Board of Health Meeting # 01-26

Public Health Sudbury & Districts

Thursday, January 15, 2026

1:30 p.m.

Boardroom

1300 Paris Street

Public Health
Santé publique
SUDBURY & DISTRICTS

AGENDA – FIRST MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, SECOND FLOOR
THURSDAY, JANUARY 15, 2026 – 1:30 P.M.

1. **CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT**

2. **ROLL CALL**

3. **REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST**

4. **ELECTION OF OFFICERS**

APPOINTMENT OF CHAIR OF THE BOARD

(2025 Chair: Mark Signoretti– 1 term)

THAT the Board of Health appoints _____ as Chair for the year 2026.

APPOINTMENT OF VICE-CHAIR OF THE BOARD

(2025 Vice-Chair: Michel Parent – 1 term)

THAT the Board of Health appoints _____ as Vice-Chair for the year 2026.

APPOINTMENT TO BOARD EXECUTIVE COMMITTEE

(2025 Board Executive: Ken Noland – 15 terms; Michel Brabant – 1 term; Natalie Tessier – 3 terms)

THAT the Board of Health appoints the following individuals to the Board Executive Committee for the year 2026:

1. **_____, Board Member at Large**
2. **_____, Board Member at Large**
3. **_____, Board Member at Large**
4. **_____, Chair**
5. **_____, Vice-chair**
6. **Medical Officer of Health/Chief Executive Officer**
7. **Director, Corporate Services**
8. **Secretary Board of Health**

APPOINTMENT TO FINANCE STANDING COMMITTEE OF THE BOARD

(2025 Finance Committee: Michel Parent – 3 terms; Natalie Tessier – 1 term; Renée Carrier – 1 term)

THAT the Board of Health appoints the following individuals to the Finance Standing Committee of the Board of Health for the year 2026:

1. **_____, Board Member at Large**
2. **_____, Board Member at Large**
3. **_____, Board Member at Large**
4. **_____, Chair**
5. **Medical Officer of Health/Chief Executive Officer**
6. **Director, Corporate Services**
7. **Secretary Board of Health**

5. DELEGATION/PRESENTATION

i) Inquest into the deaths of Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor

- Dr. Emily Groot, Acting Associate Medical Officer of Health, Public Health Sudbury & Districts

6. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Eighth Meeting – November 20, 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, January 2026

v) Correspondence

a. Draft Revised Ontario Public Health Standards and Protocols

- Memorandum from Dr. K. Moore, Chief Medical Officer of Health and Assistant Deputy Minister, dated December 9, 2025

b. National Data on Substance-Related Harms

- Statement from the Council of Chief Medical Officers of Health dated December 11, 2025

c. Monitoring Food Affordability and Implications for Public Policy and Action
- Memorandum from the Middlesex-London Health Unit Medical Officer of Health and Board of Health Chair dated December 11, 2025
- Infographic: Food Insecurity, Middlesex-London 2026

d. Adverse Childhood Experiences (ACEs) Local Policy Advancement
- Report from Windsor-Essex County Health Unit Board of Health dated November 20, 2025

e. Prevention and Response to Radon Exposures in Windsor-Essex County
- Report from Windsor-Essex County Health Unit Board of Health dated November 20, 2025

f. Windsor and Essex County School Food Programs
- Report from Windsor-Essex County Health Unit Board of Health dated November 20, 2025

g. Indigenous Membership on Boards of Health
- Letter from the alPHa Board of Directors Chair to the Deputy Premier and Minister of Health dated November 10, 2025

vi) Items of Information

a. Annual Survey Results from 2025 Regular Board of Health Meeting Evaluations

b. Annual Meeting Attendance Summary Board of Health for Public Health Sudbury & Districts 2025

APPROVAL OF CONSENT AGENDA

MOTION:

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

7. NEW BUSINESS

i) Risk Management Plan 2026 – 2028
- Briefing Note from the Acting Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated January 8, 2026
- Inherent and Residual Risk Ratings
- 2026 – 2028 Risk Management Plan

RISK MANAGEMENT PLAN 2026 - 2028

MOTION:

WHEREAS effectively planning to manage risks enables an organization to better achieve its outcomes, operate strategically, and be resilient to changing circumstances; and

WHEREAS the Ontario Public Health Organizational Requirements mandate boards of health to provide governance direction and oversight of risk management with a formal risk management framework that identifies, assesses, addresses risks; and

WHEREAS the Board of Health has engaged in a risk management process in order to systematically identify/assess current risks and controls;

THEREFORE BE IT RESOLVED that the Board of Health for Public Health Sudbury & Districts approve the 2026-2028 risk management plan.

ii) Ontario Building Code – Amendment to the Fee Schedule for Services Under Part VIII

- Briefing Note from the Acting Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated January 8, 2026
- Revised Board of Health Manual G-I-50 – By-law 01-98

AMENDMENT TO THE FEE SCHEDULE FOR SERVICES UNDER PART VIII OF THE ONTARIO BUILDING CODE

MOTION:

WHEREAS the Board of Health is mandated under the *Ontario Building Code Act* (S.O. 1992 c. 23), to enforce the provisions of this Act and the Building Code related to sewage systems; and

WHEREAS program related costs are funded through user fees on a cost-recovery basis; and

WHEREAS the proposed fees are necessary to address current program associated operational and delivery costs; and

WHEREAS the Board of Health has adopted a process of annually adjusting fees in accordance with inflation with a comprehensive review of fees conducted every five years; and

WHERAS fees have been proposed to increase in accordance with inflation for this annual adjustment; and

WHEREAS in accordance with Building Code requirements, staff have held a public meeting and notified all contractors, municipalities, lawyers, and other affected individuals of the proposed fee increases, with no concerns having been reported;

THEREFORE BE IT RESOLVED THAT the Board of Health approve the amendments in Part VIII-Ontario Building Code fees as outlined within Schedule "A" to Board of Health By-law 01-98.

iii) Board of Health Meeting Date

CHANGE IN BOARD OF HEALTH MEETING DATE

MOTION:

WHEREAS the Board of Health regularly meets on the third Thursday of the month; and

WHEREAS By-Law 04-88 in the Board of Health Manual stipulates that the Board may, by resolution, alter the time, day or place of any meeting;

WHEREAS the *Municipal Election Act* section 6(1) provides that terms of municipal elected officials end on November 14, 2026, and so municipal appointments to the Board of Health expire on November 14, 2026;

WHEREAS it is desirable to ensure continuity and quorum for the November 2026 Board of Health meeting;

THEREFORE BE IT RESOLVED THAT this Board of Health agrees that the regular Board of Health meeting scheduled for 1:30 pm Thursday, November 19, 2026, be moved to 1:30 pm on Thursday, November 12, 2026.

8. ADDENDUM

ADDENDUM

MOTION:

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

9. IN CAMERA

IN CAMERA

MOTION:

THAT this Board of Health goes in camera to deal with information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them.

Time: _____

10. RISE AND REPORT

RISE AND REPORT

MOTION:

THAT this Board of Health rises and reports.

Time: _____

11. ANNOUNCEMENTS

- January 18, 2026, Board of Health meeting evaluation
- Board of Health Unlearning Club

12. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time: ____

APPOINTMENT OF CHAIR OF THE BOARD

THAT the Board of Health appoints _____ as Chair for the year 2026.

APPOINTMENT OF VICE-CHAIR OF THE BOARD

THAT the Board of Health appoints _____ as Vice-Chair for the year 2026.

APPOINTMENT TO BOARD EXECUTIVE COMMITTEE

THAT the Board of Health appoints the following individuals to the Board Executive Committee for the year 2026:

1. **_____, Board Member at Large**
2. **_____, Board Member at Large**
3. **_____, Board Member at Large**
4. **_____, Chair**
5. **_____, Vice-chair**
6. **Medical Officer of Health/Chief Executive Officer**
7. **Director, Corporate Services**
8. **Secretary Board of Health**

APPOINTMENT TO FINANCE STANDING COMMITTEE OF THE BOARD

THAT the Board of Health appoints the following individuals to the Finance Standing Committee of the Board of Health for the year 2026:

1. **_____, Board Member at Large**
2. **_____, Board Member at Large**
3. **_____, Board Member at Large**
4. **_____, Chair**
5. **Medical Officer of Health/Chief Executive Officer**
6. **Director, Corporate Services**
8. **Secretary Board of Health**

Public Health
Santé publique
SUDBURY & DISTRICTS

MINUTES – EIGHTH MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, LEVEL 3
THURSDAY, NOVEMBER 20, 2025 – 1:30 P.M.

BOARD MEMBERS PRESENT

Ryan Anderson	Natalie Labbée	Michel Parent
Robert Barclay	Abdullah Masood	Mark Signoretti
Michel Brabant	Amy Mazey	Natalie Tessier
Renée Carrier	Ken Noland	

BOARD MEMBERS REGRET

Angela Recollet

STAFF MEMBERS PRESENT

Kathy Dokis	Stacey Gilbeau	Stacey Laforest
Renée Higgins	Emily Groot	Rachel Quesnel, Recorder
M. Mustafa Hirji	Sandra Laclé	Renée St Onge

M. SIGNORETTI PRESIDING

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

The meeting was called to order at 1:31 p.m.

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) Iceland Prevention Model: An upstream community-based substance use prevention approach

- Michaela Penwarden-Watson, Health Promoter, Health Promotion and Vaccine Preventable Diseases Division

- Jackie Balleny, Executive Director, Sudbury District Restorative Justice

Presenters were introduced and invited to present on the upstream evidence-based substance use prevention approach and to provide an overview of the model. The Icelandic Prevention Model (supported by the Planet Youth organization) is locally led and adapted to each community with the goal of increasing resiliency and well-being and reducing substance use among youth. It was noted that Public Health Sudbury & Districts is one of many committed community partners that supports the Planet Youth model in our region.

The presenters outlined how it has worked elsewhere, what it could look like locally as well as the progress made to date. The work is led by a Steering Committee, bringing together many agencies across the community. Shkagamik-Kwe Health Centre and Sudbury District Restorative Justice support the day-to-day work of the initiative. The Prevention Coalition, which includes a broader cross-section of community partners, such as school leadership, researchers, social and community services, and partners with the city of Sudbury, will ensure the project is adapted to our local context and community needs.

Currently the project is at Step 3 of the 10-step cyclical framework, working on pre-data collection planning and community engagement. The framework supports communities in building capacity, implementing strategies, reflecting on progress, and repeating the process over time. Together with our partners, dollars have been secured to contract Planet Youth to implement the IPM. Additionally, funding from PHAC YSUPP Stream 2 funding has been leveraged over 3 years for steps 4 to 10 of the Planet Youth process.

The Board of Health's support was sought in spreading the word about what Icelandic Prevention Model can do for our communities. Questions and comments were entertained and focused on youth outreach and engagement given our service area, outcomes, community partnerships including school board, as well as the involvement of researchers and evaluators for the local model. It was noted that progress updates can be shared with interested partners such as school boards outside our service area. In follow-up to a question regarding champions, the importance of having everyone at the table was critical in order to achieve outcomes.

ii) Unlearning & Undoing White Supremacy and Racism Project Unlearning Club – Foundational Obligations to Indigenous Peoples: Treaties

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

M.M. Hirji noted that this is the fourth presentation final presentation relating to the Unlearning club Foundational Obligations. The presenters were invited to speak about how the treaties in Canada, particularly the Robinson Huron Treaty of 1850 and Treaty 9, should

inform our ongoing journey of reconciliation, including how these treaties tie directly into health equity, the promises made, and our responsibilities moving forward.

The presentation highlighted key frameworks guiding this work, including the Truth and Reconciliation Commission's Calls to Action, the National Inquiry into Missing and Murdered Indigenous Women and Girls, and the United Nations Declaration on the Rights of Indigenous Peoples. These documents underscore the need for culturally safe, accessible health care and collaborative approaches. Participants were reminded that reconciliation requires more than acknowledgment—it demands systemic change, policy alignment with treaty obligations, and meaningful partnerships with Indigenous communities.

In closing, the presenters stressed that reconciliation is an ongoing process. Public health leaders have a responsibility to ensure treaty rights inform all aspects of health planning and delivery. Moving forward, continued education, relationship-building, and action rooted in trust, respect, and humility are essential to achieving health equity and honoring commitments made under these treaties.

Questions and comments were entertained and presenters thanked.

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Seventh Meeting – October 16, 2025

ii) Business Arising from Minutes

iii) Report of Standing Committees

- Unapproved Board of Health Finance Standing Committee minutes, November 3, 2025

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

a. MOH/CEO Report, November 2025

v) Correspondence

a. Grey Bruce Public Health Board of Health

- Email from Board Chair to Deputy Minister of Health dated November 2, 2025

vi) Items of Information

None.

Questions were entertained relating to Canada's measles elimination status, the status of the annual Accountability Monitoring Plan, and the proposed Digital and Data Governance Councils.

47-25 APPROVAL OF CONSENT AGENDA

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

CARRIED

6. NEW BUSINESS

i) Annual Board of Health Self-Evaluation 2025 Survey Results

- Briefing note from Dr. M.M. Hirji, Acting Medical Officer of Health and Chief Executive Officer dated November 13, 2025

It is a provincial government requirement for Boards of Health to complete an annual Board of Health self-evaluation. The 83% response rate for 2025 is high in comparison with previous years. Overall, results from the self-evaluation questionnaire indicate that most Board of Health members have a positive perception of their governance process and effectiveness. It was observed that responses were less strongly positive this year in comparison to the 2024 survey results for questions relating to satisfaction with participation in meetings; representing the interest of the organization at all times; and being well-informed about issues regarding organizational effectiveness. Reasons for the less enthusiastic responses are unknown; however, it might be due to variation in the Board's membership, or due to a shift in the quality or relevance of Board meetings.

Comments and feedback were invited, and it was suggested that the survey's five-point scale be reviewed.

ii) Recommended 2026 Cost-Shared Operating Budget

- Briefing note and schedules from Dr. M.M. Hirji, Acting Medical Officer of Health and Chief Executive Officer dated November 13, 2025

M. Parent, Chair of the Board of Health Finance Standing Committee, provided an update regarding the November 3, 2025, meeting where the committee carefully reviewed and discussed the 2026 cost-shared budget being recommended today.

It was noted that with inadequate funding by the provincial government and a growing need for Public Health's services, 2026 budget deliberations began with a projected shortfall of approximately $1.1 million to remain status quo. Today's proposed budget reflects extensive planning and rigorous due diligence and includes a bold strategy to shift the long-term cost curve of the organization by investing in technology.

The recommended budget totals $32,029,390, an increase of 3.20% over the 2025 Board approved budget. The 2026 recommended budget absorbs a decrease to projected interest income of $75,000 and adds revenue in terms provincial and municipal increases of $187,238 and $614,154, respectively.

M.M. Hirji provided additional information via a slide deck regarding the recommended 2026 budget noting he would present additional information during the in-camera session relating to staffing and levies. Additional data demonstrating increasing pressures on public health programs and services were outlined including that public health funding since 2015 has been 79% less than inflation. Given status quo was not an option if the organization is to progress and adapt to the needs of the community, budget priorities identified for 2026 were reviewed. Budget strategies to achieve a balanced budget were summarized including reductions in divisional operating costs, increased vacancy rate, modest service reductions, and 0.6 FTE staffing adjustment. It is recommended that $2,413,088 be invested in technology & technological capability through reserves, which would reduce the current reserves, totalling $8,748,792, from 12.07 weeks of emergency funds to 8.2 weeks. It was pointed out that the Board of Health Finance Standing Committee recommended the 2026 budget include $404,095 to expand vaccinations in lesser serviced areas as a pilot project, funding by the reserves.

It was concluded that the recommended budget is prudent, aligned with the Board of Health's mandate to provide essential services to the community and prioritizes the organization's long-term sustainability.

A. Masood and R. Carrier left the meeting at this point (2:59 p.m.).

Questions and comments were entertained, and discussion ensued regarding the reserve and reduction of 12 weeks of cashflow to 8.2 weeks. M.M. Hirji clarified that 8.2 weeks remains above the Ministry's recommendation of 7.5 weeks and it is the intention to continue to build the reserve for the longer term once in a better fiscal position.

IN CAMERA

48-25 IN CAMERA

MOVED BY LABBÉE – BRABANT: THAT this Board of Health goes in camera to deal with personal matters involving one or more identifiable individuals, including employees or prospective employees. Time: 3:06 p.m.

CARRIED

RISE AND REPORT

49-25 RISE AND REPORT

MOVED BY NOLAND – BARCLAY: THAT this Board of Health rises and reports. Time: 3:26 p.m.

CARRIED

It was reported that one matter was discussed to deal with personal matters involving one or more identifiable individuals, including employees or prospective employees. The following motion emanated:

50-25 APPROVAL OF BOARD OF HEALTH INCAMERA MEETING NOTES

MOVED BY PARENT – NOLAND: THAT this Board of Health approve the meeting notes of the September 18, 2025, Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the Municipal Freedom of Information and Protection of Privacy Act.

CARRIED

51-25 2026 COST-SHARED OPERATING BUDGET

MOVED BY ANDERSON – MAZEY: WHEREAS the Board of Health Finance Standing Committee reviewed and discussed the details of the proposed 2026 cost-shared operating budget at its November 3, 2025, meeting; and

WHEREAS the Finance Standing Committee recommends the proposed budget to the Board of Health for approval;

THEREFORE BE IT RESOLVED THAT the Board of Health approve the 2026 cost-shared operating budget for Public Health Sudbury & Districts in the amount of $32,029,390 (32 million, twenty-nine thousand and three hundred and ninety dollars).

AND THAT the Board of Health, per Bylaw G-I-70, authorize the transfer of up to $2,413,088 (two million, four hundred thirteen thousand and 88$) from the Reserve Funds to the operating budget to offset one-time technological investments in artificial intelligence use cases, the Information Technology Strategy & Roadmap, the onboarding of Electronic Medical Records, and the onboarding and transition to a new Human Resources/Payroll/Learning Management system.

AND THAT the Board of Health, per Bylaw G-I-70, authorize the transfer of up to $404,095 from the Reserve Funds to the operating budget to offset a pilot project to immunize seniors against seasonal respiratory infections in 2026.

CARRIED

iii) Staff Appreciation Day

M.M. Hirji noted that the Staff Appreciation Day motion is being tabled for the Board of Health's consideration.

52-25 STAFF APPRECIATION DAY

MOVED BY BARCLAY – BRABANT: WHEREAS the Board of Health has for decades provided staff with an Appreciate Day off in consideration for their excellent service to the community.

THEREFORE BE IT RESOVED THAT this Board of Health approve a Staff Appreciation Day

for the staff of Public Health Sudbury & Districts during the upcoming holiday season. The Staff Appreciation Day may be taken between the dates of December 1, 2025, to February 28, 2026. Essential services will be available and provided at all times except for statutory holidays when on-call staff will be available.

CARRIED

M. Signoretti noted that communication to Public Health Sudbury & Districts staff regarding the Staff Appreciation Day will be sent directly from the Board of Health Chair on behalf of the Board of Health.

iv) Update on alPHa Motion Regarding Indigenous Membership on all Boards of Health

a. Briefing Note from Dr. M.M. Hirji, Acting Medical Officer of Health and Chief Executive Officer dated November 13, 2025
b. Motion tabled at the alPHa General Meeting June 19, 2025
c. Letter sent by alPHa Board of Directors November 10, 2025

M.M. Hirji recapped that at the June 19, 2025, alPHa Annual General Meeting, our Board's motion was put on the floor for debate and was referred to the alPHa Board of Directors. Subsequently, on November 6, 2025, the alPHa Board of Directors decided not to adopt a position statement aligned with the motion and has written to the Minister of Health advocating for Indigenous membership on boards of health. The letter dated November 10, 2025, is attached to the agenda package.

M.M. Hirji proposed that a letter be sent to the alPHa Board of Directors. He outlined rational for today's motion that advocates for the creation of a forum with Indigenous public health staff and others to come together and dialogue on how Indigenous membership on boards of health can be advanced. The letter to the alPHa Board of Directors would outline where we believe the Board of Directors fell short in working towards reconciliation and propose steps to moving forward.

53-25 INDIGENOUS MEMBERSHIP ON ALL BOARDS OF HEALTH

MOVED BY NOLAND – TESSIER: WHEREAS on June 19, 2025, the Board of Health proposed to the Association of Local Public Health Agencies (alPHa) Annual General Meeting a resolution that all boards of health should have an Indigenous member,

AND WHEREAS the alPHa Annual General Meeting opted not to adopt the resolution, but refer it to the alPHa Board of Directors,

AND WHEREAS the alPHa Board of Directors has decided not to adopt a resolution, but has written to the Minister of Health to advocate for Indigenous membership on boards of health,

AND WHEREAS there are omissions to that advocacy as compared to the originally proposed resolution,

AND WHEREAS several elements of the process to get to this advocacy letter have revealed colonial practices in the operations of alPHa,

BE IT RESOLVED THAT the Board of Health write to the alPHa Board of Directors

1. **to thank them for the advocacy letter to the Minister of Health that advances the issue the Board of Health had raised,**
2. **to highlight considerations omitted from the advocacy letter that should nonetheless remain important for alPHa's consideration should there be further dialogue or follow-up regarding Indigenous membership on boards of health,**
3. **to share feedback on colonial ways within their process which are harmful to Indigenous persons, and which should be corrected,**
4. **to advise creation of fora that would allow Indigenous persons, boards of health, and their staff to continue dialogue around how Indigenous membership on boards of health can continue to be advanced, thus facilitating self-determination by Indigenous persons and furthering reconciliation after the process thusfar.**

CARRIED UNANIMOUSLY

7. ADDENDUM

54-25 ADDENDUM

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

CARRIED

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

i) Respiratory Virus Season: Influenza and RSV Increase is Accelerating

- Briefing Note from Acting Medical Officer of Health and Chief Executive Officer dated November 20, 2025

M. M. Hirji noted that, since the distribution of the November Board report, new data has been received that shows Influenza A and RSV are increasing more rapidly and that the influenza virus this season is likely going to be earlier and more severe than usual. Board members and Public Health staff are asked to emphasize the importance of getting vaccinated as soon as possible to Influenza and COVID-19 for all populations and RSV for infants and seniors, if not already done so in a previous year.

8. ANNOUNCEMENT

- November 20, 2025, Board of Health meeting evaluation

Board members were invited to complete the evaluation for today's Board meeting. Survey results from each meeting survey in 2025 will be rolled up and presented at the January 2026 Board meeting

- Board of Health Annual Mandatory Training: Emergency Preparedness

Under legislation, the emergency preparedness training is mandatory for Board members to review annually. Those who have not had a chance to review it are asked to do so as soon as possible.

- Board of Health Unlearning Club

M. Signoretti sought consensus from the Board to defer the unlearning club session to the new year given the length of the meeting.

- Board of Health celebration following today's Unlearning Club

Board members were invited to stay for a special Board of Health celebration following the Board meeting.

- Board of Health meetings

There is no regular Board of Health meeting in December. The next regular meeting is Thursday, January 15, 2026, at 1:30 p.m.

9. ADJOURNMENTS

55-25 ADJOURNMENT
MOVED BY TESSIER – BARCLAY: THAT we do now adjourn. Time: 3:45 p.m.

CARRIED

_____ (Chair)

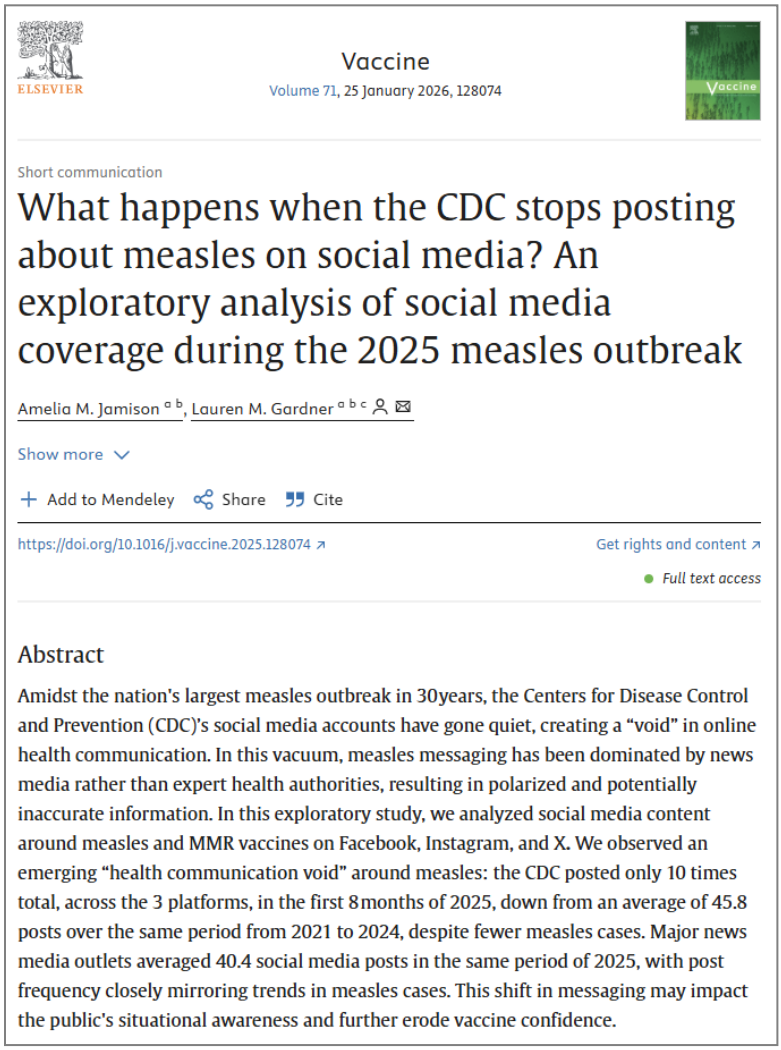
_____ (Secretary)

Public Health
Santé publique
SUDBURY & DISTRICTS

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

Words for thought

When Public Health Stops Communicating, the Void is Filled with Bias and Misinformation



ELSEVIER

Vaccine

Volume 71, 25 January 2026, 128074

Short communication

What happens when the CDC stops posting about measles on social media? An exploratory analysis of social media coverage during the 2025 measles outbreak

Amelia M. Jamison [a b], Lauren M. Gardner [a b c]

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https://doi.org/10.1016/j.vaccine.2025.128074 Get rights and content

Full text access

Abstract

Amidst the nation's largest measles outbreak in 30years, the Centers for Disease Control and Prevention (CDC)'s social media accounts have gone quiet, creating a "void" in online health communication. In this vacuum, measles messaging has been dominated by news media rather than expert health authorities, resulting in polarized and potentially inaccurate information. In this exploratory study, we analyzed social media content around measles and MMR vaccines on Facebook, Instagram, and X. We observed an emerging "health communication void" around measles: the CDC posted only 10 times total, across the 3 platforms, in the first 8months of 2025, down from an average of 45.8 posts over the same period from 2021 to 2024, despite fewer measles cases. Major news media outlets averaged 40.4 social media posts in the same period of 2025, with post frequency closely mirroring trends in measles cases. This shift in messaging may impact the public's situational awareness and further erode vaccine confidence.

This recent research study examined how the US Centre for Disease Control largely went silent on communications during the measles outbreak (which is ongoing in the United States). Despite much higher measles activity, communications on the topic plummeted (figure 1).

Stepping into that void were media outlets. However, while some media are balanced, many others take a biased stance and may frame the news with a political angle (figure 2). Indeed, many of the most prolific outlets on measles in 2025 were known for having strong political and editorial bias (for example, Breitbart News, Newsmax, The Daily Beast, and Huffington Post).

This is a cautionary tale for what happens when public health is absent from the public discourse —we cede the discourse to less reliable sources.

Misinformation is one of the most significant threats to public health, as reflected in the Risk Management Framework up for approval at today's meeting. With the evolution of the media sphere and the emergence of artificial intelligence tools, bad actors have more tools than ever to mislead the public. It will be necessary for Public Health to find the resources to scale up our messaging presence to ensure accurate information remains in the media ecosystem.

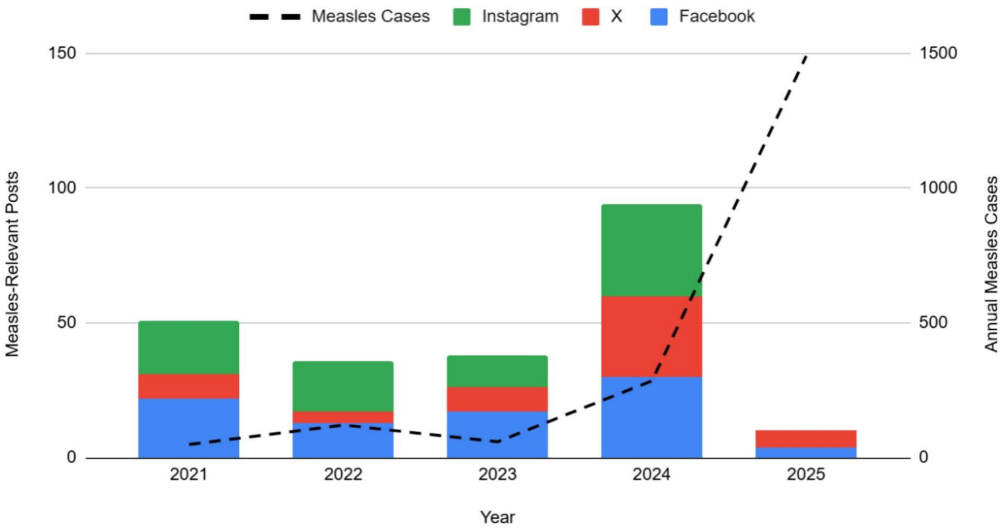


Figure 1. CDC social media posts by year against annual measles counts.

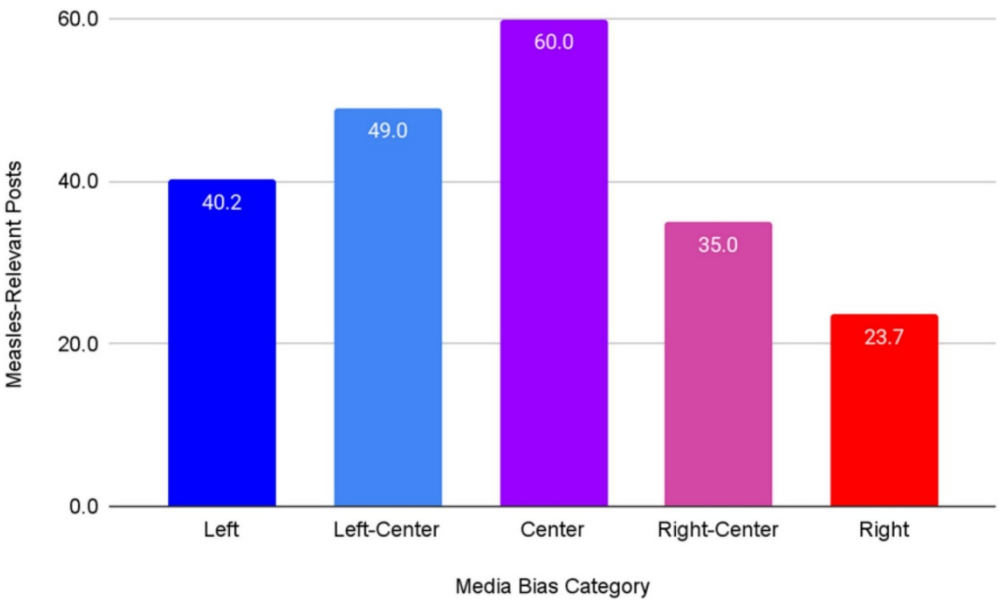


Figure 2. Average media-related posts by media bias category January 1 to August 1, 2025.

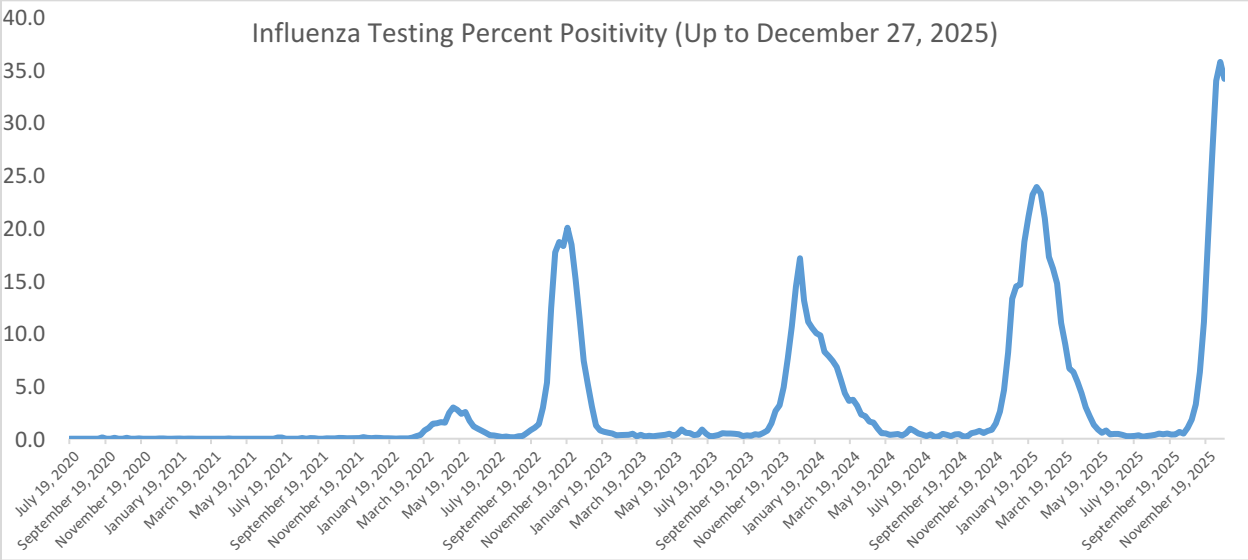
Source: What happens when the CDC stops posting about measles on social media? An exploratory analysis of social media coverage during the 2025 measles outbreak. *Vaccine*. Volume 21. https://doi.org/10.1016/j.vaccine.2025.128074

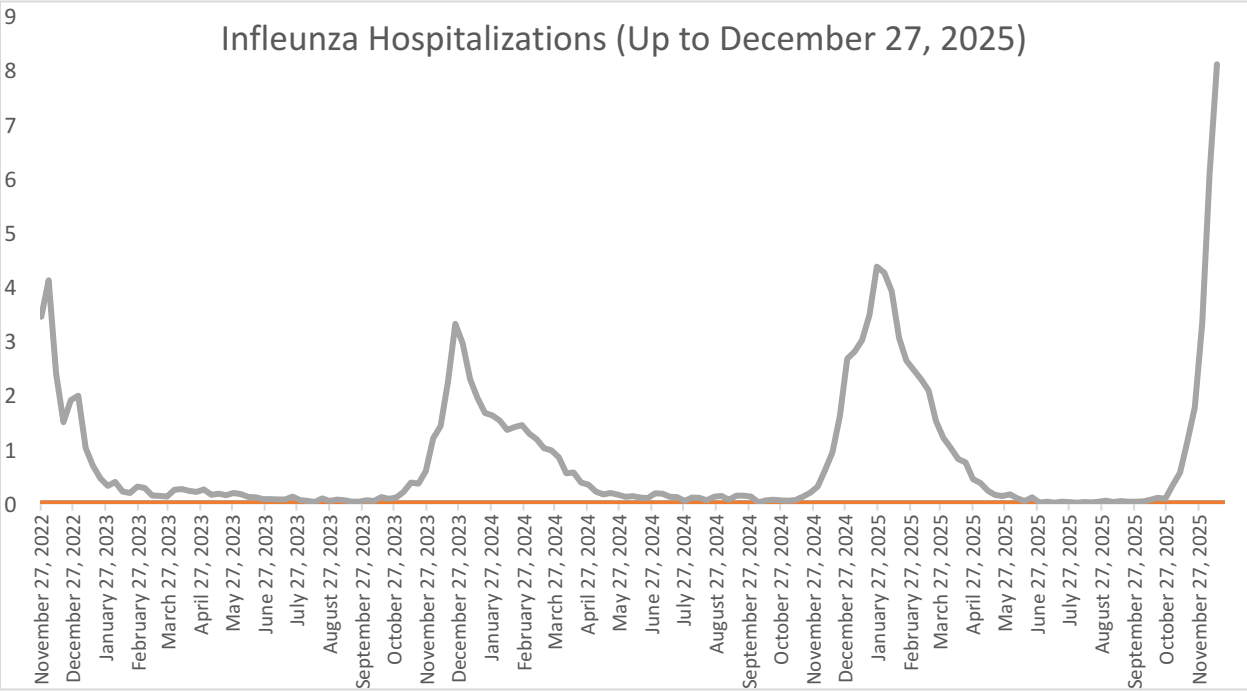
Date: January 25, 2026

Report Highlights

1. Flu Season Update

As projected in the November Board report, this flu season has come early, infected more people than usual, and resulted in more severe illness (for example, hospitalizations) than usual.





Fortunately, it appears that influenza may have peaked in late December; however, only time will confirm that. Nonetheless, hospitalizations lag infections, so the peak for hospitalizations is still to be seen. And even with infections, the peak only means we are half-way through the season. While new weekly infections will be declining, the cumulative new infections will add up to roughly as many as there were on the upswing.

In addition, influenza B as well as COVID-19 are expected to surge later this winter, so respiratory infections will continue for several more months. It remains strongly recommended to get vaccinated, stay home if one is sick so as not to spread infections, wear a well-fitted mask in crowded settings, keep ventilation systems, including at home, running continuously (set to "On" rather than "Auto") and use at least MERV 13 filters or the highest that the system can use, and practice good hygiene such as covering coughs and sneezes and washing and sanitizing hands frequently.

2. Invasive Group A Streptococcus Infections

These infections remain higher than in past years, with 58 cases thus far in 2025 compared to 29 cases in 2024, and 13 cases since November. Investigations have found few connections between infections, even in terms of bacterial typing. Investigations continue and work continues to provide education on preventive measures.

3. Immunization of School Pupils Act Enforcement Off to a Positive Start

The annual effort has begun to ensure students have vaccinations to prevent outbreaks in schools and thereby keep children safe. This year, rather than staggering suspensions of students with missing vaccinations over the course of three months, all suspensions will be done on the same date.

First notice to parents and students for missing vaccinations was sent out to 3800 students in December. That is a significant drop from 5800 in the previous year. Some 40% of students already addressed the missing vaccinations.

The positive start to this year's campaign is partly due to work done over the last three years to get students caught up post-pandemic disruption, so fewer are out-of-date. As well, stronger engagement took place with schools and particularly principals, which is likely paying dividends in their support of our efforts.

4. Collaboration with Kina Gbezhgomi Child and Family Services (KINA)

On December 11, 2025, Public Health Sudbury & Districts and Kina Gbezhgomi Child and Family Services (KINA), a First Nation child protection agency, formalized a joint protocol to strengthen collaboration in child protection services. The new agreement strives for consistent communication, timely referrals, and culturally respectful practices across all Public Health programs.

5. Provincial Profile for Pediatric Nutrition Guidelines

Public Health nutrition staff presented at Public Health Ontario Grand Rounds regarding the *Pediatric Nutrition Guidelines for Health Professionals: Birth to Six Years (2025 Edition)* and their extensive contribution to these provincial guidelines. This evidence-based resource supports optimal nutrition and feeding practices in early childhood. Congratulations to the nutrition staff on recognition of their excellent work and the product they have helped develop for the entire province!

General Report

1. Board of Health

Association of Local Public Health Agencies (alPHa) Winter Symposium

The Association of Local Public Health Agencies (alPHa) Winter Symposium and online workshops will take place from February 11 to 13, 2026. If you are interested in attending the virtual Symposium, please contact Rachel Quesnel, Board Secretary, who will look after registration.

Association of Local Public Health Agencies (alPHa) Conference/Annual General Meeting

The Association of Local Public Health Agencies Annual Conference and General Meeting will be held in person, from June 8 to 10, 2026. A motion will be included on a future Board of Health agenda concerning Board of Health attendance for Public Health Sudbury & Districts and voting delegation for the alPHa AGM.

Board of Health Code of Conduct

Board of Health members are responsible for conducting themselves in compliance with the *Code of Conduct Policy C-I-15* (*Code*) in a manner that is professional and with the highest regard for the rights of the public in accordance with the principles outlined in the *Human Rights Code* and the *Charter of Rights and Freedoms*. The standard obligations, values,

and expected behaviours outlined in the Code serve to enhance public confidence that members operate from a foundation of trust, humility, and respect.

All members are required to sign an annual declaration attesting to their understanding and acknowledgement of this Code. The *Code of Conduct Policy* and form are included in the January 15, 2026, Board of Health *Event* in BoardEffect.

The declaration form, which must be signed and submitted annually, will be available at the January Board meeting or can be completed electronically in BoardEffect under Board of Health–Collaborate–Surveys. The deadline to submit is Friday, February 6, 2026.

Board of Health Conflict of Interest

As stipulated in the Board of Health Manual *Conflict of Interest Policy and Procedure* C-I-16, members bring a perspective based on their skills and experiences to act in the best interest of Public Health Sudbury & Districts and in compliance with their duties and obligations under the *Health Protection and Promotion Act*. Members cannot act in their own personal interest or as a representative of any professional, political, socio-economic, cultural, geographic, or other organization or group.

Each individual member of the Board of Health ensures that they are in compliance at all times with the *Municipal Conflict of Interest Act* and follows the *Conflict of Interest Policy* C-I-16.

At the beginning of each calendar year, Board of Health members are required to complete the Declaration of Conflict of Interest form. *The Conflict of Interest Policy and Procedure* is included in the January 15, 2026, Board of Health *Event* in BoardEffect. The Conflict of Interest declaration form will be available at the January Board meeting or can be completed electronically in BoardEffect under Board of Health–Collaborate–Surveys. The deadline to submit is Friday, February 6, 2026.

Board of Health Vacancy – Joint Board of Health Staff Accountability Working Group

We continue to have an opening for a Board of Health member to join the Joint Board/Staff Accountability Working Group. The Working Group meets approximately one to two times per year. The next meeting is scheduled for February 2, 2026, at 1 p.m. Please let Rachel Quesnel know if you are interested in joining the Working Group.

2. Human Resources

Sandra Laclé's temporary contract as interim Director concluded on December 12, 2025. Throughout her distinguished career at Public Health Sudbury & Districts, Sandra has held several senior leadership roles and made significant contributions to advancing our mission. We

extend our sincere appreciation for her dedication and wish her a fulfilling and rewarding retirement.

3. Community and Other Presentations

As Co-Chair of the Community Drug Strategy, I presented the findings of the latest opioid usage report to the Community and Emergency Services Committee on November 24, 2025.

I presented the 2026 Board-approved budget to the City of Greater Sudbury Finance and Admin Committee on November 25, 2025.

4. Local and Provincial Meetings

I joined the COMOH (Council of Ontario Medical Officers of Health) section virtual meeting November 26, 2025.

I continue to meet with key community partners and met with the President of Collège Boréal, Daniel Giroux, on November 27, 2025.

I participated in the Ontario Public Health Index of Databases (OPHID) Advisory Council meeting on November 28, 2025.

On December 2, 2025, I met with Dr. Tamara Wallington of Public Health Ontario to share perspectives on improving quality improvement across public health in Ontario.

I also attended the Community Drug Strategy Executive Committee meeting on January 6, 2026, and the Provincial Health Indicators Work Group monthly meeting on January 12, 2026.

My participation in these monthly meetings included Public Health Sector Coordination Table meetings December 9, 2025, and January 13, 2026, as well as northern MOH group teleconferences on December 3, 2025, December 17, 2025, and January 14, 2026.

5. Financial Report

The financial statements ending November 2025 show a positive budget variance of $1,744,347 in the cost-shared programs. Cost shared revenue to date exceeds expenditure by $1,490,473. This reflects ongoing challenges with recruiting to fill staff vacancies, as well as timing of some operational budget expenditures for December 2025.

6. 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 December 19, 2025, on December 22, 2025. The Employer Health Tax has been paid, as required by law, to December 31, 2025, with an online payment date of January 13, 2026. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to December 31, 2025. There are no outstanding issues regarding compliance with the *Occupational Health & Safety Act* or the *Employment Standards Act*. There are two matters currently before the Ontario Human Rights Tribunal. No new matters have come forward pursuant to the *Accessibility for Ontarians with Disabilities Act*.

7. Chief Nursing Officer and Professional Practice Report

The Chief Nursing Officer (CNO) continues to play a vital role in advancing professional nursing practice at Public Health Sudbury & Districts, reinforcing the organization's commitment to excellence in nursing and public health service delivery.

Established in February 2012 in accordance with Ministry of Health directives, the CNO position is recognized within the *Ontario Public Health Standards* as an essential component of the Public Health Practice Domain.

As Chair of the Professional Practice Committee (PPC), the CNO leads an interdisciplinary team dedicated to fostering an environment that champions evidence-informed practice and promotes excellence across all public health disciplines. Through the PPC, staff competencies are strengthened, interprofessional collaboration is enhanced, and a forum is provided for sharing updates from professional regulatory colleges relevant to public health.

Highlights of Key Contributions in 2025

- Delivered updates to the PPC and registered nurses on professional standards and emerging trends in public health practice.
- Provided guidance and interpretation of standards established by professional regulatory colleges.
- Supported continuous quality improvement initiatives across programs and services.

To advance the nursing agenda, the CNO actively participates in strategic networks and committees, including:

- Ontario Public Health Chief Nursing Officers
- Ontario Public Health Nursing Leaders
- Northern & Rural Professional Nursing Practice Network

The CNO also serves as a liaison with local educational institutions, engaging in collaborative discussions with post-secondary partners to share best practices, operational insights, and

innovative approaches—ensuring alignment between academic preparation and evolving professional needs.

Looking Ahead

The CNO remains committed to advancing professional nursing practice and strengthening interprofessional collaboration across Public Health Sudbury & Districts. Through leadership, partnerships, and continuous quality improvement, the CNO will continue to champion evidence-informed approaches that enhance public health service delivery and support the evolving needs of our communities.

Following are the divisional program highlights.

Health Promotion and Vaccine Preventable Diseases Division

1. Chronic Disease Prevention and Well-Being

Healthy eating behaviours

In collaboration with faculty from the Laurentian University English Bachelor of Science in Nursing Program, Registered Dietitians developed, delivered, and evaluated a four-week Culinary Medicine Lab in the Fall of 2025. This evidence-based pilot project aimed to strengthen nursing students' skills and confidence in providing appropriate nutrition care in their future practice. A total of 38 third-year students participated. Workshops were held in the public health teaching kitchen and incorporated the *Food Literacy for Life* framework, emphasizing the influence of social determinants of health and health equity on nutrition-related outcomes.

Physical activity and sedentary behaviour

Staff coordinated the completion of Sport for Life's *Social Emotional Learning (SEL) in Sport and Recreation* course for 22 students in Cambrian College's Fitness & Promotion Program. The course introduced key SEL concepts, such as self-awareness, relationship skills, and responsible decision-making and demonstrated how to integrate these into sport and recreation settings. All students successfully completed the training, strengthening their ability to create supportive and inclusive physical activity programming environments.

Seniors Dental Care

Staff continued to provide comprehensive dental care at our Seniors Dental Care Clinic at Elm Place, including restorative, diagnostic, and preventive services. Clients were also referred to contracted community providers for emergency, restorative and prosthodontic services, and received assistance with enrollment in the Ontario Seniors Dental Care Program for eligible low-income seniors.

2. Healthy Growth and Development

Infant Feeding

Public health nurses provided 93 infant feeding clinic appointments to families across the service area, helping parents make informed decisions about feeding their baby. The clinic offers individualized support for both breastfeeding and formula feeding, promoting healthy growth and development. Through regular screening and monitoring, nurses identify and address feeding concerns early—such as insufficient milk supply—and track infants' weight gain and growth to ensure they remain within expected parameters.

Growth and development

To help foster healthy growth and development for families facing inequities, Public Health nursing staff participated in a collaborative learning session with staff from Noojmowin Teg. Topics included breastfeeding and cannabis use, safe sleep, the Healthy Babies Healthy Children program, positive parenting programming, and oral health.

The intent of this session was to foster ongoing learning with this key partner regarding healthy growth and development and the prevention of adverse childhood experiences (ACEs), with plans to continue these sessions in the future. Potential future topics may include enhanced learning of our *Injoy* prenatal education e-class, the period of purple crying, preparation for parenting, and healthy eating while addressing food security. Approximately 45 participants attended the session.

Public Health nutrition staff also presented at the Public Health Ontario Grand Rounds, providing an overview of the newly released *Pediatric Nutrition Guidelines for Health Professionals: Birth to Six Years (2025 Edition)*. This evidence-based resource, developed by Ontario Dietitians in Public Health, supports optimal nutrition and feeding practices in early childhood. The presentation highlighted key components of the guidelines, including developmental feeding milestones, recommended practices, and nutrition-related red flags and demonstrated how they can be applied across both clinical and public health settings. Using practical examples, presenters emphasized strategies for responsive feeding, addressing common nutrition challenges, and tailoring recommendations to family and community contexts. Overall, the session aimed to equip health professionals with consistent, evidence-based tools to promote healthy growth and development in young children. This session reached 280 participants from a variety of health professional disciplines.

To further promote healthy child development, 47 reminder postcards were sent to parents, encouraging them to book their child's 18-month well-baby visit—a key milestone that allows primary care providers to monitor development and address any emerging concerns before school entry.

Health Information Line

The Health Information Line responded to 86 inquiries from community members seeking information and support on topics such as infant feeding, healthy pregnancies, positive parenting, healthy growth and development, and mental health services. Staff also assisted callers with questions about infectious disease prevention and accessing primary health care providers, helping connect residents with the appropriate services and supports.

Healthy Babies Healthy Children

Through the Healthy Babies Healthy Children program, staff supported 16 new families and completed 157 interactions in November. The program provides tailored guidance, home visits, and community referrals to help families nurture their child's healthy growth, strengthen parenting skills, and build supportive home environments.

Healthy pregnancies

28 individuals enrolled in the *Injoy* prenatal e-Class, an interactive online platform designed to help expectant parents prepare for life with a new baby. Participants explored topics such as infant feeding, selfcare, nutrition, and the impact of a new baby on relationships, as well as labour and delivery. The course also incorporates Canadian nutritional guidelines and connects participants with local programs and services that promote healthy pregnancies and positive family transitions.

Preparation for parenting

Staff facilitated a virtual *Prep4Parenting* class with 14 parents in attendance. This class supports new parents with their transition to parenthood. Topics covered include the importance of attachment and bonding with their baby, communication strategies, roles and responsibilities between caregivers, how to care for a newborn, postpartum mood disorder, infant mental health, and awareness of various support networks across the service area.

Strengthening partnerships through cultural collaboration

On December 11, 2025, Public Health Sudbury & Districts and Kina Gbezhgomi Child and Family Services (KINA), a First Nation child protection agency, formalized a Joint Protocol to strengthen collaboration in child protection services. Previously limited to the Healthy Babies Healthy Children (HBHC) program, the protocol now applies agency-wide, ensuring consistent communication, timely referrals, and culturally respectful practices across all Public Health programs. This expansion reinforces our shared responsibility for child safety and well-being.

The signing was marked by a traditional ceremony led by KINA, beginning with smudging, followed by a talking circle led by an Elder, creating a safe space for dialogue and shared understanding. A presentation by KINA on their services provided insight into their culturally grounded approach to child and family well-being. Guests were then offered cedar tea and strawberries, and the event continued with prayer and drumming, honoring the cultural significance of the occasion and the values at the heart of this partnership. Approximately 30

Public Health staff from across clinical programs attended, demonstrating strong engagement and commitment to collaborative practice.

This protocol supports the continued strengthening of relationships between public health and child protection services. It promotes early intervention, shared accountability, and embeds Indigenous cultural practices and values into joint efforts with families. It also builds on the significant work Public Health has already undertaken with Indigenous communities and reflects our continued commitment to meaningful partnerships.

3. School Health

Oral Health

Staff continued to deliver the annual school-based oral health assessment and surveillance program, and complete case management follow ups for children requiring urgent dental care. Preventive oral health services and screenings were also provided at the Paris Street and Sudbury East offices for children enrolled in the Healthy Smiles Ontario (HSO) Program, along with enrollment assistance for families interested in applying. In addition, staff dedicated to Indigenous oral health programming conducted a dental screening clinic at the M'Chigeeng daycare on November 28.

4. Substance Use and Injury Prevention

Comprehensive tobacco control

In late fall, the Northeast Tobacco Control Area Network (NE TCAN) hosted a two-day planning event for tobacco control staff in the service area. Public health nurses, tobacco enforcement officers, and health promoters from Algoma Public Health, Northeastern Public Health (formerly Timiskaming Health Unit and Porcupine Health Unit), North Bay Parry Sound District Health Unit, and Public Health Sudbury & Districts were in attendance. During the event, participants discussed shifting work upstream and identified regional priorities to guide 2026 activities. This collaborative approach maximizes resources, reduces duplication, and supports a coordinated strategy for comprehensive tobacco control. Public Health Sudbury & Districts is the coordinating public health agency for the NE TCAN.

Substance Use

On behalf of the Planet Youth Sudbury and LaCloche steering committee, Public Health facilitated two feedback sessions to gather input from local youth on the content and structure of Planet Youth survey questions. Eight youth attended a session at the Espanola Office to provide feedback on the rural context and youth relatability, while another eight participated at the Main Office, representing youth from Greater Sudbury. Administration of the Planet Youth survey is planned for early 2026 and marks a key step toward addressing youth wellness, mental health, and substance use within our catchment area.

This month, staff also responded to several media requests related to substance use and harm reduction. These included interviews on the disparity of suspected drug-related death rates between Northern and Southern Ontario, the risks associated with limited access to health and harm reduction services, and emerging substances. Staff also provided commentary on Community Drug Strategy data presented to the Community and Emergency Services Committee.

Two drug alerts were issued to inform the public about high-risk substances detected in the local drug supply. On November 3, Public Health Sudbury & Districts issued a warning regarding heavier sedation observed in recent drug poisonings (overdoses) in the Sudbury and Manitoulin districts. On December 2, a second alert was released warning of an increase in drug poisonings (overdoses) and unexpected reactions to substances.

Harm reduction – Naloxone

In collaboration with community partners, Public Health Sudbury & District distributed 1024 naloxone doses and provided training to 99 individuals. These efforts strengthen community capacity to recognize and respond to opioid poisonings and support ongoing harm reduction initiatives.

5. Vaccine Preventable Diseases

Immunization information line

In December, staff responded to approximately 650 calls through the immunization information line. Most inquiries related to the *Immunization of School Pupils Act*, Grade 7 school-based clinics, and seasonal vaccines, including influenza, COVID-19, and respiratory syncytial viral (RSV). Staff also assisted callers with accessing immunization records, answering general vaccine questions, and submitting foreign immunization documentation—supporting timely, informed vaccination decisions for a healthier community.

Publicly funded immunization programs

Staff delivered 53 school-based immunization clinics, offering vaccines to all Grade 7 students in the service area and to Grade 8 students who were overdue. A second round of school-based clinics is scheduled for the spring. Public Health also continues to provide publicly funded immunizations to clients experiencing barriers for accessing primary care, including those without a health card.

Education, partnerships and engagement

In December, Public Health issued an advisory alert to health care providers regarding the upcoming assessment of student immunization records under the *Immunization of School Pupils Act* (ISPA). Providers were encouraged to support families by reviewing student immunization records and administering any missing vaccines required for school attendance.

A media release was also issued urging parents to check their child's records, vaccinate if needed, and report immunization updates to Public Health.

Public Health continues to collaborate with school communities to keep students protected and in school. Directors of education received ISPA timelines and a principal handbook outlining school administrator responsibilities to support timely vaccination and reporting among students.

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

In December, immunization records for all students in the service area were assessed, resulting in 3800 initial notices issued for incomplete or overdue records. Public Health continues to offer appointment-based and drop-in clinics to help families keep children protected and up to date.

Health Protection

1. Control of Infectious Diseases (CID)

In the months of November and December, staff investigated 227 sporadic reports of communicable diseases. During this time, 22 respiratory outbreaks and two enteric outbreak were declared. The causative organisms for the respiratory outbreaks were identified to be: COVID-19 (13), influenza A (5), metapneumovirus (1), and rhinovirus (1). The causative organism for the remaining respiratory outbreaks was not identified. The causative organism for the enteric outbreak was not identified.

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

Sporadic cases of influenza remain high, with 120 cases reported since the first week of November. This reflects an earlier start to the influenza season than the last two seasons; however, we often see high activity beginning mid-December. This season, it is projected for influenza cases to have an overall earlier peak of the season.

Invasive Group A infections also remain higher than in past years, with 58 cases thus far in 2025 compared with 29 in 2024, and 13 cases since November. A media release and advisory alert were issued the week of December 22, 2025, to raise community and health care provider awareness and to support early identification and treatment.

During the months of November and December, four infection control complaints were received and investigated and 10 requests for service were addressed. Public health inspectors issued one order to cease body piercing services to the owner/operator of a personal service

setting due to inadequate reprocessing of instruments. The order has since been rescinded following corrective action and the setting permitted to resume body piercing services.

Infection Prevention and Control Hub

The Infection Prevention and Control Hub provided 22 services and supports to congregate living settings in November and December. 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.

2. Food Safety

Staff issued 53 special event food service and non-exempt farmers' market permits to various organizations.

A community foodborne outbreak was declared on December 16, 2025, after public health inspectors received several complaints from individuals who became ill shortly after attending a catered luncheon on December 11, 2025. The outbreak investigation included follow up with the food premises, collecting information from attendees via a survey, and submission of food samples to the Public Health Ontario Laboratory.

3. Health Hazard

In November and December, 26 health hazard complaints were received and investigated. Further, staff provided 35 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. One Order to Comply with Section 20 of the *Health Protection and Promotion Act* was issued for lack of running water to residents in a mobile home park.

Staff will be participating in two newly formed City of Greater Sudbury committees

- The Energy Court Governance Committee is a centralized team of leadership from various City services and community partners who provide services to people utilizing the Energy Court service hub. The goal of the Committee is to provide coordinated oversight and governance to the Energy Court location, and to oversee the successful implementation, services response and maintenance of the Energy Court service hub.
- The Task Force for Disconnection of Multi-Unit Buildings is designed to address unsafe situations in multi-unit rentals. Public Health has worked with the City of Greater Sudbury on these situations in the past with teams put together on an as needed basis. This task force will include key representatives to co-ordinate and respond to situations.

4. Ontario Building Code

In November and December, 32 sewage system permits, seven renovation applications, and one consent application were received.

On December 17, 2025, Public Health submitted comments to Ministry of Municipal Affairs and Housing via the Environmental Registry of Ontario and the Ontario Regulatory Registry in response to proposed administrative changes to Ontario's Building Code. The proposed changes would result in the transferring of authority to enforce the septic system provisions in the *Building Code and Building Code Act* from the Board of Health of the Sudbury and District Health Unit to the Municipalities of St.-Charles, French River, Markstay-Warren, and Killarney building departments.

5. Rabies Prevention and Control

In November and December, 44 rabies-related investigations were conducted. Four specimens were submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis. At the time of this report, one result was pending, and three were reported as negative.

Two individuals received rabies post-exposure prophylaxis following an exposure to wild or stray animals.

6. Safe Water

One blue-green algae bloom capable of producing toxin was identified in a local waterway and health protective measures were communicated to the public.

During November and December, 71 residents were contacted regarding adverse private drinking water samples. Additionally, public health inspectors investigated 26 regulated adverse water sample results.

Three boil water orders and five drinking water orders were issued in the months of November and December. Additionally, four boil water orders and four drinking water orders were rescinded following corrective actions.

7. Smoke Free Ontario Act, 2017 Enforcement

In November and December, 13 warning letters were issued for vaping, smoking cigarettes and cannabis on school property.

8. Vector Borne Diseases

In November and December, three ticks were submitted to the Public Health Ontario Laboratory for identification, all of which were identified as Ixodes scapularis, commonly known as the blacklegged tick or deer tick. Blacklegged ticks are vectors of Lyme disease and other tick-borne diseases.

9. Emergency Preparedness & Response

In November and December, staff participated in the following Municipal Emergency Management Committee meetings:

- Township of Killarney, which included a tabletop exercise.
- Town of Espanola, which included a tabletop exercise.
- Township of Nairn & Hyman, which included a tabletop exercise.
- Greater Sudbury Emergency Management Advisory Panel.

10. Needle/Syringe Program

In November, harm reduction supplies were distributed, and services received through 2170 client visits across our service area. Public Health Sudbury & Districts and community partners distributed a total of 25 558 syringes for injection, and 49 845 foils, 13 978 straight stems, and 5045 bowl pipes for inhalation through both our fixed site at Elm Place and outreach harm reduction programs.

In November, approximately 23 297 used syringes were returned, which represents a 74% return ratio of the needles/syringes distributed in the month of October.

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

Sexual health clinic

In November and December, there were 314 drop-in visits to the Elm Place site related to sexually transmitted infections (STIs), blood-borne infections, or pregnancy counselling. As well, the Elm Place site completed a total of 672 telephone assessments related to STIs, blood-borne infections, or pregnancy counselling in November and December, resulting in 264 onsite visits.

Knowledge and Strategic Services

1. Health Equity

In November, the health promoter lead for racial equity shared updates on our ongoing racial equity work at the provincial Black Public Health Advisory Committee (BPHAC) meeting. We highlighted our partnerships with Black communities, our capacity-building efforts through equity-focused approaches and resources, our Anti-Racist and Anti-Oppressive training, and the integrating of the Racial Equity Action Framework into program planning. The information shared was well-received by colleagues and service providers working to reduce racial health disparities. Our agency's commitments to this work align with the endeavors of the BPHAC (which is co-led by the Ministry of Health and Public Health Ontario) to advance Black health equity across Ontario by supporting local public health units in meeting the requirements of the *Ontario Public Health Standards*, including improving race-based data collection and guiding system-level public health initiatives.

2. Indigenous Public Health

In November, the Board of Health received its final presentation on the Foundational Obligations to Indigenous Peoples series. The series concluded with learning about the importance of honouring treaties as a critical component of public health work. The Foundational Obligations series equips participants with knowledge and tools created by and with Indigenous peoples to guide reconciliation. The series will inform the Boards efforts with respect to working with Indigenous communities towards healthy and vibrant Indigenous communities in their pursuit of self-determined health and well-being.

3. Population Health Assessment and Surveillance

In November and December, the Population Health Assessment and Surveillance team responded to 26 internal and external requests for data, information, and consultations, excluding routine surveillance and reporting. The team also supported the successful facilitation of the generation of *Immunization of Schools Pupils Act* (ISPA) letters in collaboration with the Vaccine Preventable Disease (VPD) team and Wellington-Dufferin-Guelph (WDG) health unit. This collaborative process resulted in significant time savings, fostered stronger working relationships, and encouraged ongoing learning among the teams involved.

4. Effective Public Health Practice

In December, the Effective Public Health team delivered a presentation to the provincial Continuous Quality Improvement (CQI) Community of Practice about the agency's advancements in automation and artificial intelligence.

A member of the Effective Public Health Practice team also collaborated with two other public health units and Public Health Ontario to publish a systematic review identifying indicators and tools to measure the process of building healthy public policy.

An online tool to support program planning within the agency was officially launched in November. This new tool to support agency-wide planning leverages technology to streamline, simplify, and expedite planning, reviews, and approvals.

5. Staff Development

In November, the agency's management leadership team completed a training session on Building Resilience through Disruption. The session provided tools for managers to support staff through overall change and to recognize diverse needs during times of disruption. Ongoing planning is underway to explore ways to further support leadership development.

6. Student Placement

In November and December, four learners began placements through the Student Placement Program: two fourth-year BScN learners in Laurentian University's French nursing program and two Public Health and Preventive Medicine learners from NOSM University.

Throughout 2025, Public Health Sudbury & Districts hosted **43 learners** across various disciplines. Of these, **15 placements were observational**, providing learners with exposure to public health practice, and **28 were practical or clinical**, offering hands-on experience in service delivery.

These placements strengthen partnerships with academic institutions and support workforce development in public health.

7. Communications

Work is underway to redevelop the agency's website. Working with an external vendor, the Communications and Information Technology teams are leading and coordinating work to ensure requirements are met related to, for example, hosting, security, privacy, usability, accessibility, and design. A key area of focus for the project is to update the website's structure and information to make it easier for audiences to find clear, current, and reliable information, and to access services. Maintaining accessibility compliance and ensuring that up-to-date information is available on the current website remain top priorities. The redeveloped website is anticipated to be ready in spring or summer 2026.

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 11 Periods Ending November 30, 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	17,163,420	17,163,486	(66)	1,560,245
MOH - Unorganized Territory	826,000	757,167	757,175	(8)	68,825
Municipal Levies	11,186,768	932,250	10,254,927	(390)	931,841
Interest Earned	300,000	275,000	335,862	(60,862)	(35,862)
Total Revenues:	$31,036,499	$28,450,124	$28,511,450	$(61,326)	$2,525,049
Expenditures:					
Corporate Services:					
Corporate Services	6,320,175	5,912,803	5,938,016	(25,213)	382,160
Office Admin.	104,350	95,654	51,943	43,711	52,407
Espanola	131,102	120,702	116,964	3,738	14,138
Manitoulin	141,746	130,512	116,620	13,892	25,126
Chapleau	140,300	129,149	109,425	19,723	30,875
Sudbury East	19,530	17,903	18,478	(575)	1,052
Intake	372,587	343,926	332,538	11,388	40,049
Facilities Management	744,668	677,696	818,678	(140,982)	(74,010)
Volunteer Resources	3,850	3,529	0	3,529	3,850
Electronic Medical Records	0	0	134,803	(134,803)	(134,803)
Total Corporate Services:	$7,978,309	$7,431,874	$7,637,464	$(205,590)	$340,845
Health Protection:					
Environmental Health - General	1,272,898	1,175,109	1,226,987	(51,879)	45,910
Enviromental	2,824,889	2,609,912	2,279,518	330,394	545,371
Vector Borne Disease (VBD)	42,914	40,540	25,925	14,615	16,989
CID	1,528,164	1,410,554	1,354,089	56,465	174,075
Districts - Clinical	236,444	218,249	218,806	(557)	17,638
Risk Reduction	53,756	50,068	13,324	36,744	40,432
Sexual Health	1,508,238	1,393,196	1,395,078	(1,882)	113,160
SFO: E-Cigarettes, Protection and Enforcement	257,027	233,964	211,797	22,167	45,230
Total Health Protection:	$7,724,330	$7,131,593	$6,725,524	$406,069	$998,805
Health Promotion and Vaccine Preventable Diseases:					
Health Promotion and VPD- General	1,881,919	1,736,235	1,595,807	140,428	286,112
Districts - Espanola / Manitoulin	376,553	347,587	307,155	40,432	69,398
Nutrition & Physical Activity	1,517,404	1,404,000	1,171,127	232,873	346,277
Districts - Chapleau / Sudbury East	432,484	399,215	384,665	14,551	47,819
Comprehensive Substance Use (Tobacco, Vaping, Ca	944,307	872,926	771,313	101,613	172,994
Family Health	1,530,508	1,404,596	1,261,297	143,299	269,211
Community Drug Safety & Toxic Drug Crisis & Ment	965,213	890,335	691,865	198,470	273,348
Oral Health	524,052	483,314	457,342	25,973	66,710
Healthy Smiles Ontario	667,047	616,327	581,386	34,942	85,661
SFO: TCAN Coordination and Prevention	505,286	469,313	345,312	124,001	159,974
Harm Reduction Program Enhancement	186,709	172,309	155,154	17,156	31,555
COVID Vaccines	111,689	103,097	13,018	90,079	98,671
VPD	1,656,646	1,525,959	1,207,320	318,639	449,326
MOHLTC - Influenza	(0)	313	(1,645)	1,958	1,645
MOHLTC - Meningittis	0	86	(9,682)	9,768	9,682
MOHLTC - HPV	0	120	(9,818)	9,937	9,818
Total Health Promotion:	$11,299,817	$10,425,734	$8,921,616	$1,504,118	$2,378,201
Knowledge and Strategic Services:					
Knowledge and Strategic Services	3,048,643	2,806,846	2,842,787	(35,941)	205,857
Workplace Capacity Development	43,507	38,753	71,658	(32,905)	(28,151)
Health Equity Office	10,970	9,948	15,670	(5,722)	(4,700)
Nursing Initiatives: CNO, ICPHN, SDoH PHN	516,126	476,423	464,848	11,575	51,278
Indigenous Engagement	414,797	382,828	341,410	41,418	73,387
Total Knowledge and Strategic Services:	$4,034,043	$3,714,797	$3,736,372	$(21,575)	$297,671
Total Expenditures:	$31,036,499	$28,703,998	$27,020,977	$1,683,021	$4,015,522
Net Surplus/(Deficit)	$(0)	$(253,874)	$1,490,473	$1,744,347	

Public Health Sudbury & Districts

Cost Shared Programs
STATEMENT OF REVENUE & EXPENDITURES
Summary By Expenditure Category
For The 11 Periods Ending November 30, 2025

	Adjusted BOH Approved Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:					
MOH Funding	31,036,499	28,450,124	28,635,444	(185,320)	2,401,055
Other Revenue/Transfers	657,147	572,705	806,101	(233,396)	(148,955)
Total Revenues & Expenditure Recove	31,693,646	932,250	29,441,546	(418,717)	2,252,100
Expenditures:					
Salaries	19,358,064	17,866,114	17,583,968	282,146	1,774,096
Benefits	6,978,499	6,441,639	5,884,317	557,322	1,094,181
Travel	256,343	235,041	198,499	36,542	57,844
Program Expenses	731,066	649,491	407,980	241,510	323,086
Office Supplies	88,150	79,380	39,055	40,324	49,094
Postage & Courier Services	90,100	82,592	59,450	23,141	30,650
Photocopy Expenses	5,030	4,611	1,510	3,101	3,520
Telephone Expenses	72,960	66,880	66,103	777	6,857
Building Maintenance	528,488	479,531	608,883	(129,353)	(80,395)
Utilities	190,605	174,721	160,113	14,608	30,492
Rent	329,758	302,278	293,968	8,310	35,790
Insurance	147,768	147,352	108,926	38,426	38,842
Employee Assistance Program (EAP)	37,000	27,750	49,679	(21,929)	(12,679)
Memberships	52,250	50,068	45,984	4,084	6,266
Staff Development	151,201	138,205	228,996	(90,791)	(77,795)
Books & Subscriptions	7,045	6,352	5,589	762	1,456
Media & Advertising	111,147	99,296	40,433	58,863	70,714
Professional Fees	967,511	888,621	759,407	129,214	208,104
Translation	67,679	60,725	65,606	(4,881)	2,072
Furniture & Equipment	18,370	17,614	81,021	(63,407)	(62,651)
Information Technology	1,504,612	1,458,444	1,261,582	196,862	243,030
Total Expenditures	31,693,646	29,276,703	27,951,072	1,325,631	3,742,573
Net Surplus (Deficit)	(0)	(253,874)	1,490,473	1,744,347	

Sudbury & District Health Unit o/a Public Health Sudbury & Districts
SUMMARY OF REVENUE & EXPENDITURES
For the Period Ended November 30, 2025

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
100% Funded Programs							
Indigenous Communities	703	90,400	110,688	(20,288)	122.4%	*Dec 31*	91.7%
LHIN - Falls Prevention Project & LHIN Screen	736	100,000	42,551	57,449	42.6%	***Mar 31/2026***	66.7%
Northern Fruit and Vegetable Program	743	176,100	159,197	16,903	90.4%	*Dec 31*	91.7%
Healthy Babies Healthy Children	778	1,725,944	1,005,202	720,742	58.2%	***Mar 31/2026***	66.7%
IPAC Congregate CCM	780	932,250	508,935	423,315	54.6%	***Mar 31/2026***	66.7%
Ontario Senior Dental Care Program	786	1,315,000	968,534	346,466	73.7%	*Dec 31*	91.7%
Anonymous Testing	788	64,293	42,856	21,437	66.7%	***Mar 31/2026***	66.7%
Total		4,403,987	2,837,963	1,566,024			

Ontario

Ministry of Health
Office of Chief Medical Officer of Health, Public Health
Box 12
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Ministère de la Santé
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December 9, 2025

MEMORANDUM

TO: Public Health Unit Board of Health Chairs, Medical Officers of Health and Chief Executive Officers

FROM: Dr. Kieran Moore, Chief Medical Officer of Health and Assistant Deputy Minister

RE: Revised Ontario Public Health Standards and Protocols

Dear Colleagues,

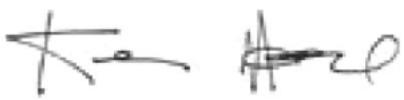
In September 2025, we shared working drafts of several documents to support planning by local Boards of Health in anticipation of a January 2, 2026 implementation date for the revised Ontario Public Health Standards (OPHS) and protocols.

I am writing to inform you that the release of the OPHS will be delayed and the current OPHS, protocols, and guidelines will continue to remain in effect. We will communicate a new release and implementation date as soon as possible. Information regarding Annual Service Plan submissions for 2026 will also be shared shortly.

Thank you for your continued input and collaboration throughout the OPHS review process.

If you have any questions, please contact us at **ophs.protocols.moh@ontario.ca**.

Sincerely,



Dr. Kieran Michael Moore, MD, CCFP(EM), FCFP, MPH, DTM&H, FRCPC, FCAHS
Chief Medical Officer of Health and Assistant Deputy Minister, Public Health

C: Elizabeth Walker, Executive Lead, Office of the Chief Medical Officer of Health, Ministry of Health
Senior Leadership Team, Office of the Chief Medical Officer of Health, Public Health, Ministry of Health
Public Health Unit Business Administrators
Michael Sherar, President and Chief Executive Officer, Public Health Ontario
Loretta Ryan, Chief Executive Officer, Association of Local Public Health Agencies
Ziyaad Vahed, Director, Ministry of Children, Community and Social Services

News From Public Health Agency of Canada

Transmitted by Cision on December 11, 2025 15:17

Statement from the Council of Chief Medical Officers of Health - Latest National Data on Substance-Related Harms

OTTAWA, ON, Dec. 11, 2025 /CNW/ - The illegal drug crisis is one of the most serious public health crises our country has ever faced. There have been too many lives lost and too many communities impacted.

Today's data release provides a picture of substance-related deaths and harms in the previous 12 months. At the national level, from July 2024 to June 2025, there were 6,161 deaths, an average of 17 deaths per day. This represents a meaningful decrease of 22% compared to the year before, and the lowest observed since 2020. The number of hospitalizations, emergency department visits, and Emergency Medical Services responses appear to have stabilized in the first half of 2025, with continued very high level of harms.

It is important to highlight that experiences vary widely between provinces and territories, municipalities and smaller communities, and even neighbourhood to neighbourhood, with some areas continuing to experience increases in harms and deaths. What's more, the impacts of the drug toxicity crisis are disproportionately experienced by Indigenous peoples given the intergenerational impacts of colonization and systemic racism. However, the available data may not fully capture or represent the lived experiences of First Nations, Métis and Inuit communities across Canada.

More research, data, and feedback from key stakeholders are contributing to a better understanding of the reasons for these changes. The Public Health Agency of Canada (PHAC) conducted an analysis into seven potential drivers of the recent decline in opioid-related toxicity deaths. These were identified in consultations with provincial, territorial and other federal partners, along with academic experts and stakeholders. The findings of this analysis are described in the data blogs released

today. Three of the seven investigated drivers were identified as likely contributing to the decreases in deaths.

One of these three drivers was changes in the illegal drug supply. This can be seen in national drug seizure data, which shows less presence of fentanyl and less high-risk combinations, such as opioids mixed with benzodiazepines. In some regions, people with lived and living experience also noted decreased fentanyl potency. However, some changes in the illegal supply present challenges. Certain provinces and territories also experienced increases in other potent substances, including nitazenes, and rising benzodiazepine and cocaine presence.

Naloxone availability was also a likely driver of the decline in deaths. A recent Alberta study showed a 23.9% reduction in deaths for every 10,000 naloxone kits in circulation, and in the past year, hundreds of thousands of kits were distributed across Canada. Data suggests people are actually using the kits, rather than simply stockpiling. Broader distribution is allowing people to address overdoses occurring in private settings, where most overdose deaths happen, as well as reaching rural and remote communities.

The third likely driver is a reduction in the number of people at high risk of overdose. Evidence points to fewer young people using opioids. Death rates have been declining among young adults - particularly males aged 20-29. People with lived and living experience refer to a noticeable change in attitudes among youth toward opioids, driving them to avoid use. Sadly, this decline also reflects the widespread loss of lives.

Now as much as ever, all regions need to continue coordinated efforts. Prevention, education, treatment, recovery, and harm reduction are all critical pieces of a response that reduces mortality and connects people to care. As such, in September 2025, we met with the Canadian Association of Chiefs of Police to explore how public health and law enforcement can keep working together to better support communities across Canada.

The Council of Chief Medical Officers of Health includes the Chief Medical Officer of Health from each provincial and territorial jurisdiction, the Chief Medical Officer from the First Nations Health Authority, Canada's Acting Chief Public Health Officer, the Chief Medical Advisor of Health Canada and the Chief Medical Officer of Public Health of Indigenous Services Canada.

SOURCE Public Health Agency of Canada

For further information: Contacts: Media Relations, Public Health Agency of Canada, 613-957-2983, media@hc-sc.gc.ca

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

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 83-25

TO: Chair and Members of the Board of Health

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

DATE: 2025 December 11

MONITORING FOOD AFFORDABILITY AND IMPLICATIONS FOR PUBLIC POLICY AND ACTION (2025)

Recommendation

It is recommended that the Board of Health:

1) *Receive Report No. 83-25 re: "Monitoring Food Affordability and Implications for Public Policy and Action (2025)" for information;*
2) *Direct staff to draft a resolution for the 2026 Association of Local Public Health Associations (alPHa) Annual General Meeting recommending the Government of Ontario increase the Ontario Works earned income exemption to match the Ontario Disability Support Program earned income exemption; and*
3) *Direct staff to forward Report No. 83-25 re: "Monitoring Food Affordability and Implications for Public Policy and Action (2025)" to Ontario Boards of Health, the City of London, Middlesex County, and appropriate community agencies.*

Report Highlights

- In 2024, 1 in 3 households in Middlesex-London were food insecure. This is a statistically significant increase from 2023.
- Local food affordability monitoring is a requirement of the Ontario Public Health Standards.
- The 2025 Ontario Nutritious Food Basket results demonstrate decreased food affordability and inadequate incomes to afford basic needs for many Middlesex-London residents.
- Food insecurity has a pervasive impact on health; and there is a need for income-based solutions.

Background

Food insecurity, defined as inadequate or insecure access to food due to financial constraints, is a key social determinant of health[1]. For children and adults, food insecurity is a strong predictor of poor health and is associated with an increased risk of a wide range of physical and mental health challenges, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress[1-3]. Poor diet quality costs Ontario an estimated $5.6 billion

annually in direct healthcare and indirect costs (e.g., lost productively due to disability and premature mortality)[4].

As a result of systemic and structural inequities, racism, and colonization, food insecurity disproportionately affects certain populations[1,3,5]. Higher rates of food insecurity are found among Indigenous People, Black people, recent immigrants, female lone parent led households, low-income households, and other marginalized populations[1]. Although households whose main income is from social assistance have the highest rate of food insecurity, 58.6% of food insecure households in Ontario rely on wages, salaries, or self-employment as their main income[1].

Routine monitoring of food affordability helps generate evidence-based recommendations for collective public health action to address food insecurity which is often tied to income inadequacy. The Ontario Public Health Standards require monitoring local food affordability as mandated in the Population Health Assessment and Surveillance Protocol, 2018.

The Ontario Nutritious Food Basket (ONFB) is a survey tool that measures the cost of eating as represented by current national nutrition recommendations and average food purchasing patterns. The Ontario Dietitians in Public Health (ODPH), in collaboration with Public Health Ontario (PHO), develop, test, and update tools for monitoring food affordability for Ontario public health units. The costing tool uses a hybrid model of in-store and online data collection.

Local Food Insecurity

The rate of food insecurity in Middlesex-London has significantly increased in recent years (Appendix B). In 2024, 1 in 3 households (31.3%) in Middlesex-London were food insecure[6]. This is a statistically significant increase from 2023 (1 in 4 households, 25.1%) and 2022 (1 in 6 households, 17.5%)[6]. Middlesex-London Health Unit is the only Ontario public health unit with a statistically significant higher food insecurity rate in 2024 than Ontario.

In 2024, an estimated 194,000 residents lived in food insecure households in Middlesex-London[6,7]. This is an increase of approximately 54,000 residents from 2023 (estimated 140,000 residents)[6,7]. However, food insecurity data are not available below the health unit level, limiting the ability to stratify prevalence estimates between the City of London and Middlesex County.

The prevalence of food insecurity across Canada suggest that food insecurity may be lower in rural areas (i.e., Middlesex County) than urban areas (i.e., City of London)[8]. However, food insecurity is still a concern for Middlesex County as evidenced by the number of meal programs and food banks in Middlesex County[9]. In addition, food bank usage underrepresents the actual rate of food insecurity, as many people who are food insecure do not access food banks[10].

Food insecurity is measured by the Household Food Security Survey Module (HFSSM) and classified as food secure, marginally food insecure, moderately food insecure, or severely food insecure (Appendix C). In recent years, moderate and severe food insecurity have increased disproportionally compared to marginal food insecurity (Appendix C)[6]. Ontario data provides an estimate for the increases at the local level, as Middlesex-London data is only available as the dichotomous variable of food secure or food insecure.

Local Food Affordability

Local food and average rental costs from May 2025 are compared to a variety of household and income scenarios, including households receiving social assistance, minimum wage earners, and median incomes (Appendix D, Appendix E). The scenarios include food and rent only and

are not inclusive of other needs (i.e., utilities, Internet, phone, transportation, household operations and supplies, personal care items, clothing, etc.). The household scenarios highlight that incomes and social assistance rates are not keeping pace with the increased cost of living. Comparing the monthly funds remaining after rent and food costs in 2025 to 2024 for various household scenarios illustrates that specific scenarios are falling further behind each year and provides evidence for the impact of income-based policy changes on food affordability (e.g., Ontario Disability Support program rate increases are indexed to inflation, while Ontario Works rate increases are not indexed to inflation).

A key indicator of food insecurity is the average monthly cost of a nutritious diet as a proportion of household income. Households with low incomes spend up to 47% of their after-tax income on food, whereas households with adequate incomes (family of 4) only spend approximately 12% of their after-tax income.

Monitoring food affordability data and methodology details, including other cost adjustments required to compare the 2024 and 2025 scenarios, are included in Appendix D.

Public Health Action
Annually, the Health Unit monitors and reports on local food affordability, the impact of health inequities due to food insecurity, effective strategies to reduce these inequities, and shares this information with the municipalities, the public, and community partners.

Ontario's Poverty Reduction Act, 2009 requires the provincial government to develop a new poverty reduction strategy every five years. The current strategy, Building a Strong Foundation for Success: Reducing Poverty in Ontario (2020-2025), is soon to expire. MLHU submitted a response to the recent Ontario Poverty Reduction Strategy (OPRS) consultation including recommendations from the food insecurity municipal primer (Appendix F).

The food insecurity municipal primer includes a recommendation to work with the provincial government to advance income-based policies and income support programs (e.g., increase the amount of income exempt from reduction of Ontario Works (OW) benefits to better support those working toward leaving the OW program) (Report No. 48-25). The current OW earned income exemption of $200 per month, with benefits reduced by 50 cents for every additional dollar earned, has not increased since 2013[11]. In 2023, the provincial government increased the Ontario Disability Support Program (ODSP) earned income exemption from $200 to $1,000 per month, with benefits reduced by 75 cents for every additional dollar earned[12].

Earlier this year, the Board of Health received a verbal delegation from the London Food Bank (LFB) about their partnership with the Health Unit and the current state of food insecurity in Middlesex-London. Feed Ontario, of which LFB is a member, advocates for solutions to end food insecurity and poverty in Ontario, including increasing the OW income exemption to align with the ODSP income exemption[13].

It is recommended that the Board of Health direct staff to draft a resolution for the 2026 Association of Local Public Health Agencies (alPHa) Annual General Meeting recommending the Government of Ontario increase the OW earned income exemption to match the ODSP earned income exemption (i.e., increase from $200 to $1000 per month, with benefits reduced by 75 cents for every additional dollar earned).

Living wages help to protect individuals against food insecurity. A living wage is the hourly wage a full-time worker needs to earn to afford basic expenses and participate in community life. In

Middlesex-London, the 2025 living wage is $21.05 per hour[14] as compared to the Ontario minimum wage of $17.60. Local food costs, as estimated using the ONFB, are shared with the Ontario Living Wage Network and used to calculate our regional living wage. The Health Unit re-certified as a living wage employer in 2025.

Next Steps
Continued work is needed to address food insecurity and its significant health and well-being implications. MLHU will continue to highlight the need for upstream income-based solutions and programs that address both food affordability and access.

Affordable housing is critical to ensuring households can afford other necessities, such as food. Policy recommendations and actions that can be taken by municipalities and housing providers are included in "The Built, Natural, and Social Environments Framework: Housing" (Report No. 82-25).

This report was written by the Municipal and Community Health Promotion Team of the Family and Community Health Division and the Population Health Assessment and Surveillance Team of the Public Health Foundations Division.

References are affixed as Appendix A.

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.

FOOD INSECURITY
MIDDLESEX-LONDON 2025

Food insecurity negatively impacts physical, mental, and social health [1]

Food insecurity is the inadequate or insecure access to food due to a lack of money [1]

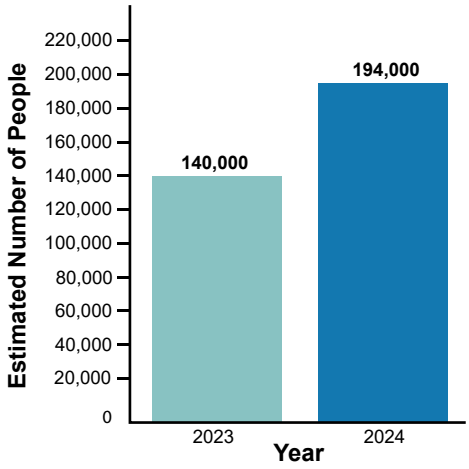
2024

1 in 3 Middlesex-London households were food insecure [2]

2023

1 in 4 Middlesex-London households were food insecure [2]

Middlesex-London Residents Living in a Food Insecure Household [2, 3]



How much money is left each month after paying for food and rent? [4]

	Single Person		Family of 4		
Income Source	OW [a]	ODSP [b]	OW [a]	Minimum Wage [c]	Median Income [d]
Food (% of Monthly Income Needed)	47%	27%	40%	23%	12%
Rent (% of Monthly Income Needed)	116%	67%	63%	37%	19%
What's Left?	-$558	$84	-$79	$2,020	$6,792

[a] Ontario Works [b] Ontario Disability Support Program [c] As of May 2025 [d] Statistics Canada, 2025.

Households still need to pay for all other expenses, including childcare, utilities, Internet, phone, tenant insurance, transportation, personal care, clothing, school supplies, gifts, recreation, out of pocket medical and dental costs, education, and savings.

Solutions are needed that help people afford the costs of living

- ☐ Adequate social assistance benefits
- ☐ Jobs that pay a living wage
- ☐ A basic income guarantee
- ☐ Affordable housing, public transit, and childcare
- ☐ Reduced income tax for low-income households
- ☐ Free tax filing support

References
1. Tarasuk V, Li T, Fafard St-Germain AA. (2022). Household food insecurity in Canada, 2021. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from https://proof.utoronto.ca/
2. Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2025). Snapshots Data File for Household Food Insecurity (2019 to 2023 (annual, 2-year combined, 3-year combined)). Retrieved from https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Household-Food-Insecurity.
3. Ministry of Finance (MOF). (2024). Ontario population projections, 2023-2051. Toronto ON: MOF.
4. Middlesex-London Health Unit (December 2025). Monitoring food affordability and implications for public policy and action (2025).

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
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Windsor-Essex County Health Unit Board of Health

RECOMMENDATION/RESOLUTION REPORT – Adverse Childhood Experiences (ACEs) Local Policy Advancement

2025-11-20

ISSUE

Early adversities or Adverse Childhood Experiences (ACES) are stressful or traumatic events occurring before the age of 18 that can trigger extreme or prolonged stress response, potentially leading to serious health issues later in life. These experiences may include physical, sexual, or emotional abuse; physical and emotional neglect; and household dysfunction such as parental separation, exposure to domestic violence, or substance use issues.

Locally, rising indications of youth mental health challenges, family stress, and community violence point to ongoing exposure to adversity among children and youth in Windsor and Essex County (WEC). Despite the well documented health and social costs of ACEs, prevention and trauma informed response are not yet fully integrated across community systems such as education, housing, health care and social services.

The issue is compounded by other broader systematic and individual traumas, including colonialism, racism, housing instability, children from low-oncome households, newcomers, and Indigenous communities. These individuals face a greater likelihood of exposure to ACES with few accessible protective supports. Without coordinated, upstream policy action, ACEs will continue to drive intergenerational cycles of trauma, health inequity and system strain.

Preventing ACES is increasingly recognized as an upstream public health strategy to reduce substance use, prevent chronic diseases and mental health issues, improve overall health, and address health inequities faced by families. A trauma-informed care approach is a foundational strategy in addressing ACEs. A trauma-informed approach acknowledges the widespread nature of trauma especially among children, youth and families and its effects on health. It involves adapting organizational policies and to foster resilience, prevent re-traumatization and promote safe, supportive environments for both clients and staff.

BACKGROUND

In May 2025, the WECHU presented a board information report outlining the significance of ACEs in our region. The presentation focused on what ACEs are, their health implications, populations most at risk, protective factors and key WECHU activities planned for 2025 which included:

- **Staff Capacity Building** – The WECHU has developed e-learning training modules on ACEs and trauma-informed care for all staff. Completion of this training will be mandatory throughout the organization and integrated into staff orientation, and annual refresher courses. In addition, the WECHU will share the e-learning modules with other community organizations and health care providers, encouraging the adoption of training within their own organization to build capacity and understanding of ACEs with their employees.
- **Policy Development/Implementation –** A corporate policy has been developed to guide implementation and integration of trauma-informed principles into daily WECHU operations. This policy ensures consistent application of training across WECHU programs and services. The WECHU will share this policy with other

community partners and health care providers to encourage adoption of similar policies to develop consistent, community wide application of ACEs and trauma informed care principles with clients.

- **Community Collaboration –** As a key priority, the WECHU is working with key community organizations to establish a working committee to address ACEs and trauma from a regional perspective. An initial meeting was held in June 2025 with interest from several local groups to work and collaborate on future initiatives focused on ACEs and trauma informed care.
- **Regional Communication Strategy-** The WECHU is developing communication messages about ACES including tips for parents and families to create positive experiences, and targeted messaging for priority populations introducing the concept of positive and adverse childhood experiences (PACES). Rollout of messaging is planned for early December 2025.

PROPOSED MOTION

WHEREAS Adverse Childhood Experiences **(**ACEs) are linked to a range of negative health and social outcomes across the lifespan, including chronic disease, mental illness, substance use disorders, and premature mortality; and

WHEREAS Adverse Childhood Experiences (ACEs) contribute to significant health inequities that disproportionately affect children and families facing poverty, racism, housing/food instability, and other systemic barriers; and

WHEREAS national data indicates that 61.6% of the population has experienced at least one Adverse Childhood Experiences (ACEs) in their lifetime and locally 19.3% of respondents had experienced at least one childhood maltreatment incident in Windsor-Essex County (Dawdy et. al., 2025)

WHEREAS the Windsor-Essex County Board of Health can endorse comprehensive policy recommendations that will help to address various health sectors in the region by focusing on the prevention and mitigation of Adverse Childhood Experiences (ACEs) and trauma; and

WHEREAS public health has a legislative mandate to promote health equity, prevent illness, and address the social determinants of health through multi-sectoral collaboration and policy advocacy.

NOW THEREFORE BE IT RESOLVED that the Windsor-Essex County Board of Health supports engaging local community partners to co-develop strategies that reduce exposure to Adverse Childhood Experiences (ACEs) and trauma and strengthen protective factors across the region by encouraging adoption of WECHU's training resources and policy within partner organizations**;**

AND FURTHER THAT the Windsor-Essex County Board of Health will support local collaboration with health care providers through the sharing of resources, research/data, best practices and recommends health care providers adopt WECHU's training resources and policies on Adverse Childhood Experiences (ACEs) and trauma informed principles within their own professional development and practices;

AND FURTHER THAT the Windsor-Essex County Board of Health calls on municipal, provincial, and federal partners to implement polices and funding that prevent ACEs by addressing poverty, housing insecurity, food access, and family supports;

AND FURTHER THAT, that the Windsor-Essex County Health Unit calls on the provincial government to ensure sustained provincial investment (i.e., funding, training and enhancement of programs and services focused on ACEs) in upstream initiatives that support at risk children, youth and families and help prevent or mitigate adverse childhood experiences, trauma and associated health issues and behaviours.

Key References:

Center for Health Care Strategies (2018). Brief: Laying the Groundwork for Trauma-Informed Care. Retrieved from https://www.chcs.org/media/Laying-the-Groundwork-for-TIC_012418.pdf

Dawdy, J., Dunford, K. and Magalhaes Boateng, K. (2025). Ontario Early Adversity and Resilience Framework. Public Health Ontario Adverse Childhood Experiences and Resilience Community of Practice

Madigan, S., (2023). Adverse childhood experiences: a meta-analysis of prevalence and moderators among half a million adults in 206 studies. World Psychiatry 2023; 22:463–471

Windsor-Essex County Health Unit Board of Health

RECOMMENDATION/RESOLUTION REPORT – Prevention and Response to Radon Exposures in WEC

2025-11-20

BACKGROUND

Radon is an invisible, odorless, and tasteless radioactive gas that results from the natural decay of uranium in soil and rock. It can enter homes and buildings through cracks, or openings in the foundation, and when the gas accumulates in enclosed spaces, it can become a health risk. As radon decays, it releases radioactive particles that can attach to dust and other substances, which can damage the cells lining the lungs when inhaled. Prolonged exposure to radon can increase the risk of lung cancer. For non-smokers, radon exposure is the primary cause of lung cancer and for people who smoke the risk of is even higher. In fact, the Government of Canada (2025) estimates that radon exposure is responsible for 16% of lung cancers in Canada, resulting in more than 3,000 deaths each year[1]. Exposure to radon poses significant health risks, especially to vulnerable populations like children, seniors, and individuals with pre-existing lung conditions. Children are particularly susceptible, as early exposure increases their lifetime risk of lung cancer.

Health Canada has set the Canadian guideline for indoor radon levels in the home at 200 Becquerels per cubic metre (Bq/m^3). A recent 2024 Cross-Canada Survey of Radon Exposure in the Residential Buildings of Urban and Rural Communities was published and found that the central region (Ontario and Quebec) of Canada has approximately 1 in 6 residential homes with an average radon level at or exceeding 200 Bq/m^3. The only way to know what the radon level is in a home or building, is to test for it. Corrective actions should be taken within one year if radon level results are at or greater than 200 Bq/m^3. Effective techniques to reduce indoor radon levels include sealing cracks or gaps in the house or the building foundation, sealing sump-pump holes, and increasing ventilation. However, if these techniques do not reduce radon levels below 200 Bq/m^3, a more extensive radon mitigation system must be installed by a certified radon professional. According to Health Canada, the expense of radon mitigation typically ranges from $2000 to $4000 which can present a significant financial burden for low-income households.

In February 2019, the WECHU Board of Health passed a resolution that outlined a number of progressive public health initiatives aimed at lowering community risks and exposures related to radon. The key actions included promoting municipal and public policy updates on testing and mitigation, along with strengthening provincial building code requirements for new constructions of homes. Since this resolution, WEC municipalities have adopted a radon rough-in requirement for all new residential construction through by-laws (2020). The Ontario Building Code further strengthened these measures by mandating a rough-in for a subfloor depressurization system in all new homes and buildings in January 2025.

The WECHU continues to promote radon awareness through educational campaigns to the community, every November during Radon Action Month, to encourage residents to test their homes.

In 2022, the WECHU provided consultation to the Essex County Library, and its branches, to implement a Radon Monitor Lending Program that offers Essex County residents the opportunity for short term borrowing of radon devices to test their homes. The program was initially funded by a grant and launched with 20 short-term radon testing devices for library cardholders. The program has continued and expanded to 54 devices. From 2022 to 2024, the devices were circulated 4,094 times. While the Essex County Library has successfully added this resource to their services, other community serving organizations throughout the community hold important opportunities to offer similar types of free access to testing devices for the public. Free access to testing is of particular benefit to low-income households in high priority neighbourhoods. A more comprehensive, community based, barrier free access approach could expand reach and access.

Municipalities are in a unique position to take a leadership role in helping communities take action to prevent and identify radon concerns by developing and implementing radon policy frameworks. Many WEC residents live and work in spaces that lack modern radon mitigation systems, and the high cost of remediation is a major barrier for residents in low-income households. By implementing testing and mitigation policies in public spaces, municipal housing, and subsidized living facilities, municipalities can not only reduce exposure but also encourage other local organizations and businesses to adopt their own comprehensive radon policies.

PROPOSED MOTION

Whereas, the 2025 Government of Canada data shows that long-term radon exposure is the leading cause of lung cancer after smoking, and can be attributed to 3000 lung cancer deaths per year in Canada; and

Whereas, the 2024 Cross Canada Study indicates that the central region (Ontario and Quebec) of Canada has approximately 1 in 6 residential homes with average radon levels at or exceeding 200 Bq/m^3, and

Whereas, testing is the only accurate way to know a home or building's radon level, and

Whereas, radon mitigation can present a significant financial challenge for many low-income homeowners in the WEC region, and

Now therefore be it resolved that the Windsor-Essex County Board of Health recommends local municipalities adopt radon policy frameworks that includes radon testing in municipally owned indoor spaces, including municipally supported congregate living sites, and implement mitigation strategies when high radon levels are detected; and

FURTHER THAT, the Windsor-Essex County Board of Health recommend local municipalities adopt a free and accessible short-term radon monitoring device lending program, in a variety of public spaces, for residents to test their homes for radon barrier free; and

FURTHER THAT, the Windsor-Essex County Board of Health continues to recommend that local municipalities explore opportunities for subsidy programs, specifically for those living in high priority neighbourhoods and low-income households, to reduce the cost of radon remediation in homes where radon is detected.

Windsor-Essex County Health Unit Board of Health

RECOMMENDATION/RESOLUTION REPORT – Windsor and Essex County School Food Programs

2025-11-20

BACKGROUND

Across Ontario, and particularly in Windsor and Essex County (WEC), inadequate nutrition among children and youth remains a significant public health challenge requiring coordinated policy action. Between 2023 and 2024, 25.7% of people in Windsor-Essex were living in a food-insecure households. Further, in 2023, 12.9% of children 1 to 17 years old in WEC lived in food-insecure households. Low-income households tend to have competing demands for scarce resources and spend less money on food compared to higher-income counterparts, making access to food out of reach for many families. Poor nutrition has serious consequences, including short-term impacts on students' academic success, mental well-being, overall growth and development, and causes increased rates of costly nutrition-related illnesses over time.

Families are struggling, which is why a comprehensive, evidence informed, community-based school food strategy is vital for our community. While school food programs are not a replacement for robust income security measures to directly address household food insecurity, they are a key component of a comprehensive social support system: they reduce children's hunger during school hours, relieve pressure from household budgets, and improve the diets of children and youth across socio-economic backgrounds.

The Ontario Student Nutrition Program (OSNP) is a government-supported initiative that provides nutritious food, such as breakfasts, lunches, and snacks, to school-age children and youth to help them learn, develop healthy eating habits, and feel a sense of belonging at school. The universal program is delivered during school hours, through a network of schools and community partners, relying on volunteers to provide meals and support students' physical, social, and academic development. This program operates under a cost-shared funding model comprising two primary sources:

- **OSNP Grant:** Start-up funding that consolidates all OSNP-administered contributions, including federal, provincial, regional, and locally raised funds.
- **School-Generated Funds:** Schools are responsible for supplementing their programs through local fundraising efforts to ensure adequate financial and material resources.

This model presents an inherent challenge, as schools with the highest levels of need often lack the fundraising capacity to sustain their programs at the required level. Further, current decision making about which schools receive what amount of funding is done largely in isolation of local collaboration with local public health units. In addition, local not-for-profits have been conducting school lunch pilot projects which operate at the same time as OSNP programs. Rather than filling gaps in service (afterschool, weekends and holidays), these programs are duplicating services. There is also limited, if any, funding from local municipal governments to support school food programs, leaving this sustainable funding source as an unused resource.

On October 10, 2025, the federal government announced that they will be introducing legislation to make the National School Food Program permanent. On that same day, the Ontario government announcement an additional $5 million of funding for this school year. These commitments to school food are welcomed, and very promising, but require a local perspective that is not the current practice.

The Windsor-Essex Food Strategy, endorsed by the Board of Health in June 2024, provides a framework of actions that can support neighbourhood focused initiatives that centre around schools identified by the WECHU, in consultation with the local school boards. The Windsor-Essex Food Policy Council can support these coordinated approaches, as we utilize school food programs to transform the local food system and provide significant opportunities to elevate the health, economy, and the food environment for all.

PROPOSED MOTION

Whereas, food insecurity affects approximately 1 in 4 households in WEC; and

Whereas, the current model for Ontario Student Nutrition Program funds does not include a locally driven, evidence-informed strategy, and does not prioritize recommendations and insight of local schools, boards and the WECHU; and

Whereas, opportunities for funding food programs outside of OSNP in schools are sporadic, time-limited, disconnected from risk-based food strategies, and not driven by local evidence of food insecurity needs in our school communities;

Whereas, the Windsor-Essex Food Policy Council network of local food system representatives can work to implement food strategy recommendations at the neighbourhood level;

Whereas, the WECHU, the Greater Essex County District School Board and the Windsor Catholic District School Board have prioritized a coordinated approach to addressing food insecurity in schools;

Now therefore be it resolved that the Windsor-Essex County Board of Health calls on the provincial government to review the current funding algorithm used in programs like the Ontario Student Nutrition Program, to ensure that local evidence informed strategy is upheld, led through insights of the local public health unit and school boards;

FURTHER THAT, local not-for-profit and community service organizations working to support food security strategies, focus on programming in high priority communities, specifically outside of school settings, with a key goal of addressing larger community-based food needs;

FURTHER THAT, local not-for-profit and community service organizations working to support food security strategies, focus on programming in high priority communities, for students and families during periods when school food programs are inaccessible (during non-school months and breaks, evenings, and weekends);

FURTHER THAT, local school boards, in consultation with the WECHU, be given the lead role in decision making and allocation of funding (new and current) for school-based food programs, to ensure a more coordinated and evidence informed local approach, reducing duplication of efforts, and utilizing existing key local data and school informed insights;

FURTHER THAT, the Windsor-Essex Food Policy Council prioritize the creation of evidence informed programs that improve physical access to foods in neighbourhoods surrounding the highest needs schools;

FURTHER THAT, the Windsor-Essex County Board recommends that local municipalities dedicate funding to sustainable food programming in schools, guided by evidence need at the recommendation of local public health and school boards.

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa's members are the public health units in Ontario.

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Dietitians in Public Health

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November 10, 2025

The Hon. Sylvia Jones
Deputy Premier and Minister of Health
Ministry of Health
College Park, 777 Bay Street
Toronto, ON M7A 2J3

Dear Minister Jones,

Re: Recommendations for Indigenous Membership on Boards of Health

The Association of Local Public Health Agencies (alPHa) advocates for a strong, local public health system that enables Boards of Health to make decisions reflecting the unique needs of their communities and their regional diversity within Ontario's public health framework. We recognize the Ministry's provincial guidance on Indigenous participation, including the *Ontario Public Health Standards (OPHS) Indigenous Engagement Protocol* and the *First Nation, Inuit, and Métis Community Engagement Guide*.

To advance reconciliation and equity, alPHa recommends Indigenous membership on Boards of Health in alignment with the Truth and Reconciliation Commission (TRC) Calls to Action, the United Nations Declaration on the Rights of Indigenous Peoples Act (UNDRIP), and the province's new Indigenous engagement guide. Indigenous participation on Boards of Health should uphold self-determination, respect local governance structures, reflect jurisdictional realities, and be developed collaboratively with Indigenous communities and partners.

Accordingly, alPHa recommends that the Ontario Government advance Indigenous membership on Boards of Health to ensure a collaborative, fair, flexible approach that is consistent with provincial guidance, and self-determination. This could be facilitated, for example, through the Public Appointments Secretariat. Such alignment will strengthen consistency, flexibility, and capacity-building to support meaningful and sustainable Indigenous engagement across Ontario's public health system.

Thank you for your ongoing leadership in strengthening Ontario's public health system and supporting reconciliation through collaborative governance.

Sincerely,

Dr. Hsiu Li Wang
Chair, alPHa Board of Directors
Association of Local Public Health Agencies

Copy: Dr. Kieran Moore, Chief Medical Officer of Health

The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to Ontario's boards of health. alPHa represents all of Ontario's boards of health, medical officers and associate medical officers of health, and senior public health managers in each of the public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology, and business administration. As public health leaders, alPHa advises and lends expertise to members on the governance, administration, and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective, and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention, and surveillance services in all of Ontario's communities.

Board of Health for Public Health Sudbury & Districts: Summary of 2025 Board Meeting Evaluations

After every regularly scheduled meeting, Board of Health members for Public Health Sudbury & Districts are invited to complete a post-meeting evaluation survey. During 2025, the overall response rate for all eight meetings was 75.7% compared to 63% in 2024. Response rates for each Board of Health meeting are indicated in the table below.

Table 1: Board of Health Response Rate by Month, 2025

Month	Completed Evaluations	Total Attendance	Response Rate%
January	8	10	80.0%
February	10	10	100.0%
April	4	7	57.1%
May	6	10	60.0%
June	5	7	71.4%
September	8	10	80.0%
October	8	9	88.9%
November	7	11	63.6%
Total	**56**	**74**	**75.7%**

In these post-meeting evaluation surveys, Board of Health members are asked to reflect on various aspects of the meeting and to state their level of agreement or disagreement with the following statements:

1. The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.
2. The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.
3. The MOH/CEO report was informative, timely and relevant to my governance role.
4. Overall, Board members participated in a responsible way and made decisions that further the Public Health Sudbury & Districts' vision and mission.

5. There is alignment with items that were included in the Board agenda package and the Public Health Sudbury & Districts' 2024-2028 Strategic Plan.
6. Board members' conduct was professional, cordial and respectful.

For the most part, Board of members regularly strongly agreed with all statements, with some exceptions.

The report includes results for each meeting, and an overall analysis for all the meetings combined.

Statement #1: The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role

When results from all eight meetings are combined, most respondents (98%) indicated strong agreement that the board agenda package contained appropriate information.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
January	8 100.0 %	0 0.0%	0 0.0%	0 0.0%
February	10 100.0 %	0 0.0%	0 0.0%	0 0.0%
April	4 100.0 %	0 0.0%	0 0.0%	0 0.0%
May	5 83.3%	1 16.6%	0 0.0%	0 0.0%
June	5 100. 0%	0 0.0%	0 0.0%	0 0.0%
September	8 100.0%	0 0.0%	0 0.0%	0 0.0%
October	8 100.0%	0 0.0%	0 0.0%	0 0.0%
November	7 100.0%	0 0.0%	0 0.0%	0 0.0%
Total	**55** **98.2%**	**1** **1.7%**	**0** **0.0%**	**0** **0.0%**

Statement #2: The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject

Across all eight meetings, 96% of respondents strongly agreed that the delegation presentation was an opportunity to improve their knowledge and understanding of an important public health subject.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
January	8 100.0 %	0 0.0%	0 0.0%	0 0.0%
February	9 90%	1 10.0%	0 0.0%	0 0.0%
April	4 100.0 %	0 0.0%	0 0.0%	0 0.0%
May	6 100.0 %	0 0.0%	0 0.0%	0 0.0%
June	5 100. 0%	0 0.0%	0 0.0%	0 0.0%
September	7 87.5%	1 12.5%	0 0.0%	0 0.0%
October	8 100.0%	0 0.0%	0 0.0%	0 0.0%
November	7 100.0%	0 0.0%	0 0.0%	0 0.0%
Total	**54** **96.4%**	**2** **3.5%**	**0** **0.0%**	**0** **0.0%**

Statement #3: The MOH/CEO report was informative, timely and relevant to my governance role

Overall, respondents consistently indicated strong agreement (100%) MOH report was informative, timely, and relevant to their governance role.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
January	8 100.0 %	0 0.0%	0 0.0%	0 0.0%
February	10 100.0 %	0 0.0%	0 0.0%	0 0.0%
April	4 100.0 %	0 0.0%	0 0.0%	0 0.0%
May	6 100.0 %	0 0.0%	0 0.0%	0 0.0%
June	5 100. 0%	0 0.0%	0 0.0%	0 0.0%
September	8 100.0%	0 0.0%	0 0.0%	0 0.0%
October	8 100.0%	0 0.0%	0 0.0%	0 0.0%
November	7 100.0%	0 0.0%	0 0.0%	0 0.0%
Total	**56** **100.0 %**	**0** **0.0%**	**0** **0.0%**	**0** **0.0%**

Statement #4: Overall, Board members participated in a responsible way and made decisions that further the Public Health Sudbury & Districts' Vision and Mission

Across all eight meetings, 87% of respondents strongly agreed and 12% somewhat that board members participated in a responsible way and made decisions that further the agency's vision and mission.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
January	8 100.0 %	0 0.0%	0 0.0%	0 0.0%
February	9 90%	1 10%	0 0.0%	0 0.0%
April	3 75.0%	1 25.0%	0 0.0%	0 0.0%
May	5 83.3%	1 16.6%	0 0.0%	0 0.0%
June	4 80.0%	1 20.0%	0 0.0%	0 0.0%
September	7 87.5%	1 12.5%	0 0.0%	0 0.0%
October	7 87.5%	1 12.5%	0 0.0%	0 0.0%
November	6 85.7%	1 14.2%	0 0.0%	0 0.0%
Total	**49** **87.5%**	**7** **12.5%**	**0** **0.0%**	**0** **0.0%**

Statement #5: There is alignment with items that were included in the Board agenda package and the Public Health Sudbury & Districts' 2024-2028 Strategic Plan

When results from all eight meetings are combined, 91% of respondents (91%) strongly agreed that the Board agenda items align with the agency's Strategic Plan.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
January	8 100.0 %	0 0.0%	0 0.0%	0 0.0%
February	8 80.0%	2 20.0%	0 0.0%	0 0.0%
April	3 75.0%	1 25.0%	0 0.0%	0 0.0%
May	6 100.0%	0 0.0%	0 0.0%	0 0.0%
June	5 100. 0%	0 0.0%	0 0.0%	0 0.0%
September	7 87.5%	1 12.5%	0 0.0%	0 0.0%
October	8 100.0%	0 0.0%	0 0.0%	0 0.0%
November	6 85.7%	1 14.3%	0 0.0%	0 0.0%
Total	**51** **91.0%**	**5** **9.0%**	**0** **0.0%**	**0** **0.0%**

Statement #6: Board members' conduct was professional, cordial and respectful

Across all eight meetings, most respondents (98%) strongly agree that the Board of Health members' conduct was professional, cordial, and respectful.

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
January	8 100.0 %	0 0.0%	0 0.0%	0 0.0%
February	10 100.0 %	0 0.0%	0 0.0%	0 0.0%
April	4 100.0 %	0 0.0%	0 0.0%	0 0.0%
May	6 100.0%	0 0.0%	0 0.0%	0 0.0%
June	5 100. 0%	0 0.0%	0 0.0%	0 0.0%
September	8 100.0%	0 0.0%	0 0.0%	0 0.0%
October	7 %	1 %	0 0.0%	0 0.0%
November	7 100.0%	0 0.0%	0 0.0%	0 0.0%
Total	**55** **98.2%**	**1** **1.8%**	**0** **0.0%**	**0** **0.0%**

Comments and suggestions

In each meeting evaluation survey, Board of Health members were given the opportunity to provide feedback on the things they liked or disliked about the meeting, and to provide suggestions on how to improve future meetings.

Meeting highlights

Overall, the majority of comments received for the monthly Board of Health meeting evaluations were positive. Taking the time to pause after meetings to reflect on their effectiveness is an important way to ensure continuous quality improvement.

- Great participation by all.
- Our new chair did an outstanding job.
- Some board members participate actively and ask interesting questions.
- Very educational and professionally run.
- Good all-around discussions, great input.
- Really enjoyed the 2 presentations (hearing about all the committees working together to help those with substance abuse and adopting the Iceland method).

Suggestions for future meetings

Only a few respondents provided suggestions on ways to improve future meetings.

Some suggestions included maintaining "chairs notes" for those who must speak as they are seen as helpful to guide the meetings.

It was also suggested that we may look into electronic voting, perhaps through Board Effect. Drafting meeting minutes as the meetings progress could also be a helpful time saver and help document true results of how the votes were collected.

It was noted that most City Councils live stream and record the regular part of their meetings. With that, it was suggested that our agency could look into live streaming the board meetings and recordings (via the future updated website) to increase openness and transparency.

Finally, it was suggested that at a future meeting, we should review the Walport report (which is a report from Expert Panel for the Review of the Federal Approach to Pandemic Science Advice and Research Coordination) and its implications for Public Health Sudbury & Districts.

Summary and conclusion

This report consolidates evaluation results from the eight monthly board meetings held in 2025. Feedback was gathered from Board members each month, providing a consistent perspective on board performance and governance practices. The analysis includes both individual meeting results and aggregated findings across all meetings.

Overall, respondents expressed high levels of agreement on key measures of board effectiveness. Across all eight meetings:

- Agenda Quality: 98% strongly agreed that the board agenda package contained appropriate information.

- Responsible Participation: 87% strongly agreed and 12% somewhat agreed that board members acted responsibly and made decisions aligned with the agency's vision and mission.
- Strategic Alignment: 91% strongly agreed that agenda items were aligned with the agency's Strategic Plan.

These results indicate strong confidence in the board's processes and decision-making throughout the evaluation period. The high level of agreement across all measures suggests that current practices are effective and well-received by members. Moving forward, the board should continue to maintain these standards while exploring opportunities for continuous improvement, such as enhancing transparency and fostering engagement to sustain this positive trajectory.

BOARD OF HEALTH MEMBER ATTENDANCE SUMMARY
2025 BOARD OF HEALTH MEETINGS

	Board of Health meeting date									
	01/16/25	02/20/25	04/17/25	05/15/25	06/12/25	09/18/25	10/16/25	11/20/25	Total	%
Board of Health member										
Anderson, Ryan	√	√	regrets	√	regrets	regrets	√	√	5/8	63%
Barclay, Robert	√	√	√	√	√	√	√	√	8/8	100 %
Brabant, Michel	√	√	√	√	regrets	√	√	√	7/8	88%
Carrier, Renée	√	√	regrets	√	√	√	regrets	√	6/8	75%
Despatie, Guy - *Resigned March 11, 2025*	√	regrets							1/2	50%
Labbée, Natalie - *Effective Jan 21, 2025*		regrets	√	√	regrets	√	regrets	√	4/7	57%
Lapierre, René - *Resigned Feb. 20, 2025*	√	√							2/2	100%
Masood, Abdullah	regrets	√	regrets	regrets	regrets	√	regrets	√	3/8	38%
Mazey, Amy - *Effective March 20, 2025*			regrets	√	√	√	√	√	5/6	83%
Noland, Ken	√	√	√	√	√	√	√	√	8/8	100%
Parent, Michel	√	√	√	√	√	√	√	√	8/8	100%
Recollet, Angela *Effective April 29, 2025*				√	√	regrets	√	regrets	3/5	60%
Signoretti, Mark, *2025 Chair*	√	√	√	regrets	√	√	√	√	7/8	88%
Tessier, Natalie	√	√	√	√	regrets	√	√	√	7/8	88%

Board of Health Manual Policy G-I-30 - By-law 04-88

Board members who are elected or appointed representatives of their municipalities shall be bound by the rules of attendance that apply to the councils of their respective municipalities. Failure to attend without prior notice at three consecutive Board meetings, or failure to attend a minimum of 50% of Board meetings in any one calendar year will result in notification of the appointing municipal council by the Board chair and may result in a request by the Board for the member to resign and/or a replacement be named.

Board members appointed by the Lieutenant Governor-in Council are answerable to the Board of Health for their attendance. Failure to provide sufficient notice of non-attendance at three consecutive meetings or failure to attend a minimum of 50% of Board meetings without just cause may result in a request by the Board for the member to resign.

APPROVAL OF CONSENT AGENDA

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

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Board of Health for Public Health Sudbury & Districts

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

Date: January 8, 2026

Re: 2026–2028 Risk Management Plan

☐ For Information ☐ For Discussion ☒ For a Decision

Issue:

Risk management enables an organization to achieve better outcomes by helping to navigate and build resilience to threats that could disrupt operations, while clarifying strategic opportunities.

Risk management is also an organizational requirement under the Ontario Public Health Standards. It is the responsibility of boards of health to provide governance direction and oversight to risk management.

In October 2025, the Board of Health participated in a risk management workshop to review a draft 2026-2028 risk management plan, identify additional risks, and discuss the inherent and residual risk ratings and controls.

Recommended Action:

That the Board of Health for Public Health Sudbury & Districts:

1. **Approve the** 2026-2028 Risk Management Plan.
2. **Receive for Information** the inherent and residual risk heat map.
3. **Receive for Information** proposed timelines for annual reporting to the Board of Health in October 2026.

Background:

Risk management is a good governance practice that highlights threats to operations and proactively plans to mitigate them, thereby bettering organizational outcomes and increasing organizational resilience. The risk management planning effort also surfaces strategic opportunities for the organization.

Risk management also is an organizational requirement under the Good Governance and Management Practices Domain in the Ontario Public Health Standards. The Board of Health is required to provide governance direction and oversight of risk management, delegating to senior staff the responsibility to

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monitor and respond to emerging issues and potential threats to the organization. Risk management is expected to include, among other issues, financial risks, human resource risks, security risks, technology risks, equity risks, and operational risks.

Organizational risk reports will be reviewed bi-annually by Senior Management with a new annual reporting to be presented to the Board of Health each October. With the approval of the new 2026-2028 risk management plan in January 2026 the Board of Health will receive its first annual risk management report in October 2026.

Background on development of 2026-2028 Risk Management Plan

As per policy and procedure, Public Health engages in ongoing risk assessments at all levels of the organization using Public Health's Risk Management Framework. Through brainstorming exercises, this framework provides a five-step approach to systematically identify, assess, and monitor risks ensuring that controls are in place to mitigate the likelihood and impact of the risk.

Engagement strategy

An engagement strategy (Appendix A) outlines the approach that was taken to develop the 2026-2028 Risk Management Plan with Senior Management Executive Committee and Board of Health. Using Public Health's Risk Management Framework, both Senior Management Executive Committee and the Board of Health had risk identification workshops to identify and assess new risks to Public Heath.

Risks

Through the identification of risks, a suite of current risks that the organization faces were identified, and then rated in terms of anticipated impact and likelihood to the organization and the public's health. These are the "**Inherent Risks**".

Controls were developed for each risk, and the rating exercise was repeated to determine the anticipated impact and likelihood to the organization and the public's health if all the identified controls were funded and fully implemented. The reduced risk profile resulting are the **"Residual Risks"**.

Matrices of both the Inherent Risks and Control Risks are included as supplementary documentation.

Controls

There are many controls currently being implemented for each of the risks outlined in the 2026-2028 risk management plan. The controls noted in the plan include controls that are currently not underway but that Public Health is committed to investing resources towards and implementing through the 2026-2028 cycle. The Board of Health will receive updates on the monitoring of how the controls are moving the risk rating from inherent risk rating to residual risk rating through the annual risk report. The following table outlines controls that are funded in 2026 budget and the controls not-yet implemented that will require funding in future budgets to operationalize.

Controls funded in 2026 budget	Controls needing funding in future budgets

• Strengthen advocacy by reorienting to demonstrate outcomes to government • Realize operational efficiencies through investing in technology • Maintain organizational financial reserves at or above the Ministry of Health's recommended threshold of 7.5 weeks operating costs in order to be able to address emergency needs and leverage strategic opportunities • Develop a skills matrix for Board of Health members by 2026 Board turnover • Implement 2025 Human Resource Strategy (includes newcomer recruitment strategies) • Invest in strengthening organizational culture and employee engagement, including psychological health and wellness* • Institute a regular employee engagement survey to support data-driven responses to disengagement* • Develop new recruitment and retention tactics, including partnering with post secondary institutions to develop employment pipelines • Strengthen staff resilience to change with skill-building education* • Increase staffing to deliver higher volume of proactive communications to the public (e.g. adding social media capacity)* • Reorient communications to be swifter and more engaging (e.g. leveraging artificial intelligence, infusion of personality, empowering communicators to respond without higher level approvals)* • Broaden communications channels/media (e.g. leverage opinion-editorials, video messages, and interactive engagements like ask-me-anything)* • Increase use of attention-grabbing spokespeople, such as the Medical Officer of Health	• Add dedicated change management capacity and expertise to the organization* • Increase skill of managers/executives in change leadership (e.g. training)* • At initiation of major projects, ensure a project lead with dedicated time, change lead, and a dedicated budget sufficient for the project • Invest in governance training after 2026 Board turnover • Refresh technology regularly by proactively budgeting a refresh cycle • Develop a continuous monitoring and auditing regimen • Leverage alternate funding opportunities (e.g. Primary Care Expansion Funding, grant funding)

• Implement 2025–2029 IT Roadmap, particularly the steps for strengthening cybersecurity posture • Establish technology governance to allocate resources aligned with organizational benefit • Establish information governance to provide oversight for the management of the agency's information and data assets • Staff training and documentation on how AI systems work and their limitations • Allocate resources to support technology, including AI and true costs. • Participate in Ontario Health Team's Primary Care Council to engage the OHT and primary care providers to solve the problem • Explore opportunities to leverage primary care funding opportunities to expand clinical care access for Public Health clients • Foster a culture that is less hierarchical and rules-based, and more supportive of risk-taking and experimenting • Enhance mechanisms for capturing partner feedback • Reorient program planning to be outcome-oriented, prioritizing population outcomes over compliance with provincial standards* • Strengthen the role of evidence in driving program planning decisions, both evidence of local need and evidence of effectiveness/outcome* • Establish a mechanism to identify emerging needs in local communities so that Public Health can be prepared to respond proactively • Implement learnings from evaluation of the 2020–2022 pandemic response, including updating the pandemic plan and emergency response plans* • Advocate for provincial and federal implementation of lessons learned from the pandemic response • Implement climate change mitigations within the organization	

• Advocate to and collaborate with federal, provincial, and local authorities for climate change prevention and adaptation • Advocate assertively and visibly on matters valued by local community • Engage with First Nation communities to offer Public Health's support if desired • Advocate to federal and provincial authorities to address the gap in services • Advocate for tariff exemptions on essential food imports. • Proactively time purchases and subscription renewals to avoid tariffs where possible. • Explore non-US suppliers for tariff-affected products • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum* • Comprehensive training on privacy obligations as part of electronic medical record project, as well as roll-out of other technology tools and digitization processes • Implementation of electronic privacy controls such as role-based restricted access, and regular auditing of use • Training and skill-building of staff around working with more diverse populations (e.g. Unlearning & Undoing project, cultural competence training, Honoring Voices Initiative)* • Integration of health equity impact assessment into program planning as a periodic mandatory element, and regular review of the data collected for ongoing action* • Regular characterization of the diversity of the Public Health workforce, and use of this data to inform recruitment efforts to better align with the population served. • Balance planning interventions based on best practice and evidence to remove bias in our efforts, with assessment of the inherent bias	

within the evidence, and possibility it may not have included equity-seeking populations (e.g. using health equity impact assessment)	

Critical controls

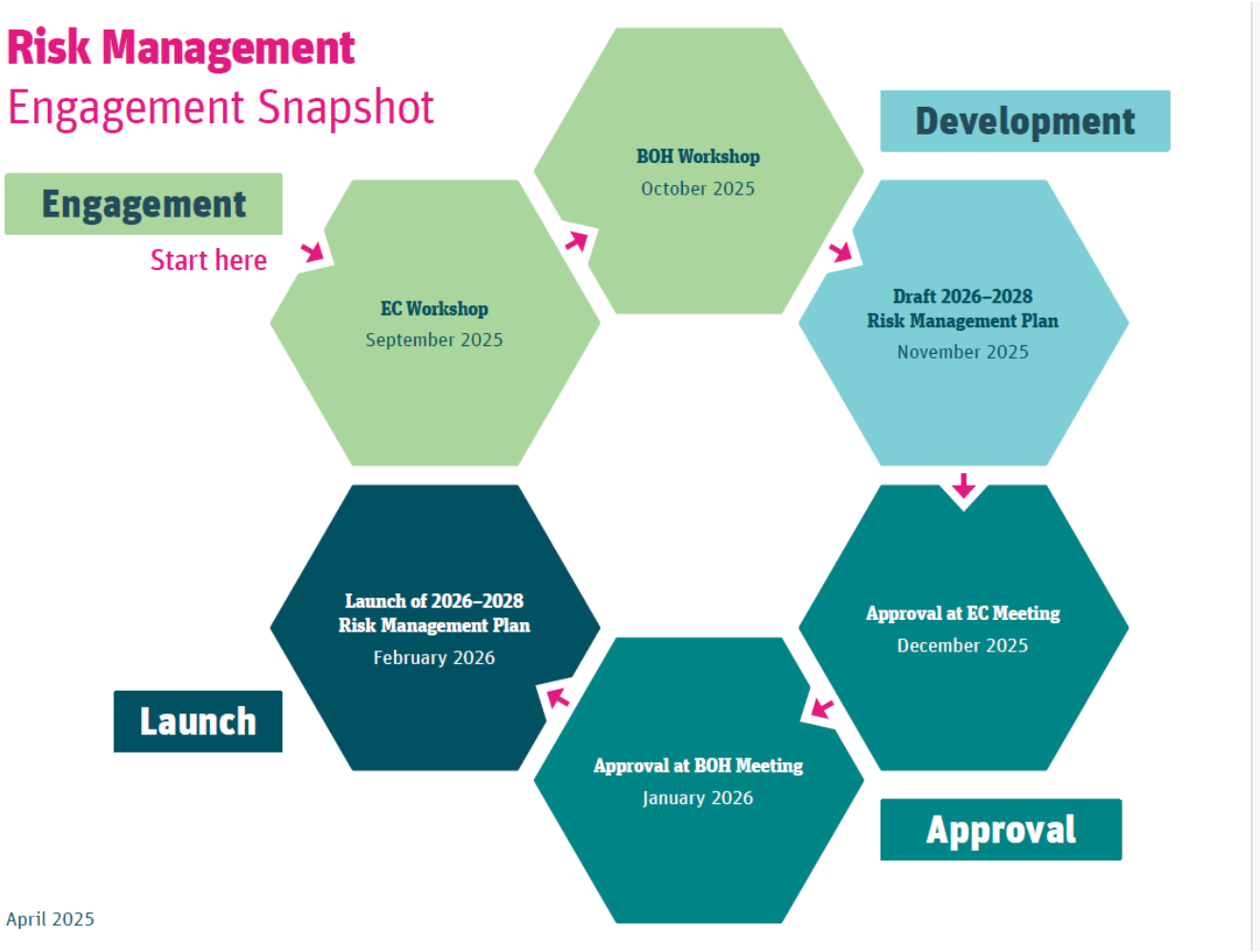
Critical controls have been identified where controls are in more than one risk thereby needing focused energy, resource allocations, and monitoring. Critical controls are noted with a * in the table above.

Financial Implications:
Some controls within 2026 budget and others require funding in future budgets.

Strategic Priority:
#3 – Excellence in public health practice

Author:
Renée Higgins, Director, Corporate Services Division

Appendix A: Risk Management Engagement Snapshot for 2026–2028 Risk Management Plan



2026–2028 Organizational Risk Management Plan: Heat Map of Inherent Risk Ratings (DRAFT)

Impact	1	2	3	4	5
5			**7.3 Service Delivery**: Delivery of the right programs and initiatives	**7.4 Service Delivery**: Measuring and evaluating outcomes	**1.1 Financial**: Inadequate funding **7.1 Service Delivery**: Absence of sector leading key aspects of clinical care
4		**8.1 Environmental**: New pandemic **9.1 Political**: Changes in political priorities **9.2 Political**: Politicization of public health decisions	**5.1 Technology**: IT infrastructure vulnerabilities	**7.2 Service Delivery**: Pace of organizational change	**3.2 Human Resources**: Change fatigue **3.3 Human Resources**: Inadequate capacity to manage concurrent initiatives **9.3 Political**: Jurisdictional ambiguity in service delivery to First Nation communities **10.1 Stakeholder / Public Perception**: Failing to demonstrate value among partners and local communities **14.2 Equity**: Systemic racism and other barriers to equity
3		**2.1 Governance**: Change in Board membership	**5.2 Technology**: Deployment of Artificial Intelligence (AI)	**3.1 Human Resources**: Recruitment and retention **9.4 Political**: Poorer health outcomes due to tariffs **14.3 Equity**: Workforce not reflective of diversity of local communities	**4.1 Information**: Ineffectively communicating to the public **14.1 Equity**: Unsuccessfully adapting to changing community demographics
2	**12.1 Security**: Uncontrolled environments		**13.1 Privacy**: Breaches with digitizing data		**8.2 Environmental**: Climate change
1					

Likelihood

Low Risk	Risks do not exist or are of minor importance and are not likely to significantly affect the achievement of objectives. Risks can be managed by routine procedures.
Medium Risk	Risks are a moderate threat to the achievement of objectives. Specific management responsibilities and specific procedures are required.
High Risk	Risks are a significant threat to the achievement of key objectives. Detailed management planning and attention is required.

2026–2028 Organizational Risk Management Plan: Heat Map of Residual Risk Ratings (DRAFT)

Impact	1	2	3	4	5
5		**7.3 Service Delivery**: Delivery of the right programs and initiatives **7.4 Service Delivery**: Measuring and evaluating outcomes		**1.1 Financial**: Inadequate funding	
4		**5.1 Technology**: IT infrastructure vulnerabilities **8.1 Environmental**: New pandemic			**7.1 Service Delivery**: Absence of sector leading key aspects of clinical care
3		**7.2 Service Delivery**: Pace of organizational change **9.1 Political**: Changes in political priorities **9.2 Political**: Politicization of public health decisions	**3.1 Human Resources**: Recruitment and retention **3.2 Human Resources**: Change fatigue **3.3 Human Resources**: Inadequate capacity to manage concurrent initiatives **10.1 Stakeholder / Public Perception**: Failing to demonstrate value among partners and local communities **14.3 Equity**: Workforce not reflective of diversity of local communities	**4.1 Information**: Ineffectively communicating to the public **9.4 Political**: Poorer health outcomes due to tariffs **14.2 Equity**: Systemic racism and other barriers to equity	**9.3 Political**: Jurisdictional ambiguity in service delivery to First Nation communities
2	**5.2 Technology**: Deployment of Artificial Intelligence (AI) **12.1 Security**: Uncontrolled environments	**2.1 Governance**: Change in Board membership **13.1 Privacy**: Breaches with digitizing data		**14.1 Equity**: Unsuccessfully adapting to changing community demographics	**8.2 Environmental**: Climate change
1					

Likelihood

Low Risk	Risks do not exist or are of minor importance and are not likely to significantly affect the achievement of objectives. Risks can be managed by routine procedures.
Medium Risk	Risks are a moderate threat to the achievement of objectives. Specific management responsibilities and specific procedures are required.
High Risk	Risks are a significant threat to the achievement of key objectives. Detailed management planning and attention is required.

2026–2028 Organizational Risk Management Plan (DRAFT)

Organizational Risk Assessment

Overall Objective: To navigate the risks facing Public Health and proactively decide which risks it will accept and which it will mitigate in order to enable maximum improvement of the health and health equity for the communities we serve.

Subordinate Objective: To coordinate and align risk mitigation strategies and provide a framework for risk assessment work at different levels within the organization.

Risk categories		Inherent risk rating	Residual risk rating	Controls to implement 2026–2028
1	**Financial**			
1.1	Inability to fund levels of programming desired by the community or mandated by the provincial government, engage in fulsome community engagement, maintain reputation adequately, nor leverage strategic opportunities due to reduced availability of revenue.	L5 I5	L4 I5	• Strengthen advocacy by reorienting to demonstrate outcomes to government • Leverage alternate funding opportunities (e.g. Primary Care Expansion Funding, grant funding) • Realize operational efficiencies through investing in technology • Maintain organizational financial reserves at or above the Ministry of Health's recommended threshold of 7.5 weeks operating costs in order to be able to address emergency needs and leverage strategic opportunities
2	**Governance / Organizational**			
2.1	Reduced quality of governance and strategic oversight, and ability to maintain high calibre of governance practices, due to changes to Board of Health membership.	L2 I3	L2 I2	• Develop a skills matrix for Board of Health members by 2026 Board turnover • Invest in governance training after 2026 Board turnover
3	**People / Human Resources**			

Risk categories		Inherent risk rating	Residual risk rating	Controls to implement 2026–2028
3.1	Inability to staff programs and support services with enough employees, talent, and institutional history due to retention and recruitment challenges resulting from (a) stiff competition from external opportunities, and (b) hybrid work which requires on-site work limiting flexibility for employee, while also allowing off-site work that can increase disengagement, decreased connection, and diminished collaboration.	L4 I3	L3 I3	• Implement 2025 Human Resource Strategy (includes newcomer recruitment strategies) • Invest in strengthening organizational culture and employee engagement, including psychological health and wellness* • Develop new recruitment and retention tactics, including partnering with post secondary institutions to develop employment pipelines • Institute a regular employee engagement survey to support data-driven responses to disengagement*
3.2	Decreased staff engagement, productivity, and well-being due to staff experiencing change fatigue from ongoing organizational changes, as well as compounding personal and professional challenges.	L5 I4	L3 I3	• Strengthen staff resilience to change with skill-building education* • Invest in strengthening organizational culture and employee engagement, including psychological health and wellness* • Add dedicated change management capacity and expertise to the organization* • Increase skill of managers/executives in change leadership (e.g. training)* • Institute a regular employee engagement survey to support data-driven responses to disengagement*
3.3	Delays in project completion, reduced quality of outcomes, and missed opportunities due to not having capacity to manage the multiple concurrent initiatives within the organization.	L5 I4	L3 I3	• Add dedicated project management & change management capacity and expertise to the organization* • Increase skill of managers/executives in change leadership (e.g. training)* • At initiation of major projects, ensure a project lead with dedicated time, change lead, and a dedicated budget sufficient for the project
4	**Information / Knowledge**			

Risk categories		Inherent risk rating	Residual risk rating	Controls to implement 2026–2028
4.1	Erosion of public trust of Public Health messaging, misinterpretation of information, and reputational damage due to communication practices that are not successful at breaking through a busy and misinformation-filled information environment.	L5 I3	L4 I3	• Increase staffing to deliver higher volume of proactive communications to the public (e.g. adding social media capacity)* • Reorient communications to be swifter and more engaging (e.g. leveraging artificial intelligence, infusion of personality, empowering communicators to respond without higher level approvals)* • Broaden communications channels/media (e.g. leverage opinion-editorials, video messages, and interactive engagements like ask-me-anything)* • Increase use of attention-grabbing spokespeople, such as the Medical Officer of Health
5	**Technology**			
5.1	Operational downtime, and compromise of sensitive data and resulting harm to reputation and trust due to IT infrastructure that is outdated, unreliable, vulnerable to security threats, or at risk of outages.	L3 I4	L2 I4	• Implement 2025–2029 IT Roadmap, particularly the steps for strengthening cybersecurity posture • Refresh technology regularly by proactively budgeting a refresh cycle
5.2	Reputational damage, operational disruptions, harm to equity, and inefficient use of staff time due to deploying AI solutions without adequate training, change management, governance, or understanding of system limitations, societal costs, or privacy and equity implications.	L3I3	L1 I2	• Establish technology governance to allocate resources aligned with organizational benefit • Establish information governance to provide oversight for the management of the agency's information and data assets • Staff training and documentation on how AI systems work and their limitations and true costs • Develop a continuous monitoring and auditing regimen • Allocate resources to support technology, including AI
6	**Legal / Compliance**			
	N/A			

Risk categories		Inherent risk rating	Residual risk rating	Controls to implement 2026–2028
7	**Service Delivery / Operational**			
7.1	Lack of available services, reduced continuity of care, and poorer health for Public Health clients due to the absence of a sector taking accountability to lead key aspects of clinical care *(specific to clinical areas that overlap with primary care mandates).*	L5 I5	L5 I4	• Participate in Ontario Health Team's Primary Care Council to engage the OHT and primary care providers to solve the problem • Explore opportunities to leverage primary care funding opportunities to expand clinical care access for Public Health clients
7.2	Missed opportunities, partner dissatisfaction, and failure to adapt to changing environments due to the organization's slow pace of change and limited agility.	L4 I4	L2 I3	• Strengthen staff resilience to change with skill-building education* • Invest in strengthening organizational culture and employee engagement, including psychological health and wellness, in order to support staff through the difficulties of change* • Add dedicated change management capacity and expertise to the organization* • Increase skill of managers/executives in change leadership (e.g. training)* • Foster a culture that is less hierarchical and rules-based, and more supportive of risk-taking and experimenting • Enhance mechanisms for capturing partner feedback
7.3	Limited community health impact and failure to meet the population's needs due to the organization not designing nor effectively delivering the right programs and initiatives.	L3 I5	L2 I5	• Reorient program planning to be outcome-oriented, prioritizing population outcomes over compliance with provincial standards* • Strengthen the role of evidence in driving program planning decisions, both evidence of local need and evidence of effectiveness/outcome* • Establish a mechanism to identify emerging needs in local communities so that Public Health can be prepared to respond proactively
7.4	Inability to demonstrate impact or drive continuous improvement due to not effectively measuring and evaluating outcomes.	L4 I5	L2 I5	• Reorient program planning to be outcome-oriented*, having clear measures of population outcomes that are tracked*

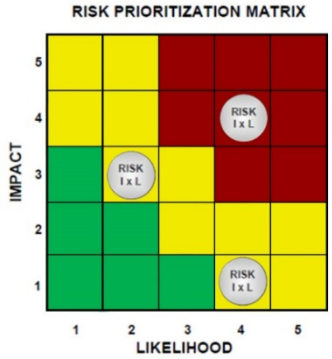
Risk categories		Inherent risk rating	Residual risk rating	Controls to implement 2026–2028
8	**Environmental**			
8.1	Strain on public health infrastructure, delayed or suspended non-pandemic services, and long-term community health impacts due to a new pandemic that significantly increases demands on Public Health for response.	L2 I4	L2 I4	• Implement learnings from evaluation of the 2020–2022 pandemic response, including updating the pandemic plan and emergency response plans* • Advocate for provincial and federal implementation of lessons learned from the pandemic response
8.2	Disruptions to service delivery and worsening of inequitable health outcomes due to climate change impacts such as heatwaves, poor air quality, and vector-borne diseases, particularly affecting vulnerable populations.	L5 I2	L5 I2	• Implement learnings from evaluation of the 2020-2022 pandemic response, including updating the pandemic plan and emergency response plans* • Implement climate change mitigations within the organization • Advocate to and collaborate with federal, provincial, and local authorities for climate change prevention and adaptation
9	**Political**			
9.1	Disruption to public health programs and misalignment of strategy due to changes in the political system that shift priorities, restructure governance, or alter public health mandates.	L2 I4	L2 I3	• Reorient program planning to be outcome-oriented*, prioritizing population outcomes over compliance with provincial standards* • Strengthen staff resilience to change with skill-building education*
9.2	Decreased public engagement and trust, reduced health outcomes, and challenges in attracting and retaining skilled professionals due to a decline in the reputation of the public health sector driven by misalignment with community values, inconsistent messaging, lack of transparency, and politicization of public health decisions made by governments.	L2 I4	L2 I3	• Strengthen the role of evidence in driving program planning decisions, both evidence of local need and evidence of effectiveness/outcome* • Increase staffing to deliver higher volume of proactive communications to the public (e.g. adding social media capacity), including messaging that delivers transparency* • Reorient communications to be swifter and more engaging (e.g. leveraging artificial intelligence, infusion of personality, empowering communicators to respond without higher level approvals)*

Risk categories		Inherent risk rating	Residual risk rating	Controls to implement 2026–2028
				• Broaden communications channels/media including tactics that promote transparency (e.g. interactive engagements like ask-me-anything)* • Advocate assertively and visibly on matters valued by local community
9.3	Inequitable delivery of Public Health services and reduced trust in public health systems due to jurisdictional ambiguity between federal, provincial, and First Nation authorities regarding service delivery to First Nation communities.	L5 I4	L5 I3	• Engage with First Nation communities to offer Public Health's support if desired • Advocate to federal and provincial authorities to address the gap in services
9.4	Increased costs, impacted quality and equity of care, and poorer health outcomes for Public Health clients due to imposition of tariffs on imported items which further strain budgets, and reduces access to necessities of daily living, like nutritious food, which particularly affects vulnerable populations.	L4 I3	L4 I3	• Advocate for tariff exemptions on essential food imports. • Proactively time purchases and subscription renewals to avoid tariffs where possible. • Explore non-US suppliers for tariff-affected products.
10	**Stakeholder / Public Perception**			
10.1	Reduced collaboration and engagement, and reduced health outcomes due to failing to demonstrate value among partners and local communities.	L5 I4	L3 I3	• Reorient program planning to be outcome-oriented, having clear measures of population outcomes that are tracked* • Increase staffing to deliver higher volume of proactive communications to the public (e.g. adding social media capacity), including messaging that delivers transparency* • Broaden communications channels/media including tactics that promote transparency (e.g. interactive engagements like ask-me-anything)* • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum*
11	**Strategic / Policy**			
	N/A			
12	**Security**			

Risk categories		Inherent risk rating	Residual risk rating	Controls to implement 2026–2028
12.1	Increased health and safety incidents, reduced quality of service delivery, and potential non-compliance with regulatory standards due to staff working in uncontrolled environments outside of PHSD-controlled settings.	L1 I2	L1 I2	• *No mitigations, not yet implemented, identified*
13	**Privacy**			
13.1	Compromise of patient confidentiality, regulatory non-compliance, and erosion of public trust due to privacy breaches within Public Health's IT assets as data is increasingly digitized e.g. Electronic Medical Record system	L3 I2	L2 I2	• Comprehensive training on privacy obligations as part of electronic medical record project, as well as roll-out of other technology tools and digitization processes • Implementation of electronic privacy controls such as role-based restricted access, and regular auditing of use
14	**Equity**			
14.1	Reduced effectiveness of programs and unmet community needs due to failing at timely adaptation to changing demographics within the community.	L5 I3	L4 I2	• Training and skill-building of staff around working with more diverse populations (e.g. Unlearning & Undoing project, cultural competence training, Honoring Voices Initiative)* • Integration of health equity impact assessment into program planning as a periodic mandatory element, and regular review of the data collected for ongoing action* • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum, with specific engagement of groups representing equity-seeking populations*

Risk categories		Inherent risk rating	Residual risk rating	Controls to implement 2026–2028
14.2	Worsening health inequities and outcomes as well as reduced trust and engagement in the public health system, particularly among marginalized populations, due to systemic racism and barriers that bias to inequitable delivery of Public Health programs and services.	L5 I4	L4 I3	• Training and skill-building of staff around working with more diverse populations (e.g. Unlearning & Undoing project, cultural competence training)* • Integration of health equity impact assessment into program planning as a periodic mandatory element, and regular review of the data collected for ongoing action* • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum, with specific engagement of groups representing equity-seeking populations* • Provide accessible, culturally safe channels for community feedback, complaints, and reporting*
14.3	Reduced community trust and missed opportunities for inclusive engagement due to a workforce that is not reflective of the diversity of the local communities Public Health serves.	L4 I3	L3 I3	• Regular characterization of the diversity of the Public Health workforce, and use of this data to inform recruitment efforts to better align with the population served. • Training and skill-building of staff around working with more diverse populations (e.g. Unlearning & Undoing project, cultural competence training)* • Balance planning interventions based on best practice and evidence to remove bias in our efforts, with assessment of the inherent bias within the evidence, and possibility it may not have included equity-seeking populations (e.g. using health equity impact assessment) • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum, with specific engagement of groups representing equity-seeking populations*

VALUE	LIKELIHOOD	IMPACT	PROXIMITY	*SCALE*
1	Unlikely to occur	Negligible Impact	More than 36 months	*Very Low*
2	May occur occasionally	Minor impact on time, cost or quality	12 to 24 months	*Low*
3	Is as likely as not to occur	Notable impact on time, cost or quality	6 to 12 months	*Medium*
4	Is likely to occur	Substantial impact on time, cost or quality	Less than 6 months	*High*
5	Is almost certain to occur	Threatens the success of the project	Now	*Very High*



Controls to implement in 2026–2028		Critical controls
Financial		
1.1	• Strengthen advocacy by reorienting to demonstrate outcomes to government • Leverage alternate funding opportunities (e.g. Primary Care expansion funding, grant funding) • Realize operational efficiencies through investing in technology • Maintain organizational financial reserves at or above the Ministry of Health's recommended threshold of 7.5 weeks operating costs in order to be able to address emergency needs and leverage strategic opportunities	
Governance / Organizational		
2.1	• Develop a skills matrix for Board of Health members by 2026 Board turnover • Invest in governance training after 2026 Board turnover	
People / Human Resources		
3.1	• Implement 2025 Human Resource Strategy (includes newcomer recruitment strategies) • Invest in strengthening organizational culture and employee engagement, including psychological health and wellness • Develop new recruitment and retention tactics, including partnering with post secondary institutions to develop employment pipelines • Institute a regular employee engagement survey to support data-driven responses to disengagement	• Invest in strengthening organizational culture and employee engagement, including psychological health and wellness (x3) • Institute a regular employee engagement survey to support data-driven responses to disengagement* (x2)
3.2	• Strengthen staff resilience to change with skill-building education • Invest in strengthening organizational culture and employee engagement, including psychological health and wellness • Add dedicated change management capacity and expertise to the organization • Increase skill of managers/executives in change leadership (e.g. training) • Institute a regular employee engagement survey to support data-driven responses to disengagement	• Strengthen staff resilience to change with skill-building education (x3) • Invest in strengthening organizational culture and employee engagement, including psychological health and wellness (x3) • Add dedicated change management capacity and expertise to the organization (x3) • Increase skill of managers/executives in change leadership (e.g. training) (x3) • Institute a regular employee engagement survey to support data-driven responses to disengagement* (x2)

3.3	• Add dedicated project management & change management capacity and expertise to the organization • Increase skill of managers/executives in change leadership (e.g. training) • At initiation of major projects, ensure a project lead with dedicated time, change lead, and a dedicated budget sufficient for the project	• Add dedicated project management & change management capacity and expertise to the organization (x3) • Increase skill of managers/executives in change leadership (e.g. training) (x3)
Information / Knowledge		
4.1	• Increase staffing to deliver higher volume of proactive communications to the public (e.g. adding social media capacity) • Reorient communications to be swifter and more engaging (e.g. leveraging artificial intelligence, infusion of personality, empowering communicators to respond without higher level approvals) • Broaden communications channels/media (e.g. leverage opinion-editorials, video messages, and interactive engagements like ask-me-anything) • Increase use of attention-grabbing spokespeople, such as the Medical Officer of Health	• Increase staffing to deliver higher volume of proactive communications to the public (e.g. adding social media capacity) (x3) • Reorient communications to be swifter and more engaging (e.g. leveraging artificial intelligence, infusion of personality, empowering communicators to respond without higher level approvals) (x2) • Broaden communications channels/media (e.g. leverage opinion-editorials, video messages, and interactive engagements like ask-me-anything) (x3)
Technology		
5.1	• Implement 2025–2029 IT Roadmap, particularly the steps for strengthening cybersecurity posture • Refresh technology regularly by proactively budgeting a refresh cycle	
5.2	• Establish technology governance to allocate resources aligned with organizational benefit • Establish information governance to provide oversight for the management of the agency's information and data assets • Staff training and documentation on how AI systems work and their limitations and true costs • Develop a continuous monitoring and auditing regimen • Allocate resources to support technology, including AI	
Legal / Compliance		
	N/A	

Service Delivery / Operational		
7.1	• Participate in Ontario Health Team's Primary Care Council to engage the OHT and primary care providers to solve the problem • Explore opportunities to leverage primary care funding opportunities to expand clinical care access for Public Health clients	
7.2	• Strengthen staff resilience to change with skill-building education • Invest in strengthening organizational culture and employee engagement, including psychological health and wellness, in order to support staff through the difficulties of change • Add dedicated change management capacity and expertise to the organization* • Increase skill of managers/executives in change leadership (e.g. training) • Foster a culture that is less hierarchical and rules-based, and more supportive of risk-taking and experimenting • Enhance mechanisms for capturing partner feedback	• Strengthen staff resilience to change with skill-building education (x3) • Invest in strengthening organizational culture and employee engagement, including psychological health and wellness, in order to support staff through the difficulties of change (x3) • Add dedicated change management capacity and expertise to the organization (x3) • Increase skill of managers/executives in change leadership (e.g. training) (x3)
7.3	• Reorient program planning to be outcome-oriented, prioritizing population outcomes over compliance with provincial standards • Strengthen the role of evidence in driving program planning decisions, both evidence of local need and evidence of effectiveness/outcome • Establish a mechanism to identify emerging needs in local communities so that Public Health can be prepared to respond proactively	• Reorient program planning to be outcome-oriented, prioritizing population outcomes over compliance with provincial standards (x4) • Strengthen the role of evidence in driving program planning decisions, both evidence of local need and evidence of effectiveness/outcome (x2)
7.4	• Reorient program planning to be outcome-oriented, having clear measures of population outcomes that are tracked	• Reorient program planning to be outcome-oriented, having clear measures of population outcomes that are tracked (x4)
Environmental		
8.1	• Implement learnings from evaluation of the 2020–2022 pandemic response, including updating the pandemic plan and emergency response plans • Advocate for provincial and federal implementation of lessons learned from the pandemic response	• Implement learnings from evaluation of the 2020–2022 pandemic response, including updating the pandemic plan and emergency response plans (x2)

8.2	• Implement learnings from evaluation of the 2020-2022 pandemic response, including updating the pandemic plan and emergency response plans • Implement climate change mitigations within the organization • Advocate to and collaborate with federal, provincial, and local authorities for climate change prevention and adaptation	• Implement learnings from evaluation of the 2020-2022 pandemic response, including updating the pandemic plan and emergency response plans (x2)
Political		
9.1	• Reorient program planning to be outcome-oriented, prioritizing population outcomes over compliance with provincial standards • Strengthen staff resilience to change with skill-building education	• Reorient program planning to be outcome-oriented, prioritizing population outcomes over compliance with provincial standards (x4) • Strengthen staff resilience to change with skill-building education (x3)
9.2	• Strengthen the role of evidence in driving program planning decisions, both evidence of local need and evidence of effectiveness/outcome • Increase staffing to deliver higher volume of proactive communications to the public (e.g. adding social media capacity), including messaging that delivers transparency • Reorient communications to be swifter and more engaging (e.g. leveraging artificial intelligence, infusion of personality, empowering communicators to respond without higher level approvals) • Broaden communications channels/media including tactics that promote transparency (e.g. interactive engagements like ask-me-anything) • Advocate assertively and visibly on matters valued by local community	• Strengthen the role of evidence in driving program planning decisions, both evidence of local need and evidence of effectiveness/outcome (x2) • Increase staffing to deliver higher volume of proactive communications to the public (e.g. adding social media capacity), including messaging that delivers transparency (x3) • Reorient communications to be swifter and more engaging (e.g. leveraging artificial intelligence, infusion of personality, empowering communicators to respond without higher level approvals) (x2) • Broaden communications channels/media including tactics that promote transparency (e.g. interactive engagements like ask-me-anything) (x3)
9.3	• Engage with First Nation communities to offer Public Health's support if desired • Advocate to federal and provincial authorities to address the gap in services	
9.4	• Advocate for tariff exemptions on essential food imports.	
Stakeholder / Public Perception		

10.1	• Reorient program planning to be outcome-oriented, having clear measures of population outcomes that are tracked • Increase staffing to deliver higher volume of proactive communications to the public (e.g. adding social media capacity), including messaging that delivers transparency • Broaden communications channels/media including tactics that promote transparency (e.g. interactive engagements like ask-me-anything) • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum	• Reorient program planning to be outcome-oriented, having clear measures of population outcomes that are tracked (x4) • Increase staffing to deliver higher volume of proactive communications to the public (e.g. adding social media capacity), including messaging that delivers transparency (x3) • Broaden communications channels/media including tactics that promote transparency (e.g. interactive engagements like ask-me-anything) (x3) • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum (x4)
Strategic / Policy		
	N/A	
Security		
12.1	• No mitigations, not yet implemented, identified	
Privacy		
13.1	• Comprehensive training on privacy obligations as part of electronic medical record project, as well as around roll-out of other technology tools and digitization processes • Implementation of electronic privacy controls such as role-based restricted access, and regular auditing of use.	
Equity		

14.1	• Training and skill-building of staff around working with more diverse populations (e.g. Unlearning & Undoing project, cultural competence training) • Integration of health equity impact assessment into program planning as a periodic mandatory element, and regular review of the data collected for ongoing action • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum, with specific engagement of groups representing equity-seeking populations	• Training and skill-building of staff around working with more diverse populations (e.g. Unlearning & Undoing project, cultural competence training) (x3) • Integration of health equity impact assessment into program planning as a periodic mandatory element, and regular review of the data collected for ongoing action (x2) • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum, with specific engagement of groups representing equity-seeking populations (x4)
14.2	• Training and skill-building of staff around working with more diverse populations (e.g. Unlearning & Undoing project, cultural competence training)* • Integration of health equity impact assessment into program planning as a periodic mandatory element, and regular review of the data collected for ongoing action* • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum, with specific engagement of groups representing equity-seeking populations* • Provide accessible, culturally safe channels for community feedback, complaints, and reporting	• Training and skill-building of staff around working with more diverse populations (e.g. Unlearning & Undoing project, cultural competence training) (x3) • Integration of health equity impact assessment into program planning as a periodic mandatory element, and regular review of the data collected for ongoing action (x2) • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum, with specific engagement of groups representing equity-seeking populations (x4)

14.3	• Regular characterization of the diversity of the Public Health workforce, and use of this data to inform recruitment efforts to better align with the population served. • Training and skill-building of staff around working with more diverse populations (e.g. Unlearning & Undoing project, cultural competence training) • Balance planning interventions based on best practice and evidence to remove bias in our efforts, with assessment of the inherent bias within the evidence, and possibility it may not have included equity-seeking populations (e.g. using health equity impact assessment) • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum, with specific engagement of groups representing equity-seeking populations	• Training and skill-building of staff around working with more diverse populations (e.g. Unlearning & Undoing project, cultural competence training) (x3) • Invest in more structured community engagement with dedicated coordinating capacity, defined outcomes, and tracking of engagement along the IAP2 spectrum, with specific engagement of groups representing equity-seeking populations (x4)

RISK MANAGEMENT PLAN 2026-2028

MOTION:

WHEREAS effectively planning to manage risks enables an organization to better achieve its outcomes, operate strategically, and be resilient to changing circumstances; and

WHEREAS the Ontario Public Health Organizational Requirements mandate boards of health to provide governance direction and oversight of risk management with a formal risk management framework that identifies, assesses, addresses risks; and

WHEREAS the Board of Health has engaged in a risk management process in order to systematically identify/assess current risks and controls;

THEREFORE BE IT RESOLVED that the Board of Health for Public Health Sudbury & Districts approve the 2026-2028 risk management plan.

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Board of Health for Public Health Sudbury & Districts

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

Date: January 8, 2026

Re: Part VIII - Ontario Building Code Fee Increases

☐ For Information ☐ For Discussion ☒ For a Decision

Issue:
In order to continue to administer the Part VIII (Sewage System) *Ontario Building Code* program on a cost-recovery basis in 2026, it is necessary for Public Health Sudbury & Districts to amend program user fees in accordance with the rate of inflation. In 2025, the Board of Health approved a process for an annual expedited review and adjustment of fees to inflation, with a more comprehensive review to occur every five years.

Recommended Action:
That the Board of Health approve the amendments in Part VIII – Ontario Building Code fees as outlined within Schedule "A" to Board of Health By-Law 01-98.

Alternative Action:
The Board of Health could opt to increase the levy on municipalities to maintain legal obligations under the *Ontario Building Code Act*. This is not recommended as it would not be in consistent with the intention of the program for municipalities to have to bear the burden of funding this program.

Background:
Public Health Sudbury & Districts is mandated under the Ontario *Building Code Act* (S.O. 1992 c. 23), to enforce the provisions of the *Act* and the *Building Code* pertaining to sewage systems.

Under the authority of the Ontario *Building Code Act*, Public Health Sudbury & Districts collects fees for Part VIII permits and services in order to recover all costs associated with administration and enforcement of the *Act*.

The current user fees were put in place in February of 2025. At the February 20, 2025, Board of Health meeting, a motion was approved to adjust Part VIII – Ontario Building Code fees on an annual basis in accordance with the rate of inflation, with a comprehensive review of fees conducted once every five

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2024–2028 Strategic Priorities

5. Equal opportunities for health
6. Impactful relationships
7. Excellence in public health practice
8. Healthy and resilient workforce

years. Inflation as measured by the average of the previous 12 months total CPI (Consumer price index - Bank of Canada) currently sits at 2.06%. The proposed increases adjusts the fees by 2% (rounded to the nearest whole number) as this is easier to communicate, calculate, and implement than fractional rates. The proposed fee increases are necessary in order to address increasing program operation and delivery costs.

In accordance with *Building Code* requirements, Public Health Sudbury & Districts has notified all contractors, municipalities, lawyers, and other affected individuals of the proposed fee increases and conducted a public meeting on January 7, 2026, to discuss the proposed changes. The notification process has now concluded with no concerns having been reported.

In accordance with *Building Code* requirements, the notification and consultation process will be completed prior to all future proposed fee increases, with the outcome reported to the Board of Health to inform their decision in approving further updates to Schedule "A" to Board of Health By-Law 01-98.

Financial Implications:
Adjusted revenue from Part VIII fees will enable Public Health Sudbury & Districts to administer the program on a cost-recovery basis. This will avoid pressure on municipal levies to fund this program.

IT team and IT infrastructure implications: Nil

Ontario Public Health Standard: Organizational Requirements – Good Governance

Strategic Priority: Excellence in public health practice

Author: Stacey Laforest, Director, Health Protection Division

2024–2028 Strategic Priorities

1. Equal opportunities for health
2. Impactful relationships
3. Excellence in public health practice
4. Healthy and resilient workforce

Board of Health Manual
Public Health Sudbury & Districts

By-Law

Category
Board of Health By-Laws

Section
By-laws

Subject
By-law 01-98

Number
G-I-50

Approved By
Board of Health

Original Date
March 26, 1998

Revised Date
January 15~~XX~~, 2026

Review Date
January 15~~XX~~, 2026

Being a By-law of the Board of Health for the Sudbury and District Health Unit respecting Construction, Demolition, Change of Use Permits, Inspections, and Fees Related to Sewage Systems.

WHEREAS the Board of Health for the Sudbury and District Health Unit is responsible for the enforcement of the provisions of the *Building Code Act* and Regulations related to sewage systems;

AND WHEREAS the Board of Health is empowered pursuant to Section 7 of the *Building Code Act* to make by-laws respecting sewage systems;

NOW THEREFORE the Board of Health for Sudbury and District Health Unit hereby enacts as follows:

Short Title

This by-law may be cited as “the Sewage System By-law”.

Definitions

In this By-law,

a) **"Act" means the *Building Code Act, 1992*, and *attendant Building Code* including amendments thereto.**

b) **"applicant" means the owner of a building or property who applies for a permit or land use planning report or any person authorized in writing by the owner to apply on the owner's behalf, or any person or corporation empowered by statute to cause the demolition of a building or buildings and anyone acting under the authority of such person or corporation.**

c) **"as constructed plans" means as constructed plans as defined in the Building Code.**

d) **"Board of Health" means the Board of Health for the Sudbury and District Health Unit.**

e) **"building(s)" means a building as defined in Section 1(1) of the Building Code.**

f) **"Building Code" means the regulations made under Section 34 of the Act.**

g) **"Notice of Substantial Completion" relates to the day on which a sewage system has been completed and is ready for a final inspection before backfilling.**

h) **"sewage system inspector" means an inspector appointed by the Board of Health under Section 3.1(2) of the Act.**

i) **"permit" means written permission or written authorization from the Chief Building Official to perform work regulated by the Act, this By-law, and the Building Code.**

j) **"permit holder" means the person to whom the permit has been issued and who assumes the primary responsibility for complying with the Act, the Building Code and this By-law.**

k) **"plumbing" means plumbing as defined in Section 1(1) of the Act.**

l) **"renovation" means the extension, alteration or repair of an existing building or sewage system or the change in use or part of the use of an existing building or sewage system.**

m) **"repair requiring permit" means the replacement of a treatment unit or the replacement or alteration of materials in a leaching bed or any component contained therein.**

n) **"sewage system" means sewage system as defined in Section 1(1) of the Act.**

o) **"sewage system permit" means a building permit as defined in Section 8(1) of the Act for the purposes of this By-law.**

Terms not defined in this By-law shall have the meaning ascribed to them in the Act or the Building Code.

Classes of Permits

Classes of permits required for the construction, demolition or change of use of a sewage system or for the renovation of an existing building or sewage system are set forth in Schedule "A" attached hereto and forming part of this By-law.

Permit Applications

To obtain a permit, an applicant shall file an application in writing by completing the form(s) prescribed and available from the Chief Building Official and satisfy the following:

1) Where application is made for a sewage system permit under subsection 8(1) of the Act, the application shall

   a) identify and describe in detail the work, use and occupancy to be covered by the permit for which application is made;

   b) identify and describe in detail the existing use(s) and the proposed use(s) for which the premises are intended;

   c) include complete plans and specifications as described in this By-law for the work to be covered by the permit and show the occupancy of all parts of the building;

   d) include the legal description, municipal address and where appropriate the unit number of the land on which the work is to be done;

   e) be accompanied by the required fees as calculated with Schedule "A";

   f) state the name, address and telephone number of the owner, and if the owner is not the applicant, the applicant's name, address and telephone number and the signed statement of the owner consenting to the application;

   g) where applicable, state the name, address and telephone number of the architect, engineer or other designer, and the constructor or person hired to carry out the construction or demolition;

   h) where any person named in clause (g) requires a license under the Act or Building Code, include the number and date of issuance of the license and the name of the qualified person supervising the work to be covered by the permit;

   i) when Section 2.3 of the Building Code applies, be accompanied by a signed acknowledgement of the owner that an architect or professional engineer, or both, have been retained to carry out the general review of the construction or demolition of the sewage system;

   j) when Section 2.3 of the Building Code applies, be accompanied by a signed statement of the architect or professional engineer, or both, undertaking to provide a general review of the construction or demolition of the sewage system;

k) include the applicant's registration number where the applicant is a builder or vendor as defined in the *Ontario New Home Warranties Plan Act*;

l) include, as the Chief Building Official deems necessary, proof of the zoning and permitted uses applicable to the land on which the work is to be done; and

m) be signed by the applicant who shall certify as to the truth of the contents of the application.

2) Where application is made for the demolition of a sewage system under subsection 8(1) of the Act, the application shall

a) contain the information and other requirements provided in subsection 4(1), and;

b) be accompanied by satisfactory proof that arrangements have been made with the proper authorities for the termination and capping of the appropriate utilities and for the removal and disposal of the sewage system components.

3) Where application is made for a renovation to an existing building under the Act and Building Code, the application shall

a) contain the information and other requirements provided in subsection 4(1), and;

b) include plans and specifications which show the current and proposed occupancy of all parts of the building, and which contain sufficient information to establish compliance with the requirements of the Building Code, including floor plans, and detailed information respecting the existing sewage disposal system and prior permits.

4) Inspections will be carried out on properties that are identified under the mandatory maintenance inspection program according to section 1.10.2 of Division C, Part 1 of the Ontario Building Code and a fee will be charged as noted in Schedule "A".

5) Where compliance with all the requirements for a permit application is unnecessary or unreasonable, the Chief Building Official may, in cases where he or she deems appropriate, authorize deletion of one or more of the requirements provided the intent and purpose of this By-law is maintained.

6) Where an application for a permit remains incomplete or inactive for six (6) months after it is made, the application may be deemed by the Chief Building Official to have been abandoned and notice thereof shall be given to the applicant.

Plans, Specifications, Documents and Information

1) Every applicant shall furnish sufficient plans, specifications, documents and other information to enable the Chief Building Official to determine whether the proposed construction, demolition, change of use or occupancy conforms to the Act, the Building Code and any other applicable law including, without limiting the generality of the foregoing:

a) zoning approval from the applicable Planning Authority;

b) plans that are legible and drawn to scale on paper, cloth or other suitable and durable material;

c) documents submitted that are legible;

d) if applicable, Conservation Authority or Ministry of Natural Resources approval.

Site plans submitted should be referenced to a current survey certified by a registered Ontario Land Surveyor and a copy of the survey shall be filed with the Chief Building Official, if deemed necessary.

Site Plans shall show

a) lot size and dimensions of the property;

b) setbacks from existing and proposed buildings to the property boundaries and to each other;

c) setbacks from existing and proposed wells, including wells on adjacent properties;

d) setbacks from property boundaries, lakes, rivers, streams, reservoirs, ponds and water drainage courses;

e) the location of any unsuitable, disturbed or compacted areas;

f) proposed access routes for system maintenance and proposed parking areas;

g) culverts, drainage patterns and swales;

h) existing and proposed utility corridors, whether above or below grade;

i) existing rights-of-way, easements and crown reserves;

j) the legal description of the property, and if available, the municipal address.

Specifications submitted shall be based on a site-specific evaluation of the property and soils and shall include

a) depth of existing soils to bedrock;

b) depth of soils to groundwater table;

c) soil properties including soil percolation test results and/or soil permeability as determined by a grain size analysis utilizing the Unified Soil Classification System;

d) soil conditions, including the potential for flooding;

e) soil profiles as determined by test pits excavated in the area of the proposed leaching bed;

f) where the applicant is proposing a raised or partially raised leaching bed, specifications on the amount of fill required, the dimensions of the area to be filled and the soil properties as noted in subsection 3(c);

g) detailed specifications on the type of sewage system proposed, the size of the sewage system proposed and detailed design drawings;

h) where deemed necessary by the Chief Building Official, a site plan shall include contour mapping, existing and finished ground elevations;

i) an application for a Class 5 system shall be accompanied by evidence that confirms that the proposal is in compliance with the Building Code.

Equivalents

1) Where an application for a permit or for authorization to make a material change to a plan, specifications, document or other information on the basis of which a permit was issued, contains an equivalent material, system or system design for which authorization under Section 9 of the Act is requested, the following information shall be provided:

a) a description of the proposed material, system or system design for which authorization is requested;

b) any applicable provisions of the Building Code, and;

c) evidence that the proposed material, system or system design will provide the level of performance required by the Building Code.

2) The Chief Building Official reserves the right to have any application requiring authorization under Section 9 of the Act referred to the Building Materials Evaluation Commission for review.

Revisions to Permit

1) After the issuance of a permit under the Act, notice of any material change to a plan, specification, document or other information on the basis of which the permit was issued, must be given in writing to the Chief Building Official together with the details of such change which is not to be made without his or her written authorization;

2) The fees for revising a permit, reviewing new plans and repeating inspections shall be set out in Schedule “A” of this By-law.

Notice Requirements

1) Notices required by Section 10.2 (1) of the Building Code shall be given by the permit holder to the Chief Building Official at least 5 business days in advance of the stages of construction specified therein.

2) A notice pursuant to clause (1) of this By-law is not effective until written or oral notice is actually received by the Chief Building Official, the sewage system inspector or designate.

3) Notice required upon completion of the sewage system Section 11 (4)a of the Building Code shall be in writing in a form designated by the Chief Building Official. The completion form shall be given to the Chief Building Official at least 10 days in advance of the intended use of the sewage system.

4) i) Where the applicant files a completion form with the Chief Building Official, the form shall

a) indicate that the sewage system was backfilled, graded and seeded or sodded in accordance with the Building Code;

b) indicate the date on which the work was completed;

c) where the applicant has retained an architect or professional engineer, or both, to carry out the general review of the construction of the sewage system, contain the written opinion of the architect or engineer that the completed work conforms to the Building Code;

d) be signed by the applicant who shall certify the truth of the contents of the information contained within the completion form.

4) ii) Where information is received by the Chief Building Official as required by this section, the Chief Building Official may, upon the signed recommendations of a sewage system inspector,

a) deem that the requirements of the Building Code have been satisfied, without having an inspection conducted to verify the information;

OR

b) the Chief Building Official may require that a set of as constructed plans of the sewage system or any part of the sewage system be submitted by the applicant;

OR

c) A site inspection must be carried out by the sewage inspector to verify that the requirements of 4 (a) have been carried out.

Transfer of Permits

1) If the registered owner of the land to which the permit applies changes, the permit is transferable only upon the new owner completing a permit application, to the requirements of Section 4 of this By-law. The new owner shall then be the permit holder for the purposes of the Act and the Building Code and assume all responsibilities for compliance with the permit documents.

2) The fee for transferring a permit shall be set out in Schedule ”A”.

Refunds

1) No refund of fees shall be made once a site inspection for a permit or a land use evaluation has been carried out.

2) All requests for withdrawal of an application shall be in writing by the applicant.

Revocation

1) The Chief Building Official may revoke a permit subject to Section 8(10) of the Act or for an “N.S.F. Cheque” that was issued as payment of fees and notice thereof shall be given to the applicant.

Fees

1) The payment of fees for a permit or maintenance inspection shall be set out in Schedule "A" and are due and payable upon submission of an application or completion of inspection.

2) No permit shall be issued until the fees therefore have been paid in full.

Forms

The Chief Building Official shall be responsible for the development and maintenance of forms required for the sewage system program. Classifications of forms shall be set out in Schedule "B" of this By-law.

Offence/Penalty

1) Every person who contravenes any provision of this By-law is guilty of an offence.

2) Every person who is convicted of an offence is liable to a fine as provided for in the Provincial Offences Act, R.S.O. 1990, cP.33.

Policies and Procedures

1) The Board of Health for Sudbury and District Health Unit shall from time to time establish policies and procedures related to sewage program activities as are appropriate.

Validity

Should any section, subsection, clause or provision of this By-law be declared by a Court of competent jurisdiction to be invalid, the same shall not affect the validity of this By-law as a whole or any part thereof, other than the part so declared to be invalid.

That this By-law shall come into force and take effect on the 6th day of April 1998.
Read and passed in open meeting this 26th of March 1998

Revised and passed by the Board of Health, Sudbury & District Health Unit this 27th day of May 1999.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 25th day of May 2000.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 22nd day of February 2001.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 19th day of February 2004.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 17th day of June 2004.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 15th day of November 2007.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 14th day of May 2009.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 20th day of January 2011.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 16th day of February 2012.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 20th day of February 2014.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 18th day of June 2015.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 16th day of February 2017.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 15th day of February 2018.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 15th day of September 2022.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 20th day of February, 2025.

SCHEDULE "A" TO BY-LAW 01-98

Cost Per Permit and Record

1) Sewage System Permits:	
a) Class 2 Sewage System (Leaching Pit)	**$71400.00**
b) Class 2 Sewage System (more than 4 sites)	**$2,85600.00**
(plus $200 for each lot over 4)	**$2040.00**
c) Class 3 Sewage System (Cesspool)	**$71400.00**
d) Class 4 Sewage System (Septic Tank and Leaching Bed)	**$1,37750.00**
e) Class 4 Sewage System (Leaching Bed Only)	**$84225.00**
f) Class 4 Sewage System (Tank Only)	**$53625.00**
g) Class 5 Sewage System (Holding Tank)	**$1,27550.00**
2) Sewage System Permits: Re-Inspection	**$2550.00**
3) Renovation Permit	**$51000.00**
4) Demolition Permit	**$3060.00**
5) Revisions to Permit (Inspection Required)	**$51000.00**
6) Revisions to Permit (No Inspection Required)	**$2550.00**
7) Transfer of Permit to New Owner	**$1020.00**
8) Extraordinary Travel Costs by Air, Water, etc.	**Full Cost Recovery**

Other Fees

Mandatory Maintenance Inspection	**$1795.00**
File Search	**$4080.00**
Consent Applications	**$3570.00 retained lot**
	Plus $3570.00 per severed lot
Review of detailed site-specific proposal (per submission)	**$61200/lot**
Minor Variance/Zoning Applications	**$3570.00**
Copy of Record	**$1285.00**
Other Government Agencies	**$3570.00**

SCHEDULE "B" TO BY-LAW 01-98

Forms for Sewage Systems

1) Sewage System Permits:

a) Application Form for a Sewage System Permit
b) Inspection Reports
c) Form Letters and Orders
d) Completion Notice Re: Readiness for Use of a Sewage System

2) Mandatory Maintenance Inspections

a) Inspection Reports

AMENDMENT TO THE FEE SCHEDULE FOR SERVICES UNDER PART VIII OF THE ONTARIO BUILDING CODE

MOTION:

WHEREAS the Board of Health is mandated under the *Ontario Building Code Act* (S.O. 1992 c. 23), to enforce the provisions of this Act and the Building Code related to sewage systems; and

WHEREAS program related costs are funded through user fees on a cost-recovery basis; and

WHEREAS the proposed fees are necessary to address current program associated operational and delivery costs; and

WHEREAS the Board of Health has adopted a process of annually adjusting fees in accordance with inflation with a comprehensive review of fees conducted every five years; and

WHERAS fees have been proposed to increase in accordance with inflation for this annual adjustment; and

WHEREAS in accordance with Building Code requirements, staff have held a public meeting and notified all contractors, municipalities, lawyers, and other affected individuals of the proposed fee increases, with no concerns having been reported;

THEREFORE BE IT RESOLVED THAT the Board of Health approve the amendments in Part VIII-Ontario Building Code fees as outlined within Schedule "A" to Board of Health By-law 01-98.

CHANGE IN BOARD OF HEALTH MEETING DATE

MOTION:

WHEREAS the Board of Health regularly meets on the third Thursday of the month; and

WHEREAS By-Law 04-88 in the Board of Health Manual stipulates that the Board may, by resolution, alter the time, day or place of any meeting;

WHEREAS the *Municipal Election Act* section 6(1) provides that terms of municipal elected officials end on November 14, 2026, and so municipal appointments to the Board of Health expire on November 14, 2026;

WHEREAS it is desirable to ensure continuity and quorum for the November 2026 Board of Health meeting;

THEREFORE BE IT RESOLVED THAT this Board of Health agrees that the regular Board of Health meeting scheduled for 1:30 pm Thursday, November 19, 2026, be moved to 1:30 pm on Thursday, November 12, 2026.

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 information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them.

Time: _____

RISE AND REPORT

MOTION:

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

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