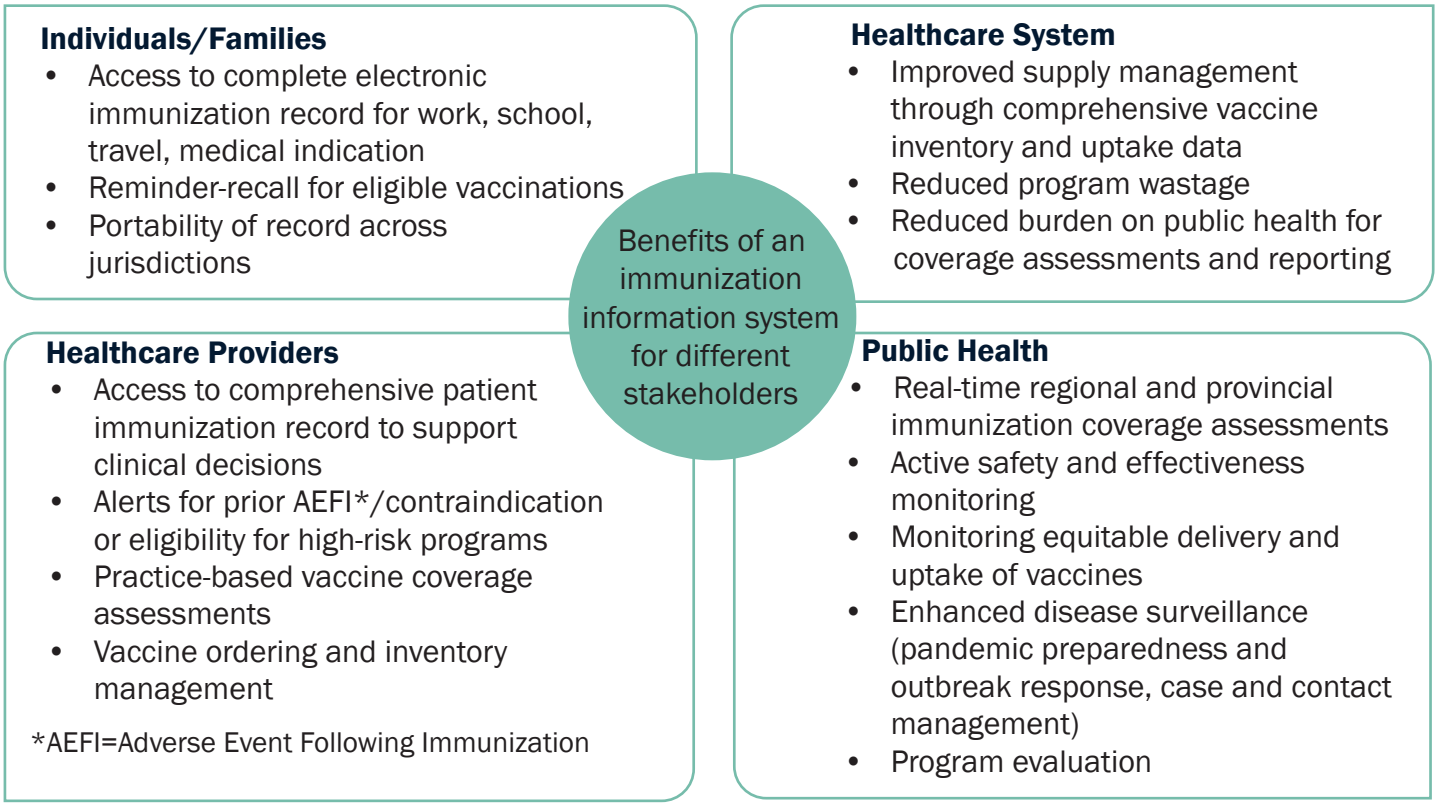
Considerations In The Collection Of Race-Based Data

The Ontario Human Rights Commission (OHRC), the Wellesley Institute and the Black Health Alliance have called on the health care system and all levels of government to strengthen their capacity to collect and use race-based data for the purpose of improving equity and promoting health.[46,47] Collecting sociodemographic data during OHIP registration or renewal has been proposed as a centralized, systematic mechanism for collection.

Effective health equity monitoring initiatives must be implemented carefully. They require clear communication about data collection goals, addressing community concerns and building trust. There must be transparency, privacy and the option to opt-in or to opt-out, as per the *Anti-Racism Act, 2017*.

Indigenous data sovereignty and adherence to specific data principles such as Ownership, Control, Access, and Possession (OCAP) for First Nations, Ownership, Control, Access and Stewardship (OCAS) for Métis and Inuit Qaujimajatuqangit (IQ) for Inuit are important components of data governance.[48]

Figure 23. Benefits of an immunization information system for Ontario



Adapted from: Ontario Agency for Health Protection and Promotion (Public Health Ontario), Ontario Immunization Advisory Committee. Position Statement: A Provincial Immunization Registry for Ontario. 2024.

Ontario has faced challenges in implementing a comprehensive immunization information system due to its complex public health system and numerous immunizers. Integrating data from various health care providers without duplicating entries has been difficult. The Ministry of Health is currently working on information technology solutions leveraging Panorama to improve data linkages and surveillance. Current efforts, such as integrating electronic medical records to enhance access, are encouraging. The end goal must be an accessible, comprehensive provincial immunization data system.

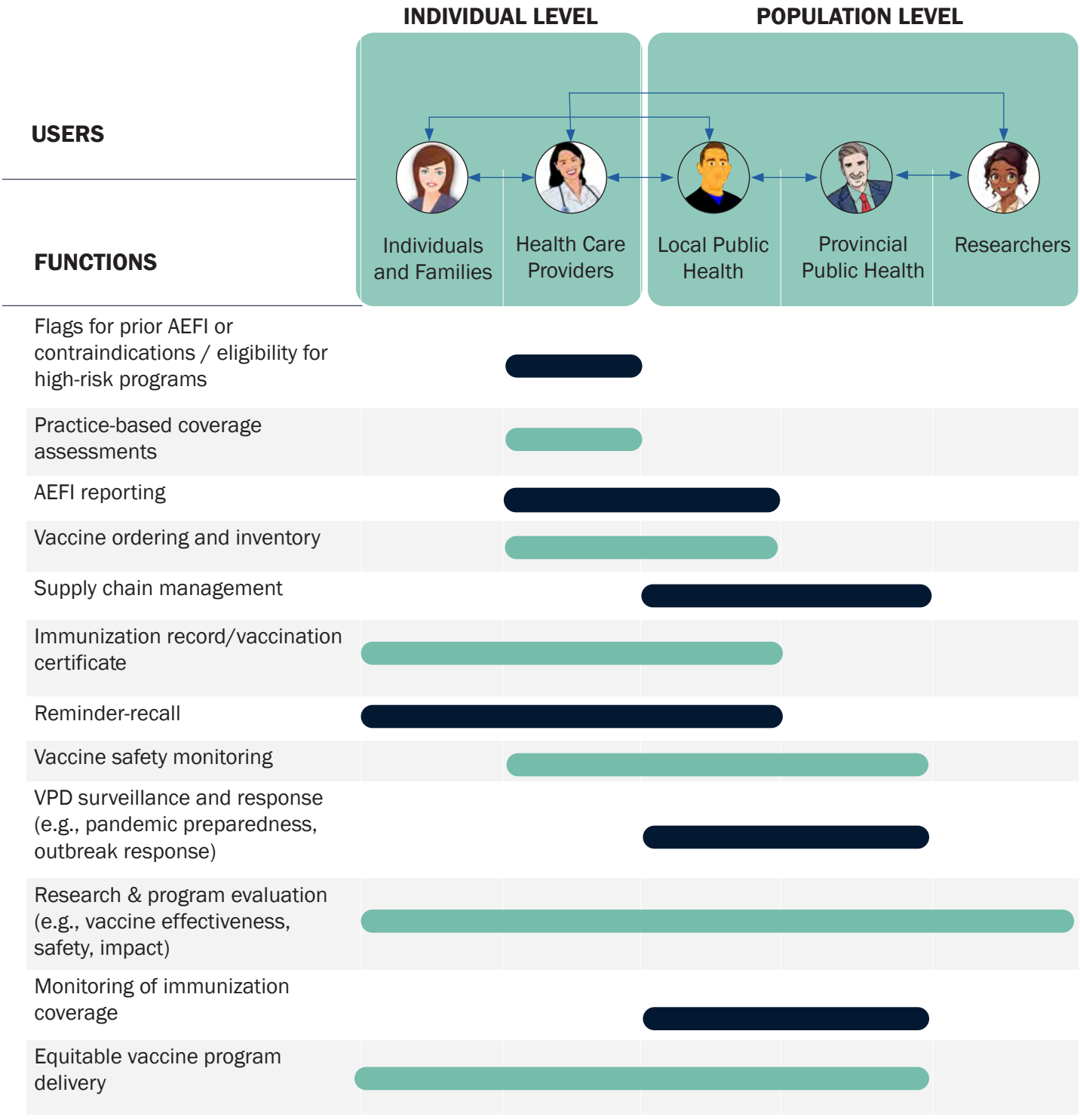
Spotlight on CoVaxON (Ontario's COVID-19 Vaccination Information System)

During the pandemic, CoVaxON was created to securely capture data on all COVID-19 vaccines administered in Ontario. The data system mandated by *The COVID-19 Vaccination Reporting Act, 2021*, allowed Ontarians to access their immunization records online and receive reminders.

CoVaxON enabled surveillance of vaccine coverage, effectiveness, and safety, helping to prioritize immunization delivery. Access to comprehensive immunization data also enabled the identification of rare adverse events, leading to preferential vaccine and dosing recommendations.

This system demonstrates the benefits and functionality of a comprehensive, secure, web-based provincial immunization information system. However, despite its benefits, the system's lack of integration with electronic medical records led to duplicative data entry which was a burden to health care providers. Future systems must eliminate this to gain health care provider support.

Figure 24. Summary of provincial immunization information system functionality by interest holder type



* VPD=Vaccine Preventable Disease

Adapted from: Ontario Agency for Health Protection and Promotion (Public Health Ontario), Ontario Immunization Advisory Committee. Position Statement: A Provincial Immunization Registry for Ontario. 2024.

Addressing Challenge #2:
Addressing Disparities In Access And Uptake

Using A Needs-Based Framework To Guide Immunization Programs

Health inequities are systematic differences in opportunities for groups to achieve optimal health, leading to unfair and avoidable differences in health outcomes.[49]

Differences in access and uptake of immunization make certain groups more vulnerable to infectious and chronic diseases, leading to poorer health outcomes in the short and long term.

Recognizing the need to address equity issues in immunization programs, NACI has adopted the Ethics, Equity, Feasibility and Acceptability Framework. This framework provides tools to evaluate and assess programs with a needs-based focus, leading to more transparent and evidence-based policy decisions.

Building Trust and Empowering Community Leadership

Differences in immunization uptake can be driven by access barriers (e.g., transportation, language barriers) or distrust of institutions due to past negative experiences accessing health care or social services.[50]

To rebuild confidence among underserved groups, including 2SLGBTQIA+, people experiencing homelessness, refugees and asylum seekers, and racialized communities, it is crucial to engage with the community and involve members in designing and planning immunization campaigns.

Spotlight: Black Health Plan

In 2020, COVID-19 infection rates among Black Torontonians were over nine times higher than white Torontonians. Reasons for this disparity included exacerbation of existing health inequities and social factors which both increased the risk of infection and undermined the impact of public health strategies on Black populations.

In response, The Black Health Plan Working Group was formed in 2020, followed several months later by the Black Scientists Table.

Additionally, The Black Physicians of Ontario, Black Health Alliance, community health centres, and community groups focused their work on the pandemic response.

Together they advocated for the collection of sociodemographic data in collaboration with Ontario's High Priority Community Strategy. They developed strategies to reduce infection, including community vaccination clinics and over 20 town hall events reaching over 6,000 people to build trust and counter misinformation.

Building on this work, Ontario published its first Black Health Plan in 2023, with recommendations to improve vaccine uptake, address hesitancy and enhance access through community initiatives and race-based data collection.

During the mpox outbreaks in Ontario, partnerships with community agencies led to the development of a highly successful community-informed immunization campaign. As Figure 26 shows, vaccine uptake was closely aligned with the number of social media posts deployed each week, demonstrating the effectiveness of awareness campaigns in increasing demand for vaccination. After a steep increase of mpox cases from May to August 2022, cases plateaued in the Fall due to vaccine uptake and changes in behaviour.[51]

Spotlight: Ontario's mpox Awareness Campaign

Mpox cases were first identified in Europe in April 2022 and by May 2022, Ontario declared an outbreak. Men who have sex with men (MSM) were at higher risk. Due to the history of stigmatizing public health responses towards 2SLGBTQIA+ populations, an effective community-led strategy was essential to success.

The Gay Men's Sexual Health Alliance (GMSH) was key to the mpox response. Partnerships between GMSH, the Office of the Chief Medical Officer of Health and community agencies were pivotal to the program's success. GMSH provided sexual health promotion expertise and advised on health and vaccine promotion strategies through weekly meetings.

A multi-lingual awareness campaign on mpox symptoms and prevention, including immunization, was launched. The social media campaign, which was accessed over 74 million times, used a sex-positive approach and candid language to communicate key public health messages.[51]

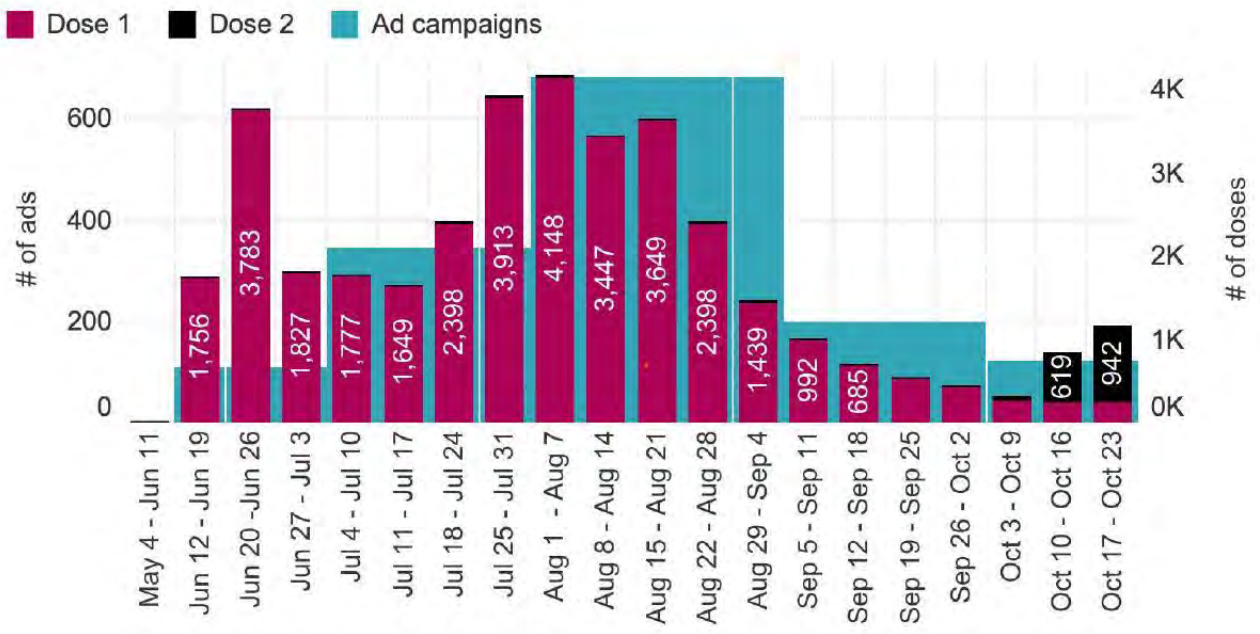
COVID-19 mass immunization clinics were expanded for the administration of mpox vaccines. Between May and October 2022, a total of 37,470 doses of mpox vaccines were administered in Ontario.

In this example, community expertise successfully guided vaccine policy and planning. Local public health also worked with community leaders to set up pop-up vaccine clinics.

Figure 25. Mpox awareness campaign

Source: Tan DHS, Awad A, Zygmunt A, et al. Community Mobilization to Guide the Public Health Response During the 2022 Ontario Mpox Outbreak: A Brief Report. Open Forum Infectious Diseases. 024;11(Supplement_2):S129-S132.

Figure 26. Timeline of social media ad campaigns compared to vaccination trends in Ontario



Source: Ismail Y, Zapotoczny V. Ontario's Mpox Awareness Campaign Evaluation: Final Report. Gay Men's Sexual Health Alliance; 2023.

Spotlight: Operation Remote Immunity

Once COVID-19 vaccines were approved in Canada, distribution became a central priority. First Nations, Inuit, and Métis communities were prioritized for immunization due to higher risks of severe outcomes from underlying conditions and challenges, such as limited access to clean water or household overcrowding.

In December 2020, Ontario launched Operation Remote Immunity (ORI). Working in collaboration with Indigenous leaders, Ornge - a non-profit organization responsible for critical transport in Ontario - assisted in delivering thousands of vaccine doses to remote communities.[52]

In its first phase, ORI delivered over 25,000 doses to 31 remote First Nations communities and Moosonee. The second phase (ORI 2.0) which began in May 2021 resulted in the administration of nearly 6,000 doses, including boosters. The third phase (ORI 3.0) which began in March 2022, resulted in the delivery of an additional 9,700 doses.

Figure 27. The timeline of Operation Remote Immunity

Source: Burton S, Hartsoe E, Li W, Wang A, Wong J. Operation Remote Immunity. Reach Alliance; 2023.

Most First Nations, Inuit, and Métis people live off-reserve, with many residing in urban areas.

During the COVID-19 pandemic, urban Indigenous communities in Toronto and London had a 20% lower vaccine uptake compared to the general population. Barriers included lack of access to culturally-safe care (defined as health care which recognizes, respects and nurtures the cultural identity of the individual),[53] systemic racism in hospitals and distrust in biomedicine due to colonial policies.

Indigenous health centres including Southwest Ontario Aboriginal Health Access Centre (SOAHAC) and Maamwesying North Shore Community Health Services responded by providing culturally-safe health care spaces for COVID-19 and routine immunizations. These centers continue to offer immunizations alongside comprehensive primary care services.

Spotlight: Na-Me-Res Vaccine Clinic Pow Wow

Na-Me-Res, an emergency shelter for Indigenous men organized a Vaccine Clinic Pow Wow at University of Toronto's Varsity Stadium during the COVID-19 pandemic to provide First Nations, Inuit and Métis people with a culturally-safe vaccination site.

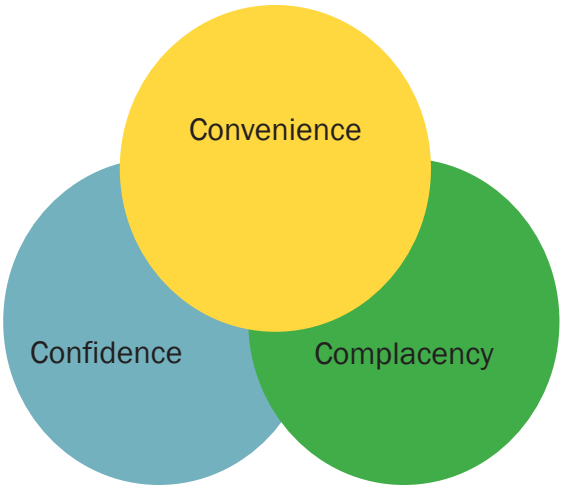
The pop-up clinic, which was arranged through a partnership between Waakebiness-Bryce Institute for Indigenous Health at the Dalla Lana School of Public Health, Well Living House, and Seven Generations Midwives Toronto, vaccinated a total of 200 people while pow wow drummers and dancers performed. The success of this clinic led to the establishment of Auduzhe Mino Nesewinong ("place of healthy breathing") which operates as an Indigenous Interprofessional Primary Care Team offering culturally-safe primary care services in Toronto.

First Nations, Inuit, and Métis people face inequities in routine and seasonal vaccine access.[22,23,54] To address this, Indigenous leaders have proposed an Indigenous Immunization Strategy in Ontario. Guided by Indigenous health leaders, and supported by local public health, the aim of this strategy is to reduce disparities in immunization uptake within Indigenous communities.

Barriers to Access

A recent review found that the second most common barrier to vaccination—after lack of information—was difficulty accessing vaccines.[55] This shows that making vaccines easier to get is just as important as providing accurate information and encouraging people to stay up to date.

Figure 28. The 3Cs of vaccine hesitancy



Adapted from: MacDonald NE. Vaccine hesitancy: Definition, scope and determinants. Vaccine. 2015;33(34):4161-4164.

Expanding Access to Immunization

Ontario's Plan for Connected and Convenient Care has broadened the range of health care professionals who can administer vaccines.

Midwives

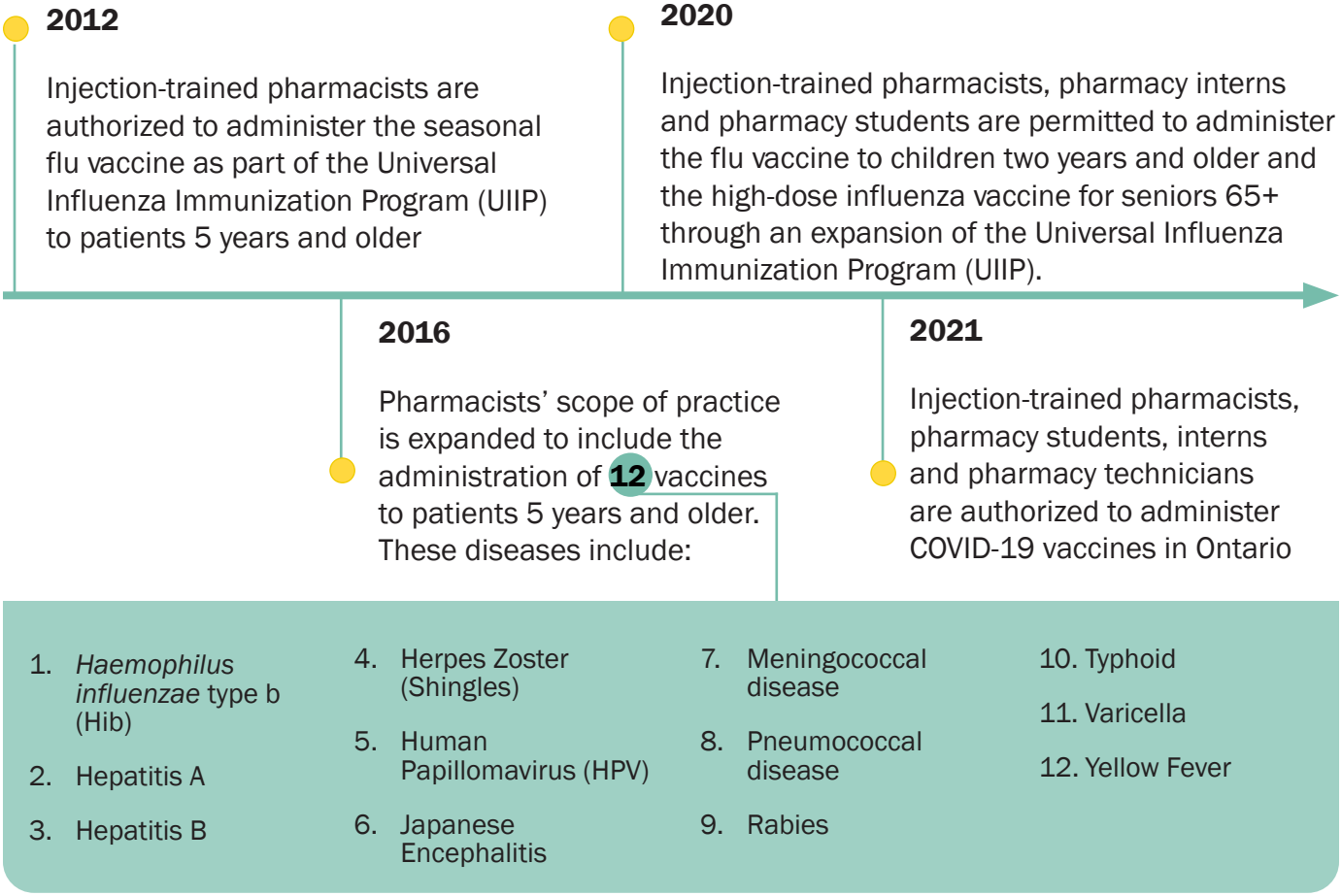
In May 2024, the Ontario government expanded midwives' scope of practice to allow the administration of vaccines like COVID-19, influenza and Tdap (tetanus, diphtheria and pertussis).

- Nearly 1 in 5 births in Ontario are attended by midwives.
- Vaccines administered during pregnancy, like Tdap, provide 91-93% protection from pertussis for infants in the first month of life before they can be immunized themselves.[56,57]

Pharmacists

Pharmacists' scope of practice related to immunization has also expanded in Ontario, providing more opportunities for Ontarians to access a wide range of vaccines in their communities (see Figure 29).

Figure 29. Expanded scope of practice for pharmacists related to immunization in Ontario



Adapted from: Ontario Pharmacists Association. 10 years of immunizations. 2022.

Primary Care and Access Gaps

In Ontario, routine childhood immunizations are primarily administered by family doctors, unlike in several other provinces where public health nurses play a larger role. This model presents challenges:

- Ontario is currently experiencing a shortage of primary care physicians.
- Individuals and families without a primary care provider may face barriers to accessing routine vaccines.
- A 2009 study found a correlation between the number of family physicians and pediatricians in Ontario and vaccine coverage among seven-year-olds.[58]

Presently, 2.2 million Ontarians are without a primary care provider, including 360,000 children, with newcomers and low-income communities being most affected.[59]

In response, Ontario announced the formation of the Primary Care Action Team (PCAT) led by Dr. Jane Philpott, whose central mandate includes a commitment to connect all Ontarians to a primary care team within four years.

Overcoming Barriers

To improve vaccine access, Ontario must adopt flexible community-focused strategies.

- **Public Awareness Campaigns:** Especially during respiratory virus season, early and widespread flu vaccine availability is critical for high-risk populations.
- **Tailored Community Approaches:** In Northern Ontario, where access to family doctors is limited, some public health units administer routine childhood vaccines directly. Since the COVID-19 pandemic, former mass vaccination sites have also been repurposed to help children catch up on missed immunizations.
    - In 2024–25, the Northwestern Health Unit provided 3,379 routine early childhood vaccines.

Community Based Solutions

Pop-up vaccine clinics at *Wellness Fairs* hosted by the **Peel Black Health and Social Services Hub** have demonstrated the effectiveness of community-based approaches:

- These fairs address common barriers like transportation, scheduling issues and fears associated with accessing immunizations in traditional health care settings including stigma or cultural barriers.
- Initially focused on COVID-19 vaccines, they now also offer routine immunizations for school-aged children.
- The Hub is supported by the **Black Health Alliance, Black Physicians Association of Ontario**, and local partners such as **Roots Community Services, Partners Community Health** and **LAMP Community Health Centre**.

These trusted, familiar settings help families catch up on missed vaccines and improve overall access.

Spotlight on: The SickKids Immunization InfoLine

The SickKids Immunization InfoLine is a free, by-appointment phone consultation service that provides expert guidance related to immunizations for children, youth, and those who are pregnant or breastfeeding. The InfoLine offers open one-on-one conversations with a specially-trained nurse. Families can ask questions and get information specific to their child on vaccine eligibility, safety, access and effectiveness in a secure and non-judgmental environment to assist in informed decision-making.

Parents and caregivers that reside in Ontario can book appointments directly through the website and do not require a referral or an OHIP/health card. The InfoLine plays a critical role in system navigation – helping families overcome access issues and find support for vaccine confidence issues, even if they are unattached to a primary care provider. For complex cases where additional consultation is necessary, the service can directly refer children and families to specialists to provide additional guidance. The InfoLine is available in multiple languages using over-the-phone language interpretation to ensure that language barriers are not an obstacle to receiving support.

The service began in 2021, specifically focused on COVID-19 immunizations (previously called "The SickKids COVID-19 Vaccine Consult Service") but has since expanded to provide support related to all routine immunizations offered during childhood and pregnancy. The consult service is staffed by a nurse with support from paediatric infectious disease physicians and is offered free of charge to all residents of Ontario and their families.

Looking Ahead: Strengthening Access Across Ontario

To ensure lifelong vaccine access for all Ontarians, we must:

- Strengthen connections to family doctors;
- Address local barriers that hinder access; and
- Explore innovative, community-specific solutions that reflect the diverse needs of Ontario's population.

Spotlight on: Quebec CLSCs

Centres Locaux de Services Communautaires (CLSCs) were established in Quebec in the early 1960s after the Castonguay-Nepveu Commission reforms. There are 147 CLSCs in Quebec, providing routine preventative care including immunizations within an integrated community-based hub. They also offer consultations with primary care physicians, nurse practitioners and allied health professionals.

Social services include social and psychological consultations, crisis response and mental health counseling. CLSCs also provide rehabilitation, chronic disease management and sexually transmitted infection (STI) prevention.

Addressing Challenge #3:
Reversing Declining Vaccine Confidence

Building Vaccine Confidence

Attitudes towards vaccination can be impacted by many factors including the context in which a person lives (i.e., geography or culture), personal experiences and attitudes which may differ depending on the vaccine.[60]

In 1998, a flawed (and later retracted) study published in The Lancet by Andrew Wakefield and colleagues falsely linked the MMR vaccine to autism, which reduced vaccine confidence despite overwhelming evidence disproving the claim. This misinformation led to increased measles cases, even in countries where the disease had been eliminated.

During the COVID-19 pandemic, a lack of confidence related to mRNA vaccines due to their novelty, despite the availability of data to support their safety and efficacy, was a major driver of hesitancy. Throughout and following the COVID-19 pandemic, social media played a central role in the amplification of myths and misinformation.[61]

Figure 30. Determinants of vaccine hesitancy

Determinants	Influenced by
Contextual (e.g., historic, socio-cultural, environmental, health system/institutional, economic, political factors)	• Communication and media environment • Influential leaders, historical influences, politics/policies • Religion/culture/gender/socio-economic • Geographic barriers
Individual and Group (e.g., personal perception or social/peer environment)	• Personal, family and/or community members' experience with vaccination • Beliefs, attitudes, knowledge and awareness about health and disease prevention • Personal experience with the heathcare system/healthcare providers • Risk/benefit (perceived)
Vaccine/Vaccination Specific Issues (e.g., Directly related to vaccine or vaccination)	• Risk/benefit (epidemiological,scientific evidence) • Introduction of a new vaccine or new vaccine platform • Mode of administration • Design of vaccination program/mode of delivery (e.g., routine program or mass vaccination campaign) • Reliability and/or source of supply of vaccine/equipment • Vaccination schedule • Costs associated vaccine or travelling to receive the vaccine • The strength of the recommendation to receive vaccine and/or attitude of healthcare professionals towards the vaccine

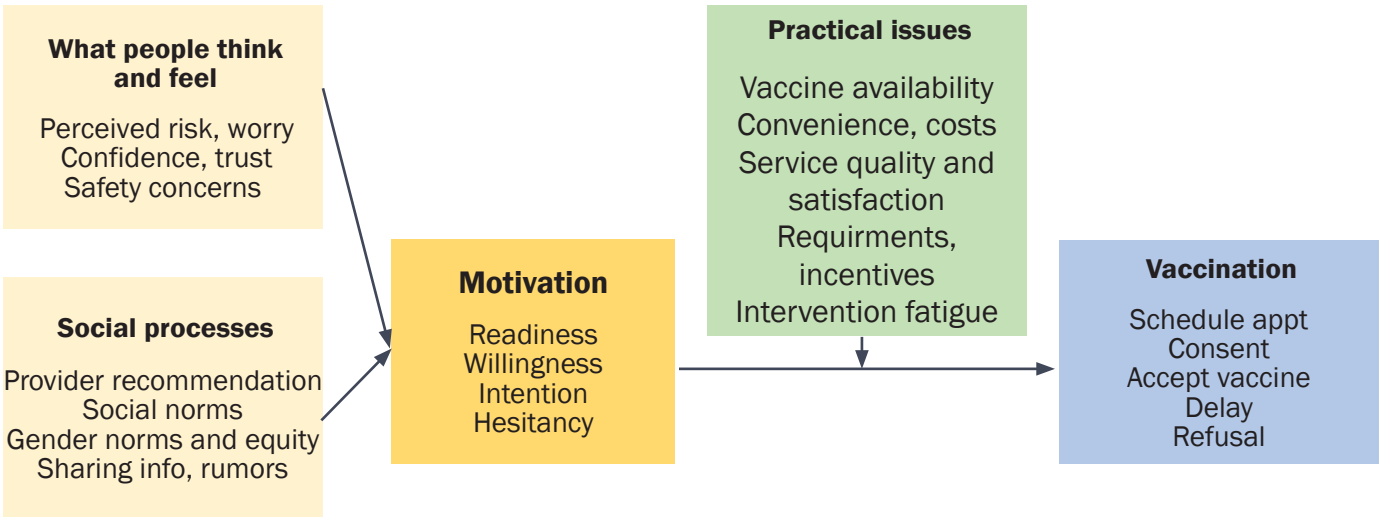
Adapted from: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Building Confidence in Vaccines, 2021.

Experiences of discrimination or negative interactions with the health care system can reduce trust and affect attitudes towards immunization and health care institutions.

Specific groups, such as those who identify as 2SLGBTQIA+, individuals experiencing homelessness, refugees and asylum seekers, and racialized communities may have experienced stigma or a lack of understanding about their specific health needs within health care settings, leading them to avoid accessing preventative health care services like vaccination.[62] Factors like age and health status also influence attitudes towards vaccination.

Social norms and information sources also play a key role in views on vaccine safety, efficacy and necessity.

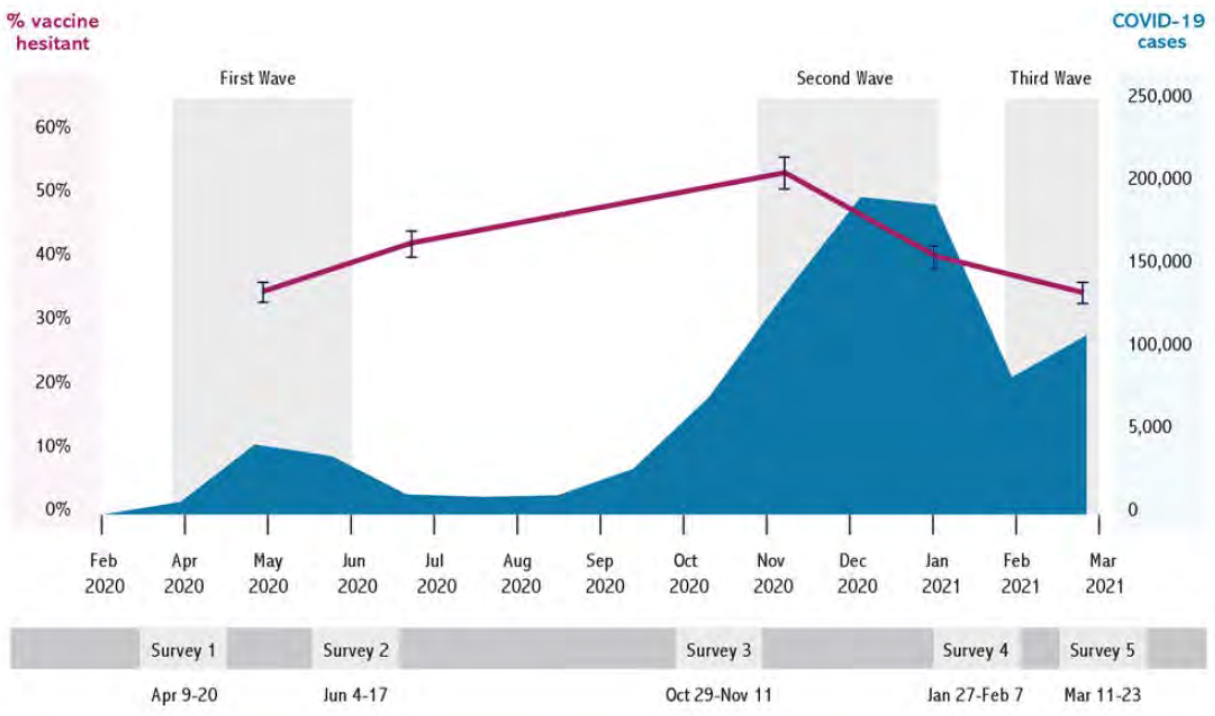
Figure 31. The behavioural and social drivers of vaccination framework



Source: Gagnon D, Beauchamp F, Bergeron A, Dube E. Vaccine hesitancy in parents: how can we help? CanVax. 2023.

Vaccine confidence changes over time, presenting both challenges and opportunities to improve trust. During the COVID-19 pandemic, self-reported vaccine hesitancy in Canada peaked at 52.9% during the second wave in November 2020, compared to 36.8% in the first wave and 36.9% in the third wave.[63]

Figure 32. Rates of vaccine hesitancy during the COVID-19 pandemic in Canada



Source: Lavoie K, Gosselin-Boucher V, Stojanovic J, et al. Understanding national trends in COVID-19 vaccine hesitancy in Canada: results from five sequential cross-sectional representative surveys spanning April 2020–March 2021. BMJ Open. 2022;12(4):e059411.

Addressing the Drivers of Vaccine Hesitancy

Building vaccine confidence is crucial for high vaccine uptake. Given the complexity of vaccine decision-making, a multi-pronged approach is needed to address various drivers of hesitancy.

Equipping Health Care Providers with the Tools to Build Vaccine Confidence

Health care providers are the most trusted source of information about vaccination.[64–66]

A recommendation from a trusted health care provider is the most powerful way to reduce vaccine hesitancy and encourage people to get vaccinated.[67] Health care providers can use several proven strategies to help build trust and boost confidence in vaccines:

Using a presumptive approach when introducing vaccines.	Telling parents which vaccines their child needs, instead of asking about their plans, leads to more parents agreeing to vaccinate their child.[68,69] Using a presumptive approach shows that immunization is common practice, helping to reinforce it as part of regular preventative health care.
Employing motivational interviewing techniques.	Motivational interviewing is a proven method for building vaccine confidence, recognized by the WHO.[70] It helps people explore their own reasons for getting vaccinated, offering personalized support based on their concerns.[71] In Quebec, the PromoVac program used motivational interviewing with new mothers in maternity wards. It led to a 30% drop in vaccine hesitancy and an 11% increase in intention to vaccinate.[72]
Providing a strong, personal immunization recommendation.	Recommendation by a health care provider has been found to be effective in increasing vaccine uptake. A strong recommendation by a health care provider (assertive language and personal pronouns) compared to recommendations that used passive language with a reference to institutional recommendations is more effective in increasing vaccine uptake.[73] Including personal statements such as what they would do for their own children was very effective in building vaccine confidence.[74]
Creating supportive health care environments to enhance trust.	Cultural training is essential for those serving priority populations including Indigenous and Black communities who face significant barriers to accessing health care due to racism. Tailored communication strategies that are culturally-informed and attuned to the needs of underserved populations are critical to creating culturally safe health care environments.
Combatting vaccine fatigue.	Clearly articulating the benefits of immunization and the importance of booster doses to maintain protection can help address vaccine fatigue. Persuasive immunization campaigns are one way to communicate these messages; one-on-one conversations with a health care provider about an individual's specific vaccination needs can also increase motivation.

Spotlight: Cultivating Culturally Supportive Health Care Settings

Ontario Native Women's Association (ONWA)

ONWA has created cultural training focused on Indigenous women to address racism and discrimination. The training aims to improve safety for Indigenous women accessing health services and is targeted towards non-Indigenous health care professionals. It is currently being piloted across Ontario.

TAIBU Community Health Centre

In response to a 2012 study showing that Black Ontarians were least likely to get the flu vaccine,[75] TAIBU Community Health Centre created an Afrocentric health promotion approach to boost vaccine uptake.[76]

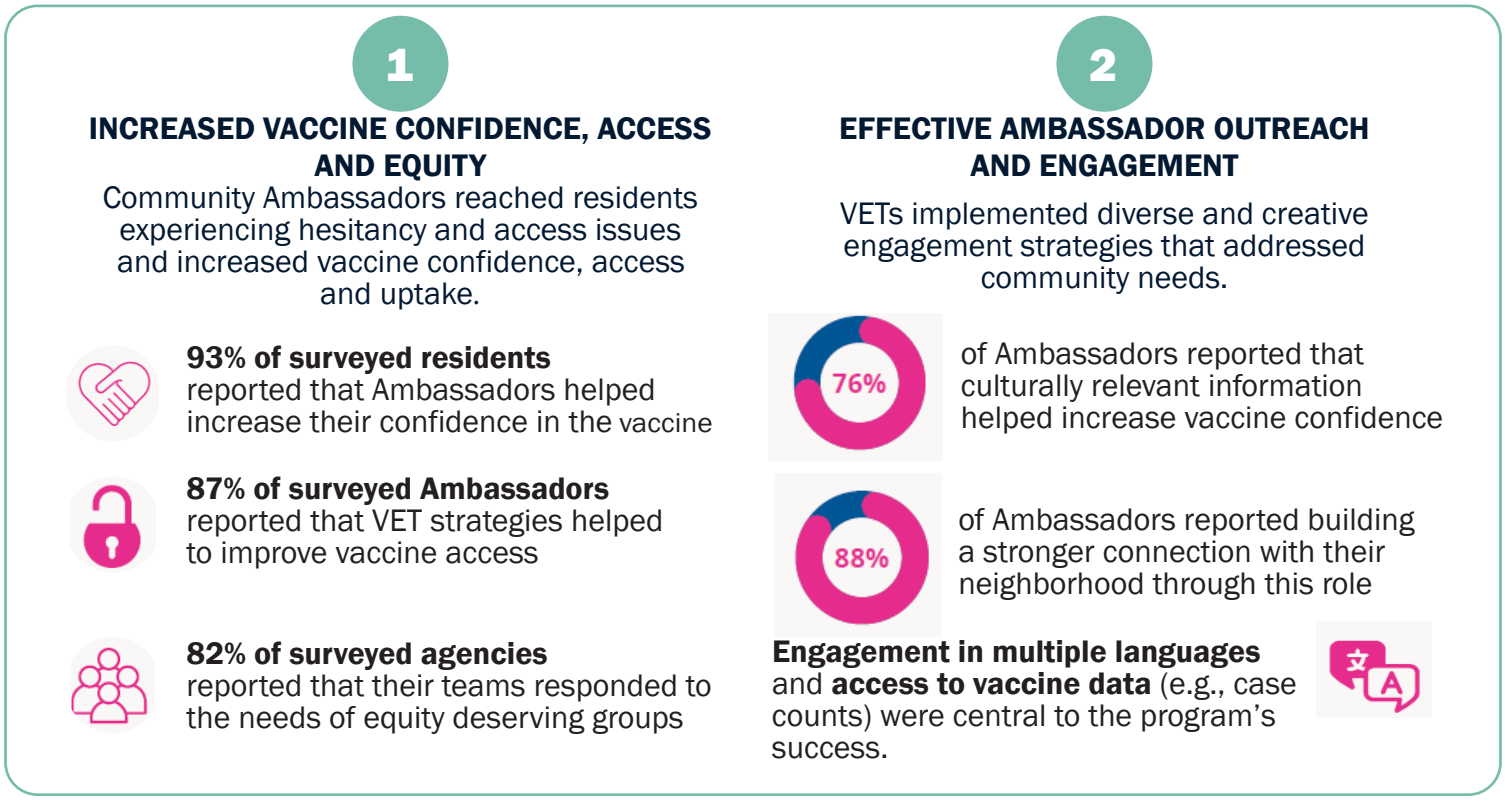
Developed with input from the community, this approach recognizes the impact of both past and present anti-Black racism in health care. It addresses vaccine concerns through culturally relevant resources that reflect the values and beliefs of the Black community.

Creating a centralized Provincial Immunization Resource Centre with up-to-date information for both health care providers and the public is an important step to build vaccine confidence in Ontario. This centre would make it easier for people to find reliable vaccine information, reduce the burden on health care providers and families, and help fight misinformation—a major cause of vaccine hesitancy.

Empowering Vaccine Ambassadors to Build Vaccine Confidence in Their Communities

Local vaccine ambassadors are important 'trusted messengers' for public health messaging, especially in marginalized and hard-to-reach communities.[77] During the COVID-19 pandemic, Vaccine Engagement Teams (VET) increased vaccine confidence, access and equity. Among those engaged by Ambassadors, 94% had their questions answered and 74% received support in accessing vaccines.[78]

Figure 33. Vaccine Engagement Teams (VETs)



Source: City of Toronto. Vaccine engagement teams: Program evaluation info sheet. 2022.

Community health workers and community ambassadors can play a complementary role to health care providers by providing opportunities for nuanced and time-intensive conversations about immunization that many individuals and families want and need, and that health care providers may not always be able to provide in clinical settings.

A provincial immunization information system would have the capacity to link vaccine coverage data to sociodemographic information, enabling monitoring of the effectiveness of vaccine confidence interventions. Ongoing monitoring will help evaluate the success of targeted approaches to improving confidence, which could include the implementation of a community health worker model.

Spotlight: ONWA's Mindimooyenh Vaccine Clinic

Ontario Native Women's Association's (ONWA)'s Mindimooyenh vaccine clinic incorporates culture by offering traditional medicine, smudging and other Indigenous supports. They use a "family unit" approach, allowing families to attend together, combining traditional and western healing.

ONWA addresses vaccine hesitancy with culturally relevant videos where community members share their vaccination experiences. The videos are shared on ONWA's website, social media and with other Indigenous partner agencies to reduce anxiety around immunization.

Mitigating Pain and Needle Anxiety

Most children and 24% of adults fear needles.[79] Up to 28% of underimmunized children cite needle fear as a barrier to immunization.[80,81] Health care providers should use techniques to manage pain and anxiety during vaccinations.[82]

The CARD™ system reduces stress reactions (pain, fear, fainting) using simple strategies. In a trial, students using CARD reported less fear and dizziness and had more positive attitudes about vaccination.[83]

Figure 34. The CARD™ system

Source: Taddio A, Bucci LM, Logeman C, Gudzak V. The CARD system: A patient-centred care tool to ease pain and fear during school vaccinations. CanVax in Brief. Published online 2020.

Optimizing Public Health Messaging

Maximizing the impact of public health messaging related to immunization is a delicate balance; too much information can cause disengagement[84] and recommendations that are seen as too strong can further entrench hesitancy.[85] Best practices in public health communication related to vaccines include:

Identifying and establishing trust with a target audience. The success of the GMSH-led mpox immunization campaign hinged on the target audience (men who have sex with men) and delivery through a trusted source (GMSH). Whenever possible, there should be partnership with community-based leaders/organizations to amplify and tailor public health messaging.

Provide information about risks and benefits. In many cases, the risks of immunization are emphasized clearly without identifying the benefits for individuals and communities. Including information about the protective benefits of immunization is critical to providing a balanced approach.[86]

Provide facts and address myths. Providing pre-emptive information to address misinformation is seen as a way of 'inoculating' against incorrect or misleading information that may be encountered in the future and enhancing health literacy.[87]

Use visual aids to explain complex risk information. Using visual aids can help illustrate concepts in ways that are accessible and easy to understand.

Use data to guide and evaluate public health communication. Tracking social media can help identify vaccine myths and concerns early, allowing public health teams to create 'pre-bunking' messages. WHO's 2024 Respiratory Pandemic Preparedness Framework highlights the importance of monitoring misinformation—something Canada has not yet fully implemented at the national or provincial level.[88] This kind of monitoring is key to delivering effective public health messages. With a provincial immunization information system, the success of public health messages could be assessed in real time.

Partner with clinicians and researchers to increase understanding of vaccination behaviors. Public health communication should be informed by evidence. Through strong partnerships between clinicians, researchers and policymakers, public health messaging can continue to evolve and adapt based on the needs and concerns of Ontarians.

Monitoring Safety and Effectiveness

Public confidence in vaccine safety and effectiveness is critically important to vaccine decision-making and uptake. Vaccine monitoring covers all phases from development to post-market surveillance. In Canada, vaccines are highly regulated and continuously monitored.

Monitoring involves Health Canada, vaccine manufacturers, PHAC, provinces, territories, and local public health authorities. PHAC and Health Canada coordinate national surveillance, while provinces and territories monitor for adverse events following immunization (AEFI) within their jurisdictions.

The goals of vaccine safety surveillance are:

- Identify rare reactions not seen in pre-licensure studies
- Monitor increases in known reactions
- Identify risk factors for adverse reactions
- Detect safety signals needing further study

Successful vaccine safety surveillance relies on three key pillars:

Passive vaccine safety surveillance: In Ontario, passive vaccine safety surveillance relies on reporting AEFIs by health care providers, vaccine recipients or their caregivers to local public health units. This data is entered into the Integrated Public Health Information System (iPHIS). Public Health Ontario (PHO) conducts routine surveillance and provides training and resources. A comprehensive assessment of AEFIs is available through an interactive online vaccine safety surveillance tool.

AEFIs reported to provincial and territorial authorities are sent to the Canadian Adverse Event Following Immunization Surveillance System (CAEFISS), maintained by PHAC. Vaccine manufacturers must report suspected adverse events to Health Canada through the Canada Vigilance Program. These processes help identify any potential vaccine safety concerns.

Active vaccine safety surveillance: Active surveillance gathers information on adverse events from vaccine recipients or clinical records. Ontario participates in the Canadian Vaccine Safety (CANVAS) Network, which conducts surveillance during the implementation of immunization campaigns (e.g., annual influenza vaccine, RSV vaccine).

Special studies: Rapid studies are conducted in response to signal detection, or serious AEFIs. PHO issues Enhanced Surveillance Directives (ESDs) to support urgent situations and timely surveillance. ESDs ensure AEFIs are reported within 24hrs and include data for assessment. PHO also produces ad hoc vaccine safety reports following enhanced surveillance.

The COVID-19 immunization program in Ontario used two key systems for vaccine safety surveillance:

COVaxON:	Ontario's COVID-19 Data Information System tracked all vaccine doses in real-time, helping estimate adverse event rates.
Integrated active and passive surveillance reporting:	Active surveillance via CANVAS and passive safety surveillance through public health reporting were used to identify adverse events.

During the COVID-19 pandemic, the Ontario COVID-19 Science Advisory Table evaluated evidence related to vaccine safety and developed resources for clinicians to support identification and reporting.

Early AEFI Detection Using the COVID-19 Immunization Data Information System

COVaxON, paired with an agile passive vaccine safety surveillance system, enabled the early detection of rare cases of myocarditis and pericarditis - mainly in young males, and often after the second dose of mRNA vaccines.

Using the available province-wide immunization data, public health authorities were able to quickly detect elevated rates of myocarditis/pericarditis with the Moderna Spikevax (mRNA-1273) compared to the Pfizer-BioNTech Comirnaty (BNT162b2) COVID-19 vaccine, especially in males aged 18-24.

These findings led Ontario to make a preferential recommendation of Pfizer for 18-24 year olds due to higher myocarditis/pericarditis rates associated with Moderna.

A robust, province-wide and national immunization information system is essential for strengthening vaccine safety monitoring. By linking immunization records with clinical data—such as electronic medical records, hospital and ICU data—safety issues can be identified early and addressed quickly.

Current systems like CANVAS are voluntary and do not cover everyone in Ontario, limiting their effectiveness. A fully integrated immunization information system would enable active, real-time surveillance across the province, ensuring accurate and timely tracking of both vaccine safety and effectiveness.

Ongoing Adverse Events Reporting

PHO communicates data on vaccine safety on an ongoing basis via their Immunization Data Tool, which contains data on AEFIs in Ontario from 2012 to 2023.

AEFIs related to COVID-19 vaccines are reported in an annual surveillance report posted on the PHO website.

Spotlight: Canada's Vaccine Injury Support Program

Serious adverse events following immunization are very rare. Vaccine injury compensation programs support people who have vaccine related injuries.

Until 2020, Canada was the only G7 country without a national vaccine injury support program in place. The United States has had the National Vaccine Injury Compensation Program since 1988, and Quebec has had its own program since 1985.

In 2021, Canada launched the Vaccine Injury Support Program, offering no-fault financial support for those who have experienced a serious and permanent injury from a Health Canada authorized vaccine on or after December 8, 2020.

Using Provincial Immunization Data to Monitor Vaccine Effectiveness

A province-wide immunization information system also enables monitoring of vaccine effectiveness including duration of protection, ideal timing for booster doses and effectiveness for priority groups (e.g., older adults, young children and pregnant individuals).

During the COVID-19 pandemic, data from the provincial COVID-19 immunization information system (COVaxON) linked with clinical records determined that:

- COVID-19 vaccines were highly effective in preventing severe outcomes and moderately effective against symptomatic infection.[89,90]
- Protection from both severe infection and moderate symptomatic infection fades over time[91] but that booster doses restore immunity.[92]
- COVID-19 vaccines are effective across the age spectrum, from children as young as six months[93] to older adults.[94]
- Vaccination during pregnancy protects infants from COVID-19 related outcomes better than vaccination in the early months of life.[95]

A comprehensive immunization information system is essential for active, real-time monitoring of vaccine safety and effectiveness. By linking vaccination data with medical and hospital records, we can quickly detect safety issues and monitor how well vaccines work over time. This approach supports better protection for high-risk groups and builds public trust through greater transparency.

Section 5. The Evolving Immunization Landscape

Responding to Emerging Threats

As the *2022 Chief Medical Officer of Health Annual Report: Being Ready* highlighted, the risk of disease outbreaks is both real and growing. Vaccines will continue to be the cornerstone of outbreak and pandemic preparedness, limiting disease spread and reducing severe illness.

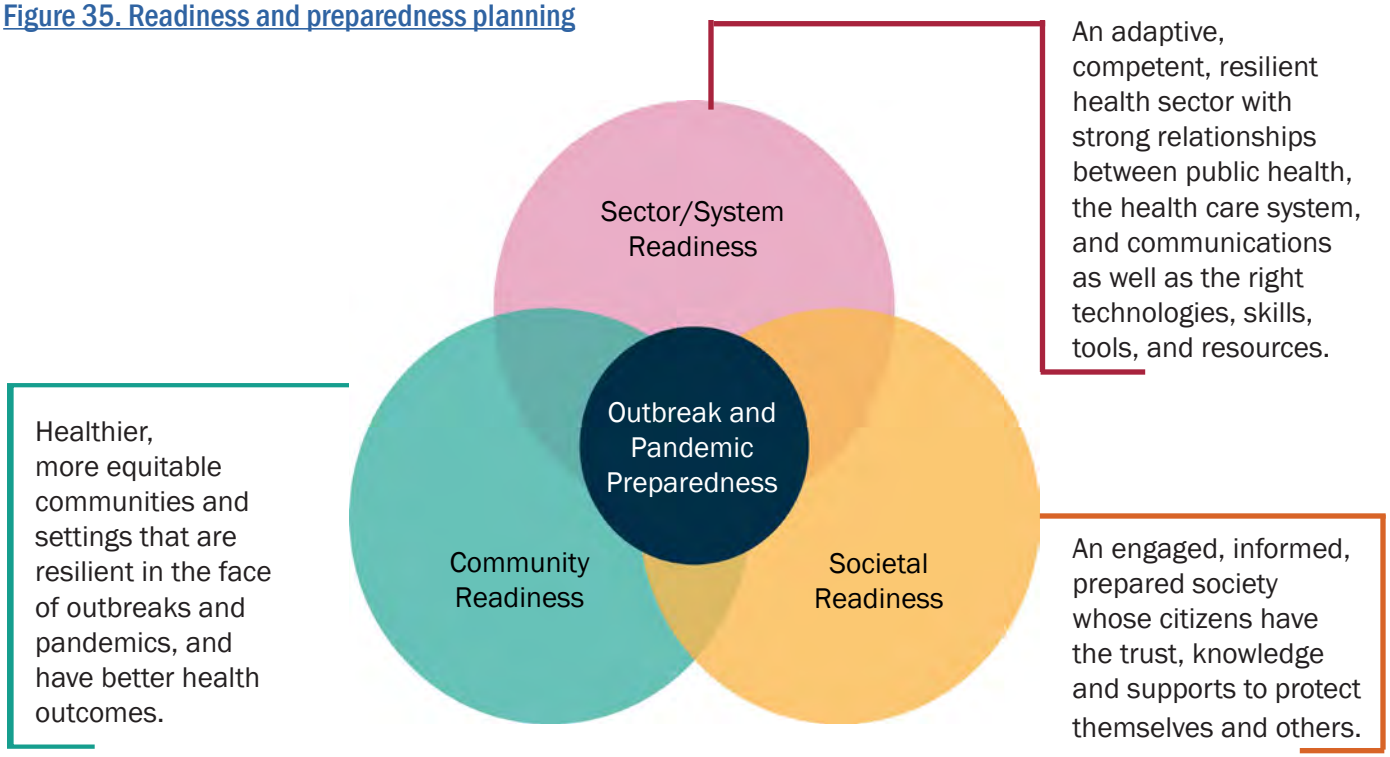
Now more than ever, strong immunization data systems play a critical role in preparedness, allowing for up-to-date assessments of individual and community-level protection and enabling rapid response in the context of an outbreak.

Timely vaccine access is a critical aspect of public health response. During global pandemics, the sudden need for vaccines may cause demand to exceed supply, risking shortages. Learning from the COVID-19 pandemic, preparedness must include working with academic centres and local manufacturers to boost Canada's biomanufacturing footprint, investing in Canadian innovation and building domestic vaccine production capacity and supply.

In alignment with Ontario's Life Sciences Strategy and Canada's Biomanufacturing and Life Sciences Strategy, growing Ontario's life sciences sector will establish Ontario as a biomanufacturing and life sciences hub, reducing reliance on international supply and leveraging provincial research and manufacturing capacity.

Alongside improvements in local vaccine production capacity, the implementation of a comprehensive provincial immunization information system would enable real-time access to immunization coverage data. This would result in rapid immunization planning and improved delivery in the context of an outbreak or pandemic.

Figure 35. Readiness and preparedness planning



Source: Office of the Chief Medical Officer of Health of Ontario. 2022 Annual Report — Being ready: Ensuring public health preparedness for infectious outbreaks and pandemics. Published online 2023.

Ontario's Preparedness

Ontario's readiness involves multiple components:

Sector/System Readiness	Community Readiness	Societal Readiness
Collaboration with agriculture, food, rural affairs, labor ministries, hospitals and primary care to ensure resources like testing, antivirals vaccines and other immunizing agents are available.	Engagement with local governments and community partners to address regional needs.	Public communication on handling sick animals, signs and symptoms of disease, testing, therapeutics and vaccines.

A One Health Approach to Pandemic Preparedness

The One Health Approach recognizes the critical linkages between people, animals, and ecosystems and the need for a collaborative, multi-sectoral and transdisciplinary approach to optimize health outcomes.[96] Approximately 60% of infectious diseases and 75% of emerging human diseases are zoonotic in origin.[97] Vaccination plays a critical role in a One Health approach to pandemic preparedness by both combatting antimicrobial resistance to prevent drug-resistant infections and in reducing the transmission of infectious disease.

Spotlight: Rabies

Rabies is a viral infection that is spread by saliva from infected animals into bites and scratches. If the rabies vaccine is not received at the time of exposure before the infection reaches the nervous system, it is almost universally fatal. In Canada, bats, skunks, foxes and raccoons are the most common animals to have rabies. In recent years, bats have been the most common animal to test positive for rabies in the province. Reducing the risk of rabies in humans and animals requires ongoing collaboration between human and animal health experts.

Since February 2025, arctic fox-variant rabies has been detected in five red foxes in Northern Ontario. The re-emergence of rabies in the red fox population is of concern not only for the risk of transmission to humans but also for dogs and other animals, both wild and domestic, residing in or near many Northern communities. Vaccination programs for animals will be needed to help control the spread of disease and protect communities.

In 2013, the Ministry of Natural Resources (MNR) helped to develop the ONRAB oral rabies vaccine bait which is licensed for use in wildlife. Each year, MNR oversees the distribution of baits for wildlife by hand delivery, bait stations and helicopter/airplane drop. Baiting occurs in Northern Ontario during the fall and summer months.

The response to the fox rabies situation in Northern Ontario has benefited from a One Health approach. The response has involved collaboration between local, provincial and federal partners with a range of expertise in public health, wildlife ecology, veterinary medicine, traditional knowledge and environmental science. Collaboration, coordination and strong communication will continue to be required to effectively manage this issue and protect the health of humans, animals and the environment.

Innovations in Immunization

Future Advancements

New immunizations for infectious diseases and cancer, new technologies, improved manufacturing techniques and expanded delivery methods will continue to enhance the impact of immunizations in Ontario.

Spotlight:

Respiratory Syncytial Virus Infant Immunization Program in Ontario

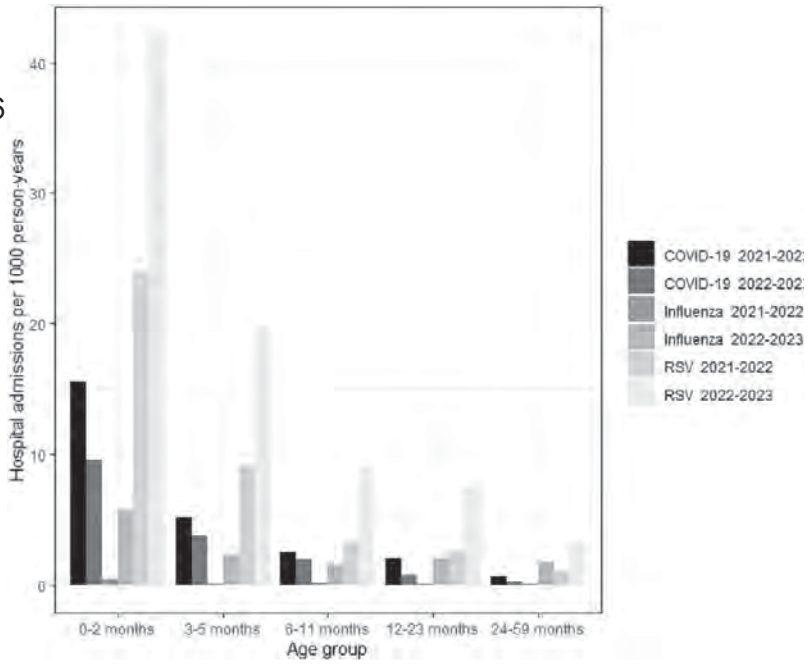
Respiratory Syncytial Virus (RSV) is a lower respiratory tract illness that can cause severe illness in young children, especially those under one year old, leading to hospitalizations and ICU admissions. While prematurity and cardiac or respiratory conditions increase the risk of severe disease, 75% of hospitalized infants are healthy with no known risk factors.[98,99] RSV is the leading cause of bronchiolitis and pneumonia in infants[100] and can result in ongoing issues like wheezing in later childhood.[101]

During the 2022-23 respiratory season, a "triple-demic" of influenza, COVID-19 and RSV overwhelmed pediatric hospitals. In Ontario, RSV admissions increased by 105-113% compared to pre-pandemic seasons, leading to 4,438 hospitalizations among children under five.[102] For children under two months, the ICU admission rate for RSV was nearly ten times that for influenza.

In 2002, palivizumab, a monoclonal antibody was approved by Health Canada and recommended by NACI (2003) to prevent RSV disease for very high-risk infants. Treatment consisted of four doses delivered at 4-6 week intervals during the respiratory season. Monoclonal antibodies provide passive immunity, offering immediate protection. This is especially beneficial for infants and immunosuppressed individuals.

In September 2024, Ontario expanded to a universal infant RSV immunization program becoming one of only three provinces in Canada to offer a universal RSV immunization program for infants. Ontario also switched to a single-dose product called nirsevimab, further reducing barriers to uptake. Both palivizumab and nirsevimab are monoclonal antibodies that prevent severe RSV infection. Studies from the US, Spain, and France show nirsevimab is 74-90% effective in preventing RSV hospitalizations.[103, 104]

Figure 36. Rates of COVID-19, influenza, and RSV related hospital admissions by age group 2021-2023



Source: Jorgensen SCJ, Hernandez A, Buchan SA, et al. Burden of Illness Associated With Respiratory Syncytial Virus, Influenza, and Coronavirus Disease 2019 in Infants and Young Children in Ontario, Canada, 2018–2023: A Population-Based Canadian Immunization Research Network Study. Open Forum Infectious Diseases. 2024;11(10):ofae601.

Preventing Dementia Through Vaccination

A recent study conducted in Wales provided preliminary evidence that receiving a shingles vaccine reduced the risk of dementia by 20% for up to seven years following immunization.[105] Although further study is needed to determine if these results can be replicated in other populations and to determine biological plausibility, these initial results are promising as there are no other interventions currently available that have been found to reduce dementia risk by a similar magnitude. If future studies support these findings, shingles vaccination could become a key component of a comprehensive dementia prevention strategy.

The Promise of mRNA Vaccines

mRNA vaccine technology has been explored for decades, having first been used in prostate cancer treatment. Trials for Middle East Respiratory Syndrome and Ebola vaccines began in 2013 and 2015. COVID-19 vaccines were the first mRNA vaccines approved for use in Canada in 2020. mRNA vaccines are safe for most people, versatile and cost-effective, with shorter manufacturing times making them crucial for rapid response during outbreaks. Various mRNA vaccines are currently in development to address significant public health challenges.

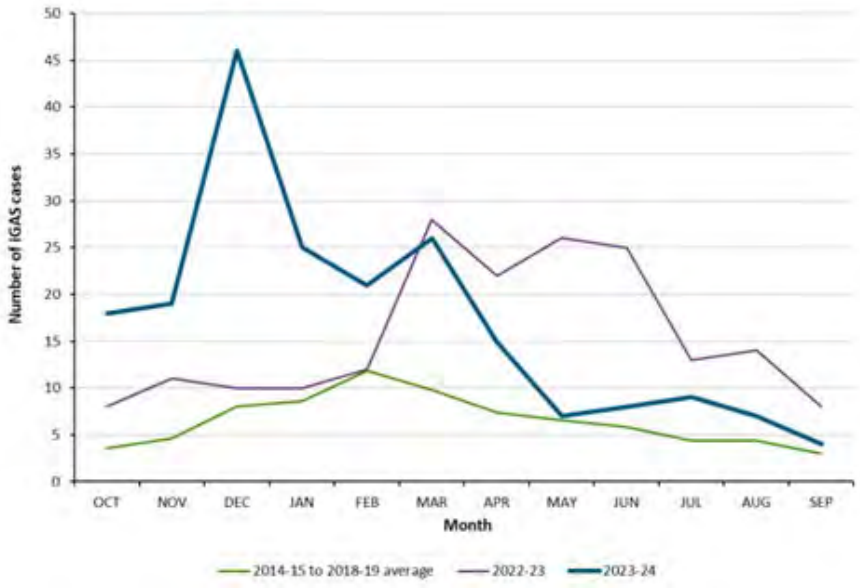
Addressing Antimicrobial Resistance Through Immunization

Spotlight: Invasive Group A Streptococcus (iGAS)

Group A Streptococcus (GAS) is a bacterial disease that can spread by direct contact with wound secretions or respiratory droplets from an infected person. Some people carry the bacteria with few or no symptoms. Symptoms usually include mild to moderate illnesses like strep throat, impetigo, cellulitis or scarlet fever. Rarely, it can lead to invasive Group A Streptococcus (iGAS), a life-threatening condition when bacteria enter deep tissue or the bloodstream.

In Ontario, older adults over 65 are most likely to develop iGAS. However, iGAS cases in those aged 14-17 increased by 46% in the 2023-24 respiratory season compared to the previous year.[106]

Figure 37. Confirmed iGAS case counts by month in children 0-17 years, 2014-2024



Source: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Invasive Group A Streptococcal (iGAS) Disease in Ontario: October 1, 2024 to June 30, 2025.; 2025.

Treating iGAS is challenging because it is hard to predict which mild cases will become severe, and infections can escalate quickly. Antibiotics are often used as a precaution, increasing the risk of antimicrobial resistance, a major global health threat. In 2019, WHO identified a Strep A vaccine as a global priority. While no vaccine is approved yet, several mRNA candidates are in Phase I trials. If approved, they could reduce antibiotic use in children by 30%, cutting nearly 300 million prescriptions annually.[107]

New Immunizations To Prevent Cancer

Epstein-Barr Virus (EBV)

Epstein-Barr Virus (EBV) is very common, with 90% of adults contracting it in their lifetime, primarily through saliva. Childhood infections are usually mild, but in teens and young adults, it can cause mononucleosis (mono), leading to fatigue for up to six months. There is no specific treatment for EBV. About 1% of cases can lead to serious complications like hepatitis, neurological issues or severe blood abnormalities.

EBV remains latent in the body for life but can sometimes lead to cancers such as nasopharyngeal carcinoma and lymphomas, especially in immunocompromised individuals. Research is ongoing to develop a vaccine to reduce EBV infections and related cancers. An early-stage clinical trial at the National Institute of Health is evaluating a preventive mRNA vaccine to reduce the severity of EBV infections, mononucleosis and EBV-associated cancers.

Preventing birth defects through immunization

Cytomegalovirus (CMV)

Cytomegalovirus (CMV) is a common virus that stays in the body for life. By age 40, over half of adults have been infected, usually with no symptoms. However, those with weakened immune systems can develop serious symptoms affecting various organs.

CMV is especially dangerous if contracted during pregnancy. In Canada, 1 in 200 newborns are infected, making it the leading infectious cause of birth defects. It can cause pregnancy loss, preterm birth, low birthweight and permanent developmental issues like hearing loss and cerebral palsy. A new mRNA vaccine in phase III trials may prevent CMV transmission from pregnant women to their babies.

New Vaccine Manufacturing Techniques

Cell-Based Influenza Vaccines

For over 70 years, influenza vaccines have been made using egg-based techniques. While effective, this method has limitations, such as supply issues during pandemics. The development of cell-based vaccines offers benefits including the ability to be rapidly scaled up during a pandemic.

Alternative Vaccine Delivery Systems

Oral, Intranasal, Inhaled, And Transdermal Vaccine Delivery Systems

Most vaccines are given by injection, but alternative delivery systems like oral and nasal vaccines exist. These methods reduce fear, need fewer trained personnel and produce less waste. However, they risk antigen degradation, leading to weaker immune responses.

Researchers at McMaster University recently received federal funding to proceed with Phase II clinical trials for a next-generation aerosol COVID-19 vaccine.[108] The new inhaled vaccine has the potential to produce even better immune responses than traditional vaccines by targeting the lungs and upper airway where viruses first enter the body.

A new method, transdermal vaccines, uses microneedles to deliver vaccines through the skin. This method could enhance immunity with a single patch, eliminating the need for multiple doses, and enabling self-administration.[109] Although not yet in clinical trials, initial research shows promise for those with needle fear and in resource-limited settings.

Section 6. Recommendations and Next Steps

To reduce the burden of vaccine-preventable diseases in Ontario and ensure that all Ontarians can access the benefits of immunization from birth to end of life, I recommend the following next steps:

Addressing Challenge #1: **Resolving Gaps In Immunization Data**

a. Ontario should create a comprehensive, accessible provincial immunization information system in collaboration with public health, primary care, and pharmacists. This will improve health surveillance, public health outcomes and coordination.

b. Ontario should advocate for federal, provincial and territorial collaboration to develop a national immunization information system.

c. Ontario should develop an integrated public health data platform that includes immunization, hospital and clinic data. By partnering with public health, primary care and the hospital sector, a platform could be developed to significantly enhance immunization program safety and effectiveness monitoring, performance and access.

d. Ontario should advocate for a harmonized national immunization schedule with federal vaccine purchasing and procurement of vaccines as part of a National Pharmacare Strategy.

e. Ontario should use comprehensive immunization data to identify and monitor disparities in immunization access and uptake.

f. Ontario should collect sociodemographic data at the clinical interface and work in partnership with Indigenous, Black and other racialized community partners to develop governance frameworks to guide the secure use of immunization data.

Addressing Challenge #2: **Addressing Inequities In Access And Uptake**

a. Ontario should guide the development and evaluation of all publicly funded immunization programs using a needs-based framework.

b. Ontario should bring together leadership from Indigenous health organizations and community leaders with local and provincial health authorities to explore a provincial Indigenous Immunization Strategy to improve the delivery of immunization programming to Indigenous communities.

c. Guided by community knowledge and leadership, work with underserved, at-risk and racialized communities to improve vaccine confidence and access to immunizations.

d. Engage with researchers, local public health, health care providers and communities to identify current barriers to access for publicly funded vaccines.

e. Improve access to primary care, particularly for young children who rely on primary care providers for access to routine early childhood vaccines.

f. Explore immunization access models, carefully considering provincial and regional contextual factors.

Addressing Challenge #3: **Reversing Declining Vaccine Confidence**

a. Ontario should develop a centralized, provincial immunization resource centre to support Ontario residents and health care providers with questions related to immunization eligibility, access, and decision-making.

b. Ontario should invest in Community Health Ambassador programs to create opportunities for community health promotion leadership and vaccine advocacy.

c. Ontario should use data to guide vaccine communication locally and provincially by monitoring the relationship between immunization uptake and public health messaging.

d. Ontario should do more to mitigate the impact of misinformation and disinformation on vaccines by investing in 'pre-bunking' and 'de-bunking' public communication campaigns.

e. Ontario should implement a province-wide active immunization surveillance system to monitor and evaluate vaccine safety and effectiveness in real time using comprehensive immunization data.

f. Develop tools to communicate vaccine safety and effectiveness data on an ongoing basis to build trust and public confidence in publicly funded immunizations.

Conclusion

The impact of immunization on human health cannot be overstated. For instance, polio once paralyzed thousands of children each year in Canada. Thanks to vaccines, the last case of wild polio acquired in Canada was reported in 1977.

Immunization is estimated to have saved nearly 100 million lives globally in 50 years and has cut infant mortality nearly in half. In Canada, many diseases that once caused significant morbidity and mortality have been controlled or eliminated. Ontario's ongoing investment in immunization programs has demonstrated a strong commitment to prevention. But as our communities continue to change from a societal, microbial and disease perspective, there is still work to be done. The burden of vaccine preventable diseases on Ontarians and our health care system remains substantial. Communities with lower vaccine coverage levels continue to be vulnerable to these diseases.

Vaccine preventable diseases are an ongoing threat that can and will re-emerge if we let our guard down. A recent outbreak of measles in Ontario has unfortunately highlighted how quickly previously controlled diseases can spread.

Despite relatively high vaccine coverage, decreases in vaccine confidence and disruptions to preventative care delivery due to the COVID-19 pandemic have made our province vulnerable to diseases circulating worldwide. Differences in immunization access and uptake in Ontario persist, fostering ongoing health disparities.

Ontario has the potential to be a leader in immunization, leveraging investments in immunization to improve the lives of Ontarians for generations to come. This requires a coordinated approach between all levels of government, local and provincial public health, primary care, the hospital sector, community organizations and local communities to ensure that no one is left behind and that our communities remain protected from vaccine-preventable disease.

All Ontarians, from birth to end of life, should reap the benefits of immunization. Whether it is a newborn receiving their first vaccines, a teen getting protected against HPV, or a senior receiving a flu shot in a pharmacy, vaccination supports health at every stage of life.

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Acknowledgements

External Advisory Committee:

Shelly Bolotin, Centre for Vaccine-Preventable Diseases, University of Toronto

Sarah Wilson, Public Health Ontario

Kwame McKenzie, Wellesley Institute

Vinita Dubey, Toronto Public Health

Doris Grinspun, Registered Nurses' Association of Ontario

Elizabeth Muggah, Ontario Health

Matthew Miller, Institute for Infectious Disease Research, McMaster University

Nicole Blackman, Indigenous Primary Heath Care Council

Jeff Kwong, Institute for Clinical Evaluation Sciences

Maxwell Smith, School of Health Studies, Western University

Justin Presseau, Ottawa Hospital Research Institute & University of Ottawa

Jaris Swidrovich, Indigenous Pharmacy Professional of Canada

Paul Bailey, Black Health Alliance

Content Lead:

Daniel Warshafsky, Associate Chief Medical Officer of Health

Writer/ Project Manager:

Kate Allan, Office of the Chief Medical Officer of Health

Design:

Zoe Liu, Office of the Chief Medical Officer of Health

Staff, Office of the Chief Medical Officer of Health:

Carol Ma, Joseph Garand, Gillian MacDonald, Elizabeth Choi, Robert Lerch, Ryan Mosher, Joanne Rey

And with thanks to the Office of the Chief Medical Officer of Health Internal Advisory Committee, Public Health Ontario, and wider partners for their contributions

2025 alPHa AGM and Conference: Recap

This year's Annual General Meeting and Conference, that took place June 18-20, continued the important conversation on the critical role of local public health in the province's Public Health System. We want to thank everyone who attended and participated as this event would not have been a success without you!

Updates have been made to the Resolutions home page, including the ones for this year. Individual Resolutions can be found here: A25-01: Integrating the Ontario Early Adversity and Resilience Framework into Public Health Practice to Improve Population Health Outcomes and A25-03: Preventing heavy metal exposure from contaminated spices, cosmetics, ceremonial powders and products sold for natural health purposes.

The Annual General Meeting Report, Annual Report, and other conference-related materials can be found on the Conference webpage. On the Presentations webpage: Conference slides (Medicine Shield Workshop and *Public Health and Engagement with Indigenous Communities*), BOH Section Meeting Slides (*BOH Legal Obligations* and *Digital Innovation and Public Health*), and the Distinguished Service Awards booklet are available. Please note, we can only post presentations we receive from the speakers. You must also log into the alPHa website to view most of the files.

Thank you to all the speakers, moderators, and participants. All of you worked extremely hard to make each day a success. Please know the time you took to help plan, speak, moderate, or attend is appreciated

The winner of the after-event survey gift card is Dr. Kathryn Marsilio, Peel Region Public Health. Congratulations!

A special shoutout goes to Trudy Sachowski for chairing the event. Much thanks to the alPHa staffwho put in many hours into making these events a success: Loretta Ryan, Gordon Fleming, Melanie Dziengo, and Lynne Russell.

We would also like to take a moment to thank Toronto Public Health for co-hosting the AGM and Conference, and acknowledge Platinum Level sponsors: vocalmeet and NaloxOne; Esri Canada as a Gold Level sponsor, and Mosey & Mosey and BrokerLink as Silver Level sponsors. We are thankful to the Pantages Hotel for providing us with an excellent venue.

2025 alPHa AGM and Conference: Distinguished Service Awards (DSAs)

The DSAs, that were presented at the conference, recognize exceptional qualities of leadership, tangible results through lengthy service and/or distinctive acts, and exemplary devotion to public health at the provincial level.

alPHa was pleased to announce this year's recipients: Sue Perras, Boards of Health Section, Northwestern Health Unit; Dr. Hsiu-Li Wang, Council of Ontario Medical Officers of Health Section, Region of Waterloo Public Health and Paramedic Services; Nancy Kennedy, Affiliates, Ontario Association of Public Health Dentistry, and Loretta Ryan, alPHa, Chief Executive Officer. To learn more about these award winners, please click here.

Congratulations to the 2025 DSA recipients!

From: allhealthunits <allhealthunits-bounces@lists.alphaweb.org> On Behalf Of alPHa communications
Sent: September 10, 2025 9:30 AM
To: All Health Units <allhealthunits@lists.alphaweb.org>
Cc: board@lists. alphaweb. org <board@lists.alphaweb.org>
Subject: [allhealthunits] Save the dates – Nov. 5-7, 2025 for the alPHa Fall Symposium

Dear alPHa Members,

This year's Fall Symposium and Workshops are being held online and will be taking place Wednesday, November 5 to Friday, November 7. Please hold these dates! You won't want to miss out on the lineup of speakers and key public health topics.

New for this year: We will be extending the symposium to an all-day program. This means you will have an opportunity to hear from even more speakers, explore more topics, and participate in more discussions!

Registration will open soon, so please keep your eye on your inboxes.

alPHa would like to thank Southwestern Public Health for being this year's Fall Symposium co-host. A shoutout also goes to Eastern Ontario Health Unit and the Dalla Lana School of Public Health for their event support.

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
Tel: 416-595-0006 x 222
Cell: 647-325-9594
loretta@alphaweb.org
www.alphaweb.org


Association of Local Public Health Agencies
Fall Symposium and Workshops
November 5-7, 2025
Co-hosted by
alPHa
Association of Local PUBLIC HEALTH Agencies
SW SOUTHWESTERN Public Health
Oxford · Elgin · St.Thomas
alPHa's Fall Symposium and Workshops will continue the important conversations on the critical role, value, and benefit of Ontario's local public health system.
Participate in engaging online workshops and in-depth plenary sessions with public health leaders.
You must be an alPHa member to participate.
Pre-Symposium Workshops are included when you register for the Fall Symposium: $399 + HST.
Registration will be available mid-September and further information will also be shared in alPHa's newsletter, InfoBreak, as details become available.
The Fall Symposium is generously supported by:
EOHU Eastern Ontario Health Unit
BSEO Bureau de santé de l'est de l'Ontario
Dalla Lana School of Public Health

APPROVAL OF CONSENT AGENDA

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

2024 Financial Report

In 2024, Public Health Sudbury & Districts launched its *2024–2028 Strategic Plan*, building on past successes and setting the direction for the future. The four strategic priorities seek to create equal opportunities for health, cultivate impactful relationships, demonstrate excellence in public health practice, and nurture a healthy and resilient workforce. Working within vibrant communities, we acknowledge and honour the enduring presence, strength, and resilience of the original Peoples of this land.

Throughout 2024, we worked to foster strong partnerships, as well as meaningful relationships with First Nations and Indigenous communities in our vast service area. This work is highlighted in our *2024 Year-in-review: Connecting the Dots* report.

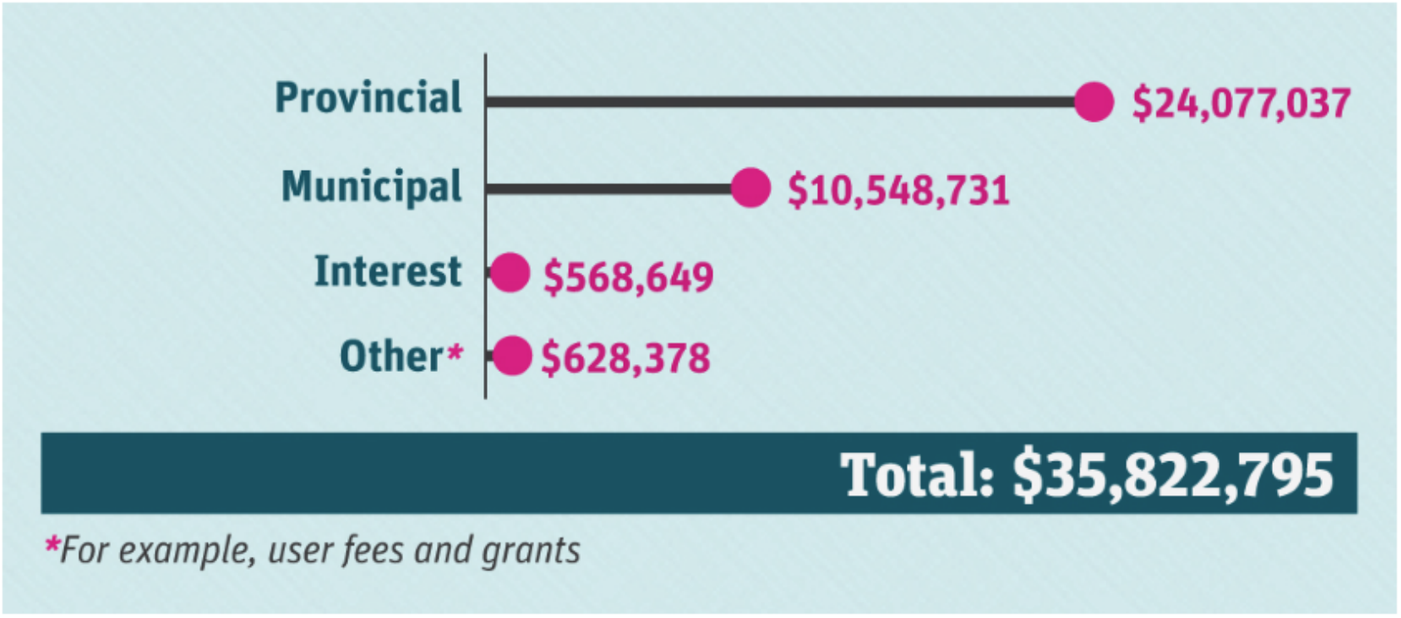
As Public Health continues to experience a period of fiscal constraint, we are refocusing our efforts to where they can achieve the greatest impact on community health. Evolving provincial directions, inflation, and growing health challenges due to the legacy of the COVID-19 pandemic require targeted allocation of resources and dedicated efforts. Led by our independent Board of Health, we strive to protect health and prevent disease for everyone, guided by our values of humility, trust, and respect.

Communities we serve

Source: Statistics Canada. 2022. Census Profile. 2021 Census. Statistics Canada Catalogue number 98-316-X2021001. Ottawa. Released February 9, 2022.

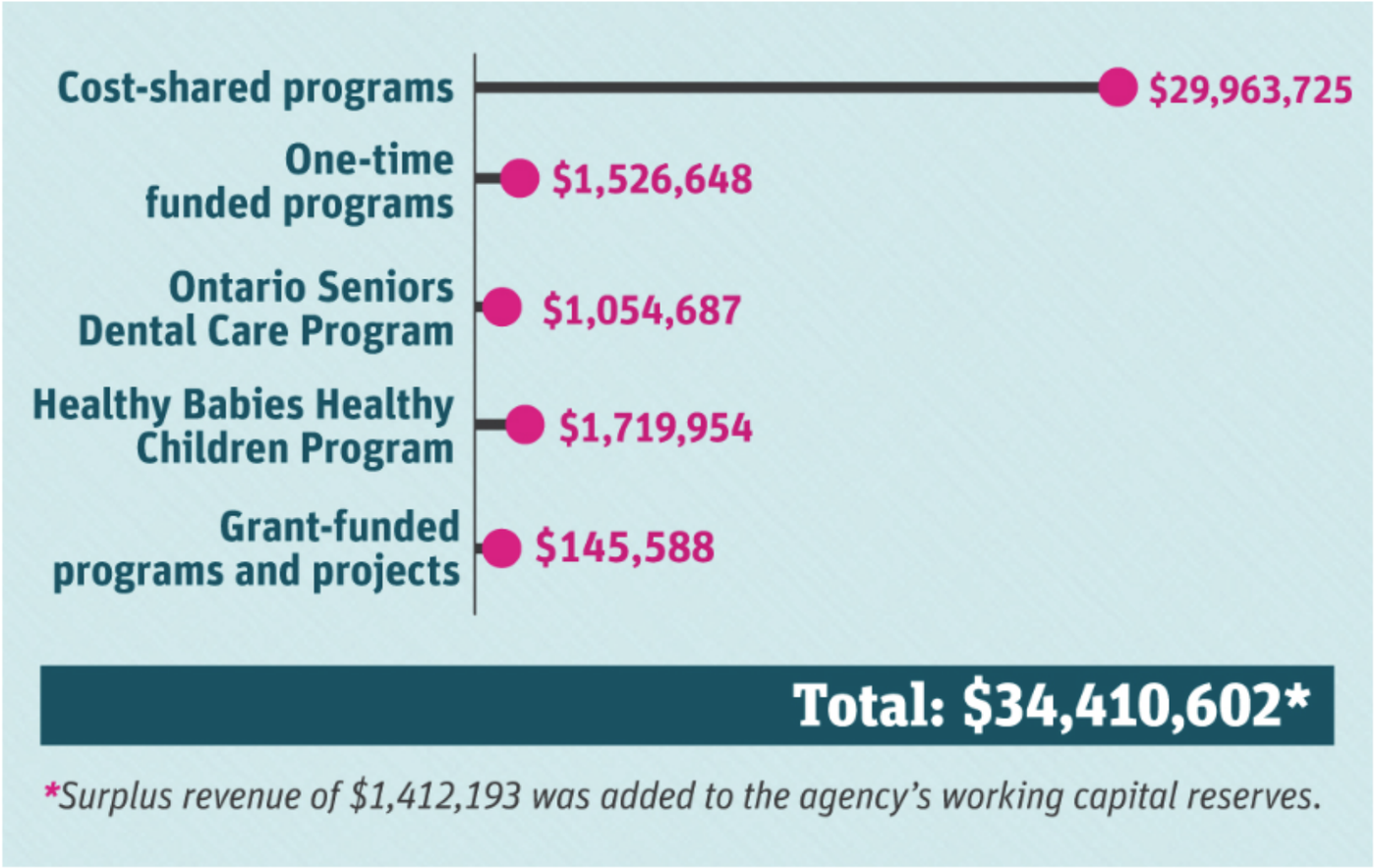
Public Health Sudbury & Districts covers a land area of 46 167.2 km^2 and operates within the Anishinabek and Cree territories. The service area is subject to the Robinson-Huron Treaty and Treaty 9 to the north.

Revenue sources:



*For example, user fees and grants

Operating expenses:



*Surplus revenue of $1,412,193 was added to the agency's working capital reserves.

Detailed information is available in the 2024 Audited Financial Statement (PDF, 394 KB) (English only).

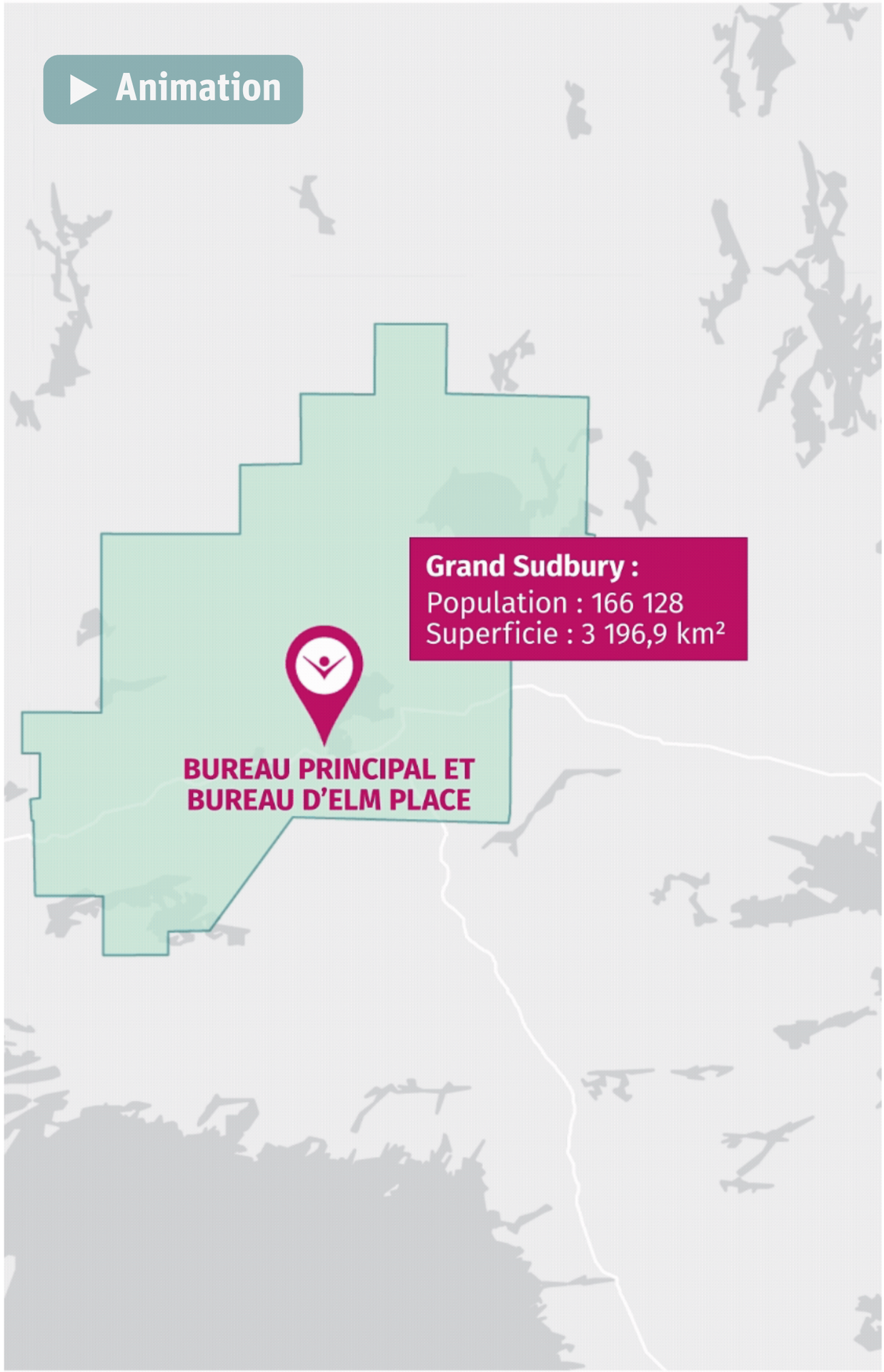
Rapport financier 2024

En 2024, Santé publique Sudbury et districts a lancé son *plan stratégique 2024-2028*. Ce dernier repose sur les réussites du passé et détermine l'orientation pour l'avenir. Les quatre priorités stratégiques se résument ainsi : offrir des possibilités égales d'être en santé, cultiver des rapports significatifs, faire preuve d'excellence en matière de pratique en santé publique et favoriser une main-d'œuvre saine et résiliente. Œuvrant au sein de communautés dynamiques, nous reconnaissons et soulignons la présence durable, la force et la résilience des premiers peuples de ce territoire.

Tout au long de l'année 2024, nous avons tâché de favoriser des partenariats solides, ainsi que des rapports significatifs avec les Premières Nations et les communautés autochtones de notre vaste zone de service. Ce travail est mis en évidence dans notre rapport *Bilan de l'année 2024 : établir les liens*.

Alors que Santé publique demeure en période de restrictions budgétaires, nous réorientons nos efforts là où ils peuvent avoir le plus d'effet sur la santé communautaire. L'évolution des orientations provinciales, l'inflation et les défis croissants en santé dus aux séquelles de la pandémie de COVID-19 exigent une affectation ciblée des ressources et des efforts soutenus. Sous la direction de notre Conseil de santé indépendant, nous nous efforçons de protéger la santé et de prévenir les maladies pour tout le monde, guidés par nos valeurs d'humilité, de confiance et de respect.

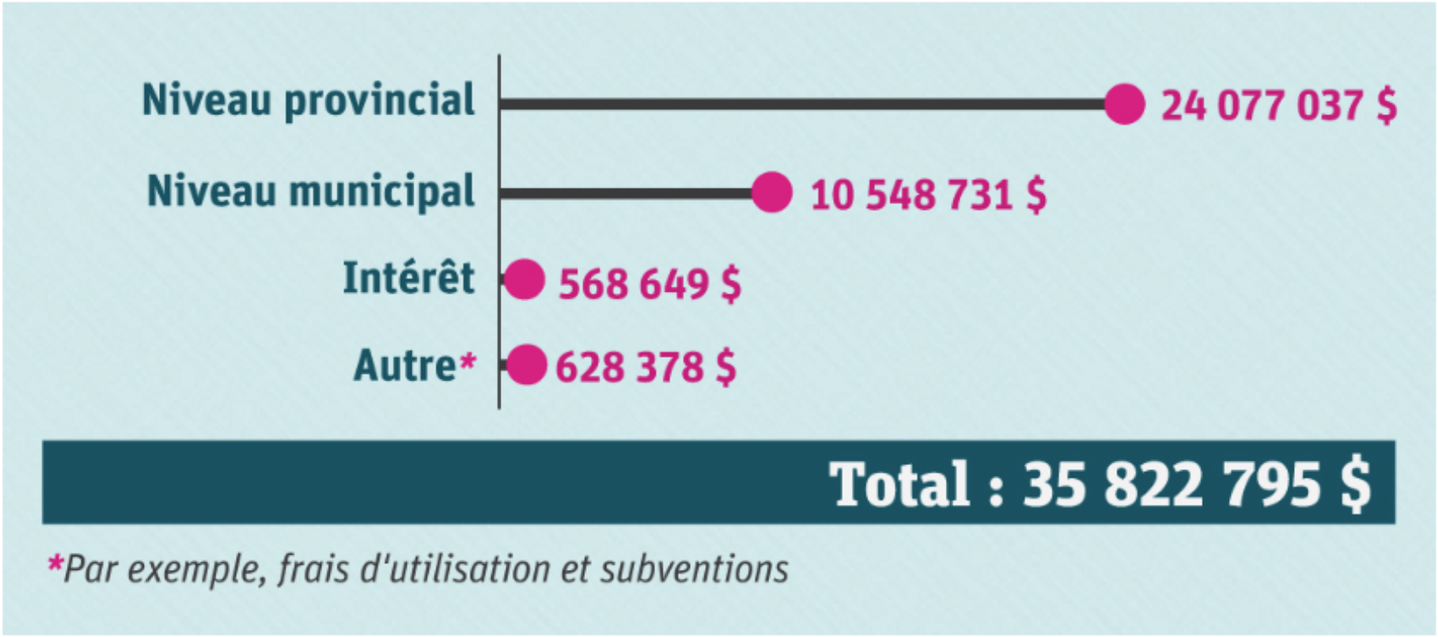
Les communautés que nous servons



Source : Statistique Canada, 2022. Profil du recensement. Recensement de 2021. Numéro de catalogue de Statistique Canada 98-316-X2021001. Ottawa. Publié le 9 février 2022. Mis à jour le 17 août 2022.

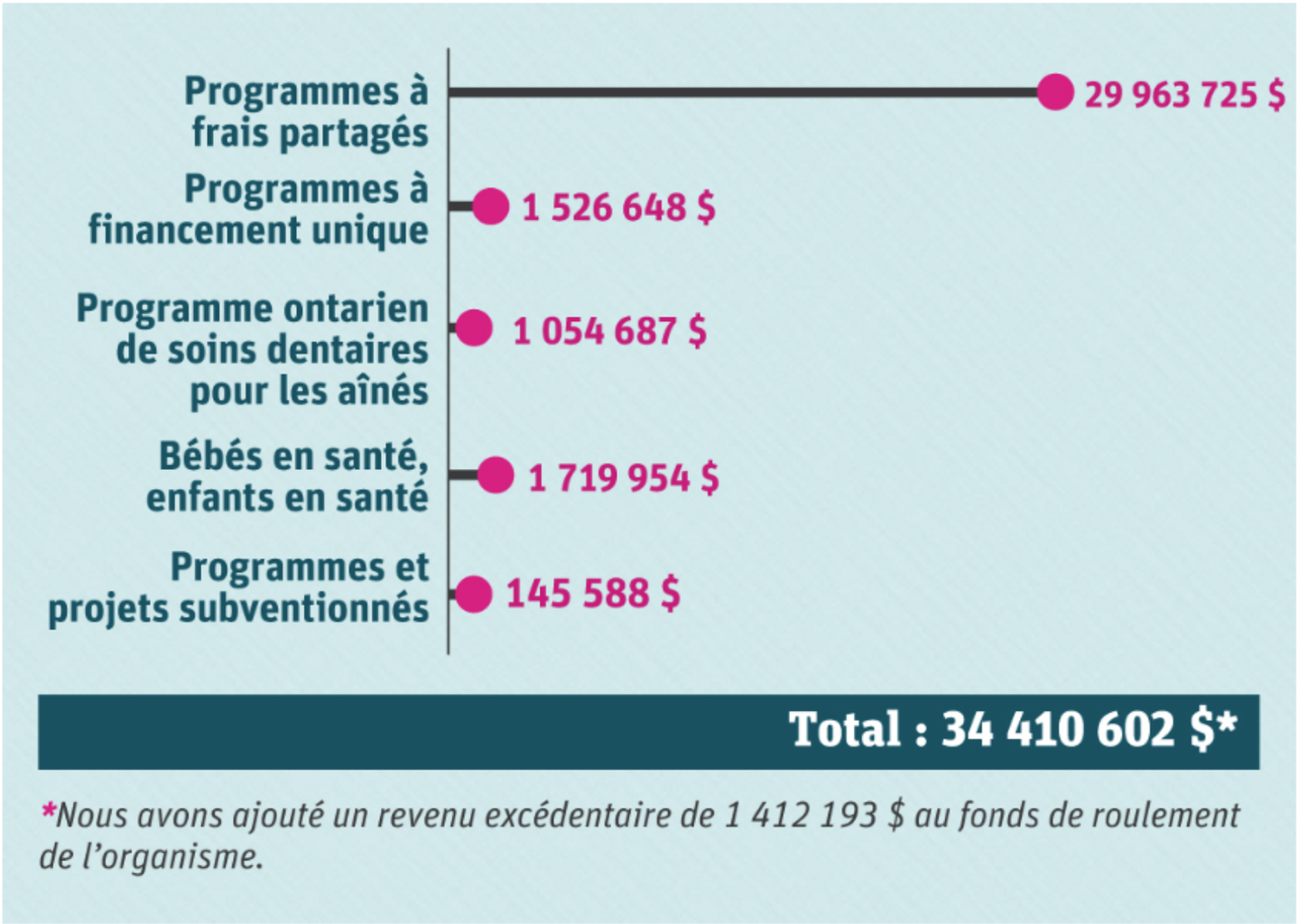
Santé publique Sudbury et districts couvre une superficie de 46 167,2 km² et exerce ses activités sur les territoires des Anichinabés et des Cris. Le *Traité Robinson-Huron* et le *Traité n^o 9* au nord englobent la zone de service.

Sources de revenus :



*Par exemple, frais d'utilisation et subventions

Dépenses de fonctionnement :



*Nous avons ajouté un revenu excédentaire de 1 412 193 $ au fonds de roulement de l'organisme.

Les *états financiers audités de 2024* (PDF, 394 Ko) (en anglais seulement) fournissent des renseignements détaillés.

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Mark Signoretti, Chair, Board of Health for Public Health Sudbury & Districts

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

Date: September 11, 2025

Re: Endorsing CIPHI-ASPHIO Joint Statement: Implementation of Recommendations from the Auditor General's 2025 Report on Non-Municipal Drinking Water Safety

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☒ For Information ☐ For Discussion ☒ For a Decision

Issue:

The Auditor General's recent report on the oversight of non-municipal drinking water safety identified gaps in inspection consistency, enforcement, workforce sustainability, and data infrastructure across Public Health Units (PHUs) in Ontario. The Auditor General made 17 recommendations for improvement: 10 to the Ministry of Health; 6 to the Ministry of Environment, Conservation, and Parks; and 1 to Public Health Ontario.

The Canadian Institute of Public Health Inspectors (CIPHI) and the Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO) have endorsed these recommendations and offered their support to the Ministry of Health to implement the 10 recommendations directed to them.

The issues raised by the Auditor-General, CIPHI, and ASPHIO align with longstanding challenges observed and experienced by Public Health Sudbury & Districts (PHSD), particularly around staffing and technology.

Recommended Action:

That the Board of Health endorse and support the joint statement of the CIPHI and ASPHIO.

Background:

Non-municipal drinking water systems are drinking water systems not owned or operated by a municipality. Typically, these systems serve residents of unorganized territories where there is no municipality, and residents of rural and remote regions where the population density is not large enough to justify investing in expensive municipal water treatment and distribution infrastructure. Non-municipal drinking water systems, often referred to as small drinking water systems (SDWS), include wells, cisterns, and other systems which draw from natural sources like lakes or rivers. Systems other than cisterns typically include treatment and disinfection. SDWSs are often used in homes, camps, or lodges and even some businesses. Such systems typically serve fewer than six connections, though some

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can serve 100 or more connections, entire business campuses, or industrial parks; many operate only seasonally.

In Northern Ontario, non-municipal systems are vital for rural and remote communities without municipal water services. However, these systems face challenges such as limited on-site technical expertise and potential contamination from natural and industrial sources. Strong regulations, regular maintenance, and trained operators are essential for ensuring water safety. Under the *Health Protection and Promotion Act* (HPPA), Boards of Health (BOH) are responsible for overseeing the safety of these systems, particularly where they serve the public. Public Health's role includes supportive private home owners with well water testing and education on optimizing safety, as well as proactively inspecting small drinking water systems and ensuring the public's safety to consume from them.

The Auditor General's report on non-municipal drinking water in Ontario highlights weaknesses with the safety and oversight of small water systems, such as private wells and community-based supplies. It notes that many of these systems lack consistent water quality testing, regular inspections, and proper training for operators. The report also points to gaps in monitoring and enforcement, which leave these systems vulnerable to contamination. Key recommendations include strengthening regulations, improving data collection, increasing inspections, and enhancing operator training to better protect public health and ensure safe drinking water.

CIPHI and ASPHIO issued a joint statement to the Ministry of Health indicating full support for the Auditor General's recommendations. In addition, the statement provided recommendations on strategies to effectively implement some of the Auditor General's recommendations and offered to collaborate with the Ministry of Health and local public health to assist with practical, system-wide improvements.

PHSD currently provides oversight for 301 SDWS and unregulated drinking water supplies. However, most oversight of unregulated water supplies is conducted on a complaint-driven basis. Based on *Ontario Regulation 319/08 Small Drinking Water Systems*, public health inspectors (PHI) conduct proactive inspections of SDWS every 2–4 years, depending on the level of risk, and monitor compliance with water testing requirements quarterly. PHSD has experienced challenges in filling PHI positions especially in the district offices. Staff retention is also a concern. These staffing challenges create risks for maintaining even the infrequent inspections required in regulation.

Risk assessment of non-municipal drinking water systems requires intensive training due to the complexity of the risk matrix and the Risk Categorization Assessment Tool (RCAT) tool. In addition, tracking of completion rates is often done manually. In general, many PHIs struggle with the assessments of the overall risk of SDWS because of the non-standardized/non-linear approach of this process. Establishing a standardized onboarding and continuing education program, along with standardized performance measures to track inspection frequency, compliance, and enforcement outcomes, would help address these challenges. This also highlights the need for modern data systems to support and streamline the operational needs of local public health.

Financial Implications:
None

Ontario Public Health Standard:

- Safe Water Standard

Strategic Priority:

- Equal Opportunities for Health

Contact:
Blessing Odia, Resident Physician, Office of the Medical Officer of Health

Appendices

- ***Office of the Auditor General of Ontario. Performance Audit Safety of Non-municipal drinking water. Independent Auditor's report. Special report. 2025.***

- ***Joint Statement from CIPHI and ASPHIO: Supporting the Implementation of Recommendations from the Auditor General's 2025 Report on Non-Municipal Drinking Water Safety. 2025.***

Performance Audit

Safety of Non-Municipal Drinking Water

// Independent Auditor's Report

Office of the
Auditor General
of Ontario

SPECIAL REPORT 2025

Table of Contents

1.0 Audit at a Glance

// Why We Did This Audit

- Contaminated drinking water can cause gastrointestinal illnesses and other potentially serious health effects, which may result in significant economic costs due to hospitalizations, doctor visits, lost work days and other related costs. As demonstrated by the Walkerton crisis, the consequences of Ontarians drinking unsafe water can be deadly.
- Nearly 3 million Ontario residents, as well as many businesses and other facilities, get their water from non-municipal drinking-water supplies.
- Non-municipal drinking-water supplies are not subject to the same requirements as municipal supplies. Some non-municipal systems that deliver drinking-water supplies are overseen by the Ministry of the Environment, Conservation and Parks (MECP), subject to a standard set of rules. Other systems are overseen by the Ministry of Health (MOH), through site-specific requirements set by the Public Health Units (PHUs). Private wells (from groundwater) and private intakes (from surface water) that serve five or fewer homes are the least regulated type of drinking-water supply.

// Our Conclusion

Reported test results provide a high level of assurance of the safety of Ontario's tested drinking water. Over 98% of all samples taken from non-municipal drinking-water systems over the past decade have met the Ontario Drinking Water Quality Standards.

This assurance, however, does not extend to all non-municipal drinking water because not all water is tested. Private wells and intakes, which are not considered to be drinking-water systems, have no testing requirements and are not included in the test results noted above. Drinking-water systems, which do have testing requirements, are generally not required to test for all contaminants. In addition, not all system owners test their water as required.

We found that MECP and MOH, in conjunction with the agencies they oversee, did not collectively have effective processes and systems in place to:

- oversee all non-municipal drinking-water systems, including inspecting systems at the required frequency, and ensure their compliance with applicable legislation, regulations and policies;
- educate users of private wells and intakes about the availability of water testing and the risks of not testing or treating their drinking water; and
- identify and manage all health risks related to non-municipal drinking water.

98%+

of all samples taken from non-municipal drinking-water systems over the past decade have met the Ontario Drinking Water Quality Standards

We also found that MECP did not have complete and accurate data on private wells. MOH did not fully measure, evaluate and publicly report on progress against its drinking-water program outcomes.

The ministries have accepted all 17 recommendations.

// What We Found

Some Small Drinking-Water Systems Have Not Been Identified, Assessed and Inspected by PHUs, Posing a Public Health Risk

- PHUs are responsible for overseeing small drinking-water systems. These are non-municipal systems that serve six or more seasonal residences or a public facility, such as a hotel, restaurant or church.
- We found that PHUs did not have effective means to identify small drinking-water systems that have not properly self-reported. Unreported systems are not inspected or assessed for risk by a public health inspector, and therefore drinking-water risks may go undetected.
- For a place to be considered a public facility, it must meet the definition in regulation. One of the listed types of public facilities in the regulation is “a place that operates primarily for the purpose of providing overnight accommodation to the travelling public.” MOH has not provided clear guidance on whether non-municipal drinking-water supplies for short-term rentals, such as homes or cottages booked through online rental platforms, are to be considered public facilities and therefore regulated by PHUs. Because of this, visitors to short-term rentals may drink or cook with water from an unregulated water supply that may or may not have been tested by the owner, thus creating a potential health risk.

- MOH requires PHUs to inspect low- and moderate-risk small drinking-water systems at least once every four years, and to inspect high-risk systems at least once every two years. However, we found that 17 (52%) of the 33 PHUs with small drinking-water systems in their region did not inspect all systems as required, with some PHUs noting inspection backlogs dating back over five years. Twelve of the PHUs with an inspection backlog attributed the backlog to staffing and/or resource challenges.

» **Recommendations 2, 3 and 4**

Many Owners of Small Drinking-Water Systems Did Not Sample Their Water as Required, and PHUs Rarely Enforced Compliance

- Owners of small drinking-water systems must sample and test their water at frequencies based on a PHU's risk assessment. We analyzed the data from five PHUs, which collectively regulate 1,660 small drinking-water systems, and found that 932 systems (56%) had missed at least one sample in the past five years. We found that 20% of the 932 systems had missed an entire year of samples, and 5% had missed multiple years.

56%
of 1,660 small drinking-water systems missed at least one sample in past five years

- We found that PHUs rarely used their enforcement powers to address issues of non-compliance. In the past five years, PHUs issued fines to the owners and operators of 11 (1%) of the 932 non-compliant systems. Nine of 10 PHUs with an enforcement backlog reported that budget or staffing constraints limited enforcement efforts. A lack of enforcement of water testing could lead to risks to water safety.

» **Recommendation 6**

MECP Has Effective Processes to Monitor and Enforce Compliance With Sampling Requirements, But Lacks Capacity to Regularly Inspect All MECP-Regulated Non-Municipal Systems

- MECP oversees non-municipal drinking-water systems that serve six or more year-round residences or a designated facility. Designated facilities are places such as schools, hospitals or nursing homes that serve people who may be more vulnerable to illness.

- We found that MECP has effective processes to monitor operators' compliance with sampling requirements. MECP uses laboratory testing data to generate a quarterly report to assess operator compliance with sampling and testing requirements.

- We also found that MECP takes steps to promptly address non-compliance when identified, and has processes to target repeat violators.

- However, we found that 34% of systems regulated by MECP had not been inspected in more than five years, and 9% had not been inspected in more than seven years. One of the systems that had not been inspected in more than seven years serves a community college that provides drinking water to 2,500 people. Inspections provide an important safeguard to pre-emptively identify and mitigate drinking-water issues that could pose a health risk.
- An internal MECP review found that the number of MECP inspections of non-municipal drinking-water systems declined 45% between 2012/13 and 2019/20. This occurred after MECP expanded the workloads of its water compliance officers to include additional responsibilities, such as inspecting municipal sewage and stormwater systems.

» **Recommendation 9**

34%
of MECP-regulated systems had not been inspected in over five years

9%
had not been inspected in over seven years

Many Private Well Owners Do Not Test Their Drinking Water

- About 1.3 million Ontarians rely on private wells for their drinking water. With little regulation and oversight of private wells, the Province's free water testing has played an important role for those Ontarians by helping to identify potentially unsafe drinking water.
- Despite the availability of free testing, less than one-third of Ontarians who rely on private wells tested their water within the past 12 months. A 2024 study attributed the low test rates to a lack of awareness about both the risks of drinking untested water and the availability of water-testing services.
- We found that there is no province-wide program focused on increasing awareness of the availability of free water testing and of the risks of not testing drinking water.
- Some cottages and other seasonal residences use private intakes for their drinking water, but there is little data on how often owners of these supplies test their water.

» **Recommendations 11 and 12**

~1.3 million
Ontarians get their drinking water from private wells

35%
of water samples from private wells and intakes from 2003 to 2022 tested positive for indicators of bacterial contamination

MECP Does Not Review Well Records for Completeness and Accuracy or for Compliance with Well Construction Requirements

- While owners of private wells are responsible for their own drinking water, MECP is responsible for regulating the construction, maintenance and decommissioning of wells in Ontario. This includes maintaining a database of well records.
- An internal MECP report estimated that roughly half of all submitted well records are incomplete or inaccurate. Our review of well records submitted over the past 10 years similarly found that records were often missing key information.
- We also found that, at the time of our audit, MECP had a backlog of 73,800 well records not fully processed and uploaded into the Ministry's wells database.

195,232
well records were submitted to MECP over the past 10 years

54,931
were missing information about well usage

73,800
were not fully processed as of August 2024

- Complete well records and an up-to-date database are important because they provide information that MECP needs for its oversight of wells. They also can provide a history of information for new well owners to manage their drinking water.
- MECP staff do not review submitted well records to verify whether the work performed complies with the required technical specifications. This creates a risk that MECP will fail to identify improperly constructed wells, which increases the risk of water-safety issues.

» **Recommendation 13**

Potentially Hundreds of Thousands of Abandoned Wells Have Never Been Properly Decommissioned

- Despite legal requirements to properly decommission wells that are not used or maintained, landowners do not always do so. Owners may be unaware of abandoned wells on their property and their legal obligations, or they may be unwilling to pay for decommissioning.
- Agriculture and Agri-Food Canada estimated in 2012 that there were likely about 730,000 abandoned wells in Ontario. As of August 2024, MECP's wells database had 108,000 records of decommissioned wells, suggesting that there may still be hundreds of thousands of abandoned wells that have not been decommissioned.
- Abandoned wells that are not properly decommissioned can create a pathway for contaminants to enter groundwater and potentially contaminate drinking-water sources in the area.

» **Recommendation 14**

MECP Has Not Fully Assessed the Feasibility of Applying Source Water Protection to Non-Municipal Sources

- Source water protection is the process of protecting water sources, such as lakes, rivers or groundwater reserves, that supply drinking water. Our Office's 2014 audit on source water protection recommended that MECP consider the feasibility of requiring source water protection plans to include private wells and intakes.
- In 2021, MECP assessed the feasibility of including non-municipal drinking water into its existing source water protection framework. The draft report concluded that it would be too costly and burdensome. However, MECP's feasibility assessment did not consider other more limited-scope measures that could still improve source water protections for non-municipal drinking water.

» **Recommendation 15**

Private Well Owners Are Not Being Notified of Potential Threats to Their Source Water

- In the last five years, MECP sent out 115 notifications to PHUs stating that chemicals that can pose serious health risks, such as arsenic and uranium, were found in groundwater in the PHU's region at levels that exceed the Ontario Drinking Water Quality Standards.
- Of the 26 PHUs that had received exceedance notifications, only four reported that they had informed private well owners about the potential chemicals in their water. PHUs told us they lacked information to identify who may be affected, and/or lacked staff experts that could assess and determine the level of risk to private well users.

» **Recommendation 16**

115
exceedance notifications were sent by MECP to PHUs in the last five years for chemicals that can pose serious health risks

4 of 26
PHUs informed private well owners about potential chemicals in their water

2.0 Background

2.1 Safe Drinking Water

Ontario is fortunate to have enormous supplies of fresh water, including hundreds of thousands of lakes, rivers and streams (known as surface water), as well as large reserves of below-ground water. Clean water is one of the critical necessities of life, essential for drinking, food preparation, bathing and other uses. The United Nations recognizes access to safe water as a basic human right and one of the 17 United Nations Sustainable Development Goals adopted by world leaders in 2015.

Water quality can be affected by various pollutants (see **Figure 1**), such as sewage from septic systems, industrial chemicals from spills, or runoff or infiltration of animal manure or fertilizer from farms or lawns. Water quality may also be affected by chemicals, such as arsenic or uranium, that are naturally present in the local soil, rocks or water. At high enough levels, such chemicals may make water unsafe to drink.

Figure 1: Examples of Threats to Drinking Water and Their Potential Health Impacts
Prepared by the Office of the Auditor General of Ontario

Threat	Potential Health Impacts	Examples of Sources
Microbiological contaminants (bacteria, viruses and parasites)		
E. coli **bacteria**	Although most strains are harmless, some can cause gastrointestinal illness (nausea, vomiting, diarrhea), as well as lead to more serious issues such as kidney failure, stroke or even death.	Sewage from septic systems; animal/wildlife manure.
Enteric viruses	Gastrointestinal illness; less commonly, can cause respiratory symptoms, central nervous system infections, liver infections and muscular syndromes.	Sewage from septic systems.
Chemical contaminants		
Arsenic	Stomach pain, vomiting, diarrhea, muscle pain and skin rashes with high levels of short-term exposure. Various types of cancer with long-term exposure.	Naturally occurring in the soil, released through soil erosion, mining or other industrial activities.

(*Figure 1 continued*)

Threat	Potential Health Impacts	Examples of Sources
Barium	Kidney damage with long-term, high-concentration exposure.	Naturally occurring element found in various minerals.
Benzene	Increased risk of cancer with long-term exposure.	Oil tank leaks; fuel spills.
Lead	Affects brain development and cognitive functioning, especially in infants and children; increased blood pressure and kidney dysfunction in adults.	Corrosion of plumbing systems, such as pipes, fittings or service connections.
Nitrate	Blue baby syndrome (methaemoglobinemia) for bottle-fed infants, and impacts to thyroid glands.	Fertilizers; animal manure; sewage.
Sodium	Excessive intake can aggravate chronic heart failure.	Road salt; sewage.
Tritium	Cancer of the lung, breast, thyroid, bone, digestive organs and skin; leukemia.	Emissions from nuclear reactors.
Uranium	Chronic exposure may affect the kidneys.	Naturally occurring in many different minerals; emissions from nuclear industry, burning coal.

2.1.1 Impacts of Unsafe Drinking Water

Contaminated drinking water can have potentially serious health effects, as well as result in significant economic costs due to hospitalizations, doctor visits, lost work days and other related costs.

For example, Public Health Ontario (PHO) modelling estimated that, for Ontario in 2016, approximately 9,600 emergency room visits, 1,100 hospitalizations and 30 deaths could be attributable to microbiological contamination (bacteria, viruses and parasites) in water.

While PHO has estimated the overall burden of microbiological contamination on the province's health-care system, it is challenging to connect individual cases to a specific water supply or to accurately calculate the true number of cases. Many people do not seek medical care for mild symptoms, and may not link their illness to drinking water, assuming it is due to contaminated food.

Health impacts from chemicals in drinking water can be even harder to track or estimate, as they can come from long-term exposure, making causal links difficult to identify.

These challenges of tracing illnesses back to drinking-water supplies hamper efforts to accurately estimate the total public health impacts attributable to unsafe drinking water.

2.2 Regulation of Drinking Water in Ontario

2.2.1 Ontario's Tiered Regulatory Framework

Ontario's regulatory framework for drinking water was largely born out of a deadly drinking-water tragedy that occurred in Walkerton, Ontario in 2000 (see **Figure 2**), and the inquiry and recommendations made to prevent such a tragedy from reoccurring. Following the inquiry, the Province introduced new laws to protect drinking-water safety, but not all legal requirements apply to all drinking-water supplies.

Municipal residential drinking-water systems, which serve a little over 80% of Ontario's population, and therefore have the highest potential impact on public health if they fail, are regulated most stringently. Municipal residential systems generally have the strictest requirements for sampling, testing, treatment, operator training and inspection frequency. Most municipal systems are also subject to additional protections through their inclusion in source water protection plans. Such plans are developed to protect the water sources used to supply municipal drinking water.

Non-municipal drinking-water supplies are subject to different rules than municipal supplies, such as for testing, treatment, training and inspection frequency. These supplies are also generally excluded from

Figure 2: The Walkerton Contaminated Drinking-Water Incident

Prepared by the Office of the Auditor General of Ontario based on the findings and conclusions in Justice O'Connor's Report of the Walkerton Inquiry (2002)

The Original Cause

In May 2000, after days of heavy rain, cow manure from a farm in Walkerton, Ontario, washed into a groundwater well and contaminated the town's water supply with a deadly strain of *E. coli* bacteria as well as *Campylobacter* bacteria.

Exacerbating Causes

The operators of the drinking-water system, who lacked training and expertise and who had improperly operated the system for years, failed to adequately treat the water with chlorine, as well as failed to promptly detect the bacteria through testing. When the operators did discover the problem, they concealed it, even after residents started to fall ill.

The Impact

The incident resulted in 65 hospitalizations, over 2,300 cases of gastrointestinal illness and seven deaths. Many of those who survived suffered long-term health effects. The tangible economic impact of the incident was estimated to be over $64.5 million.

The Response

A public inquiry, led by Justice Dennis O'Connor, examined the causes of the incident and identified failings at virtually every step of the drinking-water process. Accordingly, Justice O'Connor made 121 recommendations to strengthen protections at every step, from source water protection to treatment, testing, response protocols and, finally, distribution.

Ontario's source water protection plans. Non-municipal drinking-water supplies are divided into different types, with each type regulated differently (see **Figure 3**).

Figure 3: Types of Non-Municipal Drinking-Water Supplies by Oversight Responsibility
Prepared by the Office of the Auditor General of Ontario

Potential public health impact (from highest to lowest)

Type of Supply	Who it Serves	# in Ontario (as of March 2024)
MECP under the *Safe Drinking Water Act, 2002*		
Year-round residential system	A residential community[1] that is occupied year-round, such as apartments, condominiums, townhouses, private subdivisions (homes or cottages), trailer parks and campgrounds.	**461**
System serving a designated facility	A facility that serves people who are more vulnerable to illness, such as child-care centres, schools, camps, seniors' homes, hospitals, health-care facilities and homeless shelters.	**1,355**
MOH under the *Health Protection and Promotion Act*		
Small drinking-water system (two types):		**~10,000**
» **Seasonal residential system**	A residential community[1] that is occupied seasonally,[2] such as cottages, trailer parks and campgrounds.	
» **Public facility system**	A facility that serves the public (other than a designated facility[3]), such as hotels, motels, resorts, bed and breakfasts, restaurants, gas stations, churches and community centres.	
Owners are responsible for their own drinking water[4]		
Private well (from a groundwater source)	Five or fewer private residences (commonly for a single residence).	**~ 500,000**
Private intake (from a lake, river or stream)	Five or fewer private residences.	**Unknown[5]**

1. A residential community is defined as six or more residences.
2. Closed for at least 60 consecutive days per year.
3. If a system serves a designated facility, it is regulated by MECP.
4. Owners are responsible for their own drinking water, but MECP regulates the construction, maintenance and abandonment of wells under the Wells Regulation under the *Ontario Water Resources Act*.
5. Estimated < 1% of primary residences, but also serves seasonal residences such as cottages.

This subdivision is based on several factors, including the supply's potential public health impact, considering:

- **The number of users it serves:** A water supply that serves more people has a greater potential impact on public health if it fails compared to one that serves fewer people. For example, a system that serves many homes, or that serves a public facility that may be frequented by many visitors, has a greater potential to impact public health than a system that serves a few homes.
- **The vulnerability of users it serves:** A water supply that serves children, seniors or sick patients, who are more vulnerable to waterborne illnesses, has a higher potential for public health impacts.

~3 million Ontarians
rely on non-municipal drinking-water supplies

Non-municipal drinking-water supplies serve almost 20% of the population, or nearly 3 million Ontarians, as well as some businesses and other facilities, mostly in rural, semi-rural or remote communities.

2.2.2 Split Oversight of Non-Municipal Drinking-Water Supplies

Ontario's primary law regulating the treatment, testing and distribution of drinking water is the *Safe Drinking Water Act, 2002*. When the Province first passed this law in 2002, MECP was given sole responsibility for regulating all drinking-water systems under this act.

In 2007, based on recommendations from Ontario's Advisory Council on Drinking Water Quality and Testing Standards, the Province transferred oversight for the small drinking-water systems to MOH and local PHUs. Inspectors working in the PHUs were considered to be better positioned to:

- inspect the approximately 10,000 systems dotted across the province;
- directly reach and explain the regulatory requirements to the regulated community; and
- evaluate the health risks of these systems and determine the requirements each system needed.

In 2008, the Province introduced a new site-specific, risk-based approach for small drinking-water systems. This change was intended to alleviate some of the burden for owners of small systems, who had been struggling to apply the previous one-size-fits-all requirements to their generally less-complex systems, while maintaining drinking-water safety.

As a result, non-municipal drinking-water supplies in Ontario are now divided into three tiers, with oversight split between the two ministries under two laws, as follows (see **Figure 3**):

- **Systems that supply water to six or more year-round homes or a designated facility** continue to be regulated by MECP, subject to a standard suite of requirements under the *Safe Drinking Water Act, 2002*.
- **Small drinking-water systems**, which serve six or more seasonal residences or a public facility, are regulated by MOH and the PHUs under the *Health Protection and Promotion Act*, each with customized risk-based requirements.
- **Private wells** (from groundwater) and **private intakes** (from surface water such as lakes or rivers), which are supplies that each serve five or fewer homes and no public facility, are subject to the least regulation and oversight. There are no requirements for owners of private wells or intakes to either treat or test their drinking water. In this report, private wells and intakes are not considered drinking-water systems.

While owners of private wells are responsible for their own drinking water, MECP regulates the construction, maintenance and abandonment of wells through the Wells Regulation under the *Ontario Water Resources Act*. MECP does not regulate private intakes, and advised our Office that it discourages their use for drinking water.

2.3 Roles and Responsibilities

2.3.1 MECP

Under the *Safe Drinking Water Act, 2002*, MECP has the following roles and responsibilities that relate to non-municipal drinking water:

- Regulating and inspecting non-municipal year-round residential drinking-water systems and systems serving a designated facility.
- Setting drinking-water quality standards for all drinking water in Ontario.
- Licensing and inspecting all Ontario laboratories that perform drinking-water tests.
- Annually reporting on the overall performance of all drinking-water systems, including both MECP- and MOH-regulated systems, as well as reporting on other drinking-water related topics, such as health hazards and emerging trends.

As noted in **Section 2.2.2**, MECP is also responsible for regulating the construction, maintenance and abandonment of wells under the *Ontario Water Resources Act*.

2.3.2 MOH and PHUs

Under the *Health Protection and Promotion Act*, MOH sets the policy direction and requirements for delivery of public health programs. Local boards of health, through their PHUs, are responsible for meeting these requirements and delivering public health programs and services, including the drinking-water programs, within their geographic borders. Each local board of health is accountable to MOH.

Each PHU has a medical officer of health who reports to the local board of health. PHU duties are generally carried out by public health inspectors. Inspectors may work on other public health programs in addition to drinking water, such as recreational water or food safety.

With respect to drinking water, PHUs are responsible for:

- Overseeing small drinking-water systems: PHUs are to conduct risk assessments and inspections, enforce regulations and provide education to system owners.
- Issuing drinking-water advisories: When a board of health is made aware of an incident that may affect water quality, it assesses whether to issue a drinking-water advisory to keep the

public safe. This responsibility applies to all drinking-water systems, whether regulated by MOH or MECP.

- Education and outreach to owners of private wells and intakes: PHUs are directed to provide information to members of the public on how they can safely manage their own drinking-water supplies, and to help increase awareness of the risks of waterborne illnesses from unsafe drinking water.

At the time of our audit, Ontario had 34 local PHUs. However, as there are no small drinking-water systems or private wells within the Toronto PHU, our audit focused on the other 33 PHUs. At the time of our audit, there were 63 full-time equivalent public health inspectors that performed drinking-water related duties across the 33 PHUs.

MOH provides roughly 70% of the PHUs' total funding for water-safety programs; the remaining 30% comes from the local municipalities. MOH also provides oversight and direction to the PHUs. The Ontario Public Health Standards, published by MOH, set out the minimum programs and services that PHUs are required to provide under the *Health Protection and Promotion Act*.

2.3.3 PHO

PHO, a board-governed agency accountable to MOH, operates Ontario's 11 public health laboratories. These laboratories perform free bacterial water testing for individuals who rely on private drinking-water supplies, such as private wells and intakes. At the time of our audit, PHUs operated 195 locations across Ontario where private well and intake users can drop off water samples. PHUs then send the samples to a PHO laboratory for testing.

As well, the *Ontario Agency for Health Protection and Promotion Act, 2007*, requires PHO to "provide scientific and technical advice and support" to the Government of Ontario and the health-care system, as requested.

2.3.4 Federal and First Nations Governments

The federal government and First Nations share primary responsibility for providing safe drinking water in First Nations communities. The federal government provides funding through Indigenous Services Canada to develop, operate and maintain water-treatment facilities in these communities. MECP works with Indigenous Services Canada to provide technical support for First Nations drinking-water projects. MECP has also provided some funding for source water protection.

The scope of this audit does not include First Nations' drinking water, as this is an area of shared responsibility between the federal government and First Nations communities. However, this is a critically important issue. First Nations communities are disproportionately affected by drinking-water quality issues. As of March 2025, there were 23 active long-term drinking-water advisories impacting 22 First Nations communities in Ontario.

3.0 Audit Objective and Scope

Our audit objective was to assess whether MECP and MOH, in conjunction with PHO and the local PHUs, collectively have effective processes and systems in place to support reliable and equitable access to safe non-municipal drinking water across the province by:

- overseeing non-municipal drinking-water systems, private wells and private intakes, and their compliance with applicable legislation, regulations and policies;
- identifying and managing risks to the health and safety of Ontarians related to non-municipal drinking water; and
- measuring, evaluating and publicly reporting on the safety of Ontario's non-municipal drinking water.

Our audit scope focused on non-municipal drinking-water supplies within provincial jurisdiction. This included provincial programs and responsibilities related to private wells and intakes and non-municipal drinking-water systems. Drinking water in First Nations communities was outside the scope of this audit. (For a federal audit of this topic, see the Auditor General of Canada's 2021 report, *Access to Safe Drinking Water in First Nations Communities – Indigenous Services Canada*.) Municipal drinking-water supplies were also outside the scope of this audit.

For more details, see our **Audit Criteria**, **Audit Approach** and **Audit Opinion**.

4.0 What We Found

4.1 Water Quality Standards and Water Testing

MECP has established, by regulation, the Ontario Drinking Water Quality Standards. This regulation sets out the maximum allowable concentrations for over 150 contaminants based on health risks.

Every owner of a drinking-water system, including municipal and non-municipal systems regulated by MECP or MOH, is required to sample the drinking water at a prescribed frequency. The owners are then required to get the water sample tested by a licensed laboratory to ensure it meets the standards for the specific set of contaminants prescribed for that system.

4.1.1 Over 90% of the Ontario Drinking Water Quality Standards Meet or Are Stricter Than Federal Guidelines

Health Canada publishes the Canadian Drinking Water Quality Guidelines, which set out recommended concentration limits for drinking-water contaminants based on the most up-to-date scientific research.

Our review of the Ontario Drinking Water Quality Standards found that, for the 54 substances for which both Ontario and Health Canada have concentration limits, 93% of the standards are the same or more stringent than Health Canada's guidelines. Ontario's limits were the same for 40 substances, more stringent for 10 substances, and less stringent for four others.

The Ontario Drinking Water Quality Standards also contain 96 standards for which Health Canada does not have a corresponding guideline. Many of these standards are for less common substances, and most non-municipal drinking-water systems are not required to test for them.

4.1.2 MECP Has Not Informed the Public About Its Response to Expert Advice on the Ontario Drinking Water Quality Standards for 18 Contaminants

MECP staff with scientific expertise review the Ontario Drinking Water Quality Standards regularly. The Province also has an advisory committee of experts in health and water treatment, called the Advisory Council on Drinking Water Quality and Testing Standards (Council), that reviews research related to drinking-water safety. The Council reviews Health Canada's guidelines and provides the Minister with advice on whether to amend Ontario's standards in light of updated federal guidelines. Under the *Safe Drinking Water Act, 2002*, the Minister must consider all Council advice. Where MECP decides to amend a standard, it is required under the *Environmental Bill of Rights, 1993* to post the proposed amendment on the Environmental Registry of Ontario for public consultation.

We found that MECP provides information to the public about the Council's advice through the Minister's Annual Report on Drinking Water but is not fully transparent on how it is responding to this advice.

Since 2017, the Council has provided the Minister with advice on the standards for 18 different contaminants based on updated federal guidelines. The Council advised MECP to retain Ontario's existing standards for 11 contaminants, adopt a new standard for two contaminants, make one standard less stringent, and make four standards more stringent.

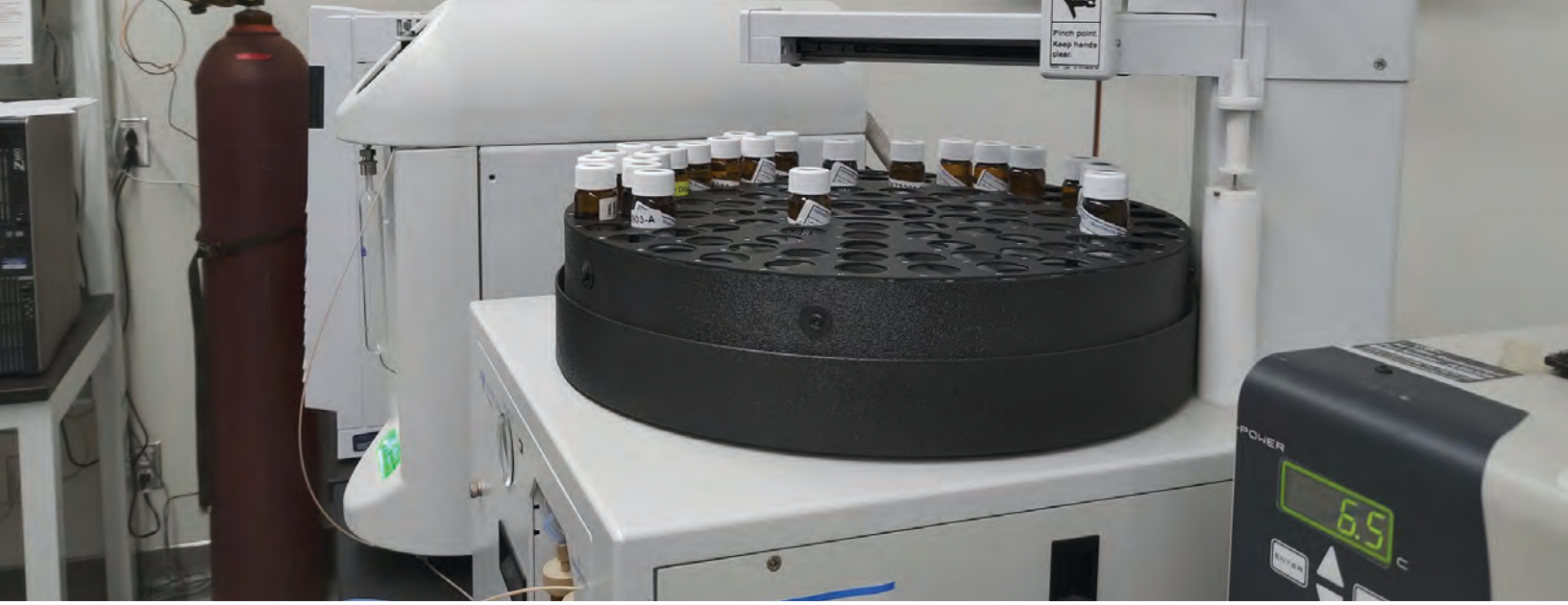
We found that MECP staff experts have reviewed all of the Council's advice and have provided internal briefings. However, MECP has provided little information to the public about the status of the Ministry's consideration of this advice or work being done in response. As a result, the public has no way of knowing whether MECP has made a decision to retain a standard, or whether the Council's advice is still under consideration.

Some of these contaminants are of high public interest. For example, 1,4-dioxane is a synthetic chemical that can leak from landfills and cause cancer. Exposure to lead can negatively affect neurological development and behaviour, and cause increased blood pressure or kidney problems. The primary source of lead in drinking water is from lead service lines, which are pipes that link a house to the main water supply, typically in municipal drinking-water distribution systems (which are outside the scope of this audit).

Recommendation 1

We recommend that MECP explore ways to enhance its reporting to the public on all advice provided by the Advisory Council on Drinking Water Quality and Testing Standards, the status of MECP's considerations of the advice provided, and any work conducted or decisions made as a result.

For the auditee's response, see **Recommendations and Auditee Responses**.



4.1.3 Over 98% of Drinking-Water Tests from Non-Municipal Systems Met Standards, But Tests Do Not Cover All Drinking Water or All Contaminants

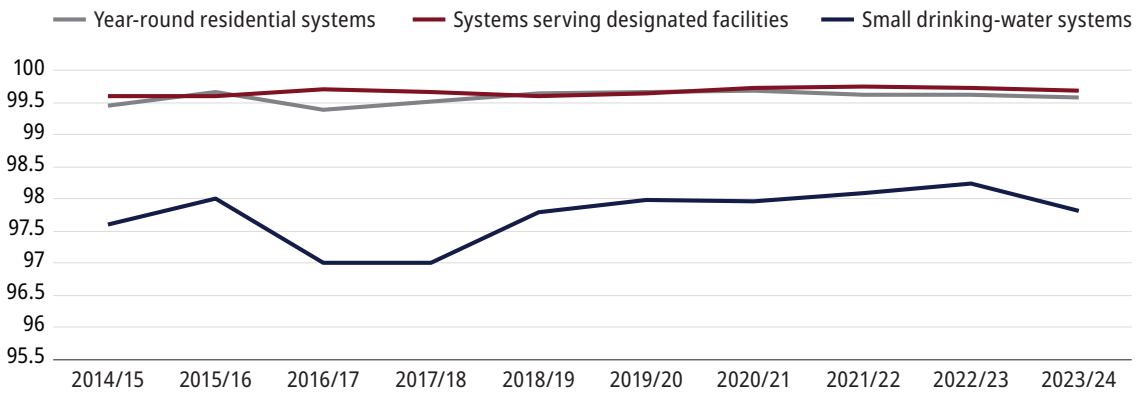
MECP reports annually on the overall results of the test samples received from municipal and non-municipal drinking-water systems in Ontario. Over the past decade, 98.7% of all tests from non-municipal systems met the Ontario Drinking Water Quality Standards. As seen in **Figure 4**, in 2023/24 (the most recent year):

- **99.68%** of tests from systems serving designated facilities met the standards;
- **99.57%** of tests from year-round residential systems met the standards; and
- **97.81%** of tests from small drinking-water systems met the standards.

These results for non-municipal systems are slightly lower than for municipal systems, where 99.87% of tests met the standards.

Figure 4: Percentage of Drinking-Water Tests That Met the Ontario Drinking Water Quality Standards for All Non-Municipal System Types (2014/15–2023/24)

Source of data: MECP



If a test result exceeds an allowable concentration in a standard, it is deemed an adverse water quality incident (AWQI). The system operator and testing laboratory must report any identified AWQI to the local PHU. The PHU must then assess whether the AWQI presents a potential health risk, and if so, the PHU may issue a drinking-water advisory to notify users.

In 2022/23 (the most recent data), PHUs issued 136 drinking-water advisories for non-municipal systems, affecting roughly 1% of all regulated non-municipal systems. As shown in **Figure 5**, 89% of these were boil water advisories due to bacterial contamination, 6% were do not drink or use advisories due to chemical contamination, and the remaining 5% were health information advisories.

Figure 5: Number of Drinking-Water Advisories, by Type, Issued for Non-Municipal Drinking-Water Systems, April 1, 2022 to March 31, 2023

Prepared by the Office of the Auditor General of Ontario

Type of Advisory	Example of Contamination That Would Trigger the Advisory	Purpose of Advisory	# Issued	% of Total Advisories
Health information	A chemical such as sodium or fluoride is found at a level that exceeds the drinking-water standard.	To notify community users of the exceedance and the recommended measures that can be taken to reduce exposure.	**7**	**5**
Boil water	Unacceptable microbiological levels of *E. coli* or total coliforms.	To notify users that they must boil their water to render it safe for use.	**121**	**89**
Do not drink	A chemical such as lead or nitrates is found at a level that exceeds the drinking-water standard.	To notify users when action(s) other than boiling the water is required to protect users. This may require some type of filtration and/or chemical or non-chemical treatment.	**7**	**5**
Do not use	Chemical contaminants such as trichloroethylene are found in the water.	To notify users that boiling or other treatments are inadequate to make the water safe for use. The operator or operating authority may also notify users of an alternate source of water, or provide one for them.	**1**	**1**

Note: Irrespective of the action taken related to an advisory, the PHUs have the authority to issue a direction or order under the *Health Protection and Promotion Act*, detailing what actions must be taken by the drinking-water system operator to provide water to users that is safe to drink.

Test results provide a high level of assurance that the vast majority of Ontario's tested drinking water is safe. However, this assurance does not extend to all non-municipal drinking water, as not all drinking water, and not all contaminants, are tested:

- **Some drinking-water systems do not test their water as required.** MECP's annual reports include the results of those systems that sampled and tested their water as required. They do not capture systems that failed to comply with the sampling requirements. Systems that have not complied with testing requirements increase the risk that unsafe drinking water may go undetected. See **Section 4.2.5** for our findings and recommendations related to non-compliance with testing.

- **There are no testing requirements for private residential wells and intakes.** The reported test results include drinking-water systems only. They do not include results on the quality of water from private wells or intakes, which supply drinking water to roughly 10% of all Ontario households. See **Section 4.4** for our findings and recommendations related to water testing for private wells and intakes.

- **The tests do not comprehensively cover all contaminants.** The testing requirements for each type of system are based on risk and vary accordingly. The most common testing requirements are for bacteria such as *E. coli*. Systems that serve designated facilities or year-round residences are required to test regularly for bacteria, and less frequently for either 58 or 60 chemicals, respectively. Small drinking-water systems are typically only required to test for bacteria, but may be directed by their local PHU to test for additional chemicals based on the individual risk assessment for that system. For example, a PHU might direct a system near a gas station to also test for benzene.

Without comprehensive testing, other protective measures, as recommended throughout the remainder of this report, are particularly important to protect drinking water. For example, see **Sections 4.6** and **4.7** for our recommendations related to protecting sources of drinking water and monitoring health data to identify potential risks from drinking water.

4.2 MOH Oversight of Small Drinking-Water Systems

As shown in **Figure 3**, MOH is responsible for establishing the drinking-water regulations and guidelines for small drinking-water systems under the *Health Protection and Promotion Act*. These are systems that serve seasonal residences or public facilities. Each PHU is responsible for overseeing the small drinking-water systems within its region, in accordance with MOH's act, regulations and guidelines.

Each PHU's responsibilities for overseeing small drinking-water systems include:

- Maintaining an inventory of systems in its region.
- Assessing the risk of the systems and, based on the risk assessment, prescribing site-specific operating requirements related to sampling, testing, treatment and operator training.
- Monitoring compliance with sampling and testing requirements, performing routine inspections of systems to monitor compliance with operating requirements and enforcing compliance with all requirements.

4.2.1 PHUs Lack Effective Processes for Identifying Unregistered Small Systems, Posing Potential Public Health Risks

We found that some small drinking-water system owners do not notify the PHUs of the existence and operation of their system as required by regulation. Over the past five years, 20 PHUs have collectively found approximately 260 unregistered systems.

Over the past five years, 20 PHUs have collectively found approximately 260 unregistered systems.

We also found that PHUs do not have effective means to identify systems in their jurisdictions that have not properly self-reported. Unreported systems are not inspected or assessed by a public health inspector, posing potential public health risks as they may not meet safety requirements.

Owners of new small drinking-water systems are required to notify their local medical officer of health (in practice, the PHU) before supplying water. This notification prompts a public health

inspector to conduct a risk assessment of the system and issue a directive with risk-based requirements intended to ensure the water is safe for consumption. Owners of new systems are not permitted to supply water to the public until they have received written permission from the medical officer of health.

Owners of new small systems are not permitted to supply water to the public until they have received written permission from their local medical officer of health.

PHUs told us that the primary reason for the lack of notification was that owners were not aware of their duty to report to the PHU.

In 2024, during the course of our audit, MOH created a new webpage with information and updated fact sheets about operating small drinking-water systems. We note that this webpage and its resources are only informative to system owners who are made aware of them. MOH does not have a provincial program to make small drinking-water system owners aware of the webpage or owners' reporting requirements.

To address this gap, some PHUs have developed processes to help identify unregistered systems. In our survey of the 33 PHUs, 11 (33%) reported that they receive some help from municipal staff in finding unregistered systems. For instance, some municipalities inform PHUs about new establishments that might have a small drinking-water system when the municipality receives an application for a new business licence.

The remaining 22 (67%) of PHUs reported that they do not receive help from municipal staff. Some of these PHUs have used other less formal and less efficient methods, such as coming across advertisements for new businesses or responding to complaints. Other PHUs have no processes for finding unregistered systems. Without effective processes in place, more unregistered systems likely remain unidentified.

We also found that PHUs rarely use enforcement tools, such as fines from tickets or court prosecutions, to address failures to notify them. Of the 20 PHUs that identified unregistered systems, 15 (75%) reported not taking any enforcement actions in response to the failure to notify them about the systems.

Recommendation 2

We recommend that MOH work with PHUs to:

- develop and implement initiatives to make small drinking-water system owners aware of the requirement to notify the local PHU before supplying water to the public; and
- examine mechanisms for PHUs to better identify unregistered small drinking-water systems.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.2.2 Lack of MOH Guidance on Drinking-Water Supplies for Short-Term Rentals May Create a Potential Public Health Risk

We found that MOH has not provided clear guidance or direction to PHUs on whether non-municipal drinking-water supplies for short-term rentals, such as homes or cottages booked through online rental platforms, are covered under MOH regulations. Consequently, each PHU independently decides whether to treat them as small drinking-water systems, which are regulated, or as private wells or intakes, which are not regulated. As a result, drinking-water supplies in short-term rentals are subject to different levels of water safety and oversight depending on their location in the province.

A regulation under the *Health Protection and Promotion Act* requires PHUs to regulate drinking-water systems that serve a "public facility." The regulation states that a public facility includes "a place that operates primarily for the purpose of providing overnight accommodation to the travelling public." Ambiguity over the term "primarily" creates uncertainty about the inclusion of certain short-term rentals. For instance, there is no clear threshold for what number of rental days would trigger a property, such as a cottage, to be classified as a "public facility."

The use of short-term rentals has grown significantly over the past decade, increasing the need for clarity of this issue. For example, in the Muskoka Region, the market share of short-term rentals in the accommodation sector increased from 19% in 2017 to 44% in 2021. In the Algonquin Park, Muskoka and Parry Sound Region, there were an estimated 3,181 short-term rentals in 2024, a 15% increase from the previous year.

One PHU sought MOH guidance in 2023 on whether drinking-water supplies serving short-term rentals fall under the regulation, but MOH did not provide a clear direction in its response. MOH stated that its policy has been for PHUs to include bed-and-breakfasts as small drinking-water systems. However, for short-term rentals, MOH stated that "as a site-specific risk-based program, there is not one approach" to regulating them. MOH stated that public health inspectors are responsible for determining if each supply should be regulated as a small drinking-water system.

Some PHUs have sought independent legal opinions on regulating drinking-water supplies in short-term rentals, resulting in conflicting advice, as well as extra legal costs. In March 2024, one PHU received a legal opinion concluding that short-term rentals can be subject to the small drinking-water system regulation depending on the amount of time and space in the premises that is used by the owner versus the travelling public. Conversely, another PHU was advised that these supplies should not be subject to the small drinking-water system regulation, in part because it is impractical to determine when short-term rentals are being used by the owner or rented out to the public.

We asked the 33 PHUs if they considered drinking-water supplies to short-term rentals as small drinking-water systems; 10 (30%) reported that they do, 19 (58%) do not and the other four (12%) were undecided. Without a consistent approach to regulating these supplies, visitors to unregulated accommodations may drink or cook with water from uninspected and untested water supplies, creating a potential public health risk.

Without a consistent approach to regulating these supplies, visitors to unregulated accommodations may drink or cook with water from uninspected and untested supplies.

We also found that a key factor in PHUs' determination about whether to regulate supplies to short-term rentals was concerns about workload. In our survey, 20 (61%) of the 33 PHUs stated that they lack sufficient staff to regulate small drinking-water systems.

Regulating short-term rentals would add workload to the PHUs. For instance, one PHU identified, based on municipal licensing information, that its region may have about 500 drinking-water supplies serving short-term rentals. This PHU currently inspects about 570 systems and already has a backlog of 300 initial risk assessments. Of the 19 PHUs that do not regulate short-term rentals, 13 reported resource limitations as a factor for why they do not, and 11 also cited a lack of MOH guidance as the reason for not regulating short-term rental supplies.

Recommendation 3

We recommend that MOH, in consultation with PHUs and short-term rental platforms:

- explore and develop options for clear provincial direction on when drinking-water supplies in short-term rental properties are regulated as small drinking-water systems under the *Health Protection and Promotion Act*, which would enable PHUs to require testing of the drinking water; and
- if the direction is to not regulate drinking-water supplies in short-term rental properties as small drinking-water systems, assess the need to develop requirements for owners of short-term rental properties to notify renters that the water is not regulated and whether the water has been tested.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.2.3 Less Than Half of PHUs Met Inspection Frequency Requirements for Small Drinking-Water Systems

MOH requires that PHUs perform routine inspections of small drinking-water systems to ensure water safety. Inspections assess compliance with requirements for operator training, water treatment and system maintenance. This includes assessing compliance with any issued directives, which remain in effect even if ownership changes.

The inspection frequency is based on the PHU's initial risk assessment. Low- and moderate-risk systems must be inspected at least once every four years, whereas high-risk systems require inspections at least once every two years. As of March 2023, of the roughly 10,000 regulated small drinking-water systems, 80% were categorized by PHUs as low risk, 12% as moderate risk and 8% as high risk.

33
PHUs have small drinking-water systems in their region

52%
have not inspected all systems as required

We found that 17 (52%) of the 33 PHUs with small drinking-water systems in their region have not inspected all systems as required. These PHUs reported that they had accumulated inspection backlogs. Eight of these 17 PHUs reported backlogs dating back over five years, with one reporting a small drinking-water system in eastern Ontario that has been due for inspection since 2010. Three PHUs also reported inspection backlogs for over 50% of their entire inventory.

In our survey, 12 (71%) of the 17 PHUs with an inspection backlog attributed the backlog to staffing and/or resource challenges. Thirteen also reported that the COVID-19 pandemic contributed to their inspection backlog.

PHUs noted that drinking-water inspections can be very time consuming. Some reported average times of over eight hours for an inspection, including the onsite visit, travel to and from the site, and follow-up work. Resource issues were a particular concern in Northern Ontario, where six of the PHUs with inspection backlogs are located. These PHUs reported needing costly flight or boat access to reach certain sites and experiencing staff shortages.

Recommendation 4

We recommend that MOH work with PHUs to:

- assess the extent of and reasons for any inspection backlogs, including resources and costs; and
- consider and develop strategies to ensure that all PHUs can deliver on their responsibilities to inspect small drinking-water systems at the required frequency.

For the auditee's response, see **Recommendations and Auditee Responses**.

Source: Walkerton Clean Water Centre

4.2.4 Inconsistent Training for Inspectors May Pose Public Health Risks

Public health inspectors are required to inspect and assess small drinking-water systems for risks. We found that public health inspectors across the province have varying levels of training to implement these responsibilities.

Inconsistent training could mean that inspectors may not inspect and assess all systems equally, creating potential risks for Ontarians who rely on small drinking-water systems. For example, if an inspector were to fail to identify a drinking-water threat, such as a nearby septic tank, this would affect how they complete the risk assessment tool. This could result in underrating a system's risk, and subjecting it to fewer conditions and less frequent inspections.

Public health inspectors hold a Certificate in Public Health Inspection (Canada), which is a national certification intended to broadly meet public health inspection needs. Thirty-two of the 33 PHUs told us that the national certification process was inadequate to prepare staff to inspect and assess the risk of small drinking-water systems and enforce requirements.

32 of the 33 PHUs told us that the national certification process was inadequate to prepare staff to inspect and assess the risk of small drinking-water systems and enforce requirements.

The Walkerton Clean Water Centre (WCWC), a provincial government agency, delivers supplemental training for public health inspectors about small drinking-water systems. MOH recommends, but does not require, that inspectors receive this training. Training is particularly important because 16 (48%) of the 33 PHUs reported that, in order to adapt to shortages of experienced staff, they have been moving away from drinking-water specialists and instead spreading the workload across generalist inspectors or using temporary inspectors or students.

When we surveyed the 33 PHUs about their inspectors' training, 18 (55%) reported that at least one of their inspectors who oversees small drinking-water systems had not taken the WCWC training. Of the 18 PHUs, six (33%) reported that at least half of their inspectors had not taken the training.

One-third of the PHUs stated that the inaccessibility of WCWC courses, including the cost, frequency and location of courses, was a barrier or challenge for them. Although PHUs reported mitigating actions, such as in-house training and job shadowing, they specifically noted that they would like the WCWC training to be more accessible, including through online training.

WCWC informed us that the location of its inspector training is based on need and requests. We obtained the inspector training calendar from WCWC for the last five years. We found that WCWC offered, on average, four courses per year. There were no online inspector training sessions and no courses in the four northernmost PHUs, which include 25% of active small drinking-water systems in Ontario; inspectors from two of these four PHUs travelled south to Sudbury to attend training.

In our survey, 14 PHUs told us that a lack of accessible WCWC training also presented an issue for operators of small drinking-water systems. When a public health inspector conducts a risk assessment, the inspector may direct the operator to take specific courses to ensure they have the knowledge and skills to sample, treat and test the water, and maintain and operate the system to provide a safe water supply. If training is not accessible, this requirement cannot be met.

As with the inspector training, this issue was greater in the north. Northern PHUs reported that WCWC rarely offers training in Northern Ontario for small drinking-water system operators, and that the in-person format can be difficult for northern residents. There is no online offering for the main operator training recommended by MOH.

Recommendation 5

We recommend that MOH take the lead to work with the WCWC to improve the accessibility and uptake of training sessions to meet the needs of both public health inspectors and small drinking-water system operators.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.2.5 Many Small Drinking-Water System Owners Do Not Comply with Sampling Requirements

Every owner of a small drinking-water system must sample the water and have it tested to ensure it meets the Ontario Drinking Water Quality Standards for the specific contaminants set out in a PHU directive. Public health inspectors prescribe the frequency of sampling for each system based on MOH guidance and the results of a risk assessment of the system. For example, for systems that have no history of test results for their water, MOH recommends sampling every week for high-risk systems that do not treat their water, and every three months for low-risk systems that do treat their water.

We analyzed the sampling compliance data from five PHUs spread across the province, which collectively regulate 1,660 small drinking-water systems. We found that 932 (56%) of these systems had missed at least one sample in the past five years. Further, 185 (20%) of the 932 systems had missed an entire year of samples, while 43 systems (5%) had missed sampling for multiple years.

4.2.6 Flaws in MOH's IT System Hinder PHUs' Ability to Monitor Sampling Compliance

We found that MOH's information technology (IT) system does not enable PHUs to effectively monitor system operators' compliance, or non-compliance, with sampling requirements.

Public health inspectors are required to enter the sampling requirements for each small drinking-water system into the Risk Categorization Tool (RCat), a MOH web-based application. PHUs are to monitor sampling compliance at least every three months.

A separate MOH application, called the Laboratory Results Management Application (LRMA), is used by laboratories to submit test results. LRMA then compares the sampling requirements from RCat against the test results to produce sampling compliance reports. In this way, LRMA is supposed to enable PHUs to track whether small drinking-water systems are complying with sampling requirements.

However, we found that LRMA's compliance reports are inaccurate. These inaccuracies are due to several shortcomings in RCat and LRMA, including:

- Some PHUs are unable to enter into RCat all sampling frequencies or different sampling frequencies for different parts of the system.
- There are problems tracking sampling compliance of seasonal systems in LRMA, as operators are not required to sample when their systems are closed. While PHUs are required to enter the opening and closing dates of seasonal systems into RCat, system owners do not always notify PHUs of these dates, creating inaccuracies.
- System owners may notify PHUs about the dates via multiple means (email, fax, mail or phone), making it inefficient for PHUs to maintain up-to-date information in RCat.

Without accurate reports, PHUs cannot rely on LRMA's reporting features to effectively fulfill their duty to monitor sampling compliance. Instead, PHUs must verify each small drinking-water system's sampling history in LRMA. While PHUs can still monitor compliance by manually comparing samples submitted against sampling requirements, this is less efficient and results in some PHUs monitoring compliance less frequently.

Upon request from our Office, eight of the 33 PHUs were unable to provide sampling compliance data. Three PHUs stated that capacity constraints prevented them from providing the data. Three acknowledged that they were not monitoring within the required three-month interval.

4.2.7 Enforcement Efforts Are Too Costly for PHUs and Rarely Used

Public health inspectors have enforcement powers, with progressive enforcement tools, to address issues of non-compliance. As appropriate, inspectors may:

- issue a verbal or written warning;
- issue a Health Hazard Order, which can require an owner or operator to take specified actions, such as close a facility, perform specific work or cease supplying water;
- issue a ticket, which carries a set fine ranging from $45 to $295 per offence; or
- for more serious issues, commence a prosecution, which upon conviction, carries higher fines of up to $5,000 for an individual, or up to $25,000 for a corporation, for each day or part of a day on which the offence occurs or continues.

We found that inspectors issued tickets to the owner or operator of 1% (11) of the 932 systems that we identified as non-compliant with the sampling requirement (see **Section 4.2.5**). We also found that inspectors did not consistently send even a warning (the lowest enforcement action) to offenders, even if they were repeat offenders. For example, a system serving a fishing and hunting lodge in Northern Ontario missed four years of samples in five years without receiving a warning or fine. In the same PHU, two systems missed three years of samples in five years and did not receive a warning, fine or even a routine inspection during that period.

We found that PHUs did not utilize the stronger enforcement tools because they were too costly or used too many resources. Nine of the 10 PHUs with enforcement backlogs told us that not having a dedicated enforcement budget or sufficient staff capacity limited enforcement efforts. For example, three PHUs with enforcement backlogs reported that their cost of issuing tickets exceeded the fines levied, which are capped at $295.

We found that PHUs did not utilize the stronger enforcement tools because they were too costly or used too many resources.

Four PHUs reported enforcement costs of over $10,000 each in the past five years. One PHU reported that prosecuting a small drinking-water system operator (a trailer park in Northumberland County with improper water treatment, among other issues) cost $71,000 in fees for legal counsel, plus additional costs for staff time and vehicle mileage. Despite the offender being fined $10,000 and ordered to pay the PHU's legal fees, the PHU ultimately only received a settlement of $22,000, resulting in a significant out-of-pocket expense for the PHU.

We note that, in contrast to the enforcement tools available to PHUs, MECP has implemented administrative monetary penalties as a less resource-intensive tool to improve enforcement rates within its ministry. These penalties do not require court proceedings, and can be more severe for violators than fines from tickets. For example, administrative penalties for spills with significant impacts can be up to $100,000 per day. At the time of our audit, MECP was planning to expand the use of this enforcement tool to include violations under the *Safe Drinking Water Act, 2002*.

Recommendation 6

We recommend that MOH:

- assess and resolve issues with the Laboratory Results Management Application and Risk Categorization Tool information systems, including exploring a more efficient way for operators to report opening and closing dates for small drinking-water systems, so that these systems provide reliable data on sampling compliance; and
- collaborate with PHUs to develop a comprehensive plan, including exploring alternative, cost-effective enforcement tools (such as monetary penalties), to better enforce small drinking-water system operators' compliance with sampling requirements.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.2.8 MOH Does Not Track Outcomes for Its Drinking-Water Program

MOH's Ontario Public Health Standards set out mandatory minimum program outcomes for each program delivered by PHUs. For the drinking-water program, the standards set out eight program outcomes, including: timely and effective detection and response to drinking-water contaminants; mitigation of waterborne illnesses; and safe operation of small drinking-water systems. The standards also include a list of indicators to assess the outcomes for several of MOH's public health programs, but none relate to its drinking-water program.

We found that MOH is not tracking progress against the eight drinking-water program outcomes. This lack of tracking means that MOH is unaware of whether all PHUs are holding system owners and operators accountable to the requirements to safely operate their drinking-water systems, in accordance with program outcomes.

4.2.9 MOH Does Not Verify PHU Performance on Drinking-Water Program

In the absence of outcome indicators, such as percentage of systems that pass inspections, MOH has instead developed activity (output) indicators, such as number of inspections, that PHUs are to report on. We found that MOH does not verify that all PHUs respond, nor verify the information provided.

For instance, MOH periodically requests that boards of health attest to conducting routine inspections of small drinking-water systems. In 2022 (the most recent attestation), 23 (70%) of the 33 boards of health attested to meeting this requirement; six (18%) reported that they did not meet this requirement, and four (12%) did not respond to the attestation request. MOH did not verify the attestations nor follow up with the PHUs that had either not responded or not met the requirements.

Although 97% of PHUs reported in 2022 that they responded to 100% of their AWQIs within 24 hours, we found that only one actually tracked its response times. Without tracking, both MOH and PHUs lack the means to verify the accuracy of this reporting.

PHUs are also required to periodically attest to the percentage of AWQIs they responded to within 24 hours. When an AWQI is reported, the PHU must initiate a response within 24 hours of being advised. The PHU must determine whether an advisory should be issued, and may direct the system owner on corrective actions that should be taken. Although 97% of PHUs reported in 2022 that they responded to 100% of their AWQIs within this time frame, we found that only one PHU actually tracked its response times. Without tracking, both MOH and PHUs lack the means to verify the accuracy of this reporting.

We also found that MOH's IT system that tracks AWQIs does not allow MOH to verify this indicator. There is no field to record a response time or the corrective action required, preventing PHUs and MOH from being able to track whether inspectors are responding to AWQIs in a timely manner.

Recommendation 7

We recommend that MOH:

- review and update the current indicator framework in the Ontario Public Health Standards to ensure that public health outcomes related to safe drinking water are measured effectively;
- implement processes for following up with PHUs that do not respond to requests for attestations or performance reports on indicators; and
- periodically verify the PHUs' reported performance with respect to these indicators.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.2.10 MOH's IT Systems Do Not Meet PHU or Ministry Needs

MOH has three main IT systems that support its drinking-water program: RCat, LRMA and the Drinking Water Advisory Reporting System (DWARS) (see **Glossary** for a brief explanation of each IT system). We found significant flaws in these IT systems that create inefficiencies for PHUs and make it more difficult to track outcomes for MOH's drinking-water program.

For example, as noted in **Section 4.2.6**, constraints in LRMA and RCat limit PHUs' ability to monitor system operators' compliance with sampling requirements. As noted in **Section 4.2.9**, constraints in LRMA limit MOH's ability to track response times for AWQIs. In a third example, we found that the lack of linkages between DWARS, where drinking-water advisories are recorded, and LRMA, where AWQIs are recorded, limits MOH's ability to track the use of advisories in response to AWQIs.

PHO has also noted IT challenges. In a 2019 PHO survey of public health inspectors, respondents reported problems using RCat during risk assessments. The respondents noted that the system times out too quickly, forcing users to log back in multiple times, and that it frequently freezes or crashes, leading to data loss. They also noted that RCat fails to capture important details, such as different required sampling frequencies for different parts of the small drinking-water system.

We found that these challenges continue. In our 2024 survey of the 33 PHUs, 21 (64%) reported challenges with RCat. For example, some noted that it can be time-consuming and difficult to use for routine risk assessments. In addition, 20 (61%) of PHUs reported challenges with LRMA, and eight (24%) reported challenges with DWARS.

In our 2024 survey of the 33 PHUs, 21 (64%) reported challenges with the RCat IT system.

MOH hired a consultant to assess the effectiveness of its various IT systems, including the IT systems for its drinking-water program. The consultant's findings, presented in January 2023, mirrored many of our findings. The consultant found that MOH's IT systems often do not meet the PHUs' needs, can be difficult to use, and have limited data-sharing and reporting capabilities.

A consultant found that MOH's IT systems often do not meet the PHUs' needs, can be difficult to use, and have limited data-sharing and reporting capabilities.

As a result of these IT constraints, PHUs often develop their own local solutions, at their own expense, to address gaps and challenges. These local solutions result in multiple different systems (including paper-based ones) to capture data. The consultant found that these practices led to inconsistent data, challenges in data sharing, and increased workloads and costs.

At the time of our audit, MOH was pursuing funding and approvals for IT modernization, including items that could help address identified deficiencies.

Recommendation 8

We recommend that MOH:

- in collaboration with PHUs, analyze limitations of the IT systems that support MOH's drinking-water program; and
- explore and develop options for a plan, with timelines, to modernize the drinking-water related IT systems, so that they address identified limitations and meet MOH's and the PHUs' tracking and data-sharing needs.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.3 MECP Oversight of Year-Round Residential Systems and Systems Serving Designated Facilities

As shown in **Figure 3**, under the *Safe Drinking Water Act, 2002*, MECP is responsible for regulating non-municipal drinking-water systems that serve year-round residences and designated facilities.

As regulator, MECP has established various requirements for these systems, including requirements for the proper installation, maintenance and disinfection of treatment equipment; requirements for mandatory training and certification for system operators; and sampling and testing requirements for specific contaminants (microbiological, chemical and lead) at specified frequencies.

MECP water compliance officers are responsible for inspecting and enforcing compliance with all of these requirements.

4.3.1 One-Third of MECP-Regulated Non-Municipal Systems Were Not Inspected at All Over a Five-Year Period

We found that MECP applies a risk-based approach to planning its annual inspection work for non-municipal drinking-water systems, but it does not have a formal target that requires inspections of these systems within a specified time frame. Some MECP staff told us there was an informal goal of inspecting systems every three to five years, although several staff stated that even five years is too long between inspections and represents undue risk. By comparison, as noted in **Section 4.2.3**, PHUs are required to inspect high-risk small drinking-water systems every two years and low- or moderate-risk systems every four years.

To select which systems to inspect in any given year, the Ministry considers various risk-based factors. These include the date and results of a system's last inspection, its sampling compliance and its history of water quality incidents. Using this approach, some higher-risk systems may be inspected multiple times in a five-year period. For example, if a compliance officer finds a deficiency during an inspection, that system must be re-inspected within a year. Conversely, lower-risk systems may not be inspected at all in this time period.

In an internal review conducted in 2023, MECP concluded that 20% of non-municipal systems in 2019/20 had not been inspected in more than six years. In our own audit work, we found that, at the end of the 2023/24 inspection cycle, 34% had not been inspected in over five years, and 9% had not been inspected in over seven years.

Many of the drinking-water systems that had not been inspected in over five years each supply water to over a hundred people. One of the systems that had not been inspected for over seven years serves a community college that, while deemed lower risk by MECP, provides drinking water to 2,500 people.

Many of the drinking-water systems that had not been inspected in over five years each supply water to over a hundred people.

While prioritizing MECP inspection resources toward higher-risk systems is an appropriate approach, even systems deemed to be lower risk should be periodically inspected to ensure they are operating properly. Inspections allow compliance officers to independently sample a system's water, verify operator training and check whether a system is operating in accordance with its approved design. In this way, inspections provide an important safeguard to pre-emptively identify and mitigate issues that could pose a health and safety risk before they affect users at the tap.

4.3.2 MECP Inspections of Non-Municipal Drinking-Water Systems Decreased Following Reorganization

A 2023 MECP internal review identified that the number of MECP inspections of non-municipal drinking-water systems in 2019/20 (the most recent data before the pandemic affected inspection rates) was 45% lower than in 2012/13. The review indicated that the decrease was the result of additional responsibilities having been transferred to water compliance officers in 2013, without additional resources.

Under the *Safe Drinking Water Act, 2002*, municipal drinking-water systems must be inspected annually. Given this legal requirement, and the greater potential impact on public health if one of these large municipal drinking-water systems fails, these inspections are the top priority for provincial water compliance officers. These officers must fulfill their other responsibilities in whatever time remains in their schedule after municipal inspections are completed.

Prior to 2013, these officers' only other responsibility was inspecting non-municipal drinking-water systems. In 2013, following an internal MECP reorganization, water compliance officers' workloads were expanded. Officers took on the responsibility for responding to well complaints, inspecting municipal sewage and stormwater systems, and responding to spills from these systems.

MECP's 2023 internal review also examined the need to improve efficiencies across all inspection areas. Staff put forward suggestions to improve the efficiencies of internal processes for inspections of municipal drinking-water systems, which would free up time for inspections of non-municipal drinking-water systems. While the number of MECP inspections of

32%

decrease in MECP inspections of non-municipal drinking-water systems between 2012/13 and 2023/24

non-municipal drinking-water systems in 2023/24 was higher than in 2019/20 (the year before COVID-19), it remained 32% lower than in 2012/13. As of the time of our audit, MECP had not implemented any of the initiatives identified by staff.

Recommendation 9

We recommend that MECP:

- implement measures and efficiencies to further increase the rate of MECP inspections of non-municipal drinking-water systems; and
- set and meet formal inspection policies and targets for non-municipal drinking-water systems that it regulates.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.3.3 MECP Tracks Compliance with Sampling Requirements and Takes Steps to Address Non-Compliances

Operators of MECP-regulated systems are required to sample their water and have it tested by a licensed laboratory for microbiological contaminants at least once a month or more, depending on the system's treatment equipment and whether it serves a designated facility or year-round residences. We found that MECP had effective processes for tracking compliance with this requirement and for promptly addressing non-compliance.

From 2019/20 to 2023/24, there were, on average, 57 cases indicating non-compliance with the sampling requirements per quarter across the province.

On a quarterly basis, a drinking-water assessment specialist within MECP generates a report of the water-testing data submitted by the testing laboratories. The purpose of the quarterly report is to determine whether system operators have complied with their microbiological sampling requirements. If test results are missing for a system for an entire quarter, the specialist follows up with the system operator to confirm the non-compliance and remedy as needed. If the operator fails to follow the specialist's direction and remains non-compliant, the case is referred to a water compliance officer and prioritized for further follow-up and possible inspection.

We reviewed the quarterly reports from 2019/20 to 2023/24 (excluding the period during the COVID-19 pandemic) to determine whether MECP followed up on non-compliant system operators. During this time, there were, on average, 57 cases indicating non-compliance with the sampling requirements per quarter across the province.

We found that MECP took steps to resolve these issues. MECP was able to promptly bring almost all systems back into compliance, except for three systems that remained non-compliant with

sampling requirements for all five years we reviewed, from 2019/20 to 2023/24 (see **Figure 6**). MECP has taken multiple steps over the years to try to bring these three systems into compliance, including inspecting the systems and issuing an order to one. At the time of our audit, all three remained non-compliant with their sampling as well as multiple other requirements, and were operating under a drinking-water advisory.

Although three systems represent just 0.2% of the total 1,816 non-municipal drinking-water systems serving year-round residences and designated facilities, any system that is not testing its drinking water for bacterial contamination poses a public health risk.

Figure 6: MECP-Regulated Non-Municipal Drinking-Water Systems That Did Not Meet Sampling Requirements for at Least Five Years, April 1, 2019 to March 31, 2024

Source of data: MECP

Location	Community Served	# of People Served	Date of Last Sample
Sudbury	Trailer park	35	June 2016
Sault Ste. Marie	Subdivision	40	No record of any sampling
Sudbury	Trailer park	40	February 2019

4.3.4 MECP Is Enhancing Its Processes to Address Repeat Non-Compliance

We found that MECP takes steps to escalate serious issues of non-compliance. We also found that, in March 2024, during our audit, MECP implemented a procedure to more effectively and consistently focus its compliance and enforcement efforts on repeat violators.

According to MECP's procedures, if an issue of non-compliance is identified at an MECP-regulated system, the water compliance officer is to work with the system operator to resolve the issue if it is not severe and there is a good compliance history. If a non-compliance is serious, the water compliance officer may use various tools, including issuing an order or referring the matter to MECP's Environmental Investigations and Enforcement Branch.

In 2023/24, MECP water compliance officers detected 217 deficiencies at 62 MECP-regulated, non-municipal drinking-water systems. A deficiency is a violation of the *Safe Drinking Water Act, 2002* or its regulations that poses a drinking-water health hazard. In response, MECP issued an order in four cases, posted a notice of violation in three cases and referred three drinking-water systems to investigations. MECP determined that the operators of the remaining systems voluntarily brought their systems into compliance.

In 2023/24, MECP water compliance officers detected 217 deficiencies at 62 MECP-regulated, non-municipal drinking-water systems.

Over the past five years, there were 14 convictions related to MECP-regulated systems, which resulted in fines totalling $84,150. The two most common convictions were for failing to have a properly trained person operate the system, and failing to collect and submit the required samples. The case that resulted in the largest fines, totalling $33,000, was against the former owner and the former operator of a drinking-water system that served a mobile home park near Thunder Bay with 66 homes and approximately 150 residents. This case resulted in multiple convictions, including failing to ensure the required water treatment equipment was provided and failing to ensure sampling requirements were met.

The two most common convictions were for failing to have a properly trained person operate the system, and failing to collect and submit the required samples.

In March 2024, during our audit, MECP implemented an updated strategy across all compliance programs to flag individuals or companies with a repeated pattern of non-compliance for a more targeted follow-up. MECP's goal is to effectively identify repeat violators across the province, and to focus compliance and enforcement efforts on these higher-risk individuals and companies, including drinking-water owners and operators.

4.3.5 Recent Science Raises Questions About the Advisability of MECP's Treatment Exemption

Generally, all MECP-regulated drinking-water systems are required to provide treatment to prevent or inactivate bacterial contamination. Under the *Safe Drinking Water Act, 2002*, a non-municipal year-round residential drinking-water system, such as a trailer park, may be exempted from the usual requirement to treat its drinking water if it meets specific criteria. We found that recent scientific research suggests that there are risks associated with this exemption.

As of May 2024, 38 year-round residential drinking-water systems were operating pursuant to this exemption. Collectively, these systems, which serve apartments, condominiums, trailer parks and campgrounds, supply drinking water to about 2,000 people.

To qualify for a treatment exemption, a non-municipal year-round residential drinking-water system must use groundwater, and must test its water supply every month without detecting bacterial contaminants such as *E. coli* for 12 consecutive months. Once exempted, the system operator must continue to test its untreated water monthly and its distributed water weekly. If these contaminants are detected, the exemption no longer applies.

Supplying untreated drinking water can present risks to the users of these year-round systems. Recent scientific research suggests that the criteria for the exemption may not be sufficient to offset the added risk of not treating water. For example, a 2019 Health Canada study indicated that

a negative bacterial test does not necessarily mean there are no harmful viruses in the untreated groundwater. Numerous other academic studies have similarly confirmed that the absence of bacterial contaminants determined through periodic testing alone does not guarantee that the untreated water is safe.

In 2020, internal MECP documents noted the risks associated with this exemption. In 2021, MECP staff began work to determine the number of drinking-water systems holding the treatment exemption and the potential impact on such systems if the exemption were removed. Staff completed this work in 2024. During our audit, MECP staff were exploring options and evaluating next steps to address these risks.

Recommendation 10

We recommend that MECP:

- create outreach materials outlining exemption requirements and information about the risks of supplying and consuming untreated drinking water, and deliver them to owners, operators and users of drinking-water systems with treatment exemptions; and
- assess whether any regulatory amendments are needed to minimize the risks of not treating drinking water on the basis of periodic bacterial testing.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.4 Supports for Users of Private Drinking-Water Wells and Intakes

About 1.3 million Ontarians rely on private wells for their drinking water. While few primary residences in Ontario obtain their drinking water from private intakes (from lakes, rivers and streams), some seasonal residences, such as cottages, rely on private intakes.

Unlike both municipal and non-municipal drinking-water systems, there are no requirements for owners of private wells and intakes to treat or test their water unless the water is made available to the public. As a result, owners of private wells and intakes may choose if and how they treat and test their water. Private wells and intakes are also not proactively inspected by provincial inspectors, and are not included in the source water protection plans applied to municipal drinking water (see **Section 4.6**).

To help reduce the risks of unsafe drinking water, the Province, through PHO, provides free drinking-water testing for individuals who rely on private drinking-water supplies, such as private wells and intakes, to test for bacterial contamination such as *E. coli*. The annual budget provided by the Province for PHO's free water testing services is $1.5 million, although actual expenditures are typically lower, averaging $1.3 million per year. If individuals want to test for chemicals in their drinking water, such as lead or sodium, they must use a private laboratory at their own expense.

4.4.1 Over One-Third of Private Well Samples Tested Positive for Bacteria, Highlighting Importance of Water Testing

With little regulation and oversight for private wells and intakes, PHO's free water testing has provided an important role for Ontarians who rely on these sources by helping to identify potentially unsafe drinking water. Water testing helps detect contamination and deter consumption of unsafe drinking water, which can reduce illnesses and their associated health costs from doctor visits and hospitalizations.

Almost four million samples from private wells and intakes were submitted to PHO laboratories from 2003 to 2022, averaging about 200,000 samples tested per year. PHO labs detected indicators of bacterial contamination in 35% of these samples. This represents an average of about 62,500 positive test results per year.

Of the positive tests, 67% showed more serious contamination, such as *E. coli* bacteria or evidence of actual fecal contamination in the sample. For this level of contamination, PHO advises the well users that the drinking water may be considered unsafe to drink.

The other 33% of positive tests showed low levels of non–*E. coli* bacteria. PHO does not interpret these samples from private wells and intakes as unsafe to drink. PHO advises these well users that "no significant bacterial contamination was found."

We note that samples from municipal or non-municipal drinking-water systems with any bacterial contamination are considered unsafe under the Ontario Drinking Water Quality Standards. Similarly, 10 of the other 12 Canadian provinces and territories consider private well water with any indication of bacterial contamination to be unsafe to drink. Ontario's less stringent threshold for bacteria that is applied to private wells and intakes dates back to 1990, when it was first established by MECP.

Ontario is not unique in offering free bacterial testing for private wells. Alberta, Prince Edward Island, Newfoundland and Labrador, and Yukon also provide this service to the public. Some Canadian jurisdictions, such as Alberta and Prince Edward Island, also offer free or subsidized testing for certain chemical contaminants.

4.4.2 Lack of Awareness of Risks and of the Availability of Free Water Testing Contributes to Many Private Well Users Not Testing Their Drinking Water

We found that, while thousands of private wells users make use of Ontario's free water testing program each year (see **Section 4.4.1**), many more private well users do not test their water even once a year. A number of studies have attributed the low test rates to a lack of awareness about both the risks of drinking untested water and the testing services. For private intakes, there is less data available on test frequency by owners.

While various government organizations provide educational materials to help owners of private wells and intakes safely supply water (see **Section 4.4.3**), we found that there is no province-wide program focused on increasing awareness of the availability of free

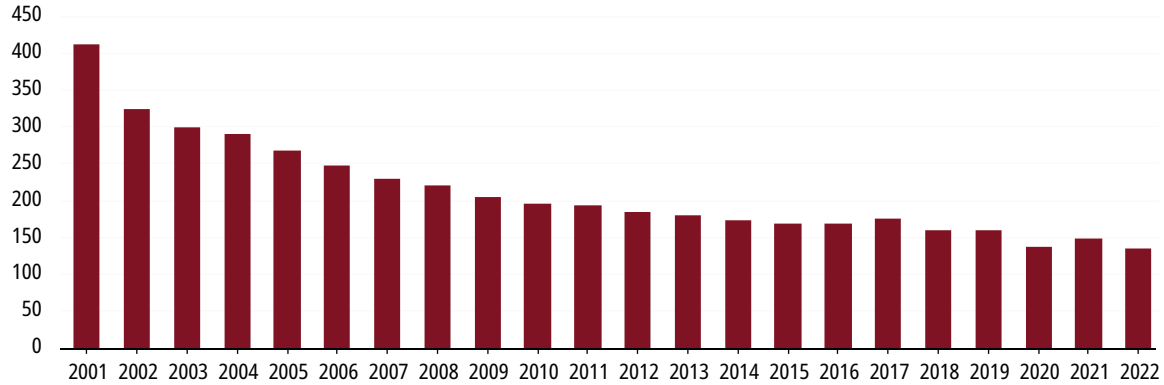
water testing and of the risks of not testing drinking water. Increased education and outreach to users of private wells and intakes could increase uptake of the Province's water testing and reduce the risks of Ontarians drinking unsafe water.

Various studies have found low rates of private well water testing in Ontario. A 2021 Statistics Canada survey found that less than one-third (32%) of Ontario households that rely on private wells had tested their water in the previous 12 months. A 2020 joint study by Queen's University and PHO found that only 28% of well owners in Ontario had submitted at least one water sample to a PHO laboratory in a five-year period (2012–2016). Low test rates have also been corroborated by some individual PHUs.

We also found that test rates for wells have been dropping over the past two decades. According to internal data, the number of annual private well water samples submitted to PHO for testing declined 67% between 2001 and 2022 (see **Figure 7**). This downward trend was observed in almost all PHUs across the province.

Figure 7: Number of Samples from Private Drinking-Water Supplies Submitted to PHO's Laboratories for Testing, 2001–2022 (000s)

Source of data: PHO



Note: PHO's laboratories test water samples from both private wells and private intakes. PHO does not ask submitters to provide details about the type of drinking-water source; however, private wells comprise the majority of private drinking-water supplies in Ontario.

A 2024 joint study by Queen's University and PHO found several reasons why private well owners do not test their well water, which can be grouped into two main issues:

- **Lack of awareness of the risks of not regularly testing the water:** For example, some well owners concluded that a previous good test result, even from years ago, meant that their water was safe to drink. Water quality can change over time, and a test result is just a snapshot of the water quality at that moment. Some owners did not see the need for testing or treatment because they had not become ill after drinking their water. And some owners believed frequent testing was not necessary if their wells appeared to be in good physical shape.
- **Lack of awareness of availability of testing:** Some owners did not know how or where to collect and submit water samples.

Low test rates for private wells is troubling, as private wells are subject to less oversight. Some public health studies suggest that users of private wells are more at risk of waterborne illnesses than users of municipal water systems. According to a 2021 Statistics Canada survey, 40% of private well owners in Ontario do not treat their water, making the lack of water testing even riskier.

According to a 2021 Statistics Canada survey, 40% of private well owners in Ontario do not treat their water, making the lack of water testing even riskier.

In the absence of a province-wide awareness program, some PHUs are adopting innovative approaches to try to increase test rates. For example, one PHU has launched a pilot program (still under development) to boost testing rates by enabling well owners to fill out their information and receive their test results online. The online system then encourages regular testing by sending automated reminder emails to well owners and allows them to track their well's performance over time.

Recommendation 11

We recommend that MOH take the lead to:

- collaborate with MECP to review the definition of "unsafe to drink" to ensure that the threshold for bacteria in private wells and intakes is sufficiently protective of human health; and
- collaborate with PHO to develop and implement a plan, including through the exploration of innovative approaches, to raise awareness about the risks of consuming water that has not been frequently tested, and about the availability of free microbiological testing for private well and intake owners and users in Ontario.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.4.3 Inconsistent and Duplicative Education and Information for Owners of Private Wells and Intakes

We found that various government organizations provide similar information and educational materials to help owners of private wells and intakes in Ontario supply safe drinking water. This duplication of effort has created inefficiencies in government resources. We also found inconsistencies in the materials, which could lead to confusion and varied safe water practices across the province.

In Ontario, information for supplying safe drinking water is provided to owners of private wells and intakes through various government organizations, including:

- **PHUs**, which are mandated by the Ontario Public Health Standards to provide information on safe management practices to private citizens who operate their own drinking-water supplies. Educational materials are posted on PHU websites for public access.
- **PHO**, which publishes some information on well water testing and disinfection.
- **MECP**, which has developed a two-page information package that well contractors are to give to well owners after working on a well. It provides general information and resources on maintenance and water testing. Additional well information, including a comprehensive technical best management practice manual, is available on MECP's website. MECP also operates a public help desk to answer well-related questions.
- **Ontario Ministry of Agriculture, Food and Agribusiness (OMAFA)**, which has created a series of educational guides for farmers and rural residents on private groundwater supplies.

Our analysis of educational materials found a significant overlap in the content. Basic information on safe drinking water is largely uniform, except for small regional administrative differences, which suggests an opportunity for it to be standardized by a central expert organization.

We also found that six PHUs had produced different well water-testing videos, and five had created distinct private water well manuals. The content of all of these was similar enough to suggest that a centralized effort could use resources more efficiently.

Our analysis of the educational materials also found inconsistencies in the testing advice provided to well owners. For instance, we found that the recommended frequency for well water testing differed depending on the organization providing the advice.

Our analysis of the educational materials found inconsistencies in the testing advice provided to well owners.

While PHO advises testing well water "often" and "frequently," our review of materials posted by the PHUs found they provide varying advice. Among the PHUs, 17 advise testing at least three times a year, one advises testing four times a year, seven recommend regular or frequent testing, two give different frequencies for dug and

drilled wells, and six gave no advice. OMAFA recommends that test frequency be based on factors that affect the quality and stability of well water, such as spring melts.

Recommendation 12

We recommend that MOH take the lead to work with all the other parties, including MECP, OMAFA, PHO and the PHUs, to undertake a review of educational materials for private wells and intakes (including best practices, guides and videos) to identify opportunities to improve consistency and minimize duplicative work.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.5 MECP Oversight of Well Construction and Abandonment

Under the *Ontario Water Resources Act* and Regulation 903 (Wells Regulation), MECP is responsible for regulating the construction, maintenance and decommissioning (plugging and sealing) of wells. As the regulator, MECP has established:

- **Technical specifications** for well structures, such as for the well depth and the thickness of the well casing, which are set out in the Wells Regulation.
- **Licensing requirements**, including education, work experience, training and insurance requirements for well contractors (the individuals or companies that are in the business of constructing wells) and well technicians (who are employed by contractors to conduct the actual labour on wells).
- **Well record requirements** whenever a well is constructed or altered. The well contractor or technician who conducts the work is required to complete a well record and provide a copy to both the well owner and MECP. When a well is decommissioned, the person decommissioning the well is required to submit a well record to notify MECP. The well record contains important information about the well, including its location, status (such as newly constructed or decommissioned), how it was constructed (such as dug, drilled or bored) and its technical specifications.

MECP's Water Well and Municipal Industrial Strategy for Abatement Reporting Unit (Wells Unit) receives all submitted well records, reviews licence applications for well contractors and technicians, and provides support to well contractors, technicians and the public.

Wells provide direct access to groundwater. If improperly constructed, maintained or abandoned, wells can create a pathway for pollutants to enter and contaminate the groundwater. We estimate, based on data from various sources, that there are about 500,000 active drinking-water wells across the province. These wells are primarily used to supply non-municipal drinking water as most municipal systems rely on surface water from lakes or rivers instead.

4.5.1 MECP Does Not Have Complete and Accurate Data on Wells

We found that MECP does not have complete and accurate data on the number, location and types of active wells in Ontario. This is partly because there is an unknown number of wells that were constructed before MECP brought in well record requirements, which began in 1944 but did not apply to all wells until 1984. Information on wells prior to 1984 may not be available.

In addition, we found that MECP does not have effective systems in place to review and resolve errors in the well records that are submitted to its Wells Unit. We identified a range of issues that contributed to inefficiencies and gaps in MECP's well information, including:

- **Well contractors do not always complete all fields in the well records.** An internal MECP report estimated that roughly half of all submitted well records are incomplete or inaccurate. Our own review of information in the wells database similarly found that records were often missing key information. For example, well contractors are required to indicate what the well is to be used for, such as for supplying drinking water, monitoring or irrigation. We found that 28% of well records submitted over the past 10 years (2013/14 to 2022/23) were missing the required information about well usage (see **Figure 8**).

Figure 8: Usage of Wells, as Indicated in Well Records (2013/14–2022/23)

Source of data: MECP

	#	%
Monitoring or test hole	87,068	45
Not indicated (left blank)	54,931	28
Private drinking-water supply	47,567	24
Other*	5,666	3
Total well records	**195,232**	100

* Other includes wells used for the purposes of livestock, irrigation, industrial, commercial, cooling, dewatering, or municipal or non-municipal drinking-water systems.

- **MECP relies on an outdated wells database.** MECP's wells database, which is over 30 years old, does not have the functionality to automatically flag gaps and errors, nor to enable staff to easily track such information. For example, our analysis of information in MECP's wells database identified at least 72 instances in which multiple well records for the same private drinking-water well cited different

locations, in some cases hundreds of kilometres apart. Our analysis was conducted by cross-referencing different datasets, as MECP's database does not have the ability to automatically identify such types of inaccuracies.

- **MECP's Wells Unit is unable to review all submitted records for completeness and accuracy.** MECP receives, on average, about 24,000 well records per year. Ministry staff advised us that, while they do attempt to verify and correct the accuracy of information, such as the well's location, cited in each well record, staff capacity to do so is limited.

- **Most well contractors continue to submit paper-based well records.** The use of paper-based forms creates inefficiencies, as MECP staff must manually process each one. After receiving a paper-based record, MECP staff electronically scan and upload this copy of the record into the database. Staff then enter some key information, such as the contractor name and well location, into the database. The rest of the information, such as construction details, is not immediately entered. As of August 2024, MECP had a backlog of 73,800 well records that had not yet been fully processed. MECP receives some well records electronically, which are uploaded into the wells database. This not only avoids the need for staff to manually input data, but also helps to improve the completeness of MECP's database because all mandatory fields must be completed before a contractor can submit an electronic form. MECP told us that contractors prefer using the paper-based, rather than the electronic, form.

Complete and accurate well information is important to enable MECP to effectively oversee and inspect wells. Accurate well information is also important for new homeowners during land transfers, and to help owners, contractors and technicians when maintaining or altering a well. Conversely, incomplete and inaccurate information about wells hinders MECP from effectively delivering programs; it also affects the delivery of PHU programs that are intended to protect well users (see **Section 4.6.2**).

In 2023, MECP hired external consultants to identify challenges faced by the Wells Unit. The consultants identified many of the same issues discussed above. During our audit, MECP was procuring an IT solution to address the identified challenges.

4.5.2 MECP Does Not Review Information in Well Records to Assess Compliance

We found MECP staff do not review the submitted well records to ensure that each well construction, alteration or decommissioning, as reported in the well records, complies with the technical specifications in the Wells Regulation. MECP staff may review well records for compliance with the regulation in response to a well complaint.

We were told by MECP that the staff receiving the records are not trained in well construction methods and therefore would be unable to conduct such a technical review. Also, as noted in

Section 4.5.1, the Ministry has a large backlog of well records to be processed, preventing staff from reviewing forms when submitted.

This lack of a technical review creates a risk that MECP will fail to identify improperly constructed wells. It also limits MECP's ability to prosecute violations that are identifiable through the well records.

For example, in August 2014, a well construction problem was brought to MECP's attention through a complaint by a well owner. MECP staff subsequently reviewed other records from wells constructed by the same contractor and referred the case for investigation. Through the investigation, MECP determined in June 2016 that numerous wells appeared to have been constructed improperly and recommended that a case be launched against the contractor for improper construction. However, because the contractor had submitted well records in January 2014, MECP decided not to lay charges, partly because it could be deemed to have known of the violations the moment it received the records, but the two-year statute of limitations meant that MECP could not prosecute.

Recommendation 13

We recommend that MECP:

- develop and implement a plan to clear the backlog of submitted well records by inputting the outstanding information into the wells database;
- develop and implement new processes to flag missing or inaccurate information in well records to improve the reliability and accuracy of MECP's information on wells; and
- develop and implement an IT system that enables MECP staff to manage and track information on wells in an effective, reliable and timely manner.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.5.3 Potentially Hundreds of Thousands of Abandoned Wells Have Never Been Properly Decommissioned

Many now-abandoned wells were built before recordkeeping requirements began in 1944. This makes it challenging for MECP to accurately determine the number of abandoned wells. Agriculture and Agri-Food Canada estimated in 2012 that there were likely about 730,000 abandoned wells in Ontario, based on typical rural settlement patterns and historical well use on rural properties. As of August 2024, MECP's wells database had 108,000 records of decommissioned wells. This suggests that there may still be hundreds of thousands of abandoned wells that have not been decommissioned (that is, plugged and sealed).

Abandoned wells that have not been properly decommissioned pose a risk to drinking water by creating a potential pathway for contaminants to enter the groundwater.

In Ontario, property owners are legally required to properly decommission wells that are not used or maintained, but there are various reasons a property owner might not do so. An owner may:

Abandoned wells that have not been properly decommissioned pose a risk to drinking water by creating a potential pathway for contaminants to enter the groundwater.

- be unaware of the presence or location of a well if it is hidden by plant growth or built structures;
- not know that they are required to decommission the well;
- not see the need to have the well decommissioned; or
- not be willing to pay for decommissioning, which could be costly depending on the circumstances.

Some conservation authorities and municipalities have provided subsidies to assist with decommissioning costs. For example, the City of Hamilton provides landowners with up to $1,000 per well to decommission abandoned private wells (with a limit of two wells per property), while Halton Region covers 50% of the cost, up to $1,000.

MECP has also provided some funding for well decommissioning in the past. Between 2007 and 2011, as part of a program to fund actions to protect municipal drinking-water sources, MECP helped fund the decommissioning of about 740 wells. Other provinces, such as Saskatchewan and Manitoba, also provide funding to property owners to properly decommission unused wells.

Recommendation 14

We recommend that MECP explore and implement options, such as education, to increase the number of properly decommissioned abandoned wells.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.6 Source Water Protection

Source water protection is the process of protecting a water source (such as a lake, river or groundwater reserve) that is used to supply drinking water.

While water testing and treatment are important steps for detecting and addressing drinking-water contaminants, source water protection adds a pre-emptive layer of defence by trying to prevent contamination or supply issues in the first place. It includes proactively identifying potential risks and taking actions to reduce, control or eliminate these risks. A preventative approach can not only increase protection, but also help avoid future costs to treat contamination or, in worse cases, find a new source of drinking water.

Source water protection adds a pre-emptive layer of defence by trying to prevent contamination or supply issues in the first place.

Ontario's *Clean Water Act, 2006*, administered by MECP, sets out extensive source water protection requirements for municipal drinking-water sources that are within a source protection area. This act sets out a process for local committees to undertake assessments of the potential risks to the sources of each municipal drinking-water supply in a source protection area, and then to develop source protection plans to address those threats.

The Province has several laws that regulate pollutants, such as manure, septic sewage, home heating fuel and pesticides, to help reduce risks to drinking water. The *Clean Water Act, 2006* established additional powers and tools that the local committees could use to address these and other risks, including enhanced powers to restrict, regulate or prohibit site-specific activities or land uses. For example, a source protection plan might prohibit a new waste disposal site near a water intake, or create a septic system inspection program to reduce risks from sewage contamination.

4.6.1 MECP Has Not Fully Assessed the Feasibility of Applying Source Water Protection Measures to Non-Municipal Sources

We found that MECP has not fully assessed the feasibility of different approaches to improve source water protections for Ontarians on non-municipal drinking-water supplies, beyond assessing the feasibility of including these supplies in the *Clean Water Act, 2006* framework.

Given the costs, resources and time that would be required to complete intensive source protection planning for every single drinking-water supply across Ontario, the Province initially focused the program on municipal drinking-water systems, which typically serve more people and therefore pose a higher public health risk.

The *Clean Water Act, 2006* allows municipalities, or the Minister, to include a non-municipal drinking-water system or a First Nations drinking-water system in a source protection plan, but no non-municipal systems have been included. While municipal source protection plans may help protect any non-municipal sources in the area covered by a plan, the nearly 3 million Ontarians who rely on non-municipal supplies do not benefit from the full source water protections under this act.

The nearly 3 million Ontarians who rely on non-municipal supplies do not benefit from the full source water protections under the *Clean Water Act, 2006*.

Our audit on Source Water Protection from our *2014 Annual Report* recommended that MECP consider the feasibility of requiring source protection plans to identify and address risks to sources of water that supply private wells and intakes. In response to this recommendation, in 2021, MECP staff completed a feasibility assessment and drafted a report. However, as of December 2024, the report had not been finalized or approved by the Minister or shared publicly.

The draft report concluded that mandating the inclusion of non-municipal drinking-water supplies, including private wells and intakes, under the *Clean Water Act, 2006* would impose additional costs and burdens on landowners, businesses, municipalities, conservation authorities and the Province.

The draft report also concluded that the impact may be disproportionate to the benefit, given that there are other existing tools to protect water sources. The draft report proposed to not include private wells and intakes in the source water protection framework at that time.

The draft report proposed to instead develop best practices for source water protection. In February 2022, MECP published a best practices document for source water protection on its website. The document includes guidance for owners of all non-municipal drinking-water supplies on how to identify and assess risks to a drinking-water source, and how to reduce or manage these risks.

We noted that these best practices are voluntary, and owners of non-municipal drinking-water supplies may not want to voluntarily spend money to conduct risk assessments or implement measures to control identified risks. In addition, owners may be unaware of these best practices, or lack the technical knowledge and skills to properly conduct a risk assessment.

MECP has provided funding to partners to promote awareness of the best practices, as well as funding to help communities implement the best practices through collectively assessing risks to their drinking-water sources, and developing action plans to address them. For example, in 2024, MECP provided funding to the Federation of Ontario Cottagers' Associations for a source water protection project in the Kawartha Lakes.

Beyond the best practices, MECP's assessment did not consider the feasibility of implementing other options to improve protections for non-municipal drinking-water supplies, such as:

MECP's assessment did not consider the feasibility of implementing other options to improve protections for non-municipal drinking-water supplies.

- additional tools to encourage owners of non-municipal supplies to adopt best practices;
- a risk-based approach that provides source water protections for non-municipal supplies that serve higher-risk populations, such as retirement homes and child-care centres; or
- additional tools to control the most significant risks to all non-municipal drinking-water sources, such as septic systems and fuel tanks.

We conducted a jurisdictional scan and found no Canadian provinces or territories that have applied a full source water protection framework to non-municipal supplies. We identified, however, some approaches from other jurisdictions that address components of source water protection that might be explored.

For example, the United Kingdom requires local authorities to conduct a risk assessment for all non-municipal water supplies every five years; operators are then required to develop action plans to reduce and control the key threats identified. The service is also provided upon request to owners of private wells.

Adopting this approach in Ontario and applying it to water supplies that serve higher-risk populations, such as retirement homes, health-care facilities and schools, could be a step toward expanding drinking-water protection for more Ontarians.

Lastly, MECP could leverage all of the work done by source protection committees to identify the tools most commonly used to manage the most significant threats in municipal drinking-water supplies, and to consider ways to expand these tools to non-municipal drinking-water supplies.

Recommendation 15

We recommend that MECP:

- complete an updated feasibility assessment of potential measures to increase source water protections for non-municipal drinking-water supplies; and
- based on the outcome of the assessment, consider whether any measures are suitable for implementation, and consult with the public on any policy proposals.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.6.2 Owners of Private Wells Are Not Being Notified of Potential Threats to Their Source Water

Ontario operates the Provincial Groundwater Monitoring Network Program, a program that collects baseline information on the quantity and quality of groundwater through a network of over 450 monitoring wells. The program also tests for a variety of chemicals in these groundwater sources. Some of these chemicals could pose a health risk if consumed in high quantities.

Recognizing the risk of chemicals in drinking water, when a groundwater test from a monitoring well exceeds the Ontario Drinking Water Quality Standards, MECP is to notify the relevant PHU pursuant to an MECP protocol. In addition, PHUs help raise awareness amongst private well owners of the importance of maintaining and testing their wells for chemicals.

In the last five years (April 1, 2019, to March 31, 2024), MECP sent out 115 exceedance notifications to PHUs for chemicals that can have serious health impacts, such as arsenic, barium, boron, uranium, nitrates, nitrites or selenium.

In the last five years, MECP sent out 115 exceedance notifications to PHUs for chemicals that can have serious health impacts, such as arsenic, barium, boron, uranium, nitrates, nitrites or selenium.

According to the MECP protocol, MECP should then conduct a hydrogeological study and hold a meeting with the relevant PHU to discuss the study findings and potential next steps. Next steps may include the PHUs notifying owners of private wells in the area of an exceedance and advising them on how to reduce their risk of consuming unsafe drinking water.

We found that, for the 115 exceedances in the five-year period, only one meeting was held between MECP and a PHU. This meeting was to discuss the risk of arsenic in a monitoring well. MECP advised us that, despite the protocol, its practice was to rely on PHUs to take the lead in identifying if a meeting was needed. In August 2024, during our audit, MECP updated its protocol to state that it is the responsibility of the PHU to initiate a meeting if the PHU deems it to be necessary.

In our survey of the 26 PHUs that had received exceedance notifications, only four reported that they had informed private well owners about potential chemicals in their water over the past five years. PHUs said the reasons they may not notify private well owners include a lack of information to identify who may be affected, and a lack of staff experts, such as hydrogeologists, that could assess and determine the level of risk to private well users from the groundwater chemicals.

Many of the MECP notices during this period were for populated areas with numerous drinking-water wells. Some areas received repeated notices, indicating ongoing water-quality issues rather than isolated incidents. For example, MECP issued five notices for excess uranium in one monitoring well and six notices for excess nitrates and/or nitrites in another monitoring well in one region. Similarly, MECP issued five notices for excess arsenic in one monitoring well in another region. All three of these monitoring wells had private drinking-water wells within a one-kilometre

radius; one had 41 private drinking-water wells within a one-kilometre radius, 10 of which were within 500 metres and two within 250 metres.

PHO has a mandate to provide scientific expertise and technical assistance to support informed and evidence-based decisions on public health. We note that, as part of this mandate, PHO could play a role helping PHUs assess when an exceedance is a health risk. PHO has already created a map, based on data published by MECP, that displays chemical concentrations in untreated groundwater and surface water across the province. The **map**, which is online and publicly available, was last updated in 2018.

PHO could play a role helping PHUs assess when an exceedance is a health risk.

Separately, MECP has mapped the location of many wells in Ontario, although the information is incomplete (see **Section 4.5.1**). These maps could be updated and combined to identify the private drinking-water sources at risk from chemicals.

Recommendation 16

We recommend that PHO take the lead, working with MECP, to provide support to PHUs to ensure they have the information they need to assess the health risk of chemical exceedances, so that they can identify when they need to notify owners of private wells that may be at risk of drinking-water threats.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.7 Investigation of Health Risks and Trends from Drinking Water

4.7.1 Health Risks from Drinking Water May be Overlooked Given Limited Analysis

Under MOH's Ontario Public Health Standards, PHUs are responsible for analyzing the patterns, causes, risk factors and trends of diseases and illnesses associated with drinking water. This work is known as epidemiological analysis.

We found that 20 (or 61%) of the 33 PHUs were not undertaking this work, and that MOH does not provide direction on what work is required or track what work has been completed. This creates a risk that drinking-water threats that cause illness or disease may go undetected.

Epidemiological analysis increases the chance that a health risk from drinking water is detected, so that actions can be taken to address the risk. For example, through epidemiological analysis, a PHU may be able to identify a cluster of illnesses in an area and trace the cause back to a specific water source; or PHUs could identify a previously unknown connection between an illness and a particular contaminant.

We asked the 33 PHUs to provide us with their epidemiological work related to drinking water for the past five years. Nine (27%) provided no evidence of such work. A further 11 (33%) provided only a document listing the number of gastrointestinal illnesses reported in their area, but with no analysis of trends or risk factors.

Only 13 (39%) of 33 PHUs had conducted some analysis related to drinking water, using the data from the provincial health information database.

Only 13 (39%) of PHUs had conducted some analysis related to drinking water, using the data from the provincial health information database. For instance, two PHUs had analyzed cases of reported gastrointestinal illness in their area and identified where private drinking-water supplies were a risk factor; this information could be used to target interventions. Another PHU mapped clusters of reported gastrointestinal illnesses to identify regional trends over time, which could help identify vulnerable regions.

PHUs told us that the obstacles to conducting such analysis include a lack of training and resources, a lack of information on private wells (see **Section 4.5.1**) and private intakes needed to identify patterns and vulnerable populations, and a provincial health information database that is outdated and hard to use.

At a provincial level, PHO's mandate includes leading or supporting activities related to illness surveillance. However, PHO confirmed to us that it does not conduct routine epidemiological analysis of provincial trends in health risks related to drinking water.

Recommendation 17

We recommend that MOH take the lead, while working with PHO, to develop and share minimum requirements, best practices and data analysis tools to help PHUs conduct epidemiological analysis related to drinking water.

For the auditee's response, see **Recommendations and Auditee Responses**.

4.8 MECP Oversight of Drinking-Water Testing Laboratories

We found that MECP oversees drinking-water testing laboratories as required. In Ontario, only licensed laboratories are authorized to perform drinking-water tests. MECP is responsible for issuing these licences. As of July 2024, 48 laboratories were licensed to perform drinking-water tests in Ontario, including 11 PHO laboratories, as well as ministry, municipal, academic and privately run laboratories. These laboratories are required to renew their licences every five years.

Specialized MECP laboratory inspectors are required to fully inspect all licensed laboratories at least twice per year, with one in every two inspections unannounced. The inspectors are also required to conduct a renewal inspection prior to renewing a licence. We reviewed the inspection data for the past five years and found full compliance with the inspection requirements. We also reviewed the renewals data and confirmed that all renewal inspections were conducted, and licences were renewed, within the required timeline.

In 2018, MECP launched a pilot project to conduct virtual inspections, such as through audio or video calls, document review and video/photographic assessments. The project was expanded during the COVID-19 pandemic. In October 2023, MECP formalized a procedure for inspectors to determine whether a laboratory is eligible to receive a virtual inspection. As part of the procedure, inspectors must complete a form to ensure only those laboratories that meet all criteria receive a virtual inspection.

From September 2023 to March 2024, MECP conducted 24 virtual inspections. We reviewed all forms for these inspections and found that each was completed and assessed as required.

Recommendations and Auditee Responses

Recommendation 1

We recommend that MECP explore ways to enhance its reporting to the public on all advice provided by the Advisory Council on Drinking Water Quality and Testing Standards, the status of MECP's considerations of the advice provided, and any work conducted or decisions made as a result.

MECP Response

MECP accepts that transparency in government decision-making is important and will report on advice received from the Advisory Council on Drinking Water Quality and Testing Standards through the Minister's Annual Report on Drinking Water.

Recommendation 2

We recommend that MOH work with PHUs to:

- develop and implement initiatives to make small drinking-water system owners aware of the requirement to notify the local PHU before supplying water to the public; and
- examine mechanisms for PHUs to better identify unregistered small drinking-water systems.

MOH Response

MOH agrees with the recommendation and will work with the PHUs to make small drinking-water system owners aware of their notification requirements, and to examine mechanisms for PHUs to better identify unregistered small drinking-water systems.

Recommendation 3

We recommend that MOH, in consultation with PHUs and short-term rental platforms:

- explore and develop options for clear provincial direction on when drinking-water supplies in short-term rental properties are regulated as small drinking-water systems under the *Health Protection and Promotion Act*, which would enable PHUs to require testing of the drinking water; and

- if the direction is to not regulate drinking-water supplies in short-term rental properties as small drinking-water systems, assess the need to develop requirements for owners of short-term rental properties to notify renters that the water is not regulated and whether the water has been tested.

MOH Response

MOH agrees with the recommendation. The Ministry acknowledges the need for a consistent approach to drinking-water supplies at short-term rental properties and will explore options to prevent illness from drinking water at short-term rental properties, such as notification through rental platforms to inform potential users if the water is not regulated and whether the water has been tested.

Recommendation 4

We recommend that MOH work with PHUs to:

- assess the extent of and reasons for any inspection backlogs, including resources and costs; and
- consider and develop strategies to ensure that all PHUs can deliver on their responsibilities to inspect small drinking-water systems at the required frequency.

MOH Response

MOH agrees with the recommendation, and that inspections are an important safeguard to mitigate issues that could pose a health and safety risk. The Ministry agrees to assess the extent of and reasons for any inspection backlogs, including resources and costs; and will work with the local PHUs to explore strategies to inspect small drinking-water systems based on assessed risk.

Recommendation 5

We recommend that MOH take the lead to work with the WCWC to improve the accessibility and uptake of training sessions to meet the needs of both public health inspectors and small drinking-water system operators.

MOH Response

MOH agrees with the recommendation. MOH will continue to work with the WCWC to improve the accessibility and uptake of training sessions to meet the needs of both public health inspectors and small drinking-water system operators.

Recommendation 6

We recommend that MOH:

- assess and resolve issues with the Laboratory Results Management Application and Risk Categorization Tool information systems, including exploring a more efficient way for operators to report opening and closing dates for small drinking-water systems, so that these systems provide reliable data on sampling compliance; and
- collaborate with PHUs to develop a comprehensive plan, including exploring alternative, cost-effective enforcement tools (such as monetary penalties), to better enforce small drinking-water system operators' compliance with sampling requirements.

MOH Response

MOH agrees with the recommendation. MOH is committed to assessing and resolving issues with our Laboratory Results Management Application and Risk Categorization Tool information systems. Additionally, MOH will collaborate with PHUs to further develop a comprehensive plan, exploring alternative, cost-effective enforcement tools to enhance compliance with sampling requirements for small drinking-water systems.

Recommendation 7

We recommend that MOH:

- review and update the current indicator framework in the Ontario Public Health Standards to ensure that public health outcomes related to safe drinking water are measured effectively;
- implement processes for following up with PHUs that do not respond to requests for attestations or performance reports on indicators; and
- periodically verify the PHUs' reported performance with respect to these indicators.

MOH Response

MOH agrees with the recommendation. The Ministry is committed to reviewing the current indicator framework in the Ontario Public Health Standards related to all public health outcomes, including safe drinking water. MOH is also committed to strengthening accountability reporting with PHUs to ensure timely and appropriate follow up and verification of information reported by PHUs through accountability reports.

Recommendation 8

We recommend that MOH:

- in collaboration with PHUs, analyze limitations of the IT systems that support MOH's drinking-water program; and
- explore and develop options for a plan, with timelines, to modernize the drinking-water related IT systems, so that they address identified limitations and meet MOH's and the PHUs' tracking and data-sharing needs.

MOH Response

MOH agrees with the recommendation and will explore developing options, in collaboration with PHUs, to analyze and address the limitations of the IT systems supporting the drinking-water program.

Recommendation 9

We recommend that MECP:

- implement measures and efficiencies to further increase the rate of MECP inspections of non-municipal drinking-water systems; and
- set and meet formal inspection policies and targets for non-municipal drinking-water systems that it regulates.

MECP Response

MECP agrees that inspections are an important safeguard to mitigate issues that could pose a health and safety risk. The Ministry accepts this recommendation and will review and consider implementing the initiatives put forward to improve the procedural efficiencies of municipal drinking-water system inspections.

The Ministry sets inspection targets each fiscal year during planning using risk-based criteria, which includes a maximum frequency between inspections. Once MECP has implemented procedural efficiencies, the Ministry agrees to review current criteria to decrease the length of time between non-municipal drinking-water systems inspections.

Recommendation 10

We recommend that MECP:

- create outreach materials outlining exemption requirements and information about the risks of supplying and consuming untreated drinking water, and deliver them to owners, operators and users of drinking-water systems with treatment exemptions; and
- assess whether any regulatory amendments are needed to minimize the risks of not treating drinking water on the basis of periodic bacterial testing.

MECP Response

MECP accepts this recommendation and will develop outreach materials and deliver them to owners and operators of drinking-water systems, who can then share them with the users of their systems.

The Ministry will evaluate how to best address the risks of allowing a treatment exemption and whether proposing regulatory amendments is needed.

Recommendation 11

We recommend that MOH take the lead to:

- collaborate with MECP to review the definition of "unsafe to drink" to ensure that the threshold for bacteria in private wells and intakes is sufficiently protective of human health; and
- collaborate with PHO to develop and implement a plan, including through the exploration of innovative approaches, to raise awareness about the risks of consuming water that has not been frequently tested, and about the availability of free microbiological testing for private well and intake owners and users in Ontario.

MOH Response

MOH agrees with the recommendation. The Ministry will collaborate with MECP to review the definition of "unsafe to drink" to ensure that the threshold for bacteria in private wells and intakes is sufficiently protective of human health.

MOH will also collaborate with PHO to explore innovative approaches, to raise awareness about the risks of consuming water that has not been frequently tested, and about the availability of free microbiological testing for private well and intake owners and users in Ontario.

Recommendation 12

We recommend that MOH take the lead to work with all the other parties, including MECP, OMAFA, PHO and the PHUs, to undertake a review of educational materials for private wells and intakes (including best practices, guides and videos) to identify opportunities to improve consistency and minimize duplicative work.

MOH Response

MOH agrees with the recommendation. The Ministry will work with all the other parties, including MECP, OMAFA, PHO and the PHUs, to undertake a review of educational materials for private wells and intakes to consider potential opportunities for improving consistency and duplication.

Recommendation 13

We recommend that MECP:

- develop and implement a plan to clear the backlog of submitted well records by inputting the outstanding information into the wells database;
- develop and implement new processes to flag missing or inaccurate information in well records to improve the reliability and accuracy of MECP's information on wells; and
- develop and implement an IT system that enables MECP staff to manage and track information on wells in an effective, reliable and timely manner.

MECP Response

MECP accepts the recommendation to address the backlog of well records. The importance of maintaining complete and current records for effective oversight is understood. The Ministry will consider how to best address the backlog of submitted well records.

MECP acknowledges the need to enhance the reliability and accuracy of well record information. The Ministry will continue to emphasize the importance and awareness of accurate well record submission in informative interactions between Wells Helpdesk, Ministry compliance staff and Ministry-licensed professionals. The Ministry will also consider how to best improve the accuracy of information.

MECP recognizes the need for an IT system to manage and track well information effectively and reliably. In order to address this need, the Ministry is working on a Wells Modernization IT project to design an automated IT system for licensing, well tags and well records.

Recommendation 14

We recommend that MECP explore and implement options, such as education, to increase the number of properly decommissioned abandoned wells.

MECP Response

MECP accepts this recommendation and will explore potential measures, including education, to encourage the proper decommissioning of abandoned wells.

Recommendation 15

We recommend that MECP:

- complete an updated feasibility assessment of potential measures to increase source water protections for non-municipal drinking-water supplies; and
- based on the outcome of the assessment, consider whether any measures are suitable for implementation, and consult with the public on any policy proposals.

MECP Response

MECP accepts this recommendation and will update, where appropriate, its existing feasibility assessment of potential measures to enhance source water protections for non-municipal drinking-water supplies. The Ministry will also consider, where appropriate, whether any identified measures are suitable for implementation, consulting publicly on any resulting policy proposals.

Recommendation 16

We recommend that PHO take the lead, working with MECP, to provide support to PHUs to ensure they have the information they need to assess the health risk of chemical exceedances, so that they can identify when they need to notify owners of private wells that may be at risk of drinking-water threats.

PHO Response

PHO accepts the recommendation and will, in co-ordination with MECP, support PHUs with the information needed to assess the health risk of chemical exceedances related to private wells.

Recommendation 17

We recommend that MOH take the lead, while working with PHO, to develop and share minimum requirements, best practices and data analysis tools to help PHUs conduct epidemiological analysis related to drinking water.

MOH Response

MOH agrees with this recommendation. The Ministry acknowledges the importance of providing clarity and information to support local PHUs in conducting epidemiological analysis of surveillance data to meet requirements under the Ontario Public Health: Requirements for Programs, Services and Accountability Standards.

Audit Criteria

In planning our work, we identified the audit criteria we would use to address our audit objective (outlined in **Section 3**). These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at MECP and MOH (on behalf of PHUs and PHO) reviewed and agreed with the suitability of our objectives and associated criteria:

1. MOH, in conjunction with local PHUs, and MECP have operational requirements (including sampling, testing and treatment), as well as operator training requirements, for all non-municipal drinking-water systems that are risk-based and aligned with best practices.

2. Inspections of non-municipal drinking-water systems are timely and risk-based, and conducted by appropriately trained inspectors.

3. MOH, through local PHUs, and MECP take consistent and timely enforcement actions to address non-compliance issues by owners and operators of non-municipal drinking-water systems.

4. Complete, accessible and consistent information on best practices, as well as on the availability of water testing and on any drinking-water threats identified by the MECP or a local PHU, is provided to owners of private wells and intakes across the province to ensure the safety of their drinking water.

5. MECP and MOH, in conjunction with PHO, work together to ensure that there are accessible drinking-water laboratory testing services available for all Ontarians to assess the safety of their non-municipal drinking-water supplies.

6. MECP and MOH, in conjunction with local PHUs, respond to adverse water-quality incidents in accordance with legislated and policy requirements.

7. Information systems and databases are secure and able to provide timely, accurate and complete information on non-municipal drinking water, and are used to inform decision-making and oversight.

8. Performance of programs related to non-municipal drinking water are monitored, evaluated and publicly reported on, and corrective actions are taken if issues are identified.

Audit criteria applicable to MECP only:

9. MECP oversees the construction, maintenance and abandonment of private wells in a manner that minimizes drinking-water health risks.

10. MECP has processes to identify the key threats to source water for non-municipal drinking-water supplies, and, working with other ministries, develops processes to minimize these threats.

11. MECP inspects laboratories that conduct drinking-water tests in accordance with applicable requirements, and ensures laboratories promptly address any issues of non-compliance.

Audit Approach

We conducted our audit between January 2024 and October 2024. We obtained written representation from each ministry's management that, effective March 18, 2025, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

As part of our audit work, we:

- interviewed relevant staff from both ministries, as well as met with staff from seven PHUs;
- surveyed 33 PHUs (all PHUs except Toronto) on a range of issues about their practices and processes;
- reviewed documents from both ministries, including websites, policies, procedures and guidelines, to gain an understanding of program requirements;
- analyzed data on inspections, enforcement and compliance, AWQIs and drinking water advisories, to determine whether inspections were being conducted and advisories being issued as required;
- analyzed data on well records to assess the quality, completeness and accuracy of the information in the forms and MECP's database;
- analyzed data and information on private well water testing from PHO to assess education efforts and accessibility of laboratory services; and
- attended inspections of both MECP- and MOH-regulated systems, as well as an inspection of a drinking-water testing laboratory, to observe the inspections.

We also met with external stakeholders and subject-matter experts, including those representing the Association of Public Health Inspectors of Ontario, the Canadian Environmental Law Association, the Federation of Ontario Cottagers' Associations, Green Communities Canada, Health Canada, the Ontario Drinking Water Advisory Committee, the Ontario Ground Water Association, Public Health Ontario, the Walkerton Clean Water Centre, and experts from the University of Guelph, Queen's University and the University of Waterloo.

Audit Opinion

To the Honourable Speaker of the Legislative Assembly:

We conducted our work for this audit and reported on the results of our examination in accordance with the Canadian Standards on Assurance Engagements 3001—*Direct Engagements* issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies Canadian Standards on Quality Management and, as a result, maintains a comprehensive system of quality management that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our conclusions.

March 31, 2025

Shelley Spence, FCPA, FCA, LPA
Auditor General
Toronto, Ontario

Acronyms

Acronym	Definition
AWQI	Adverse water quality incident
DWARS	Drinking Water Advisory Reporting System
LRMA	Laboratory Results Management Application
MECP	Ministry of the Environment, Conservation and Parks
MOH	Ministry of Health
OMAFA	Ontario Ministry of Agriculture, Food and Agribusiness
PHO	Public Health Ontario
PHU	Public Health Unit
RCat	Risk Categorization Tool
WCWC	Walkerton Clean Water Centre

Glossary

Term	Definition
Adverse water quality incident (AWQI)	A test result where a concentration (such as for *E. coli*) exceeds the Ontario Drinking Water Quality Standards, or where an observation (such as a broken pipe) signals a potential problem that may affect drinking-water safety; does not necessarily mean users are at risk of becoming ill, but rather that there is a potential problem that requires investigation and, if needed, corrective action.
Designated facility	A facility that serves people who are more vulnerable to illness, such as child-care centres, schools, camps, seniors' homes, hospitals, health-care facilities and homeless shelters.
Drinking water advisory	A notification issued by a PHU to potential water users when a PHU has determined that a water supply poses a risk to health if consumed or used.
Drinking Water Advisory Reporting System (DWARS)	Ministry of Health database used by PHUs to record drinking-water advisories and the actions operators take to address them.
Drinking water testing	Testing conducted to detect whether there are contaminants in the water that may cause health problems.
Drinking water treatment	The process to remove or inactivate contaminants that may pose a health risk. Treatment processes vary widely depending on the purity of the source water and the size and type of the water supply. Treatment processes typically include a disinfection stage (such as adding chlorine) to remove bacteria and viruses. Some systems also use filters to remove other contaminants. More complex systems may include additional screening and chemical treatment processes to remove even more contaminants.
Laboratory Results Management Application (LRMA)	Ministry of Health database used by laboratories to upload test results for small drinking-water systems; also used by public health inspectors to monitor small drinking-water system operators' compliance with sampling requirements and to track adverse water quality incidents.
Public Health Units (PHUs)	Local agencies that provide health programs and services to members of their respective communities according to the Ontario Public Health Standards. They are one of three pillars of Ontario's public health system, along with MOH and PHO.
Risk Categorization Tool (RCat)	MOH tool that helps public health inspectors conduct risk assessments for small drinking-water systems; inspectors record information in RCat about each system, including sampling requirements. Contains a list of all small drinking-water systems in Ontario along with their risk categorization.
Small drinking-water system	The term used by the Province for drinking-water systems that serve seasonal residences or public facilities.
Source water protection	Actions taken to keep potential contaminants, such as manure, sewage, fuel and chemicals, away from a drinking-water source.

ISBN 978-1-4868-8480-3 (PDF)

An electronic version of this report is available at **www.auditor.on.ca**
Ce document est également disponible en français.

Canadian Institute of Public Health Inspectors (CIPHI (ON Br.)
Email: president@ciphi.on.ca

Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO)
Email: chair@asphio.ca

May 28, 2025

Honourable Sylvia Jones
Deputy Premier and Minister of Health
Ministry of Health
5th Floor
777 Bay St.
Toronto, ON, Canada M7A 2J3

Subject: Joint Statement from CIPHI and ASPHIO: Supporting the Implementation of Recommendations from the Auditor General's 2025 Report on Non-Municipal Drinking Water Safety

Dear Minister,

On behalf of the Canadian Institute of Public Health Inspectors (CIPHI (ON Br.) and the Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO), we extend our appreciation for the comprehensive 2025 Special Report by the Auditor General of Ontario on the Safety of Non-Municipal Drinking Water. We commend the Ministry of Health for accepting all 10 recommendations aimed at the Ministry of Health and for its commitment to strengthening Ontario's public health infrastructure.

We write to express our strong support for the Ministry's efforts and to offer our collaboration in implementing several key recommendations from the report. As outlined in the *ASPHIO White Paper (June 2023)*, public health inspectors (PHIs) are uniquely positioned to support these efforts through specialized training, regulatory expertise, and community engagement skills.

Ontario's Public Health Units (PHUs) and their dedicated public health inspectors are vital in ensuring millions of people have access to safe drinking water. Although there are ongoing challenges regarding capacity due to recruitment challenges in the northern and rural regions of Ontario, and an increasing workload, Public health inspectors excel in conducting risk assessments and inspections of small drinking-water systems, issuing advisories to protect public health, providing education and outreach to private well owners and system operators, and facilitating access to free water testing through Public Health Ontario laboratories. Thanks to these concerted efforts, over 98% of water samples meet

Ontario Drinking Water Quality Standards, highlighting the crucial role PHIs play in safeguarding our communities' health and well-being.

1. Enhancing Oversight and Inspection Capacity (Recommendations 2–4, 6, 7)

The Auditor General's report highlights inspection backlogs and inconsistent enforcement across PHUs. ASPHIO and CIPHI can support the Ministry by:

- Assisting in the development of standardized inspection protocols and risk assessment tools.
- Supporting inter-public health unit (PHU) mentorship and training programs to build inspection capacity, especially in under-resourced regions.
- Collaborating on the design of performance indicators to track inspection frequency, compliance, and enforcement outcomes.
- Assisting in evaluating Small Drinking Water System definitions about short-term rental properties and supporting the development of strategic direction, including considerations related to PHU budget implications.
- Engaging with PHUs to validate the need to secure additional and sustainable funding for timely inspections and consistent enforcement.

2. Improving Training and Workforce Development (Recommendations 5, 17)

The ASPHIO White Paper emphasizes the urgent need for a resilient PHI workforce. In addition, CIPHI's Continuing Professional Competencies (CPC) promotes workforce development by ensuring that public health inspectors maintain and enhance their professional and technical skills and knowledge while meeting the standards for maintaining the CPHI(C) credential. We recommend:

- Expanding tuition support and Ministry-funded practicum placements for PHI students, particularly in Northern and rural Ontario.
- Developing standardized onboarding and continuing education modules in partnership with academic institutions and the Walkerton Clean Water Centre.

3. Public Education and Outreach (Recommendations 11, 12, 16)

To address low testing rates among private well owners and improve awareness of water safety:

- CIPHI and ASPHIO can assist in reviewing and disseminating public education campaigns on the risks of untreated water and the availability of free testing.
- We can help standardize educational materials across PHUs to ensure consistency and clarity.

- We can support PHO's role in developing risk communication tools and contribute PHI expertise to these efforts.

4. Data Modernization and Program Evaluation (Recommendations 6, 7, 8)

The lack of integrated data systems hinders effective oversight. We propose:

- Participating in Ministry-led consultations to modernize IT systems (e.g., RCat, LRMA, DWARS) and ensure they meet the operational needs of PHUs.
- Supporting the development of standardized provincial indicators to evaluate environmental health program outcomes.

5. Preparedness for Future Drinking Water Emergencies

Public health inspectors played a critical role during the COVID-19 pandemic. To ensure readiness for future public health emergencies:

- We recommend sustained investment in PHI surge capacity, cross-training, and emergency preparedness planning.
- ASPHIO and CIPHI are prepared to assist in scenario planning and tabletop exercises to test and refine emergency response protocols.

We are dedicated to collaborating with the Ministry of Health and local public health units to ensure the safety of Ontario's drinking water and the resilience of our public health system. Securing sustainable funding for public health inspectors and public health programming is essential to promoting community well-being. These investments will lead to healthier living conditions and improved health outcomes.

By leveraging the expertise of CIPHI (ON Br.) and ASPHIO, as well as the knowledge and experience of its members, we can further enhance a public health system capable of successfully implementing the Auditor's recommendations and addressing contemporary challenges. We welcome the opportunity to meet and discuss how our associations can contribute to effectively implementing these recommendations.

Yours sincerely,

Ken Diplock, Ph.D., CPHI(C)
President, Canadian Institute of Public Health Inspectors (Ontario Branch)

Dominque Bremner, CPHI(C)
Chair, Association of Supervisors of Public Health Inspectors of Ontario

Cc:
Dr. Kieran Moore, Chief Medical Officer of Health, Kieran.Moore@ontario.ca
Dr Wajid Ahmed, Associate Chief Medical Officer of Health, Wajid.Ahmed@ontario.ca
Jodi Melnychuk, Director, Health Protection, Policy and Partnerships Branch, Ministry of Health, Jodi.Melnychuk@ontario.ca
Loretta Ryan, Executive Director, Association of Local Public Health Agencies, loretta@alphaweb.org
Dr. Tamara Wallington, Chief and VP, Population Health, Public Health Ontario, tamara.wallington@oahpp.ca
Rena Chung, Senior Director, Operations, Population Health, Public Health Ontario, Rena.chung@oahpp.ca

References

1. Association of Supervisors Public Health Inspectors of Ontario (ASPHIO). (2023). Highlighting the vital role of public health inspectors within a responsive and effective public health workforce: A report to the Ontario Ministry of Health. Retrieved from https://ciphi.ca/on/documents-ontario/

ENDORSING CIPHI & ASPHIO JOINT STATEMENT: IMPLEMENTATION OF RECOMMENDATIONS FROM THE AUDITOR GENERAL'S 2025 REPORT ON NON-MUNICIPAL DRINKING WATER SAFETY

MOTION:

WHEREAS the *Health Protection & Promotion Act* mandates the Board of Health to prevent water-borne illness related to drinking water, including non-municipal drinking water;

AND WHEREAS the Auditor General's 2025 performance audit on non-municipal drinking water safety made 17 recommendations, including 10 to the Ministry of Health for improvement;

AND WHEREAS the Canadian Institute of Public Health Inspectors (CIPHI) and the Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO) have endorsed these recommendations and offered their support the Ministry of Health to implement the recommendations;

AND WHEREAS the recommendations of the Auditor General, CIPHI, and ASPHIO align strongly with addressing challenges observed and experienced by Public Health Sudbury & Districts;

THEREFORE BE IT RESOLVED THAT this Board of Health endorses and supports the "Joint Statement from CIPHI and ASPHIO: Supporting the Implementation of Recommendations from the Auditor General's 2025 Report on Non-Municipal Drinking Water Safety, 2025".

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Board of Health

From: M. Mustafa Hirji, Acting Medical Officer of Health & Chief Executive Officer

Date: September 11, 2025

Re: Communications between the Chief Medical Officer of Health and the Grey Bruce Health Unit Board of Health, & Governance Implications for Public Health Sudbury & Districts

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☐ For Information ☐ For Discussion ☒ For a Decision

Issue:
In 2024–2025, the Ministry of Health conducted an assessment of the Grey Bruce Health Unit's (GBHU) Board of Health's performance. As an outcome of that report, changes were directed by the Chief Medical Officer of Health to the make-up of that board of health, including replacing municipal politicians who sit on the Board of Health with only non-politicians. Since that time, although the Chair of Board of Health has supported the recommended changes, there has arisen public disagreements between the Chief Medical Officer of Health (CMOH) Office and the Chair.

The Chair of the GBHU Board of Health has shared with all Boards of Health in Ontario various communications between himself and the CMOH.

While Public Health Sudbury & Districts is only an observer to these events, there are lessons within it for improvement of our board governance.

Recommended Action:

1. The Board of Health receive the communications between the Chief Medical Officer of Health and the Chair of the Grey Bruce Health Unit Board of Health (Appendices) for information.

2. The Board of Health recommit to vigilance around its governance practices, including its ongoing work to strengthen governance training, its financial oversight work, and its efforts to ensure municipal politics do not impact Board discussions; this includes that all Board members set aside any considerations of or loyalties to other organisations in order to exercise their fiduciary duty as Board members.

3. The Board of Health direct the Acting Medical Officer of Health & CEO to build on the recent request to municipalities to include an Indigenous person on the Board of Health, to now broaden that and recommend a comprehensive skills-matrix to guide municipalities and the Public Appointments Secretariat in future Board of Health appointments.

Alternative Actions:
The Board of Health receive the communications for information, and not exercise leadership in moving ahead with improvements to governance at this time.

Background:
On July 18, 2025, the CMOH informed the GBHU Board of Heath regarding the results of the assessment done on the Board during 2024-2025. The details of that assessment report are not known at this time, however, the CMOH has noted that it found, in part, the following:

- *The Board of Health failed to fulfil its governance responsibilities and did not have the structures in place to operate effectively, leading to a lack of stable leadership over the period assessed, lack of clear roles and responsibilities for members of the board, and instances of poor communication and conflict among board members and staff;*
- *There were numerous examples of alleged non-compliance with the Act and leading governance practices not being followed including failure by the Board of Health to ensure appropriate financial oversight of expenses; and,*
- *The Board of Health failed to implement specific recommendations from an audit conducted by the Ministry of Health in 2018.*[1]

The CMOH, in that July 18 communication, directed the Board of Health to make changes to the composition of its Board of Health, particularly around removing municipal politicians from the Board. The Chair of the Board of Health supported these changes, and acted quickly to implement them.

On August 14, 2025, the CMOH communicated to the Board of Health to cease its actions in follow-up to the July 18 direction. Instead, it invoked the CMOH's ability to exercise the powers of the Board of Health and directed the Board of Health, the Medical Officer of Health, and the staff of the Grey Bruce public health agency to follow his direction and report to him.

Since that time, open disagreements between the CMOH Office and the Board Chair have arisen on several items of legality and process around how events involved between July 18 and August 14.

As bystanders to this affair, we are unable to assess the veracity of any of these claims, many of which require lawyers.

The key learnings and implications from this episode for the Board of Health for Public Health Sudbury & Districts are as follows:

1. Boards of health are accountable to the Provincial government, and must conduct themselves to the highest standard, consistent with the Ontario Public Health Standards' Organizational Requirements. If there is poor governance by a board, the Provincial government may intervene.

[1] "Direction of the Chief Medical Officer of Health (the "CMOH") to the Board of Health for the Grey Bruce Health Unit (the "Board of Health") under section 77.1 of the ***Health Protection and Promotion Act*** (the "Act"). Direction issued by Dr. Kieran Moore, Chief Medical Officer of Health & Assistant Deputy Minister, Public Health. August 14, 2025.

This is what has happened with GBHU. It has also previously occurred with Algoma Public Health in 2015 (for which Public Health Sudbury & Districts played a key role in helping the Provincial Government to respond), as well as Muskoka-Parry Sound Health Unit in 2006 (which led to its dissolution and merger of parts into two other local public health agencies). Public Health Sudbury & Districts has strong governance and financial oversight policies and procedures. It is recommended that the Board recommit to the importance of these, and continue with intentions to strengthen governance training.

2. There seems to be particular concern to the CMOH with GBHU Board of Health's municipal appointees being municipal councillors. While specifics are not known, it may be that municipal politics impacted Board of Health decision-making. Notwithstanding this, the *Health Protection & Promotion Act* continues to permit municipal politicians serving as Board members. Therefore, no change is recommended for our Board of Heath regarding this. However, the Ontario Public Health Standards emphasize board members exercising fiduciary duty: in other words, concerning themselves entirely with what is best for the organization the board oversees (i.e. Public Health Sudbury & Districts), without regard to the concerns of the organization from which they have been appointed (i.e. municipalities) or to which they are associated (e.g. employer). It is recommended that board members recommit to their fiduciary duties no matter what considerations or loyalties they have to other organizations.

3. The CMOH directed the GBHU Board of Health to develop a "skills-based matrix" to select new Board of Health members. This direction aligns with the May 2006 recommendation of the Capacity Review Committee for "skills-based boards of health"[2]. The goal of skills-based boards was for members of board of health to be selected based on the skills and perspectives they bring in order to constitute a diverse group with the skill and competency mix to best govern public health[3]. This was in contrast to selecting board members based on membership on a municipal council. While there is no direction at this time for Public Health Sudbury & Districts to develop a skills matrix, there is a 20-year history of this approach being recommended and not actioned for the system, as well as seeming current interest by the CMOH. The Board of Health for Public Health Sudbury & Districts has an opportunity to once again be a leader within the province by moving forward this long-outstanding recommendation. A skills matrix would build on the Board's recent recommendation to municipalities to appoint an Indigenous person to the Board of Health, broadening this recommendation to a comprehensive set of skills and perspectives that would be desirable on the Board. Having a skills matrix would further lessen the risk of this Board experiencing governance challenges due to its make-up. And noting the province has observed governance issues with many school boards as well, taking proactive action now would position this Board as ahead of any provincial push to improve board governance.

[2] Revitalizing Ontario's Public Health Capacity: The Final Report of the Capacity Review Committee. May 2006.
[3] Revitalizing Ontario's Public Health Capacity: A Discussion of Issues and Options. Interim Report of the Capacity Review Committee, November 2005.

Financial Implications:
There are no direct financial implications to this report. It is believed that some of the provincial government's concerns with respect to the Grey Bruce Board of Health have to do with financial management, and so this incident serves as a reminder for good financial oversight by the Board.

IT team and IT infrastructure implications:
There are no IT implications to this report.

Ontario Public Health Standard:
The contents of this report relate to the importance of the Organizational Requirements under the OPHS, particularly, governance, fiduciary, and financial accountability requirements.

Strategic Priority:
N/A

Contact:
M. Mustafa Hirji, Acting Medical Officer of Health & CEO

Appendices

1. "Assessment Report of the Board of Health for the Grey Bruce Health Unit – Direction issued under section 83 of the ***Health Protection and Promotion Act***". Letter sent by Dr. Kieran Moore, Chief Medical Officer of Health & Assistant Deputy Minister, Public Health to Nicholas Saunders, Chair, Board of Health Grey Bruce Health Unit. July 18, 2025.
2. "Termination of Your Appointment to the Grey Bruch Health Unit Board". Template of letter to be sent by Nicholas Saunders Chair, Board of Health Grey Bruce Health Unit. August 6, 2025.
3. "Direction of the Chief Medical Officer of Health (the "CMOH") to the Board of Health for the Grey Bruce Health Unit (the "Board of Health") under section 77.1 of the ***Health Protection and Promotion Act*** (the "Act"). Direction issued by Dr. Kieran Moore, Chief Medical Officer of Health & Assistant Deputy Minister, Public Health. August 14, 2025.
4. "Successive Directions under the ***Health Protection and Promotion Act***". Letter sent by Nicholas Saunders, Chair, Board of Health Grey Bruce Health Unit to Dr. Kieran Moore, Chief Medical Officer of Health & Assistant Deputy Minister, Public Health. August 15, 2025.
5. "Request for Public Retraction Regarding Statements on August 14, 2025". Electronic communication sent by Nicholas Saunders, Chair, Board of Health Grey Bruce Health Unit to Medical Officers of Health with request to forward to Boards of Health. August 25, 2025.

Ontario

Ministry of Health
Office of Chief Medical Officer of Health, Public Health
Box 12,
Toronto, ON M7A 1N3
Fax: 416 325-8412

Ministère de la Santé
Bureau du médecin hygiéniste en chef, santé publique
Boîte à lettres 12
Toronto, ON M7A 1N3
Téléc. :416 325-8412

July 18, 2025

Nicholas Saunders
Chair, Board of Health
Grey Bruce Health Unit
101 17th Street East
Owen Sound ON N4K 0A5

Re: Assessment Report of the Board of Health for the Grey Bruce Health Unit – Direction issued under section 83 of the *Health Protection and Promotion Act*

Dear Mr. Saunders:

I am writing to inform you that the assessment of the Board of Health of the Grey Bruce Health Unit has been completed. Attached is a copy of the Assessment Report to be shared with Board of Health members.

As per my letter of April 29, 2024, the objective of the assessment was to assess the quality of the management and administration of the affairs of the Board of Health for the Grey Bruce Health Unit under section 82(3)(c) of the *Health Protection and Promotion Act* (HPPA), and to ascertain whether the Board of Health is complying in all other respects with the HPPA and the regulations under section 82(3)(b) of the HPPA.

The Ministry takes the Assessment Report and recommendations very seriously given the significant issues revealed in the areas of governance and administration practices, management of funds, public health leadership, organizational culture, human resource management, and stakeholder relations. Overall, the assessment found that that the Board of Health has failed to ensure the adequacy of the quality of the administration or management of its affairs.

I strongly support the key recommendations contained in the Assessment Report and that the recommendations will provide support and guidance for the Board of Health to move forward and will assist with ensuring the provision of public health programs and services for the Grey Bruce community.

…/2

Nicholas Saunders

I am, as a result of the Assessment Report, issuing you a direction pursuant to section 83 of the HPPA. I direct you to respond to me, in writing, as to the Board of Health's response to the Assessment Report and its recommendations **within 30 days** following receipt of this letter. The Board of Health response should include an action plan, for the Ministry's review and approval, detailing how the Board of Health will address the recommendations in the Report, the time frame in which recommendations will be rectified, with high-risk recommendations given priority. Failure to respond within the 30 days may result in me taking additional actions available under the HPPA.

Given the concerning findings of the assessment, and to ensure compliance with legislative requirements and successful implementation of the report's recommendations, I am requesting that the Board of Health take the following immediate actions (updates of which should be addressed as part of the Board of Health's action plan noted above):

- Implement a skills-based matrix for new Board of Health members.
- Work with the Counties of Bruce and Grey and the Ministry to immediately replace the municipal members on the Board of Health, with strong consideration for the appointment of non-elected municipal appointments.
- Rectify issues identified in the Assessment Report regarding the current Medical Officer of Health.

To improve the overall governance of the Board of Health, the Office of Chief Medical Officer of Health, Public Health Division will also work with the appropriate government officials to maximize the number of provincial representatives on the Board of Health for the Grey Bruce Health Unit.

My office will be in contact with you shortly to schedule a meeting with your Board of Health to discuss the Assessment Report and next steps.

If you have any questions, please contact Brent Feeney, Director, Accountability and Liaison Branch, at (416) 671-3615 or Brent.Feeney@ontario.ca.

Yours truly,

Dr. Kieran Michael Moore, MD, CCFP(EM), FCFP, MPH, DTM&H, FRCPC, FCAHS
Chief Medical Officer of Health and Assistant Deputy Minister, Public Health

Attachment

…/3

c: Chad Richards, Vice-Chair, Board of Health, Grey Bruce Health Unit
Elizabeth Walker, Executive Lead, Office of Chief Medical Officer of Health, Public Health
Dr. Wajid Ahmed, Associate Chief Medical Officer of Health
Brent Feeney, Director, Accountability and Liaison Branch
Sandra Han, Manager, Accountability and Liaison Branch

Grey Bruce Public Health

IN CONFIDENCE

Delivered by email; original to follow by registered mail.

Date: August 6, 2025

Ms./Mr. [Full Name]
Address[address]

Ms. [name]

Subject: Termination of Your Appointment to the Grey Bruce Health Unit Board

At its meeting on 25 July 2025, the Board received and discussed a letter from the Chief Medical Officer of Health, dated 18 July 2025.

The letter directed the Board to "(w)ork with the Counties of Bruce and Grey and the Ministry to immediately replace the municipal members on the Board of Health, with strong consideration for the appointment of non-elected municipal appointments." The Board was further directed to implement "a skills-based matrix for new Board of Health members."

Pursuant to this directive, your appointment as a municipal appointee to the Grey Bruce Health Unit (GBHU) Board of Health has been terminated effective immediately.

This action aligns with ongoing efforts to strengthen the governance and operational effectiveness of the GBHU Board of Health, in accordance with the Health Protection and Promotion Act.

Should you require further information, please contact my office, in writing, at the coordinates below.

I thank you for your time, effort, and service.

Sincerely,

Nicholas Saunders
Chair, Board of Health

Grey Bruce Health Unit
101 17th Street East
Owen Sound, ON N4K 0A5
AdminMedicalOfficer@publichealthgreybruce.on.ca

Ontario

Ministry of Health

Office of Chief Medical Officer of Health, Public Health

Box 12,
Toronto, ON M7A 1N3

Fax: 416 325-8412

Ministère de la Santé

Bureau du médecin hygiéniste en chef, santé publique

Boîte à lettres 12
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Téléc. :416 325-8412

ONTARIO MINISTRY OF HEALTH

IN THE MATTER Of the *Health Protection and Promotion Act*
R.S.O. 1990, c. H.7

DIRECTION OF THE CHIEF MEDICAL OFFICER OF HEALTH (the "CMOH") TO THE BOARD OF HEALTH FOR THE GREY BRUCE HEALTH UNIT (the "Board of Health") UNDER SECTION 77.1 OF THE *HEALTH PROTECTION AND PROMOTION ACT* (the "Act")

WHEREAS under subsection 77.1 (1) of the Act, if the CMOH is of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, the CMOH may investigate the situation and take such action as the CMOH considers appropriate to prevent, eliminate or decrease the risk.

AND WHEREAS under subsection 77.1 (2) of the Act, for the purpose of subsection 77.1 (1), the CMOH may exercise any of the powers of a board of health or a medical officer of health, and may direct a person whose services are engaged by a board of health to do, anywhere in Ontario, any act that the person has the power to do under the Act.

AND WHEREAS an Assessor was appointed on April 1, 2024 pursuant to section 82 of the Act to assess the quality of the management or administration of the affairs of the Board of Health and ascertain whether the Board of Health was complying in all other respects with the Act and regulations.

AND HAVING REGARD TO the Assessor's Report of the Board of Health dated December 2024, pursuant to subsection 82(3) of the Act, which found, in part that:

…/2

- The Board of Health failed to fulfil its governance responsibilities and did not have the structures in place to operate effectively, leading to a lack of stable leadership over the period assessed, lack of clear roles and responsibilities for members of the board, and instances of poor communication and conflict among board members and staff;
- There were numerous examples of alleged non-compliance with the Act and leading governance practices not being followed including failure by the Board of Health to ensure appropriate financial oversight of expenses; and,
- The Board of Health failed to implement specific recommendations from an audit conducted by the Ministry of Health in 2018.

AND HAVING REGARD TO recent actions taken by the Board of Health since the Assessor's Report was issued in July 2025, including, but not limited to:

- The Chair's attempt on August 6, 2025 to unilaterally remove municipal representatives on the Board of Health without authority to do so; and,
- The Board of Health's reluctance to share the Assessor's Report with affected parties, such as municipalities, while it develops its Action Plan in response to the Report.

AND HAVING REGARD TO the lack of trust among local partners, including municipalities, about the capacity of the existing Board of Health to function and meet its legislative responsibilities including under section 5 of the Act to provide or ensure the provision of health programs and services.

I AM THEREFORE OF THE OPINION that the findings of the Assessor's Report, together with the Board of Health's actions since the release of the Report, and the lack of confidence among local partners in the Board of Health, compromise the Board of Health's ability to competently provide for the organization and delivery of public health programs and services, the prevention of the spread of disease, and the promotion and protection of the health of the people of Grey Bruce Health Unit as required by the Act. This constitutes or may constitute a risk to the health of persons in the public health unit pursuant to subsection 77.1(1) of the Act.

AS SUCH, EFFECTIVE THE DATE OF THIS DIRECTION:

I, the Chief Medical Officer of Health, will exercise all of the powers of the Board of Health under the Act pursuant to subclause 77.1(2)(a)(i).

…/3

TO ENABLE MY EXERCISE OF THE POWERS OF THE BOARD OF HEALTH, I DIRECT the members of the Board of Health, the Medical Officer of Health, and the staff of the Grey Bruce Health Unit to:

1. Follow my instructions and the instructions of persons whom I may instruct in writing to assist me in carrying out this Direction.

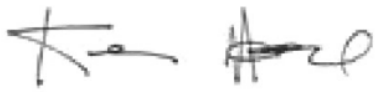
2. Provide any record, document, or other information that I, or persons specified in section 1 above, may ask for to carry out this Direction, that is in the custody or under the control of the members of the Board of Health, the Medical Officer of Health, or the staff of the Grey Bruce Health Unit.

3. Cooperate fully with this Direction and not hinder or obstruct me, or the persons specified in section 1 above, in any respect.

I FURTHER DIRECT the Medical Officer of Health to report to me as required under section 67 of the Act. The Medical Officer of Health shall be responsible to me, exercising the powers of the Board of Health, for the management of public health programs and services under the Act or any other legislation.

This Direction shall remain in force until such time as it is revoked.

DATED at Toronto this 14th day of August, 2025.



Dr. Kieran Moore
Chief Medical Officer of Health and Assistant Deputy Minister
Office of Chief Medical Officer of Health, Public Health

TO: Board of Health for the Grey Bruce Health Unit
101 17th Street East
Owen Sound ON N4K 0A5
AdminMedicalOfficer@publichealthgreybruce.on.ca

14-075

Grey Bruce Public Health

August 15, 2025
BY EMAIL

Dr. Kieran Moore
Chief Medical Officer of Health
and Assistant Deputy Minister, Public Health
Ministry of Health
Box 12
Toronto, Ontario
M7A 1N3

Dear Dr. Moore:

Successive Directions under the *Health Protection and Promotion Act*

I write in response to your July 18 written direction and your August 14 written direction.

On July 14, purportedly under section 83 of the HPPA, you issued a written direction to me. Specifically, you wrote:

> I am, as a result of the Assessment Report, issuing you a direction pursuant to section 83 of the HPPA. I direct you to respond to me, in writing, as to the Board of Health's response to the Assessment Report and its recommendations within 30 days following receipt of this letter. The Board of Health response should include an action plan, for the Ministry's review and approval, detailing how the Board of Health will address the recommendations in the Report, the time frame in which recommendations will be rectified, with high-risk recommendations given priority. Failure to respond within the 30 days may result in me taking additional actions available under the HPPA.
>
> Given the concerning findings of the assessment, and to ensure compliance with legislative requirements and successful implementation of the report's recommendations, I am requesting that the Board of Health take the following immediate actions (updates of which should be addressed as part of the Board of Health's action plan noted above):
>
> …
>
> - Work with the Counties of Bruce and Grey and the Ministry to immediately replace the municipal members on the Board of Health, with strong consideration for the appointment of non-elected municipal appointments.
>
> …

Frankly, I am dismayed and disappointed that your August 14 correspondence claims that I "attempt[ed] on August 6, 2025 to unilaterally remove municipal representatives on the Board of Health without authority to do so."

I was not acting unilaterally but was attempting to comply with your July 18 written direction "to immediately replace the municipal members on the Board of Health."

As Chair of the Board, I took extremely seriously the assessment report and my legal obligations to respond to your direction. After receiving your July 18 written direction, I was in continued communication with your office on the Action Plan you directed me to submit.

Your July 18 direction required that the Action Plan address the recommendations in the Assessment Report, with "high-risk recommendations given priority." Among the high-risk, priority recommendations that you directed me to address in the Action Plan was the following:

> In addition, the requirement to have the Wardens of the counties to be members of the [Board of Health] should be ***revised immediately*** and the appointment of non-elected municipal members should be considered to represent community interests.

History of Communication with Your Office

On July 31, I wrote to Brent Feeney, Director of the Accountability and Liaison Branch, to request a meeting to clarify next steps and ensure alignment. In the same e-mail, I informed Mr. Feeney of the steps underway to compose the Action Plan and meet the 30-day deadline mandated in your July 18 written direction. I requested that he respond by August 5 with "any concerns or feedback … to ensure timely implementation."

In the July 31 email, I expressly informed Mr. Feeney that, "We will initiate immediate communication with the Counties of Bruce and Grey, in coordination with your office, to replace municipal members with non-elected appointees who align with the skills-based matrix."

On August 1, Mr. Feeney replied that "the process for developing the Action Plan remains at the discretion of the Board." He further encouraged the Board to communicate directly with the Counties of Bruce and Grey, given that your office had "already provided the Counties with a high-level overview of the governance findings and recommendations in the Report, so they are expecting to hear from the Board."

Accordingly, on August 6, I informed Elizabeth Walker, Executive Lead for Public Health that letters had been sent to all of the municipal appointees on the Board to notify them that their appointments had been terminated and to begin working with the Counties of Bruce and Grey for appointing non-elected members who meet the skills-based matrix, pursuant to your July 18 written direction. I asked her provide feedback "and any concerns regarding the Action Plan" by August 11. On August 8, she replied, "Thanks Nick, appreciate the update."

Given that I had kept your officials updated on the various steps being taken to implement your July 18 written direction to me, I was surprised to receive Ms. Walker's August 11 e-mail telling me that I was to rescind "all termination letters issued to municipal members" of the Board and that your direction was instead merely a request.

Your July 18 correspondence expressly stated that it was a direction. You wrote, "I am, as a result of the Assessment Report, issuing you a direction pursuant to section 83 of the HPPA." You directed me to send you an Action Plan and you directed that the Action Plan must include an update on "immediate actions" including "to immediately replace the municipal members on the Board of Health."

At all times, I acted pursuant to your July 18 written direction, and I worked in lock-step with officials in your office. Consequently, the allegation that I acted unilaterally is inaccurate and extremely unfair.

Authority to Issue Direction under Section 83

Until two days ago, I presumed that you possessed the statutory authority to issue your July 18 direction. As previously stated, upon receiving that direction, I took my responsibility to act and ensure the Board's compliance with the HPPA extremely seriously. I consistently communicated the Board's proposed course of action to ensure compliance with the HPPA to your officials, including the termination of municipal members of the Board. I was told, on more than one occasion, that developing the Action Plan fell within the Board's discretion, but that the Action Plan must specifically address the direction you provided in your letter.

The Board of Health has consulted external legal counsel and we now understand that your July 18 direction to replace the municipal members was unlawful. The power to appoint and to replace municipal members rests solely with the County of Grey and the County of Bruce, and not with the Board of Health. Because neither the Board of Health nor the Chair has authority to replace any member, let alone all the municipal members, your July 18 direction "to immediately replace the municipal members on the Board of Health" is and always was of no effect.

Further, subsection 49(2) of the HPPA requires that "there shall be not fewer than three and not more than thirteen municipal members of each board of health." A direction to remove all the municipal members would, of course, contravene that requirement.

I am perplexed why you gave me a July 18 direction to send you an Action Plan that was to include immediate action to address "immediately replac[ing] the municipal members on the Board of Health" when there was no authority under the HPPA to direct me to do so.

I am also concerned that you are now trying to blame me for the replacement controversy, which was triggered, not by me, but by your July 18 written direction.

Your August 14 Direction

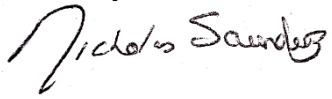
I confirm receipt of your August 14 direction, and I will share it with all members of the Board of Health.

Your August 14 direction transfers to you all powers of the Board of Health.

I assume that your August 14 direction replaces your July 18 written direction to me, and I invite you to confirm the same.

I confirm that I will comply with your August 14 direction but, for the reasons set out above, I do not agree with the premises on which your direction is based or with the history of events as you have characterized them.

Yours truly,



Chair, Board of Health
Grey Bruce Health Unit

cc:
Hon. Doug Ford, Premier for Ontario
Hon. Sylvia Jones, Deputy Premier and Minister of Health for Ontario
Dr. Theresa Tam, Canada's Chief Public Health Officer
Board of Health for Grey Bruce Public Health
Chad Richards, Vice Chair, Board of Health, Grey Bruce Health Unit
All Boards of Health in Ontario
Council of Medical Officers of Health of Ontario
alPHa Board of Directors and Chief Executive Officer, alPHa-Association of Local Public Health Agencies
Ruff, Alex - M.P., Bruce-Grey-Owen Sound
Paul Vickers, MPP, Bruce – Grey – Owen Sound
Hon. Lisa Thompson, MPP, Huron – Bruce
Brian Saunderson, MPP, Simcoe – Grey
Sol Mamakwa, Ontario NDP
Luke Charbonneau, Warden, Bruce County
Andrea Matrosovs, Warden, Grey County

cc:
Chief Darlene Johnston, Chief and Council, Chippewas of Nawash Unceded First Nation
Chief Conrad Ritchie, Chief and Council, Saugeen First Nation
Tracy Antone, Chief Operating Officer, Chiefs Of Ontario
Mathew Hoppe, CEO, The Independent First Nations Alliance (IFNA)
National Chief Cindy Woodhouse Nepinak, First Nations and Inuit Health Branch, Indigenous Services Canada
Ontario Federation of Indigenous Friendship Centres
Chief Bobby Cameron, Federation of Sovereign Indigenous Nations
Camden Maracle, President, Native Canadian Centre of Toronto

From: Nick Saunders <nick.saunders@makhosinc.com>
Date: Mon., Aug. 25, 2025, 12:08 a.m.
Subject: Request for Public Retraction Regarding Statements on August 14, 2025
To: <kieran.moore1@ontario.ca>
Cc: <doug.fordco@pc.ola.org>, <sylvia.jones@ontario.ca>, <CPHOCorrespondence@phac-aspc.gc.ca>, <chadwlrichards@gmail.com>, <comoh-bounces@lists.alphaweb.org>, <comoh@lists.alphaweb.org>, <communications@alphaweb.org>, <gordon@alphaweb.org>, <Alex.Ruff@parl.gc.ca>, <paul.vickers@pc.ola.org>, <lisa.thompson@pc.ola.org>, <brian.saunderson@pc.ola.org>, <sol.mamakwa@ontariondp.ca>, <LCharbonneau@brucecounty.on.ca>, <Andrea.Matrosovs@grey.ca>, <bevwilkins@bmts.com>, <hctingling@gmail.com>, <kcraig@brucecounty.on.ca>, <Shirley.keaveney@grey.ca>, <JKirkland@brucecounty.on.ca>, <dmurray@brucecounty.on.ca>, <nawashfiredept@nawash.ca>, <doran.ritchie@saugeen.org>, <health.director@saugeen.org>, <chiefsdesk@nawash.ca>, <Tracy@coo.org>, <isak.vaillancourt@coo.org>, <comms@ifna.ca>, <asanderson@ifna.ca>, <infopubs@sac-isc.gc.ca>, <ofifc@ofifc.org>, <info@fsin.com>, <president@ncct.on.ca>, <leona.roote@saugeen.org>

Dear Dr. Moore,

Given the Ministry's acknowledgement this past Friday, we can now put to rest the inaccurate and unfair allegation that I unilaterally attempted to remove the municipal representatives from the Board of Health.

On Friday, August 22, your office convened a virtual meeting. In attendance were all members of the Board of Health for Grey Bruce Public Health, the Medical Officer of Health for Grey Bruce, your advisor Mr. Jim Pine, and the following Ministry officials: Dr. Kate Bingham, Mr. Brent Feeney, Ms. Kate Mason, and Ms. Carol Ma.

During this meeting, Mr. Feeney acknowledged that I did not act unilaterally in issuing termination letters to municipal appointees but rather acted in coordination with him and others in your office.

Mr. Feeney's candour and transparency were refreshing and very much appreciated. His admission on behalf of the Ministry of Health directly contradicts your August 14 correspondence and other public statements you have made.

While an apology is deserved, I merely ask you to confirm that you are withdrawing the allegation so we can get back to our primary focus of working collaboratively to rebuild relationships and support public health in Grey Bruce.

Sincerely,

Nicholas Saunders

Chair, Board of Health

Grey Bruce Health Unit

cc:

Hon. Doug Ford, Premier for Ontario

Hon. Sylvia Jones, Deputy Premier and Minister of

Health for Ontario

Dr. Theresa Tam, Canada's Chief Public Health Officer

Board of Health for Grey Bruce Public Health

Chad Richards, Vice Chair, Board of Health, Grey Bruce

Health Unit

All Boards of Health in Ontario

Council of Medical Officers of Health of Ontario

alPHa Board of Directors and Chief Executive Officer,

alPHa-Association of Local Public Health Agencies

Ruff, Alex - M.P., Bruce-Grey-Owen Sound

cc:

Chief Darlene Johnston, Chief and Council,

Chippewas of Nawash Unceded First Nation

Chief Conrad Ritchie, Chief and Council, Saugeen

First Nation

Tracy Antone, Chief Operating Officer, Chiefs Of

Ontario

Mathew Hoppe, CEO, The Independent First Nations

Alliance (IFNA)

National Chief Cindy Woodhouse Nepinak,

First Nations and Inuit Health Branch, Indigenous

Services Canada

Ontario Federation of Indigenous Friendship Centres

Paul Vickers, MPP, Bruce – Grey – Owen Sound

Hon. Lisa Thompson, MPP, Huron – Bruce

Brian Saunderson, MPP, Simcoe – Grey

Sol Mamakwa, Ontario NDP

Luke Charbonneau, Warden, Bruce County

Andrea Matrosovs, Warden, Grey County

Chief Bobby Cameron, Federation of Sovereign

Indigenous Nations

Camden Maracle, President, Native Canadian Centre

of Toronto

COMMUNICATIONS BETWEEN THE CHIEF MEDICAL OFFICER OF HEALTH AND THE GREY BRUCE BOARD OF HEALTH, & GOVERNANCE IMPLICATIONS FOR PUBLIC HEALTH SUDBURY & DISTRICTS

MOTION:

WHEREAS the Ministry of Health has intervened with Boards of Health in response to governance issues in 2006 with the Muskoka-Parry Sound Health Unit, in 2015 with Algoma Public Health, and now in 2025 with Grey Bruce Health Unit;

AND WHEREAS the 2006 Capacity Review Committee recommended skills-based boards of health, which have not been realized;

AND WHEREAS the Chief Medical Officer of Health has recommended to Grey Bruce Health Unit the development of a "skills matrix" for board of health members as a consequence of this most recent incident, in order to establish a skills-based board of health there;

AND WHEREAS Public Health Sudbury & Districts has a long history and strong reputation for excellence in governance practices and financial oversight;

AND WHEREAS Public Health Sudbury & Districts has been a leader in the province around governance improvements, most recently establishing the inclusion of Indigenous membership on the Board of Health;

THAT the Board of Health receive the communications between the Chief Medical Officer of Health and the Chair of the Grey Bruce Health Unit Board of Health for information;

AND THAT the Board of Health recommit to vigilance around its governance practices, including its ongoing work to strengthen governance training, its financial oversight work, and its efforts to ensure municipal politics do not impact Board discussions; this includes that all Board members set aside any considerations of or loyalties to other organizations in order to exercise their fiduciary duty as Board members;

AND THAT the Board of Health direct the Acting Medical Officer of Health & CEO to build on the recent request to municipalities to include an Indigenous person on the Board of Health, to now broaden that and recommend a comprehensive skills-matrix to guide municipalities and the Public Appointments Secretariat in future Board of Health appointments.

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 a personal matter about an identifiable individual, including municipal or local board employees.

Time: ____

RISE AND REPORT

MOTION:

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

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