Board of Health Meeting # 01-25

Public Health Sudbury & Districts

Thursday, January 16, 2025

1:30 p.m.

Boardroom

1300 Paris Street

René Lapierre
rene.lapierre@greatersudbury.ca
rene.lapierre@grandsudbury.ca

January 3rd 2025

Dear Dr. Hirji,

Councillor Ward 6
Conseiller Quartier 6

200 Brady Street
P.O. Box 5000, Stn A
Sudbury, ON P3A 5P3

200, rue Brady
C.P. 5000, Succ. A
Sudbury, ON P3A 5P3

705-923-5669
705-673-1651

www.greatersudbury.ca
www.grandsudbury.ca

I am writing to formally tender my resignation as Chair of the Board of directors for Public Health Sudbury & Districts, effective at the January 2025 meeting. I will be stepping down as Chair at that time and will be leaving the board completely after the February 2025 board meeting.

Serving as Chair of this vital organization has been an immense honour and privilege. I am deeply proud of the work we have accomplished together to promote and protect the health and well-being of our community. Collaborating with such a dedicated team of professionals and board members has been one of the most rewarding experiences of my career.

After thoughtful consideration, I have decided that this is the appropriate time for me to step down. This decision was not made lightly, as I hold this role and its responsibilities in the highest regard. The reason for my resignation is that I have been asked to lead new large projects at the College, which will take up much of my time.

This decision will enable me to assist the incoming Chair with succession planning to ensure a smooth and effective transition. I am committed to ensuring a smooth transition and will work closely with my colleagues and the incoming Chair to provide any necessary support during this period. Please do not hesitate to reach out if there are specific tasks or initiatives I can assist with to facilitate the handover process.

René Lapierre
rene.lapierre@greatersudbury.ca
rene.lapierre@grandsudbury.ca

Greater | Grand Sudbury

Councillor Ward 6
Conseiller Quartier 6

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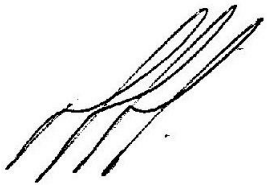
I want to express my heartfelt gratitude to the Board, staff, and community members who have supported me throughout my tenure. I am confident that Public Health Sudbury & Districts will continue to thrive and uphold its mission to serve the community with dedication and excellence.

Thank you once again for the opportunity to serve in this role. I look forward to witnessing the continued success of Public Health Sudbury & Districts in the years to come.

Sincerely,



René Lapierre
Chair, Public Health Sudbury & Districts

From: Pauline Fortin
To: Rene.Lapierre@greatersudbury.ca; Rachel Quesnel; Mustafa Hirji
Cc: Clerks City of Greater Sudbury; Paul Lefebvre; Eric Labelle
Subject: Public Health
Date: December 17, 2024 8:15:43 AM

Good Morning
I will be leaving Public Health as of December 31, 2024.
I have decided to step back from a couple of boards I sit on to give myself a little more personal time and focus on other issues in my ward.
Although I was only a member for a little while, I very much enjoyed being on the Board and meeting all the members and staff and I am confident that under the Boards' and Dr. Hirji's leadership, the great work being done will continue.
Yours truly,
Pauline Fortin
Je parle français
Councillor Ward 4
City of Greater Sudbury
c. 249-377-8027

Public Health
Santé publique
SUDBURY & DISTRICTS

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
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f: 705.522.5182

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phsd.ca

January 8, 2025

Pauline Fortin
City of Greater Sudbury

Dear Pauline:

Re: Public Health Sudbury & Districts Board of Health

Further to your resignation on the Board of Health on December 17, 2024, I am extending my gratitude on behalf of the Board of Health for your service as a member of our Board since your appointment by the City of Greater Sudbury Council in April 2024.

Your support of Public Health was very much appreciated. We look forward to your continued engagement with Public Health in your role as a City Councillor.

Sincerely,

Original signed by

René Lapierre, Chair
Board of Health

cc: Dr. Mustafa Hirji, Medical Officer of Health and Chief Executive Officer
Board of Health, Public Health Sudbury & Districts

Public Health
Santé publique
SUDBURY & DISTRICTS

AGENDA – FIRST MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, SECOND FLOOR
THURSDAY, JANUARY 16, 2025 – 1:30 P.M.

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

- Letter from René Lapierre dated January 3, 2025, re: resignation from the Board of Health for Public Health Sudbury & Districts
- Email from Pauline Fortin dated December 17, 2024, re: resignation from the Board of Health for Public Health Sudbury & Districts
- Thank you letter to Pauline Fortin from the Board of Health Chair dated January 8, 2025

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

4. ELECTION OF OFFICERS

APPOINTMENT OF CHAIR OF THE BOARD

(2024 Chair: René Lapierre – 10 terms)

THAT the Board of Health appoints _____ as Chair for the year 2025.

APPOINTMENT OF VICE-CHAIR OF THE BOARD

(2024 Vice-Chair: Mark Signoretti – 2 terms)

THAT the Board of Health appoints _____ as Vice-Chair for the year 2025.

APPOINTMENT TO BOARD EXECUTIVE COMMITTEE

(2024 Board Executive: René Lapierre – 10 terms; Ken Noland – 14 terms; Mark Signoretti – 2 terms; Natalie Tessier – 2 terms; Abdullah Masood – 1.5 term (effective September 2023)

THAT the Board of Health appoints the following individuals to the Board Executive Committee for the year 2025:

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

(2024 Finance Committee: René Lapierre – 10 terms; Mark Signoretti – 8 terms; Ken Noland – 3 terms; Michel Parent – 2 terms)

THAT the Board of Health appoints the following individuals to the Finance Standing Committee of the Board of Health for the year 2025:

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) Highly Pathogenic Avian Influenza

- Jonathan Groulx, Manager, Health Protection Division

6. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Seventh Meeting – November 21, 2024

ii) Business Arising from Minutes

iii) Report of Standing Committees

a. Board of Health Executive Committee – Unapproved Minutes, December 23, 2024

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

a. MOH/CEO Report, January 2025

v) Correspondence

a. Food Insecurity

- Letter from Peterborough Public Health Board of Health Chair to the Minister of Families, Children and Social Development and the Minister of Health, Government of Canada, dated December 24, 2024
- Report and infographics from Middlesex-London Health Unit dated December 12, 2024

b. Strengthening of Public Health

- Memorandum from Elizabeth Walker, Executive Lead, Office of the Chief Medical Officer of Health, Public Health dated December 23, 2024

c. Perspectives from Northern Ontario for the Public Health Funding Review
(Related motion from Board of Health Public Sudbury & Districts Motion #49-24)

- Letter from the Municipality of Killarney to the Minister of Health, dated November 20, 2024

vi) Items of Information

a. Annual Survey Results from 2024 Regular Board of Health Meeting Evaluations

b. Annual Meeting Attendance Summary Board of Health for Public Health Sudbury & Districts 2024

APPROVAL OF CONSENT AGENDA

MOTION:

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

7. NEW BUSINESS

i) Immunization Registries

- Briefing Note from the Acting Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated January 9, 2025
- Letter from Peterborough Public Health Board of Health Chair to the Deputy Minister and Minister of Health, dated November 29, 2024

SUPPORT FOR IMMUNIZATION REGISTRIES

MOTION:

WHEREAS neither Ontario nor Canada currently have a reliable, complete or timely way to record immunization information for residents;

WHEREAS a national immunization registry has been a longstanding recommendation for strengthening public health in Canada;

WHEREAS in September 2024, the Ontario Immunization Advisory Committee released a position statement[i] strongly urging the Ontario Ministry of Health to develop a provincial immunization registry; and

WHEREAS Peterborough Public Health (Motion 9.3.6) and Wellington-Dufferin-Guelph Public Health (Resolution 32) have also passed motions to support a provincial immunization registry;

THEREFORE BE IT RESOLVED THAT the Board of Health endorses the establishment and implementation of an Immunization Registry for Ontario;

AND THAT the Board of Health supports the establishment of a pan-Canadian immunization registry that integrates with any provincial registries.

ii) Response to Propose Amendment of Section 22 of the *Health Protection & Promotion Act*

- Briefing Note from the Acting Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated January 9, 2025

RESPONSE TO PROPOSE AMENDMENT OF SECTION 22 OF THE *HEALTH PROTECTION & PROMOTION ACT*

MOTION:

WHEREAS Class Orders under Section 22 of the *Health Protection & Promotion Act* were created in 2003 in the wake of the first wave of SARS to better equip local public health to respond to time-sensitive and severe public health emergencies;

WHEREAS Class Orders were used in novel ways during the COVID-19 pandemic response, ways that were much broader in scope than likely intended in 2003;

WHEREAS additional checks and balances on Class Orders are reasonable give the novel use of these orders to ensure they do not inappropriately impact public freedoms;

WHEREAS *Bill 231, More Convenient Care Act, 2024* proposes an amendment to the *Health Protection & Promotion Act* that would require provincial review and approval for any Class Order;

WHEREAS seeking provincial review and approval would create significant time delays with issuing Class Orders contrary to the need identified during the SARS response;

WHEREAS provincial review and approval of a local medical officer of health's actions to deal with local outbreaks and local health risks would represent an unusual infringement on local autonomy and independence in dealing with local concerns;

WHEREAS there are many recommendations that have arisen around improving the use of Section 22 orders dating back to SARS, many of which have not been implemented;

THEREFORE BE IT RESOLVED THAT the Board of Health recommends that the Legislative Assembly of Ontario that amending section 22 of the *Health Protection & Promotion Act* warrants more careful study, and that a dedicated task force to review this provision is recommended prior to any amendments; *Health Protection & Promotion Act;*

AND THAT the Board of Health recommends that any amendment of Section 22 Class Orders should distinguish between the original use of Class Orders which were narrowly targeted to small groups concerning time-sensitive risk of a local nature, and the novel use of Class Orders which area applied across an entire health unit on a risk diffuse throughout the province.

iii) Endorsement of the Recommendations of the Walport Report, and Support for Continued focus on Public Health Emergency & Pandemic Preparedness

- Briefing Note from the Acting Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated January 9, 2025
- Letter from Peterborough Public Health Board of Health Chair to the Deputy Minister and Minister of Health and the federal Minister of Health, dated November 27, 2024

ENDORSEMENT OF THE RECOMMENDATIONS OF THE WALPORT REPORT, AND SUPPORT FOR CONTINUED FOCUS ON PUBLIC HEALTH EMERGENCY & PANDEMIC PREPAREDNESS

MOTION:

WHEREAS for the past two decades, there have been Public Health Emergencies of International Concern approximately every two years, several of which have impacted Canada;

WHEREAS in a world that is increasingly more complex, interconnected, and uncertain, future public health emergencies maybe more impactful and difficult to manage;

WHEREAS the are opportunities to learn lessons from the COVID-19 pandemic response, both of around successes and areas for improvement;

WHEREAS The Time to Act is Now: Report of the Expert Panel for the Review of the Federal Approach to Pandemic Science Advice and Research Coordination (aka The Walport Report) is one detailed effort to learn lessons from the COVID-19 pandemic response;

WHEREAS The Ontario Chief Medical Officer of Heath's 2022 Annual Report Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics presented a laudable path forward to be better prepare for future public health emergencies;

THEREFORE BE IT RESOLVED THAT the Board of Health endorses the Walport Report and its 12 recommendations;

AND THAT the Board of Health encourages both the Federal government and the government of Ontario to act with deliberate resolve in implementing the Walport Report as well as the 2022 Chief Medical Officer of Health report, respectively.

iv) Board of Health Meeting Date

CHANGE IN BOARD OF HEALTH MEETING DATE

MOTION:

WHEREAS the Sudbury & District 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 2025 Association of Local Public Health Agencies Annual (alPHa) in-person Conference and General Meeting will be held from June 18 to 20, 2025;

THEREFORE BE IT RESOLVED THAT this Board of Health agrees that the June 19, 2025, regularly scheduled Board of Health meeting date be changed to Thursday, June 12, 2025 at 1:30 p.m.

8. ADDENDUM

ADDENDUM

MOTION:

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

9. ANNOUNCEMENTS

10. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time: ____

[i] Ontario Agency for Health Protection and Promotion (Public Health Ontario), Ontario Immunization Advisory Committee. Position Statement: a provincial immunization registry for Ontario. Toronto, ON: King's Printer for Ontario; 2024.

APPOINTMENT OF CHAIR OF THE BOARD

THAT the Board of Health appoints _____ as Chair for the year 2025.

APPOINTMENT OF VICE-CHAIR OF THE BOARD

THAT the Board of Health appoints _____ as Vice-Chair for the year 2025.

APPOINTMENT TO BOARD EXECUTIVE COMMITTEE

THAT the Board of Health appoints the following individuals to the Board Executive Committee for the year 2025:

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 2025:

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**

MINUTES – EIGHTH MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, SECOND FLOOR
THURSDAY, NOVEMBER 21, 2024 – 1:30 P.M.

BOARD MEMBERS PRESENT

Ryan Anderson	Guy Despatie	Ken Noland
Robert Barclay	Pauline Fortin	Marc Signoretti
Michel Brabant	René Lapierre	Natalie Tessier
Renée Carrier	Abdullah Masood	

BOARD MEMBERS REGRET

Michel Parent

STAFF MEMBERS PRESENT

Kathy Dokis	Stacey Laforest	Renée St Onge
Stacey Gilbeau	Rachel Quesnel	
M. Mustafa Hirji	France Quirion	

R. LAPIERRE PRESIDING

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

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

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

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

4. DELEGATION/PRESENTATION

i) The drug toxicity crisis and ongoing local efforts

- Nicole Gauthier, Health Promoter, Health Promotion and Vaccine Preventable Diseases Division
- Rachelle Roy, Public Health Nurse, Health Promotion and Vaccine Preventable Diseases Division

N. Gauthier and R. Roy were invited to provide an overview on the local toxic drug crisis and the progress made following the Greater Sudbury Summit on Toxic Drugs held in December 2023.

A fictional case example illustrated a scenario resulting of an opioid death, which sadly, is not unique to the story. Locally in 2020, there were 107 deaths due to opioids in comparison with 17 such deaths in 2016, representing an increase of 529% in a four-year span. This local increase is consistent with what we've observed across Northern Ontario. Annual rates of suspected drug toxicity deaths for PHSD are almost three times that of the provincial average. From January to September 2024, the rate of drug toxicity deaths in the district of Sudbury and Manitoulin is 64.5 per 100, 000 people and three times higher than the provincial rate of 22.9.

It was recapped that, per the Ontario Public Health Standards, the board of health is mandated to develop and implement a program of public health interventions that addresses risk and protective factors to reduce the burden of preventable injuries and substance use in the health unit population (*Substance Use Prevention and Harm Reduction Guideline, 2018)*.

Addressing the toxic drug crisis continues to require a multifaceted approach. Public Health Sudbury & Districts remains committed to evidence-based, upstream approaches, including

- Monitoring and surveillance of substance use trends
- Promoting healthy public policy
- Addressing stigma, discrimination, and the broader social determinants of health

Public Health Sudbury & Districts is one of many partners in the community collaborating and contributing to harm reduction including

- Provision of a needle syringe programs and the distribution of sterile harm reduction supplies
- Provision of naloxone training and distribution
- Issuing drug alerts and warnings

Public Health Sudbury & Districts also provides leadership and coordination to the region's Community Drug Strategies and co-chair the four local drug strategies within our catchment area, including Manitoulin, Lacloche Foothills, Sudbury East, and Greater Sudbury. The purpose of the local drug strategies is to improve the health, safety, and well-being of communities by reducing substance use-related harms.

The Community Drug Strategy in Greater Sudbury is committed to advancing the recommendations from the Greater Sudbury Summit on Toxic Drugs. Since the Summit, the CDS has reinvigorated its structure and membership to better align with the three streams of the Summit, including health promotion, wrap-around supports, and substance use care

with overarching priorities to address structural stigma, improve collaboration, center equity and eliminating barriers to access, and ensure adequate funding. Priorities for each of the three streams were outlined.

Questions and comments were entertained. The yearly stats for local opioid-related deaths were recapped and possible factors influencing the increase in the rate of deaths discussed. It was clarified that there is no Community Drug Strategy in Chapleau; however, there is good work happening. Public Health Sudbury & Districts will be going to Chapleau for a round table discussion with community partners to discuss opportunities that can be leveraged to address community needs. It was also noted that Public Health Sudbury & Districts played a supportive role in the development of HART hub applications and provided surveillance and data to help inform that application.

Presenters were thanked for the informative presentation.

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Seventh Board of Health Meeting – October 17, 2024

ii) Business Arising from Minutes

iii) Report of Standing Committees

a. Board of Health Finance Standing Committee Unapproved Minutes dated November 4, 2024
b. Board of Health Executive Committee Unapproved Minutes dated November 4, 2024

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

a. MOH/CEO Report, November 2024

v) Correspondence

a. Funding Support for Student Nutrition Program

- Letter from Peterborough Public Health Board of Health Chair to the Premier of Ontario, Minister of Child, Community and Social Services and Minister of Education, dated October 29, 2024

b. Phasing out free water well testing for private wells
(Related Motion from Board of Health for Public Health Sudbury & Districts Motion 48-24)

- Letter from Northwestern Health Unit Board of Health Chair to the Minister of Health and Public Health Ontario President and Chief Executive Officer, dated October 25, 2024
- Resolution from Municipality of Killarney supporting the Town of Goderich, dated May 8, 2024

c. Recommendations for Government Regulation of Nicotine Pouches
(Related Motion from Board of Health for Public Health Sudbury & Districts Motion 26-24)

- Resolution from Municipality of Wawa supporting the Municipality of St-Charles, dated October 15, 2024
- Email from Natural and Non-prescription Health Products Directorate Consultation, Health Canada, dated October 11, 2024
- Letter from The Corporation of the Township of Dubreuilville to Public Health Sudbury & Districts, dated October 11, 2024

Comments and questions were entertained regarding the November MOH/CEO report, including MOH reflections regarding the US election and lessons from it around the risk to trust of public institutions such as PHSD.

In response to a question, it was clarified that staff vacancies contributing to the positive variance in the year-to-date financial statements span all disciplines across the agency, including public health inspectors, IT staff, public health nurses, health promoters and managers.

Additional information was provided pursuant to an inquiry regarding the health and safety risk assessment undertaken by Human Resources in collaboration with management.

The Board Chair clarified that the Board of Health Finance Standing Committee unapproved minutes are tabled for information. The recommendation from the November 4, 2024, meeting will be discussed under 6.v).

R. Barclay and R. Lapierre provided an update regarding the virtual alPHa Fall Symposium held November 6 to 8, 2024. The Artificial Intelligence (AI) and Public Health all day workshop was held on November 6 and Reducing Alcohol Harms in Ontario: Canada's Guidance on Alcohol and Health and Public Education Workshop took place November 7. The Board of Health section meeting was held November 8. Symposium materials will be posted to the alPHa website. R. Lapierre also reported on the alPHa Board of Directors.

62-24 APPROVAL OF CONSENT AGENDA

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

CARRIED

6. NEW BUSINESS

i) Annual Board of Health Self-Evaluation 2024 Survey Results

a) Briefing Note from the Medical Officer of Health and Chief Executive Officer to the Board of Health Chair dated November 14, 2024

Part of the requirement of the Ontario Public Health Standards is that a Board of Health conducts a period self-evaluation. Board of Health Manual Policy C-I-14 notes that *the Board of Health shall engage in an annual self-evaluation process of its governance practices and outcomes.* This Board has routinely conducted a self-evaluation survey and provides Board members a chance to reflect on their individual performance, the effectiveness of Board policy and processes, and the Board's overall performance as a governing body.

Thanks was extended to those who completed the self-evaluation survey. A total of 10 out of 11 Board members completed the survey, for a response rate of over 90%. Overall results from the self-evaluation questionnaire indicate that most Board of Health members have a positive perception of their governance process and effectiveness.

Questions were entertained and the response rate was observed to be higher than in previous years. It was clarified that the results are for internal reflection and although not shared with the province, the agenda package is made available to the public. Dr. Hirji also clarified that if concerns were identified, appropriate action would be taken.

ii) Medical Officer of Health and Chief Executive Officer (MOH/CEO) Mid-Point Check-In

The Board Chair reported, that as part of good governance, he discussed a mid-point check-in review with Dr. Hirji. The Board of Health Executive Committee met on November 4, 2024, to discuss the MOH/CEO performance appraisal processes and mid-point evaluation process.

The Board of Health Executive Committee agreed that the MOH/CEO performance appraisal process will remain the same as in the past with the MOH/CEO performance appraisals conducted on an annual basis, starting approximately one year after they began in their role; therefore in April 2025 for Dr. Hirji.

The mid-point check-in review process will also be coordinated by the Board secretary and will occur in November and December 2024. The mid-point check-in will be carried out via a survey including questions about things done well and things to do even better.

R. Lapierre shared that Dr. Hirji's employment contract includes, pursuant to a request by Dr. Hirji, the conduct of 360-degree evaluation for the purposes of professional development to be conducted 18 months after commencing the role, or around September 2025. The Board Executive Committee agreed that the 360-degree evaluation remain separate from the annual performance appraisal, noting that the 360-degree evaluation is

solely for professional development purposes. The agency may rely on services of an external Human Resources Firm for the 360-degree evaluation only.

63-24 MID-POINT CHECK IN FOR THE MOH/CEO

MOVED BY NOLAND – SIGNORETTI: THAT upon recommendation from the Board of Health Executive Committee:

THAT this Board of Health support that a mid-point check-in take place for the Medical Officer of Health and Chief Executive Officer; and

THAT Board of Health members and positions that report directly to the MOH/CEO be invited to complete a confidential questionnaire responding to two questions; Things Done Well and Things To Do Even Better;

AND a summary report, prepared by the Board Secretary, be shared with the Board of Health Executive Committee members. Subsequently, the Board Chair would conduct a 1:1 meeting with the MOH/CEO to share the results and the Board would be informed once the process is completed.

CARRIED

iii) Staff Appreciation

M.M. Hirji recapped for the newer Board members that this motion is unique to Public Health Sudbury & Districts and has been tabled for the Board's consideration yearly dating back to the mid-70's. The Staff Appreciation Day has been a symbol of the Board's appreciation and grants staff a day off with pay. Previous motions aligned with the holiday season and the block of time that staff can take the paid day off has been expanded to be more cognizant of cultural diversity. Staff have shown their gratitude in the past by submitting thank you notes. The motion is tabled for the Board's consideration again this year.

64-24 STAFF APPRECIATION DAY

MOVED BY CARRIER – ANDERSON: 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, 2024, to February 28, 2025. Essential services will be available and provided at all times except for statutory holidays when on-call staff will be available.

CARRIED

iv) Consultation Regarding Amendment to the Fee Schedule for Servicers under Part VIII of the Ontario Building Code

a) Briefing Note from the Acting Medical Officer of Health and Chief Executive Officer dated November 14, 2024
b) Revised Board of Health G-I-50, By-Law 01-98

The briefing note speaks to the Part VIII *Ontario Building Code* program regarding private septic systems which are not connected to the Municipal sewer lines.

M.M. Hirji noted that the Ontario *Building Code Act* sets out the minimum standards related to sewage system and our agency is designated as the inspection agency responsible for the enforcement within our service areas. This is an important role to ensure our water stays free of pathogens.

Under the authority of the *Ontario Building Code*, Public Health Sudbury & Districts collects fees for Part VIII permits and services to recover all costs associated with administration and enforcement of the *Act*. The Part VIII program cannot be revenue generating and must be administered on a cost-recovery basis. The current fees, in place since 2018, are no longer cost-neutral and becoming a budget liability. There has been substantial inflation in the broader economy since 2018 which has similarly increased costs to deliver this program. The proposed fee increases are necessary to address increasing program operation and delivery costs.

The *Building Code Act* requires that public consultation take place of the proposed fee increases. The Board of Health's approval, in principle, was sought for the proposed increase in Part VIII – Ontario Building Code fees as outlined within Schedule "A" to Board of Health By-Law 01-98. Following the public meeting, the final proposed revisions will be tabled, likely in February 2025, for the Board's endorsement.

Questions and comments were entertained. It was suggested that future annual fee increases be implemented for a few years rather than for one year. The phased approach suggestion will be taken back for consideration for future years. The intent and process of a public consultation was outlined. M.M. Hirji clarified that the gaps in funds due to increasing program operation and delivery costs for Part VIII have been addressed via gapped operational funding.

It was noted that the proposed motion applies for 2025 and further consideration will given to a multi-year increase starting in 2026.

65-24 CONSULTATION REGARDING AMENDMENT TO THE FEE SCHEDULE FOR SERVICERS UNDER PART VIII OF THE ONTARIO BUILDING CODE

MOVED BY TESSIER – DESPATIE: WHEREAS the Board of Health is mandated under the Ontario Building Code (O. Reg. 332/12), under the Building Code Act 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 increased program associated operational and delivery costs; and

WHEREAS in accordance with Building Code requirements, staff will hold a public meeting and notify all contractors, municipalities, lawyers, and other affected individuals of the proposed fee increases; and

WHEREAS an update will be provided to the Board of Health following conclusion of the notification process with recommendation coming forward at the February 2025 Board of Health meeting to formally approve the updated Schedule "A" to Board of Health By-Law 01-98;

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

CARRIED

v) Proposed 2025 Cost-Shared Operating Budget

a) Briefing Note and Schedules from the Acting Medical Officer of Health and Chief Executive Officer dated November 14, 2024

M. Signoretti, Chair of the Board of Health Finance Standing Committee reported that at its November 4, 2024, meeting, members carefully reviewed the recommended 2025 cost-shared operating budget.

Dr. Hirji and team were commended for the work they have done to bring forward a responsible and transparent budget. The recommended budget focuses on five priorities: sustainability, leveraging of technology, focusing on outcomes, fostering culture and engagement, and a continued commitment to the implementation of the Indigenous Engagement Strategy. The recommended budget manages the fixed cost increases which we cannot control with targeted budget reductions to limit pressure on municipal levies and balancing all this with making important strategic investments to advance the organization Strategic Plan.

Budget deliberations began with a projected shortfall of approximately $891,000. The budget recommended by the Board Finance Standing Committee to the Board of Health today totals $31,036,499. This represents an increase of $963,420 (3.20% over the 2024 Board approved budget). The 2025 recommended budget incorporates increases to projected interest income of $140,000, provincial and municipal increases of $185,383 and $638,037, respectively, and overall reductions of $113,024.

This budget strikes a balance of cost containment and investments in strategic priorities while continuing to respond to local needs and carry out the Board's responsibilities.

M.M. Hirji reviewed details, including the assumptions that underpin the recommended budget and the specifics of the budget recommendations. It was noted that the full details of the resource and service implications will be discussed during the in-camera session.

Public Health funding has not kept up with inflation over the last ten years. Public Health Sudbury & Districts has been working diligently to maximize financial efficiencies to delivery programs, services, and address local needs with limited resources. The outcomes are still unknown related to the Ministry's Strengthening of Public Health initiative that included voluntary mergers, review of Ontario Public Health Standards, and funding review.

Representing 87% of the budget, the most significant pressure relates to salaries and benefits. Growth in employee benefits costs also remains well above inflation. Benefits are projected to increase by 15% for 2025 and is primarily driven by usage.

Growth in expenditures is to stay status quo for the 2025 budget. A 1% increase in province funding leaves $891,061 to be bridged and recommendations from Board Finance Standing Committee are to be discussed.

Operational pressures that drive our work such as life expectancy, opioid related death, changing patterns of infectious diseases/outbreaks, such as increases in Tuberculosis as well as Syphilis infections as well as pressures in the vaccine preventive diseases (VPD) program were reviewed. These pressures are met with staffing recruitment and retention challenges. Pressures relating to the backbone services were also outlined. M.M. Hirji concluded that we want to focus on the 2024–2028 Strategic Plan priorities while addressing and balancing other pressures.

IN CAMERA

66-24 IN CAMERA

MOVED BY FORTIN – CARRIER: 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: 3:02 pm

CARRIED

RISE AND REPORT

67-24 RISE AND REPORT

MOVED BY BARCLAY – SIGNORETTI: THAT this Board of Health rises and reports. Time: 3:52 P.M.

CARRIED

It was reported that two personal matters involving one or more identifiable individuals, including employees or prospective employees were discussed for which the following motions emanated:

68-24 APPROVAL OF BOARD OF HEALTH INCAMERA MEETING NOTES

MOVED BY MASOOD – ANDERSON: THAT this Board of Health approve the meeting notes of the October 17, 2024, 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

69-24 2025 COST-SHARED OPERATING BUDGET

MOVED BY NOLAND – BARCLAY: WHEREAS the Board of Health Finance Standing Committee reviewed and discussed the details of the proposed 2025 cost-shared operating budget at its November 4, 2024, 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 2025 cost-shared operating budget for Public Health Sudbury & Districts in the amount of $31,036,499.

CARRIED

70-24 APPOINTMENT OF PUBLIC HEALTH SUDBURY & DISTRICTS ASSOCIATE MEDICAL OFFICER OF HEALTH

MOVED BY ANDERSON – NOLAND: WHEREAS the Health Protection and Promotion Act, R.S.O. 1990, c.H.7, s.62 states that every board of health may appoint one or more associate medical officers of health (AMOH).

WHEREAS the Capacity Review Committee recommended that every local public health agency have at least one AMOH.

WHEREAS the AMOH position is vacant.

THEREFORE BE IT RESOLVED THAT the Board of Health appoint Dr. Emily Groot as Associate Medical Officer of Health, effective January 6, 2025, subject to approval of the appointment by the Minister of Health.

CARRIED

7. ADDENDUM

None.

8. ANNOUNCEMENTS

R. Lapierre and M.M. Hirji acknowledged that this is the last Board of Health meeting that F. Quirion will be attending given her pending retirement. Her leadership and significant contributions to Public Health Sudbury & Districts were highlighted and the Board applauded France on her successful career. A warm thanks and congratulations were extended.

Board members are to review the annual mandatory Emergency Preparedness PowerPoint presentation and email R. Quesnel to confirm once the review is completed.

Each board member was asked to complete the evaluation for today's Board meeting in BoardEffect.

There is no regular Board of Health meeting in December. The next regular meeting is Thursday, January 16, 2025, at 1:30 p.m. Effective January 2025, board delegations/presentations and Q&A will be recorded and posted on YouTube and phd.ca

Board members were invited to join Senior Managers for a celebration in the boardroom following today's meeting to recognize their contributions to the Board of Health and Board of Health Standing Committees.

9. ADJOURNMENT

The next regular Board of Health meeting is Thursday, January 16, 2025, at 3:59 p.m.

71-24 ADJOURNMENT

MOVED BY BARCLAY – SIGNORETTI: THAT we do now adjourn. Time: 3:59 p.m.

CARRIED

_____ _____

(Chair) (Secretary)

Public Health
Santé publique
SUDBURY & DISTRICTS

UNAPPROVED MINUTES
BOARD OF HEALTH EXECUTIVE COMMITTEE
MONDAY, DECEMBER 23, 2024 – 2 P.M.
VIRTUAL MEETING

BOARD MEMBERS PRESENT

René Lapierre	Abdullah Masood	Ken Noland
Mark Signoretti	Natalie Tessier	

STAFF MEMBERS PRESENT

M. Mustafa Hirji	Rachel Quesnel	France Quirion

M. SIGNORETTI PRESIDING

1. CALL TO ORDER

The meeting was called to order at 2:01 p.m.

2. ROLL CALL

3. REVIEW OF AGENDA / DECLARATION OF CONFLICT OF INTEREST

The agenda was reviewed and approved as circulated. There were no declarations of conflict of interest.

4. APPROVAL OF BOARD EXECUTIVE COMMITTEE MEETING NOTES

4.1 Board of Health Executive Committee Meeting Notes dated November 4, 2024

08-24 APPROVAL OF BOARD OF HEALTH EXECUTIVE COMMITTEE MEETING NOTES

MOVED BY LAPIERRE – NOLAND: THAT the meeting notes of the Board of Health Executive Committee meeting of November 4, 2024, be approved as distributed.

CARRIED

5. NEW BUSINESS

- *Personal matters about an identifiable individual, including municipal or local board employees*

IN CAMERA

09-24 IN CAMERA

MOVED BY MASOOD – TESSIER: THAT this Board of Health Executive Committee goes in camera to deal with personal matters about an identifiable individual, including municipal or local board employees. Time: 2:04 p.m..

CARRIED

RISE AND REPORT

10-24 RISE AND REPORT

MOVED BY MASOOD – TESSIER: THAT this Board of Health Executive Committee rises and reports. Time: 2:53 p.m.

CARRIED

It was reported that one personal matter about an identifiable individual, including municipal or local board employees, was discussed and the following motion emanated:

11-24 APPROVAL OF BOARD OF HEALTH EXECUTIVE COMMITTEE IN-CAMERA MEETING NOTES

MOVED BY LAPIERRE – NOLAND: THAT this Board of Health Executive Committee approve the meeting notes of the November 4, 2024, 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

6. ADJOURNMENT

12-24 ADJOURNMENT

MOVED BY LAPIERRE – NOLAND: THAT we do now adjourn. Time: 2:57 p.m.

CARRIED

_____ _____

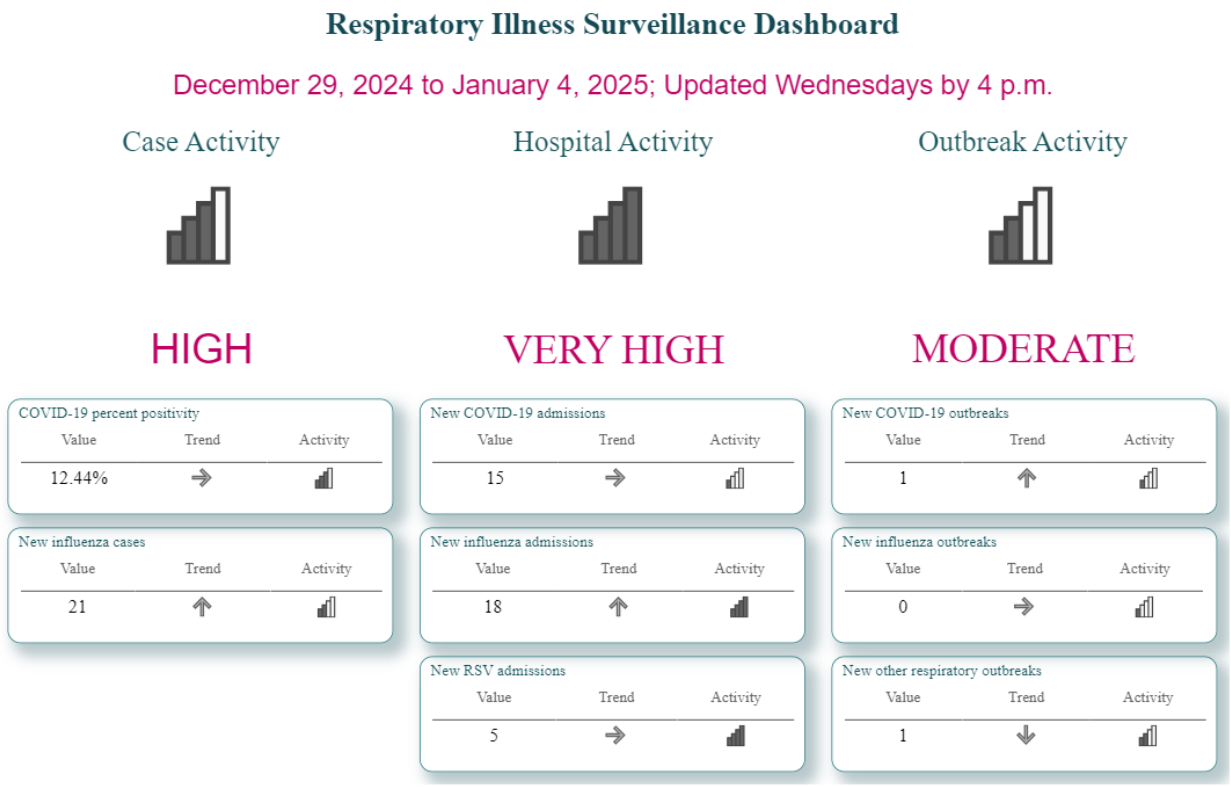
(Chair) (Secretary)

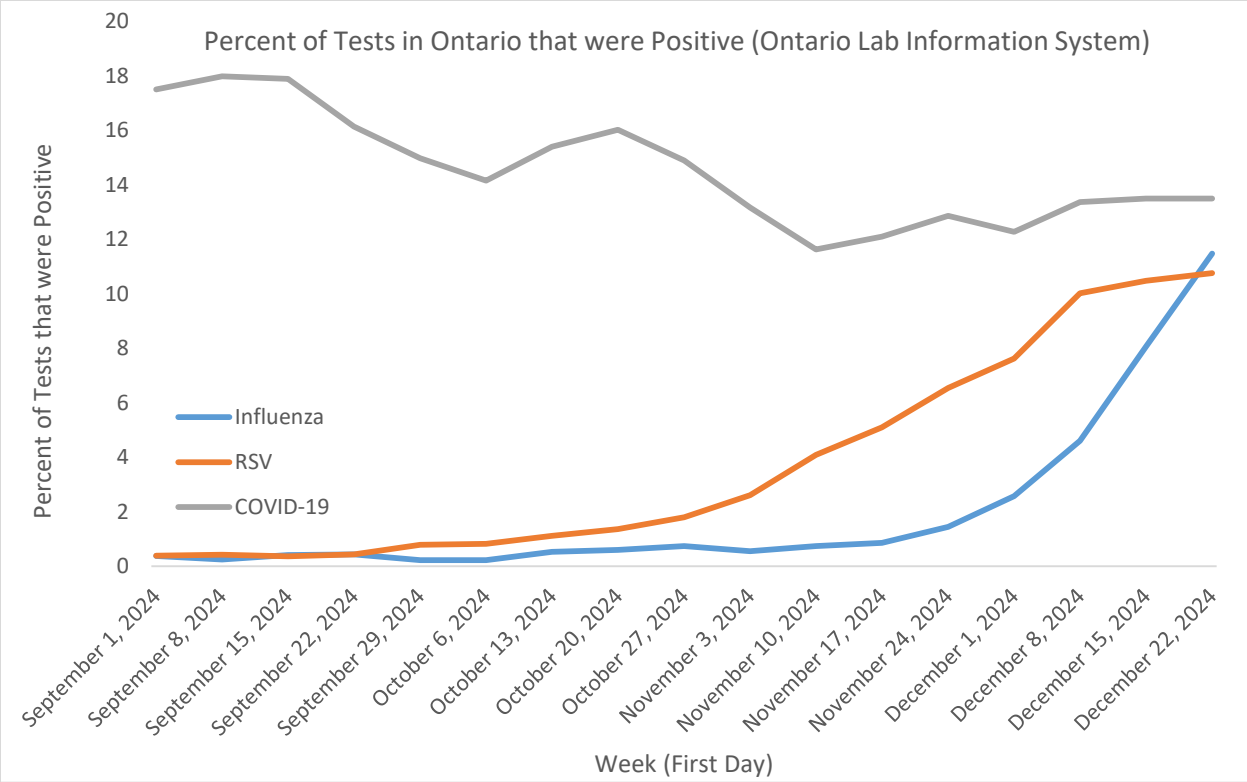
Medical Officer of Health/Chief Executive Officer
Board of Health Report, January 2025

Words for thought

Respiratory Infections Expectedly on the Rise

Public Health Sudbury & Districts Respiratory Infections Dashboard (January 8, 2024) & Public Health Ontario Respiratory Virus Tool (January 3, 2025):





Surveillance both locally and provincially is showing that RSV is likely peaking around now, and influenza is on a rapid increase heading towards its peak in the coming weeks. This is not unexpected. Influenza in most years peaks in January. It is likely that a contributor to this is the seasonal holiday festivities in December which provide opportunity for more circulation of the virus and supercharge its spread going into January.

COVID-19 remains at its baseline level between surges which continues to be a high baseline. It is likely that in the coming weeks we will see the next surge of COVID-19 driven by the same population mixing that occurred during December festivities.

As a society, there are a few lessons we can take from this:

1. As January is a higher risk period for respiratory viral infections, now is the time to increase our vigilance to respiratory infections. This means being mindful of how we feel and staying home if sick; choosing to wear a mask for the next few weeks, especially in crowded settings; and if one hasn't yet been vaccinated to influenza, COVID-19, or RSV (if eligible), seeking those immediately.
2. Given December activities seem to supercharge infections in January, we should consider being proactive to limit that supercharging in future years. This could mean reducing social interactions in December for some people, but that is not a good option for most people given the social importance of the month. Perhaps we should

encourage more working from home and/or remaining on vacation into early January to reduce viral spread.

3. Given viruses do not stop, and in the case of COVID-19, never reduce to lower levels, we should look at more definitive action against respiratory viruses. A needed action is to remove viruses from the air we breathe through improved ventilation, filtration, and even ultraviolet disinfection. Over 100 years ago, water-borne diarrheal infections were the third leading cause of death in Canada. By cleaning the water, we consumed and washed in through treated drinking water and sewage disinfection, we now rarely hear of anyone getting sick of diarrheal infections, let alone dying. We need to make similar investments to the air we breathe so that respiratory infections, the fourth leading cause of death in Canada, can similarly be relegated to a minor cause of illness for Canadians. As an added benefit, if viruses cannot easily spread through the air, we will be protected from new respiratory virus pandemics, such as new coronaviruses or avian influenzas. The time to act is now.

Source: Public Health Sudbury & Districts - Respiratory Illness Surveillance Dashboard
Ontario Respiratory Virus Tool | Public Health Ontario

Date: January 8, 2024 & January 3, 2024

Report Highlights

1. Respiratory Infections On the Rise

The seasonal increase in respiratory infections has begun, as discussed in more detail through Words For Thought. Of note, hospitalizations for RSV have been much higher in 2024 (52 versus 24 in 2023). The reason for this is not known at this time.

2. Infection Prevention & Control HUB

The provincial government has confirmed that they will provide $465,050 of funding for each of the next 5 years for the IPAC HUB initiative, alongside an additional $465,050 of one-time funding for the 2024-25 fiscal year. This represents confirmation of 50% of this program's funding for the longer term, with the balance continuing one-time for the coming year.

The IPAC HUB works with congregate care settings in the community to proactively increase preparedness for infection prevention and avoid outbreaks. Long-term continuation of this funding is most welcome. Unfortunately, the 5-year funding announced includes no increment each year for inflation, nor population growth.

3. Provincial Mergers

In early December, the province gave approval to four proposed mergers under the Strengthening Public Health initiative, and those mergers have taken effect as of January.

We welcome our new local public health peer agencies:

- Northeastern Public Health (formerly Porcupine Health Unit & Timiskaming Health Unit)
- South East Health Unit (formerly Kingston, Frontenac and Lennox & Addington Public Health, Hastings Prince Edward Public Health, and Leeds, Grenville and Lanark District Health Unit)
- Haliburton Kawartha Northumberland Peterborough Health Unit (formerly Haliburton, Kawartha, Pine Ridge District Health Unit and Peterborough Public Health)
- Grand Erie Public Health (formerly Haldimand-Norfolk Health Unit and Brant County Health Unit)

The province at this time has made no indication of any further efforts around public health mergers.

4. Budget Changes

As a consequence of the 2025 budget and reduction of certain programming, Public Health has been actively communicating to partners (meeting with several directly) as well as to clients and affected staff. Most changes have been implemented as of January 1, including sunsetting of several staffing contracts.

General Report

5. Board of Health

Staff Appreciation Day

Several staff have extended their thanks for the Board of Health motion 64-24 Staff Appreciation Day. Thank you notes from the staff can be viewed on the BoardEffect landing page.

Association of Local Public Health Agencies (alPHa) Winter Symposium

The Association of Local Public Health Winter Symposium will be held from February 12-14, 2025. The Symposium details will be shared once available from alPHa.

Association of Local Public Health Agencies (alPHa) 2025 Conference/ Annual General Meeting

The Association of Local Public Health Agencies Annual Conference and General Meeting will be held from June 18 to 20, 2025, in person. A motion will be included on the April Board agenda concerning Board attendance and voting delegation for the alPHa Annual General Meeting. Given the conflict with the regular June 19, 2025, Board of Health meeting, a motion is included on the January Board agenda recommending the June 19, 2025, Board meeting be moved to a week earlier on June 12.

2024 Mandary Training for Emergency Response

Ten out of eleven Board of Health members completed the annual mandatory emergency response training for 2024.

Board of Health Code of Conduct

All members are required to sign an annual declaration attesting to their understanding and acknowledgement of this Code. The Code of Conduct Policy is included in the January 16, 2025, Board of Health *Event* in BoardEffect.

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.

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. Deadline to submit is Friday, February 7, 2025.

Board of Health Conflict of Interest

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 16, 2025, Board of Health *Event* in BoardEffect. The Conflict of Interest 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. Deadline to submit is Friday, February 7, 2025.

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 in order 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.

6. Human Resources

Acting Medical Officer of Health and Chief Executive Officer

Mid-Point Evaluation

The Board of Health Executive Committee met on December 23, 2024, to review the Acting Medical Officer of Health and Chief Executive Officer's mid-point evaluation results. The Board Chair subsequently held a 1:1 in person meeting with Dr. Hirji to review the feedback. The results have been sent to Human Resources for the personnel file.

Associate Medical Officer of Health

I am pleased to share that Dr. Emily Groot began as part-time Associate Medical Officer of Health on January 6, 2025. Recruitment is underway for an additional part-time 0.6 FTE AMOH.

Interim Director Corporate Services Division

I am also pleased to share that Sandra Laclé, retired Director, Health Promotion Division, has rejoined Public Health on a temporary contract, as Interim Director, Corporate Services, and began work on December 16, 2024. Sandra is covering this portfolio now that France Quirion has retired while recruitment efforts are ongoing.

7. Community & Other Presentations

I presented the 2025 Board approved budget to the City of Greater Sudbury on December 2, 2025.

I presented and participated in an agency engagement meeting with the Black Community on December 11, 2024. My presentation outlined how society's treatment of race is a social determinant of health.

I participated on an international panel discussion around translating signals of infectious disease threats into public health action. I participated on this panel alongside the Director of Epidemiology of the City of Chicago and the Senior Global Medical Expert (Real World Evidence and Partnerships, Vaccines) for Sanofi. The panel was organized and chaired by BlueDot, a Toronto company that innovates in infectious disease intelligence.

8. Local and Provincial Meetings

I participated at a PHSD Equity, diversity and inclusion learning and planning/priority setting session on December 3, 2024.

Public Health Sector Coordination Table (PHSCT) and Northern MOH meetings on December 10, 2024. I also attended the Northern MOH group teleconference on January 8. On January 14, 2025, I will attend the January PHSCT meeting.

9. Teaching & Education

For NOSM University's Public Health & Preventive Medicine residency training program, I participated as an oral examiner for the December 6, 2024, Objective Structured Clinical Exams. I also led problem-based learning program rounds on December 13, 2024, also joining in career planning discussion that same day. I attended the Residency Program Committee on January 9. I will participate in interviews for incoming resident applicants on January 23.

On December 13, 2024, I also chaired the latest meeting Assessment & Promotion Committee for the McMaster University Public Health & Preventive Medicine residency training program.

10. Financial Report

The financial statements ending November 2024, show a positive variance of $2,590,693 in the cost-shared programs. This variance is largely due to high turnover of staff. Senior Management Executive Committee identified program pressures and strategic investments in 2024, and directed some of the variance as one-time expenditures towards these pressures and investments. The 2025 budget was prepared with the assumption of an increased estimate of staff turnover as a reflection of this year, and also includes several investments in recruitment and retention to reduce the turnover for the longer term.

11. 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 and Canada Pension Plan and Employment Insurance premiums, as required by law to December 20, 2024, on December 23, 2024. The Employer Health Tax has been paid, as required by law, to December 31, 2024, with an online payment date of January 14, 2025. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to December 31, 2024, with an online payment date of January 31, 2025. There are no

outstanding issues regarding compliance with the *Occupational Health & Safety Act* or the *Employment Standards Act*. No new matter has come forward pursuant to the Ontario Human Rights Code or the Accessibility for Ontarians with *Disabilities Act*.

12. Chief Nursing Officer and Professional Practice Report

The Chief Nursing Officer (CNO) for Public Health Sudbury & Districts was officially appointed in February 2012, following Ministry of Health directives. The 2018 revision of the Ontario Public Health Standards further required Boards of Health to designate the CNO role within the Public Health Practice Domain.

The CNO position is integral to advancing professional practice role at Public Health Sudbury & Districts (PHSD). Serving as the chair of the Professional Practice Committee (PPC), the CNO leads an interdisciplinary group of staff members committed to fostering an environment that supports evidence-based professional practice and promotes excellence in public health practice across all disciplines. The PPC enhances staff competencies, develops systems to improve inter-professional collaboration, and provides a platform for staff to share updates from their respective professional colleges relevant to public health.

In the past year, the CNO actively

- Shared updates with the PPC and registered nurses on topics such as professional standards and emerging public health practices.
- Responded to requests for guidance and interpretation of standards set by professional regulatory colleges.
- Supported continuous quality improvement processes.

To further the nursing agenda, the CNO participated in several strategic committees, including the Ontario Public Health Chief Nursing Officers, The Ontario Public Health Nursing Leaders and Northern & Rural Professional Nursing Practice Network.

Following are the divisional program highlights.

Health Promotion and Vaccine Preventable Diseases Division

1. Chronic Disease Prevention and Well-Being

Healthy eating behaviours

To increase awareness of the critical link between income solutions to address food insecurity, staff collaborated with the Sudbury Food (In)Security group to host a public screening of the film *It's Basic* at the Sudbury Indie Cinema. The film presented a compelling case for income-

based interventions, such as a basic income guarantee as a means to address food insecurity and create a more just and equitable society. The screening emphasized the significant role of social determinants of health—particularly income stability—in shaping access to adequate nutrition and overall well-being. Food insecurity is closely tied to low income, housing instability, and systemic inequities, disproportionately affecting marginalized populations. By showcasing the potential of income solutions to alleviate these inequities, the event highlighted how addressing upstream factors like income can improve health outcomes, reduce chronic disease rates, and foster a more inclusive society.

The event also encouraged dialogue among attendees, fostering a deeper understanding of how structural policies can impact health and the importance of collective action to address the root causes of food insecurity.

Physical activity and sedentary behaviour

Staff continue to collaborate on securing funding to support of Active Sudbury's efforts to implement Sport for Life's *Physical Literacy for Communities* (PL4C) strategy. A new collaborative agreement has been signed to strengthen partnerships and sustain the PL4C framework, which emphasizes building intersectoral, community-based partnerships to improve physical literacy and increase physical activity. In partnership with SportLink, staff have supported the submission of a funding application to the Ontario Trillium Foundation's Grow Grant for a proposed three-year project. The initiative aims to enhance sector collaboration, build capacity for evidence-based programming, and promote inclusivity by reducing barriers for underrepresented groups, including 2SLGBTQIA+ individuals, racialized communities, and newcomers.

In partnership with the Sport for Life Society, staff advocated for and supported an application to the Government of Canada's *Canadian Sport for All Initiative 2025-2026*. This funding aims to support community sport programming and reduce barriers to participation. Sport for Life is the main applicant, focusing on advancing Physical Literacy for Communities projects like Active Sudbury. The initiative emphasizes collaboration with the local sport sector to deliver quality sport programs, projects and services relevant to the goals of the *Canadian Sport Policy.*

As members of the Rural Active Transportation Collaborative (RATC), a working group of the Ontario Society of Physical Activity Promoters in Public Health, staff contributed to a response to the Government of Ontario regarding Bill 212 – the Reducing Gridlock, Saving You Time Act, 2024. Specifically, addressing the framework for bicycle lanes requiring the removal of a traffic lane (ERO# 019-9266). The submission outlined potential public health impacts, including risks to injury prevention, safety, chronic disease prevention, health equity and sustainable transportation. Despite Bill 212 receiving Royal Assent in late November, the RATC remains committed to supporting municipalities in prioritizing physical activity and investing in natural and built environments that include new bicycle lanes.

Oral health

Staff continued to provide comprehensive dental care to clients at our Seniors Dental Care Clinic at Elm Place, including restorative, diagnostic, and preventive services. Staff also continued to provide client referrals to our contracted community providers for emergency, restorative and/or prosthodontic services, and enrollment assistance to low-income seniors eligible for the Ontario Seniors Dental Care Program.

A media release was issued on December 20, 2024, to inform the residents of Espanola that, due to ongoing technical issues at the Espanola Water Treatment Plant, fluoride concentrations in the municipal drinking water were below therapeutic levels required for optimal oral health. The media release was also emailed to local oral health professionals.

2. Healthy Growth and Development

Infant feeding

Staff provided a total of 195 clinic appointments to clients at the main office, as well as the Val Caron, Espanola, and Manitoulin locations. This service empowers parents to make informed decisions about feeding their baby. Clients learn skills that promote, protect and support breastfeeding while also receiving guidance on infant feeding options such as formula feeding. Additionally, the nurse conducts assessments to screen for potential concerns such as tongue tie, insufficient milk supply, and to ensure the infant's weight gain and growth are within expected parameters.

Growth and development

A total of 116 48-hour follow-up calls were made to parents of newborns, covering topics such as infant feeding, post-partum care, and information about community resources.

In partnership with Laurentian University and Cambrian College, staff provided instruction to nursing students on infant feeding, the benefits of breastfeeding, the Healthy Babies Healthy Children program, and Public Health services in general. These sessions aim to enhance evidence-based knowledge among nursing students preparing to enter the workforce while highlighting Public Health's role in the current health care system. In total, 135 students participated.

Health Information Line

The Health Information Line received 182 calls on topics including infant feeding, healthy pregnancies, parenting, healthy growth and development, mental health services and finding a nearby family physician.

Healthy Babies Healthy Children

Staff continued to support to over 192 client families, completing 2450 interactions. Public health dietitians also provided ongoing support to clients identified as being at high nutritional risk.

Healthy pregnancies

Eighty-seven individuals signed up for the new Informed Journey (INJOY) prenatal eClass, which covers topics such as life with a new baby, infant feeding, the importance of self care, and the impact a new baby has on relationships. This interactive platform incorporates the latest Canadian nutritional guidelines, information on labour and delivery, and promotes local programs and services that support families.

Positive Parenting

During the months of November and December, four parents registered for the online Triple P parenting program. This program is designed to increase the skill level of parents with the goal of addressing specific behaviours that their child is displaying (e.g., hitting, being defiant, trouble with bedtime routines etc.). Ultimately, this program improves the parent's confidence in raising children and creating a positive home environment for families.

3. School Health

Healthy eating behaviours

The Northern Fruit and Vegetable Program began its eleventh year of program implementation at 95 participating schools within the service area. Working in partnership with the Ontario Fruit and Vegetable Growers' Association and the Ministry of Health, the program will provide a coordinated approach to increase likeability, acceptance, and consumption of fresh fruit and vegetables among students at public elementary schools and schools within First Nation communities.

In collaboration with the Ontario Dietitians in Public Health, staff co-led a professional development session to 60 members of the Ontario Healthy Schools Coalition on the significance of a positive school food climate on students' long-term health and wellbeing. The audience, which represent Public Health professionals, School Boards administrators, and educators, were engaged in conversations on evidence-based strategies and tools for guiding schools to create supportive environments that foster students' positive relationship with food, eating, and their bodies.

The Government of Ontario recently joined the Government of Canada's National School Food Program securing $108.5 million in federal funding over three years alongside the annual provincial funding for the Ontario Student Nutrition Program and First Nations Student Nutrition Program. Public Health Sudbury & Districts continues to support a universal, fully funded school food program. The Board of Health for Public Health Sudbury & Districts has

unanimously passed motions 02-20, 61-23, and 36-24, calling for a school food policy that ensures all Ontario students have equal access to healthy food at school.

Mental Health Promotion

Staff facilitated a professional development workshop featuring the Brain Architecture Game for 500 educators and staff at a School Board. The purpose of this tabletop game-based activity is to build an understanding of the powerful role experiences play in early brain development—what promotes it, what derails it, and the consequences for society. The workshop emphasized the importance of addressing the social determinants of health such as income, education, housing, and access to nutritious food in supporting healthy childhood development. Participants explored how adverse experiences like poverty, trauma, and inadequate support systems can derail brain development, leading to challenges in learning, behavior, and overall well-being. Conversely, they learned how nurturing relationships, stable environments, and equitable access to resources serve as protective factors.

Oral Health

Staff continued to deliver the annual school-based oral health assessment and surveillance program, providing dental screenings to students in schools across the Greater Sudbury, Manitoulin, Espanola, and Sudbury East areas, including those in First Nation communities. Staff also continued to provide preventive oral health services at the Paris Street office to children enrolled in the Healthy Smiles Ontario (HSO) Program, conduct case management follow-ups for children with urgent dental care needs, and offer enrollment assistance for families interested in applying for HSO.

Staff also hosted a drop-in dental screening clinic at the Paris Street office on the school professional activity day on November 30. Of the 59 children and youth screened at the clinic, eight (14%) required a referral to a dentist for urgent care, eighteen (31%) needed preventive services, and fifteen (25%) were enrolled in HSO. A large proportion of the participating children and youth were from newcomer families.

4. Substance Use and Injury Prevention

Mental health promotion

In November, all public health staff participated in a training session on Structural Stigma, facilitated by Dr. Scott Neufeld, an expert from Brock University. Structural stigma refers to policies and practices that create and perpetuate unequal and unfair treatment for people facing inequities, resulting in disparities in access to and quality of physical and mental health care. While the session primarily focused on the impact of structural stigma on people who use drugs, staff were encouraged to reflect on and identify examples of structural stigma they have encountered, either directly or indirectly. To deepen this learning, staff were invited to participate in a reflective circle session.

Substance Use

On December 9, 2024, a drug alert was issued after fentanyl analogs were detected in the Sudbury and Manitoulin districts. This rapid response to adverse drug reactions or new substances helps protect the public and prevent further harm. The alert garnered significant attention, leading to two media interviews and over 1,400 Facebook shares.

Public Health has focused on raising awareness about substance use harms and promoting community resources. During National Addictions Awareness Week (November 24-30), three social media posts highlighted the importance of collaboration in addressing these issues.

In December, harm reduction campaigns included two Bell Media initiatives promoting the National Overdose Response Service (NORS) and naloxone use, along with three harm reduction images shared across various media outlets. These efforts encouraged individuals to access resources for safety and support.

The Community Drug Strategy (CDS) for Greater Sudbury held one Steering Committee meeting and three stream meetings in November and December, continuing its work to reduce substance-related harms.

The team also responded to two requests for stigma and substance use training referrals.

Violence

Public Health used social media to highlight key dates addressing violence against women. On November 25, 2024, a post recognized the International Day for the Elimination of Violence Against Women, and on December 6, 2024, another honored the National Day of Remembrance and Action on Violence Against Women. These efforts reflect Public Health's commitment to raising awareness and promoting dialogue on violence prevention.

Harm reduction – Naloxone

In November, a new Memorandum of Understanding (MOU) was signed with a community partner for the Ontario Naloxone Program, bringing the total number of agreements with community partners to 51. While not all partners are active, staff continue to provide naloxone distribution and training support. In November, 1,678 naloxone doses were distributed, and 76 individuals were trained.

The Sudbury East Community Drug Strategy Committee launched the "Naloxone Saves Lives" mailout campaign to raise awareness about naloxone's role in reversing opioid overdoses. Targeting approximately 2,500 households in December, the campaign addressed local challenges, such as limited transportation and healthcare access, by delivering critical information directly to residents. The revised brochure encouraged residents to carry naloxone, understand its use, and access free kits, aiming to equip the community to respond effectively to opioid poisonings and save lives.

Smoke Free Ontario Strategy

In December, the North East Tobacco Control Area Network (NE TCAN) ran a YouTube Shorts campaign aimed at educating youth aged 13 to 18 about the risks of vaping. The campaign focused on raising awareness about nicotine dependence and its impact on mental health, while encouraging meaningful engagement with NotAnExperiment.ca, a key TCAN-led vaping prevention initiative. During this time, the NE TCAN also promoted The Centre for Addiction and Mental Health's STOP on the Net program to increase regional uptake to free nicotine replacement therapy and cessation support. This effort was strategically timed to align with the winter break, a period known for a high number of quit attempts.

5. Vaccine Preventable Diseases

Publicly funded immunization programs

Staff completed the first round of the school-based immunization program, offering immunizations to all Grade 7 students in the service area. They also took the opportunity to immunize Grade 8 students who were overdue for their Grade 7 vaccines. The second round of school-based clinics is scheduled for the spring.

Education, partnerships and engagement

In November, an Advisory Alert was sent to health service partners notifying them of changes to services following the 2025 budget approval. These changes include offering only publicly funded vaccines and providing services exclusively to those facing barriers to accessing vaccines in the community, such as individuals without a primary care provider or a health card.

As part of an on-going effort to encourage parents to report their children's immunizations to Public Health, promotional materials were created and distributed to school boards, schools, and daycares (e.g., rack cards, magnets). Promotion in the community was also rolled out, including billboards and bus ads.

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

In preparation for the upcoming ISPA campaign, scheduled to start in January 2025, activities were carried out to encourage parents to have their children vaccinated and report immunizations to Public Health. A letter was sent to all parents via School Boards, encouraging them to update their children's vaccine records with Public Health prior to the ISPA assessment period. This letter generated many calls, allowing staff to update records and immunize children ahead of the ISPA assessment. Additionally, students with no records on file were identified, and calls were made to as many parents as possible before the ISPA assessment period.

Health Protection

1. Control of Infectious Diseases (CID)

In the months of November and December, staff investigated 107 sporadic reports of communicable diseases. During this timeframe, 32 respiratory outbreaks were declared. The causative organisms for the respiratory outbreaks were identified to be: SARS-CoV-2/COVID-19 (28), human coronavirus (1), rhinovirus (1) and RSV (1). The remaining outbreak was of unknown cause.

Hospitalizations attributed to respiratory syncytial virus (RSV) began earlier this season, with numbers beginning to rise in October, in comparison with December of 2023. The total number of RSV hospitalizations from November 3-December 14 were higher compared to the same period in 2023, while hospitalizations attributed to COVID-19 were much lower than in 2023 (Table 1). An Advisory Alert was issued on December 12, 2024, notifying local clinicians of the increase in the number of respiratory illness hospitalizations, and reinforcing the importance of symptom assessment, treatment, and immunization.

Table 1: RSV and COVID-19 hospitalizations from November 3-December 14 for 2023 and 2024

Activity	2024	2023
RSV hospitalizations	52	24
COVID-19 hospitalizations	77	339

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

During the months of November and December, nine infection control complaints were received and investigated, and six requests for service were addressed.

Infection Prevention and Control Hub

After several years of only one-time provincial funding for this program, multi-year provincial funding has been received for half the Infection Prevention and Control (IPAC) Hub budget, ensuring this program will continue in the future. An intention to make the entire budget funded has been orally communicated. Unfortunately, the multi-year funding does not include any provision for inflation or population growth, meaning the full costs have not been funded by the provincial government at this time.

The IPAC Hub provided 79 services and supports to congregate living settings in November and December. These included proactive IPAC assessments, education sessions, feedback on facility policies, and working with facility staff to respond to cases and outbreaks of acute respiratory infection (ARI) and COVID-19, to ensure that effective measures were in place to prevent further transmission.

2. Food Safety

Staff issued 60 special event food service and non-exempt farmers' market permits to various individuals and organizations.

Four Food Handler Training and Certification Program sessions were offered in November and December, and 70 individuals were certified as food handlers. December 3, 2024, was the last in-person Food Handler Training and Certification program that will be offered to members of the public as this service has been eliminated as part of the 2025 budget.

3. Health Hazard

In November and December, 51 health hazard complaints were received and investigated. Four of these complaints involved marginalized populations.

4. Ontario Building Code

In November and December 36 sewage system permits, 14 renovation applications, and six consent applications were received.

5. Rabies Prevention and Control

In November and December, 55 rabies-related investigations were conducted. One specimen was submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis, and was subsequently reported as negative.

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

6. Safe Water

During November and December, 67 residents were contacted regarding adverse private drinking water samples. Additionally, public health inspectors investigated 16 regulated adverse water sample results.

Two boil water orders and one drinking water order were issued in the months of November and December. Additionally, two boil water orders and one drinking water order were rescinded following corrective actions.

7. Smoke Free Ontario Act, 2017 Enforcement

In November and December, *Smoke Free Ontario Act* Inspectors charged three individuals for smoking/vaping on school property, and one employer for failure to meet their obligations under the Act.

8. Vector Borne Diseases

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

9. Emergency Preparedness & Response

In November and December, staff participated in two municipal emergency management committee meetings (City of Greater Sudbury, Town of Espanola). Staff also participated in two tabletop emergency exercises (Municipality of Central Manitoulin, City of Greater Sudbury/Vale Hazardous Material Release Exercise).

10. Needle/Syringe Program

In October and November harm reduction supplies were distributed, and services received through 3 285 client visits across our service area. Public Health Sudbury & Districts and community partners distributed a total of 41 768 syringes for injection, and 99 690 foils, 22 690 straight stems, and 6 479 bowl pipes for inhalation through both our fixed site at Elm Place and outreach harm reduction programs.

In October, approximately 45 937 used syringes were returned, which represents a 91% return rate of the needles/syringes distributed in the month of September.

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

Sexual health clinic

In November and December, there were 183 drop-in visits to the Elm Place site related to sexually transmitted infections, blood-borne infections and/or pregnancy counselling. As well, the Elm Place site completed a total of 618 telephone assessments related to STIs, blood-borne

infections, and/or pregnancy counselling in November and December, resulting in 367 onsite visits.

Growing Family Health Clinic

In November and December, the Growing Family Health Clinic provided services to a total of 149 patients.

Knowledge and Strategic Services

1. Health Equity

In December, an Equity, Diversity, Inclusion and Accessibility (EDIA) learning and priority setting session was held with various staff across the organization, including members of the senior management team, the Health Equity Steering Committee, and the Equity, Diversity and Inclusion Committee. This session was facilitated by an expert in this topic and helped increase learning while giving space to set organizational approaches and priorities for this important work in 2025.

On December 9 and 12, staff from the Health Equity team hosted two engagement sessions with members of the Black community (including 1 French session). Goals included sharing information about race and health, validating findings of previous consultations held in November 2022 and June 2023, hearing additional feedback, and discussing ideas for multi-sectoral collaboration. Fifteen attendees shared valuable insights that will help guide our agency's efforts in racial equity into 2025.

2. Indigenous Engagement

In November, the Indigenous Engagement team launched the Indigenous Data Sovereignty Project, which aims to help inform how we collect and use Indigenous Data. This project aligns with other agency initiatives including the development of an agency Information Governance Framework.

The team also worked to support embedding considerations for Indigenous Engagement into program planning for 2025 and beyond.

Additionally, the team hosted a learning session about the First Nations Mental Wellness Continuum Framework, facilitated by the Indigenous Engagement Health Promoter, with 55 staff attending over two sessions. This professional development opportunity focused on incorporating a First Nation-made, nationally endorsed mental wellness tool into public health work. The session was an opportunity for individualized problem solving and overcoming potential barriers to teams implementing the Indigenous Engagement Strategy.

The team also supported the creation of a Frequently Asked Questions (FAQ) sheet for the Unlearning Project with key details about the voluntary Unlearning Club, which will launch in March 2025.

The team also supported the Board's effort to promote the selection of Indigenous municipal and provincial appointees to the Board of Health by preparing letters that were sent to the Minister of Health, the Mayors of each municipality, local First Nations Chiefs and Health Directors, and Indigenous Health Organizations.

3. Population Health Assessment and Surveillance

In November and December, the Population Health Assessment and Surveillance team responded to 45 requests, including routine surveillance and reporting, media requests, and other internal and external requests for data, information, and consultation. This included 9 project related requests (e.g., dashboard development, database, report development, and process improvement projects). The team continues to support agency data needs by preparing regular internal reports and dashboards, such as reports on Control of Infectious Diseases and vaccination data.

A current state assessment on information and data governance at Public Health was recently completed, informed by a series of key informant interviews and group engagement sessions. This also included the development of an agency-wide data/information inventory and repository of information governance guidance documents. The current state assessment will be used to inform and recommend next steps to advance the development of an Information Governance Framework for the agency.

4. Effective Public Health Practice

Agency-wide 2025 program plans continue to be reviewed and finalized through January. Upon completion, content will be collated into the agency’s Annual Service Plan and Budget Submission to the Ministry of Health in late February.

In June 2023, the agency adopted Public Health Ontario’s expanded ethical framework, creating significant updates and changes to the agency’s Research Ethics Review Committee’s (RERC) policies and procedures in order to mitigate potential risks associated with evidence-generating projects. To further advance these processes, two ethical decision-making guides were developed to support staff in determining whether a project requires review by the agency’s Research Ethics Review Committee (RERC).

Phase one of the development of the Artificial Intelligence (AI) Strategy for Public Health was completed in December. A current state assessment was drafted, informed by a documentation review, staff engagement sessions, and a staff survey assessing skills and capabilities. Next

steps include the prioritization of an inventory of AI solutions based on the needs, assets, capabilities, and readiness of the agency. This next phase is expected to be completed in January.

In December, the agency finalized the Infectious Disease Incident Management System (IMS) Response Guide, an internal tool for responding to large-scale, community-wide, infectious disease emergencies. The Response Guide provides assurance that key activities for each IMS function are launched smoothly in a timely manner, supporting an effective and quality emergency response. It complements Public Health's Emergency Response Manual and Business Continuity Plan, and incorporates learnings gleaned from internal and external community partner COVID-19 response debrief sessions held in 2022.

5. Staff Development

By the end of December, various training initiatives were successfully delivered to a number of staff around the agency. This training included all-staff training on 'Structural Stigma' (November 25 and 26) and management leadership development training (December 6). In addition, a small number of staff were registered for OCAP® training with the First Nations Information Governance Centre, augmenting knowledge on the First Nation principles of ownership, control, access, and possession (OCAP®) of Indigenous data.

6. Student Placement

The Student Placement Program successfully offboarded 8 students by the end of December. January saw learners begin their placements in Human Resources, Master of Public Health, and nursing. On January 21, the agency will host two NOSM U students participating in a 'Foundations of Interprofessional Team Based Care in the North' (FIT) observational experience.

7. Communications

The Communications team continues to collaborate with programs to develop timely messaging for a variety of topics, such as influenza and COVID-19 vaccination and various awareness campaigns, including National Addiction Awareness Week, the National Day of Remembrance and Action on Violence Against Women, and the International Day of Persons with Disabilities. The agency also released information about the 2025 budget and the appointment of Dr. Emily Groot, Acting Associate Medical Officer of Health. News releases also provided the community with updates about boil water and drinking water advisories, drug alerts, and water fluoridation disruptions. Spokespeople were supported to respond to information and interview requests related to, for example, the 2025 budget, respiratory illness hospitalizations, protective measures during the respiratory illness season, and rodents.

8. Accountability Monitoring Plan

Data collection for the 2024–2028 Accountability Monitoring Plan Strategic Priority Performance Measures is beginning in early January, with a view to present the annual 2024 Accountability Plan Report to the Board of Health at its February 2025 meeting.

Respectfully submitted,

Original signed by

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, 2024

Cost Shared Programs

	Adjusted BOH Approved Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over)/under	Balance Available
Revenue:					
MOH - General Program	18,538,348	16,993,486	16,993,529	(43)	1,544,819
MOH - Unorganized Territory	826,000	757,167	757,172	(5)	68,828
Municipal Levies	10,548,731	9,669,670	9,669,697	(27)	879,034
Interest Earned	160,000	146,667	430,892	(284,225)	(270,892)
Total Revenues:	$30,073,079	$27,566,989	$27,851,290	$(284,301)	$2,221,789
Expenditures:					
Corporate Services:					
Corporate Services	5,662,649	5,208,908	5,049,284	159,624	613,365
Office Admin.	111,350	102,071	64,701	37,370	46,649
Espanola	126,473	116,430	108,722	7,708	17,751
Manitoulin	137,892	126,959	114,868	12,091	23,024
Chapleau	139,699	128,578	105,709	22,869	33,990
Sudbury East	19,270	17,664	18,009	(345)	1,261
Intake	354,886	327,586	284,718	42,868	70,167
Facilities Management	684,866	627,794	618,266	9,528	66,600
Volunteer Resources	3,850	3,529	0	3,529	3,850
Total Corporate Services:	$7,240,935	$6,659,519	$6,364,277	$295,242	$876,658
Health Protection:					
Environmental Health - General	1,355,382	1,251,507	1,177,004	74,503	178,378
Enviromental	2,934,156	2,710,831	2,422,073	288,759	512,083
Vector Borne Disease (VBD)	93,347	89,486	66,114	23,371	27,233
Small Drinking Water Systems	209,356	193,252	160,256	32,996	49,101
CID	1,075,284	974,729	943,415	31,314	131,869
Districts - Clinical	224,061	206,819	206,312	507	17,749
Risk Reduction	53,756	50,068	23,103	26,965	30,653
Sexual Health	1,416,735	1,307,176	1,333,608	(26,432)	83,127
SFO: E-Cigarettes, Protection and Enforcement	278,625	253,913	160,712	93,201	117,913
Total Health Protection:	$7,640,702	$7,037,780	$6,492,598	$545,182	$1,148,104
Health Promotion and Vaccine Preventable Diseases:					
Health Promotion - General	1,573,805	1,452,731	1,386,622	66,108	187,182
School Health and Behavior Change	992,613	930,612	861,408	69,203	131,205
Districts - Espanola / Manitoulin	369,527	340,508	335,074	5,434	34,453
Nutrition & Physical Activity	1,735,325	1,603,967	1,464,299	139,668	271,026
Districts - Chapleau / Sudbury East	419,200	386,912	366,210	20,702	52,990
Tobacco, Vaping, Cannabis & Alcohol	683,597	637,179	272,363	364,816	411,234
Family Health	1,357,541	1,252,799	1,001,439	251,359	356,102
Mental Health and Addictions	750,336	692,411	775,933	(83,523)	(25,597)
Dental	501,055	462,084	447,600	14,484	53,454
Healthy Smiles Ontario	665,118	614,547	562,988	51,560	102,130
Vision Health	11,670	11,670	4,428	7,242	7,242
SFO: TCAN Coordination and Prevention	485,266	447,196	323,174	124,022	162,092
Harm Reduction Program Enhancement	173,699	160,300	159,274	1,025	14,425
COVID Vaccines	232,400	214,523	97,009	117,514	135,391
VPD and COVID CCM	1,386,516	1,275,325	1,194,887	80,438	191,629
MOHLTC - Influenza	(0)	309	(5,867)	6,176	5,867
MOHLTC - Meningittis	(0)	83	(12,946)	13,029	12,945
MOHLTC - HPV	(0)	121	(16,286)	16,407	16,286
Total Health Promotion:	$11,337,668	$10,483,277	$9,217,612	$1,265,666	$2,120,057
Knowledge and Strategic Services:					
Knowledge and Strategic Services	3,301,486	3,042,742	2,906,788	135,954	394,698
Workplace Capacity Development	23,507	11,753	14,593	(2,840)	8,914
Health Equity Office	14,940	13,632	28,629	(14,997)	(13,689)
Nursing Initiatives: CNO, ICPHN, SDoH PHN	503,611	464,871	385,942	78,930	117,669
Strategic Engagement	10,230	7,032	3,777	3,255	6,453
Total Knowledge and Strategic Services:	$3,853,774	$3,540,030	$3,339,729	$200,302	$514,045
Total Expenditures:	$30,073,079	$27,720,606	$25,414,215	$2,306,392	$4,658,865
Net Surplus/(Deficit)	$(0)	$(153,617)	$2,437,075	$2,590,693	

Public Health Sudbury & Districts

Cost Shared Programs
STATEMENT OF REVENUE & EXPENDITURES
Summary By Expenditure Category
For The 11 Periods Ending November 30, 2024

		Adjusted BOH Approved Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:						
	MOH Funding	30,073,079	27,566,989	27,992,332	(425,343)	2,080,747
	Other Revenue/Transfers	706,252	647,398	604,592	42,806	101,660
	Total Revenues & Expenditure Recoveries:	30,779,331	28,214,387	28,596,924	(382,537)	2,182,407
Expenditures:						
	Salaries	19,295,938	17,790,896	17,050,476	740,420	2,245,462
	Benefits	6,691,083	6,176,331	5,550,671	625,661	1,140,412
	Travel	269,257	249,479	191,727	57,751	77,530
	Program Expenses	818,855	751,119	419,596	331,523	399,259
	Office Supplies	75,150	68,951	31,187	37,764	43,963
	Postage & Courier Services	90,100	82,592	57,788	24,803	32,312
	Photocopy Expenses	5,030	4,611	2,565	2,045	2,464
	Telephone Expenses	70,050	64,213	62,266	1,947	7,784
	Building Maintenance	476,961	437,214	429,153	8,062	47,808
	Utilities	236,920	217,177	135,165	82,012	101,755
	Rent	328,254	300,900	297,504	3,396	30,751
	Insurance	208,850	208,433	200,694	7,739	8,156
	Employee Assistance Program (EAP)	37,000	33,917	33,440	477	3,560
	Memberships	42,389	39,277	45,886	(6,609)	(3,497)
	Staff Development	127,701	107,733	95,247	12,486	32,454
	Books & Subscriptions	7,445	6,839	4,937	1,902	2,508
	Media & Advertising	133,828	117,532	32,608	84,924	101,220
	Professional Fees	440,684	407,294	421,791	(14,497)	18,893
	Translation	61,152	56,008	110,682	(54,674)	(49,530)
	Furniture & Equipment	22,120	20,034	77,471	(57,437)	(55,350)
	Information Technology	1,340,564	1,227,457	908,997	318,460	431,567
	Total Expenditures	30,779,331	28,368,004	26,159,849	2,208,155	4,619,482
	Net Surplus (Deficit)	0	(153,617)	2,437,075	2,590,693	

	C-S Programs	
Gapped Salaries & Benefits	1,366,081	52.73%
Gapped Operating and Other Reve	1,224,612	47.27%
Total gapped funding at November	**2,590,693**	

Sudbury & District Health Unit o/a Public Health Sudbury & Districts
SUMMARY OF REVENUE & EXPENDITURES
For the Period Ended November 31, 2024

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
100% Funded Programs							
Indigenous Communities	703	90,400	100,350	(9,950)	111.0%	*Dec 31*	91.7%
LHIN - Falls Prevention Project & LHIN Screen	736	100,000	47,579	52,421	47.6%	*Mar 31/2025*	66.7%
Northern Fruit and Vegetable Program	743	176,100	158,777	17,323	90.2%	*Dec 31*	91.7%
Healthy Babies Healthy Children	778	1,725,944	932,475	793,469	54.0%	*Mar 31/2025*	66.7%
IPAC Congregate CCM	780	930,100	513,076	417,024	55.2%	*Mar 31/2025*	66.7%
Ontario Senior Dental Care Program	786	1,315,000	947,047	367,953	72.0%	*Dec 31*	91.7%
Anonymous Testing	788	64,293	42,864	21,429	66.7%	*Mar 31/2025*	66.7%
Total		4,401,837	2,742,168	1,659,669			

Peterborough Public Health

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December 24, 2024

The Honourable Jenna Sudds
Minister of Families, Children and Social Development
Government of Canada
edsc.min.feds-fcsd.min.esdc@hrsdc-rhdcc.gc.ca

The Honourable Mark Holland
Minister of Health
Government of Canada
hcminister.ministresc@hc-sc.gc.ca

Dear Honourable Ministers:

Re: Federal Strategy to Address Severity and Prevalence of Household Food Insecurity

At its December 11, 2024 meeting, the Board of Health for Peterborough Public Health received a presentation and report on the concerning impacts of household food insecurity on mental and physical health of community members, including families with children.

Household food insecurity refers to inadequate or insecure access to food due to financial constraints.[1] In Peterborough County and City, nearly 1 in 5 households faced food insecurity between 2021-2023.[2] Across the ten provinces between 2021-2023, there has been an increase in both prevalence and severity of food insecurity.[3] The rate of severe food insecurity has almost doubled, meaning that a growing number of Canadians are reducing their food intake, skipping meals, and even going for days without eating, because they don't have enough money for food.[3, 4] For every four children facing food insecurity in 2023, three of them lived in moderate or severely food insecure households, forced to make compromises in quality/quantity of food, or miss meals due to not enough money for food.[3, 4] This trend of increasing severity is alarming, due to the association between higher severity of food insecurity and more serious health consequences, such as early mortality.[5] Food insecurity can also have negative, long-lasting impacts on child health and well-being.[5]

Household food insecurity is an income problem that requires income solutions.[6] While there are several policies that support incomes of Canadians, there is evidence that these policies could be more effectively designed to reduce household food insecurity. For example, evidence demonstrates that when the Canada Child Benefit (CCB) was introduced in 2016, it lowered the severity of food insecurity especially for households with the lowest incomes.[7] However, research also indicates that the Canada Child Benefit could be designed to address household food insecurity more effectively.[8] Below are examples of specific recommendations from networks and researchers across Canada:

- **Increase CCB for lowest income families:**
  Increasing the child benefit for the lowest income families could help to address food insecurity prevalence and severity. Organizations and networks such as Campaign 2000, Children First Canada, PROOF Food Insecurity Policy Research, and Ontario Dietitians in Public Health have recommended supplements to the CCB, and/or increasing CCB, to protect children from poverty and improve child health:
    - Campaign 2000 and PROOF recommended introduction of a CCB end of poverty supplement to significantly decrease child poverty and improve children's health, in a Submission to the Standing Committee on Health (HESA) on Children's Health.[9]
    - The Ontario Dietitians in Public Health recommended the following in the 2023 federal pre-budget consultation: "That the government increase the Canada Child Benefit (CCB) amount for low-income families." [10]
    - Campaign 2000 and the 2024 Raising Canada report recommend development of a non-taxable Canada Child Benefit End of Poverty Supplement (CCB-EndPov) for families experiencing deep poverty, which would provide an additional $8,500 per year to a family with an earned income of less than $19,000 for the first child, and scaled reductions for additional children."[11, 12]

- **Remove the reduction in CCB for children ages 6-18:**
  Research conducted by PROOF Food Insecurity Policy Research at the University of Toronto indicated that matching CCB amounts provided for children under 6, with those for children 6 and over for families with the greatest risk of food insecurity, would create a reduction in the probability of food insecurity for these families.[8]
    - The Ontario Dietitians in Public Health recommended the following in their 2023 federal pre-budget consultation submission: "That the government equal CCB amounts for families with children over 6 years old so that they are not receiving less when their children turn 6."[13]

The example of the Canada Child Benefit demonstrates the importance of designing income policies to address household food insecurity, for maximum impact. A federal food insecurity strategy could allow for income policies to be intentionally designed for this purpose. It is important to note that costs for goods and services have had large increases in 2022 and 2023,[14] when some of the above recommendations were developed. An effective food insecurity strategy should ensure that sufficient income is provided to cover basic needs, in the midst of inflation.

Food insecurity and income strategies should also address Indigenous Food Sovereignty. Indigenous health inequities are connected with complex historical and ongoing acts of colonization, and restricted access to traditional lands, water, and food sources. Indigenous Peoples strengths, resilience, and wisdom should be supported through allyship towards Indigenous self-determination, Food Sovereignty, and positive community-led changes.

Thank you for your attention and for exploring how income policies may be intentionally designed to address household food insecurity, and support the health and well-being of children, families, and communities.

Sincerely,

Original signed by

Councillor Joy Lachica
Chair, Board of Health

cc: Local MPs
Chief Keith Knott, Curve Lake First Nation
Chief Laurie Carr, Hiawatha First Nation
Association of Local Public Health Agencies
Ontario Boards of Health

References

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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 82-24

TO: Chair and Members of the Board of Health

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

DATE: 2024 December 12

MONITORING FOOD AFFORDABILITY AND IMPLICATIONS FOR PUBLIC POLICY AND ACTION (2024)

Recommendation

It is recommended that the Board of Health:

1) *Receive Report No. 82-24 re: "Monitoring Food Affordability and Implications for Public Policy and Action 2024" for information; and*
2) *Direct staff to forward Report No. 82-24 re: "Monitoring Food Affordability and Implications for Public Policy and Action 2024" to Ontario boards of health, the City of London, Middlesex County, and appropriate community agencies*.

Report Highlights

- In 2023, 1 in 4 households in Middlesex-London were food insecure. This is a statistically significant increase from 2022.
- Local food affordability monitoring is a requirement of the Ontario Public Health Standards.
- The 2024 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]. 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[2-9] (Appendix A). 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)[10].

As a result of systemic and structural inequities, racism, and colonization, food insecurity disproportionately affects certain populations[1,11,12]. 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) develops, tests, and updates 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

In 2023, 1 in 4 households in Middlesex-London were food insecure (25.1%, CI 21.8-28.4%)[13] (Appendix B). The rate was higher than in Ontario and the Peer Group comparator (i.e., mainly urban centres with moderate population density); however, this was not a statistically significant difference. The 2023 rate represents a statistically significant increase from 2022; and the highest rate reported in Middlesex-London since the Canadian Income Survey started measuring food insecurity in 2019. In 2022, 1 in 6 households in Middlesex-London were food insecure (17.5%, CI 14.1-20.9%)[13]. Local food insecurity rates are not yet available for 2024.

Nearly 44,000 more Middlesex-London residents lived in food insecure households in 2023 as compared to 2022[13,14]. An estimated 151,477 residents lived in food insecure households in Middlesex-London in 2023, as compared to 107,835 residents in 2022[13,14].

Local Food Affordability

Local food and average rental costs from May 2024 are compared to a variety of household and income scenarios, including households receiving social assistance, minimum wage earners, and median incomes (Appendix C, Appendix D). 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.

A key indicator for 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.

Comparing the monthly funds remaining after rent and food costs in 2024 to 2023 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.

Scenario	Monthly Funds Remaining After Rent and Food Costs		Income-Based Policy
	2023	2024	
Single Person ODSP	-$186	-$172	As of July 2023, ODSP rate increases are indexed to Ontario's Consumer Price Index.
Single Person OW	-$420	-$522	OW rate increases are not indexed to inflation.
Family of 4 Minimum Wage	$1,351	$1,579	As of 2015, under the Employment Standards Act, minimum wage rates are set and adjusted annually based on changes to Ontario's Consumer Price Index in the previous year.
Family of 4 Refugee Claimants Minimum Wage	N/A	$310	Refugee claimants are not eligible for the Canada Child Benefit. A refugee claimant is a person who left their country and is asking for protection in another country because it is unsafe to return to their home country.

ODSP = Ontario Disability Support Program
OW = Ontario Works

Monitoring food affordability data and methodology details, including cost adjustments required to compare the 2023 and 2024 scenarios, are included in Appendix C.

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.

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 2024 living wage was $19.50 per hour[15], an increase from $18.85 in 2023 and as compared to the Ontario minimum wage of $17.20. Local food costs, as estimated utilizing 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 2024.

Over the past year, the Board of Health:
- Sent a letter to the federal government in support of S-233 and C-223 "An Act to develop a national framework for a guaranteed livable basic income" (Report No. 49-24). The Board's letter was endorsed by Haliburton, Kawartha, Pine Ridge District Health Unit and Peterborough Public Health.
- Sent a letter to the provincial government to advocate for increased social assistance rates in regards to the affordability of food (Report No. 25-23 Minutes).

The Association of Local Public Health Agencies (alPHa) endorsed ODPH-sponsored resolutions that included advocacy to the Province of Ontario to:
- Support income-related policies to reduce food insecurity, especially for households with children (A24-05)
- Utilize food affordability monitoring results from public health units in determining the adequacy of social assistance rates to reflect the current costs of living and to index Ontario Works rates to inflation (A23-05)

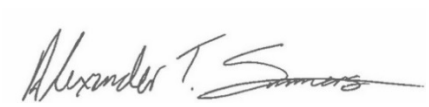
- Legislate targets for reduction of food insecurity as part of Ontario's plan for poverty reduction (A23-05)

Next Steps
Health Unit staff are exploring the development of a municipal primer on food insecurity as an important public health and local issue and actions municipalities can take to address it.

The ODPH Food Insecurity Workgroup and PHO are collaborating on a provincial food affordability report planned for release February 2025. The report will include various household and income scenarios utilizing data submitted by Ontario public health units, health outcomes of food insecurity, and discussion of income-based solutions.

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

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



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

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

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

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

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

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

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

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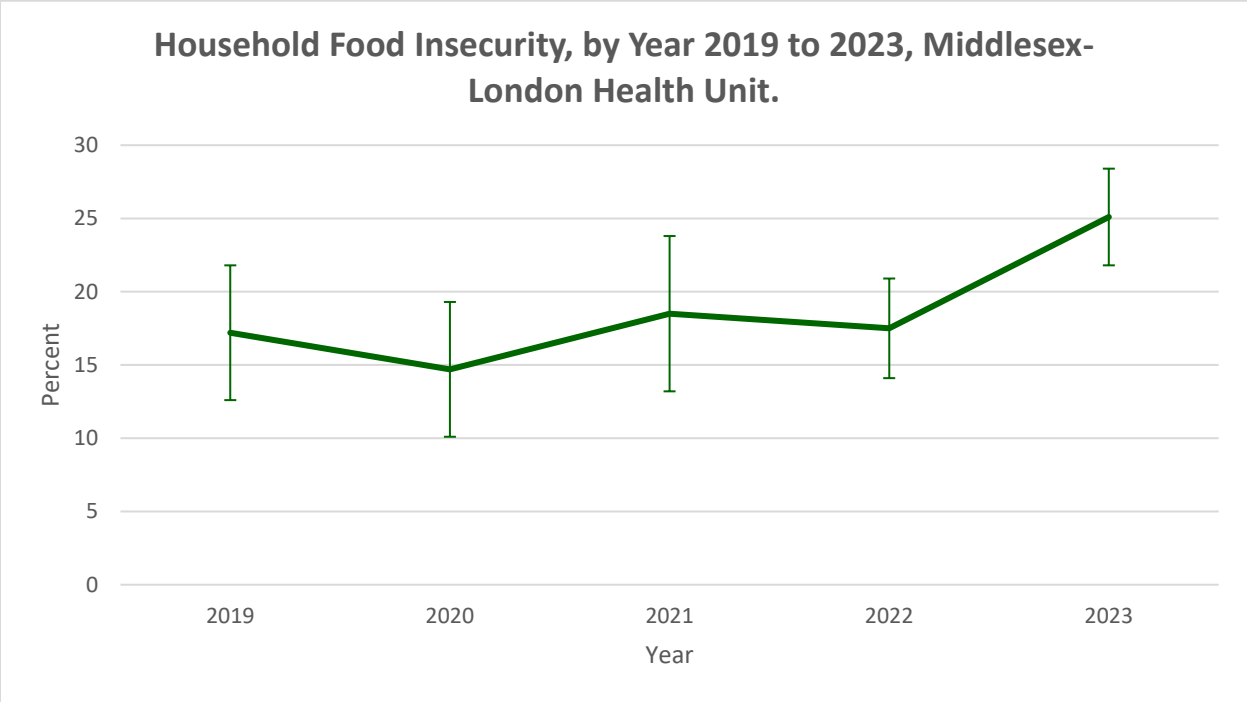

Indicator	Year	Geography	Per cent (%)	95% Confidence Interval (Lower)	95% Confidence Interval (Upper)	Margin of Error
Food insecure (household level)	2019	Middlesex-London Health Unit	17.2	12.5	21.8	4.6
Food insecure (household level)	2020	Middlesex-London Health Unit	14.7	10.1	19.3	4.6
Food insecure (household level)	2021	Middlesex-London Health Unit	18.5	13.2	23.7	5.3
Food insecure (household level)	2022	Middlesex-London Health Unit	17.5	14.1	20.9	3.4
Food insecure (household level)	2023	Middlesex-London Health Unit	25.1	21.8	28.4	3.3

Reference: Ontario Agency for Health Protection and Promotion (Public Health Ontario). 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.

Middlesex-London Income and Cost of Living Scenarios for 2024

Income Source	Monthly Income[1]	Monthly Rent[2] / % Income		Monthly Food[3] / % Income		What's Left?[4] 2024	What's Left?[4,5] 2023
Single Person Ontario Works	$881	$988	112%	$415	47%	**-$522**	**-$420**
Single Person Ontario Disability Support Program	$1,465	$1,222	83%	$415	28%	**-$172**	**-$186**
Single Pregnant Person Ontario Disability Support Program	$1,505	$1,222	81%	$440	29%	**-$157**	**-$170**
Single Person Old Age Security/Guaranteed Income Security	$2,069	$1,222	59%	$296	14%	**$551**	**$553**
Single Parent with 2 Children Ontario Works	$2,670	$1,523	57%	$890	33%	**$257**	**$309**
Family of 4 Ontario Works	$2,908	$1,734	60%	$1,194	41%	**-$20**	**-$15**
Family of 4 Minimum Wage Earner (full-time)	$4,507	$1,734	38%	$1,194	26%	**$1,579**	**$1,351**
Family of 4 Median Income (after tax)	$9,685	$1,734	18%	$1,194	12%	**$6,757**	**$6,475**
Family of 4 Refugee Claimants Minimum Wage Earner (full-time)	$3,238	$1,734	54%	$1,194	37%	**$310**	**N/A**

The household scenarios spreadsheet is prepared annually by Ontario Dietitians in Public Health (ODPH) to support Ontario public health units to monitor local and provincial food affordability.

What's Left?[4]

People still need additional funds for childcare, utilities, Internet, phone, tenant insurance, transportation, household operations and supplies, personal care items, clothing, school supplies, gifts, recreation and leisure, out of pocket medical and dental costs, education, savings, and other costs.

Income [1]

WoodGreen Community Services calculated the incomes for each scenario.

Income estimates for each scenario include all family and tax benefit entitlements available to Ontario residents (e.g., Climate Action Incentive Payment, Ontario Trillium Benefit, Canada Child Benefit, GST/HST credit, Canada Worker Benefit). Individual incomes may be lower if individuals do not file their income tax and/or do not apply for all available credits and benefits.

The main income for each scenario was estimated for May/June 2024. The exception is median income obtained from Statistics Canada, as the most recent data are from 2022. Combined Ontario median income for couples with children was utilized, with deductions made for income tax, Employment Insurance, and Canada Pension Plan.

Rent [2]

Average apartment rental costs are estimates based on the Canadian Mortgage and Housing Corporation (CMHC) Ontario Rental Market Report. CMHC provides a consistent data source with a known methodology. CMHC does not publish a statistic if its reliability is too low or if publication would violate confidentiality rules. However, CMHC's data likely underestimate local rental costs, and as a result the amount of funds remaining for each scenario would likely be lower and the percentage attributable to rent would be higher.

The Rental Market Survey is conducted in urban areas with populations of 10,000 or more. The survey includes both new and existing units in privately initiated structures with at least 3 rental units. The cost for a new tenant would likely be higher, as current tenants are protected from large annual increases by Ontario's residential rent increase guideline.

Utility costs (e.g., heat, electricity, hot water) may or may not be included in the rental amounts.

CMHC cost estimates were for October 2023. Cost estimates were adjusted for inflation using the Consumer Price Index (CPI) for shelter in Ontario for the estimated increase from October 2023 to May 2024.

Accommodation size for most scenarios was selected based on suitability as defined by the National Occupancy Standard (NOS). The standard includes various criteria, including a maximum of 2 people per bedroom. Most scenarios utilize 1, 2, or 3-bedroom apartments, depending on the household size and composition. Exceptions were made for 2 scenarios where the suitable accommodation size may not be realistic due to what is available or affordable. The scenario with a single person receiving Ontario Works is costed with a bachelor apartment. The scenario with a single parent with 2 children receiving Ontario Works was costed with a 2-bedroom apartment.

Food[3]

Food costs are calculated using the Ontario Nutritious Food Basket (ONFB), which is based on the National Nutritious Food Basket (NNFB). The ONFB survey tool is revised annually by ODPH, in collaboration with Public Health Ontario (PHO). The ONFB measures the cost of basic eating that represents current nutrition recommendations and average food purchasing patterns.

The NNFB is based on Canada's Food Guide, national food intake data, and Dietary Reference Intakes (DRIs). The NNFB and Canada's Food Guide are not inclusive for all religious and cultural groups. The ONFB does not reflect sourcing of traditional Indigenous foods. These are significant limitations of this data collection and may limit the generalizability and relevance of the food costs to different population groups.

London Food Bank volunteers and a Western University Dietetic Practicum Student completed the food costing, with training and support provided by a Health Unit Registered Dietitian. Costing was conducted May 19 to June 1, 2024, at 10 full-service grocery stores in Middlesex County and the City of London, both online and in person, including premium and discount stores. Average costs were calculated for 61

food items. If preferred food items were unavailable, similar items (i.e., proxy items) were used with minor differences between nutrition and/or price.

An adjustment factor was applied to the food costs depending on the household size in the scenario to account for the additional costs per person to feed a small group and the lower costs per person to feed a larger group.

Comparing 2024 to Previous Year's Scenarios[5]

Adjustments to the food and rent costs for the 2023 and 2022 scenarios are required before comparison to the 2024 scenarios. Comparing 2024 food costs to years prior to 2022 is not appropriate due to methodology changes (e.g., introduction of online costing; revisions to the NNFB to be consistent with 2019 Canada's Food Guide, updated national food intake data, and updated DRIs).

Local food costing was not completed in 2020 or 2021 due to the COVID-19 pandemic.

Food Adjustments
In 2024, Health Canada adjusted the NNFB spreadsheet due to revisions to Dietary Reference Intakes for Energy for groups where the Estimated Energy Requirement (EER) increased by more than 100 kcal/day (i.e., Males 14-18 years old, Females 14-18 years old, Pregnant <19 years old y, Pregnant 19-30 years old, Pregnant 31-50 years old, Breastfeeding <19 years old, and Breastfeeding 19-30 years old).

The 2024 Monitoring Food Affordability in Ontario Master Spreadsheet was updated to reflect the increased EER for these groups. Weekly cost of ONFB in 2024 for these groups increased significantly compared to 2023 and 2022 due to the increased EER.

Rent Adjustments
In 2024, a CPI adjustment to rent costs was made to more accurately reflect actual local rental costs. This adjustment was not made in previous years. CMHC cost estimates were for October 2023. Cost estimates were adjusted for inflation using the CPI for shelter in Ontario for the increase from October 2023 to May 2024.

Data Sources

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FOOD INSECURITY
MIDDLESEX-LONDON 2024

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]

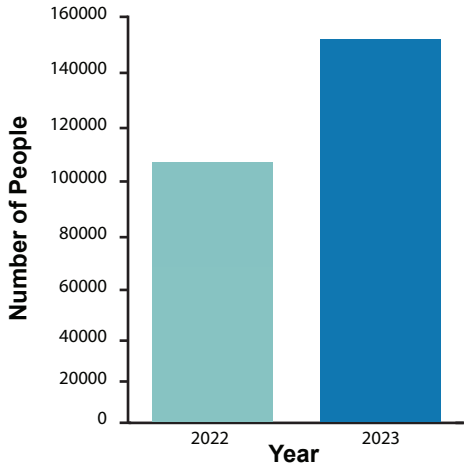
2023

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

2022

1 in 6 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]	Minimun Wage [c]	Median Income [d]
Food (% of Monthly Income Needed)	112%	83%	60%	38%	18%
Rent (% of Monthly Income Needed)	47%	28%	41%	26%	12%
What's Left?	-$522	-$172	-$20	$1,579	$6,757

[a] Ontario Works [b] Ontario Disability Support Program [c] As of May 2024 [d] Statistics Canada, 2024.

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
- Learn more at www.healthunit.com/food-insecurity

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December 23, 2024

To: Medical Officers of Health and Chief Executive Officers

Re: Strengthening Public Health Updates

Dear Colleagues,

Further to the memo from Dr. Kieran Moore dated December 11, 2024, I am writing to share an update on the planned release and implementation of the revised Ontario Public Health Standards (OPHS) as well as public health funding.

The sector provided valuable input throughout the OPHS consultation, and the ministry is working to address and incorporate your feedback as well as exploring additional opportunities to further clarify responsibilities to reduce the workload burden at the local level.

The ministry recognizes boards of health require time to plan for the implementation of the revised OPHS. **Therefore, the revised OPHS and incorporated documents will be released to the sector by August 2025, with an effective date of January 2, 2026**.

Throughout 2025 the ministry will explore implementation supports via sector engagement, such as the OPHS Review Table.

The current OPHS and incorporated protocols and guidelines remain in effect, please find the current standards here.

As part of the Strengthening Public Health initiative, the ministry is providing growth base funding of 1% for three calendar years (2024, 2025, and 2026) to address the urgent need for stabilization while change processes are underway and undertaking a review of the provincial funding methodology for public health.

The ministry thanks everyone who participated in public health funding review engagement sessions over the summer, and we look forward to sharing more information on next steps, including timelines, as it is available.

Thank you for your continued collaboration in strengthening public health in Ontario. If you have any questions, please contact ophs.protocols.moh@ontario.ca.

Sincerely,

Elizabeth Walker
Executive Lead, Office of the Chief Medical Officer of Health, Public Health

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

Municipality of Killarney

November 20, 2024

Honourable Minister Sylvia Jones
Minister of Health
5th Floor, 777 Bay Street
Toronto, ON M5G 2C8
Email Only: sylvia.jonesco@pc.ola.org

Main Office:
32 Commissioner Street
Killarney, Ontario
P0M 2A0

Tel: 705-287-2424
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E-mail:
inquiries@municipalityofkillarney.ca

Public Works Department:
1096 Hwy 637
Killarney, Ontario
P0M 2A0

Tel: 705-287-1040
Fax: 705-287-1141

website:
www.municipalityofkillarney.ca

Dear Minister:

Re: Perspectives from Northern Ontario for the Public Health Funding Review

Attached hereto is Resolution #24-392 that was passed by the Council of the Municipality of Killarney at their Regular Meeting held November 13th, 2024. The Municipality of Killarney supports resolution #49-24 passed by the Board of Health on September 19th, 2024 which endorses the August 16th, 2024 letter from the Northern Ontario Medical Officers of Health entitled "Perspectives from Northern Ontario for the Public Health Funding Review."

We look forward to your favorable reply regarding this request.

Sincerely,
THE MUNICIPALITY OF KILLARNEY

(Mrs.) Angie Nuziale
Administrative Assistant

cc: Rene Lapierre, Board of Health Chair, Public Health Sudbury & District
Dr. M.M. Hirji, Acting Medical Officer of Health & Chief Executive Officer
Dr. Kieran Moore, Chief Medical Officer of Health
Frances Gelinas, MPP - Nickelbelt
Jamie West, MPP – Sudbury
Michael Mantha, MPP – Algoma-Manitoulin

Word: Letters-Public Health Funding Review-20-11-2024

The Corporation of the Municipality of Killarney
32 Commissioner Street
Killarney, Ontario
P0M 2A0

MOVED BY: Nikola Grubic

SECONDED BY: Dave Froats

RESOLUTION NO. 24-392

BE IT RESOLVED THAT the Municipality of Killarney support resolution #49-24 passed by the Board of Health on September 19th, 2024 which endorses the August 16th, 2024 letter from the Northern Ontario Medical Officers of Health entitled "Perspectives from Northern Ontario for the Public Health Funding Review";

FURTHER THAT this resolution be forwarded to all those noted in the letter sent by the Public Health Sudbury & Districts.

Resolution Result	Recorded Vote		
	Council Members	YES	NO
■ CARRIED	Mary Bradbury		
☐ DEFEATED	VACANT SEAT		
☐ TABLED	Dave Froats		
☐ RECORDED VOTE (SEE RIGHT)	Nikola Grubic		
☐ PECUNIARY INTEREST DECLARED	Michael Reider		
☐ WITHDRAWN	Peggy Roque		

I, Candy K. Beauvais, Clerk-Treasurer of the Municipality of Killarney do certify the foregoing to be a true copy of Resolution #24-392 passed in a Regular Council Meeting of The Corporation of the Municipality of Killarney on the 13th day of November 2024.

Candy K. Beauvais
Clerk Treasurer

Public Health
Santé publique
SUDBURY & DISTRICTS

October 16, 2024

VIA ELECTRONIC MAIL

Honourable Minister Sylvia Jones
Minister of Health
Ministry of Health
5th Floor, 777 Bay Street
Toronto, ON M5G 2C8

Dear Minister Jones:

Re: Perspectives from Northern Ontario for the Public Health Funding Review

At its meeting on September 19, 2024, the Board of Health carried the following resolution #49-24:

> *THAT the Board of Health endorse the August 16, 2024 letter by the northern Ontario Medical Officers of Health entitled "Perspectives from Northern Ontario for the Public Health Funding Review"*

Our Board of Health supports your government's undertaking of a funding review for local public health. We hope this review can result in stable, predictable funding for public health at levels that truly strengthens the public health sector's ability to keep Ontarians heathier.

Recently, the seven medical officers of health in Northern Ontario wrote to the Chief Medical Officer of Health outlining some thoughts on the funding review from the viewpoint of Northern Ontario. In short, some key perspectives shared included:

- Northern Ontario has a vast geography, a complex diversity of population and community organizations, a health care system that struggles with gaps in care, and municipalities with limited capacity. These have a significant impact on the cost and ability of public health agencies in Northern Ontario to deliver services.

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
t: 705.522.9200
f: 705.522.5182

Elm Place
10 rue Elm Street
Unit / Unité 130
Sudbury ON P3C 5N3
t: 705.522.9200
f: 705.677.9611

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
t: 705.222.9201
f: 705.867.0474

Espanola
800 rue Centre Street
Unit / Unité 100 C
Espanola ON P5E 1J3
t: 705.222.9202
f: 705.869.5583

Île Manitoulin Island
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

Chapleau
34 rue Birch Street
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

toll-free / sans frais
1.866.522.9200

phsd.ca

- Northern Ontario experiences worse health outcomes as a consequence of some of the challenges of delivering services, and we would not wish to see service diminished further for a population that needs support.
- Metrics such as the Census and the Ontario Marginalization Index have limitations for understanding the population of Northern Ontario due to undercounting of Indigenous persons and unreliability of these metrics in areas of low population.

Overall, the Northern Ontario medical officers of health recommend that the funding review not focus on achieving equal per capita funding, but rather equitable funding in light of the unique circumstances on the ground in Northern Ontario.

The letter by the medical officers of health is enclosed for your review. Our Board of Health would be pleased to meet with you or your staff to discuss these topics in further detail or support the funding review in other ways.

Thank you for your and your government's leadership in reviewing funding as we seek a Stronger Public Health Sector.

Sincerely,

René Lapierre
Chair, Board of Health

Encl.

cc: Dr. M.M. Hirji, Acting Medical Officer of Health and Chief Executive Officer
Dr. Kieran Moore, Chief Medical Officer of Health
Dr. Fiona Kouyoumdjian, Associate Chief Medical Officer of Health
France Gélinas, Member of Provincial Parliament, Nickel Belt
Jamie West, Member of Provincial Parliament, Sudbury
Michael Mantha, Member of Provincial Parliament, Algoma – Manitoulin
Association of Local Public Health Agencies
Local Municipalities

August 16, 2024

To: Kieran Moore
Chief Medical Officer of Health & Assistant Deputy Minister

From: Medical Officers of Health
for the 7 Northern Ontario Local Public Health Agencies

Subject: **Perspectives from Northern Ontario for the Public Health Funding Review**

We are writing to you as the seven local public health agencies in Northern Ontario to share some perspectives unique to the North regarding the current Public Health Funding review.

Before we outline our perspectives, we do wish to note our support of the government undertaking a funding review. It has been our perspective, and that of the local public health field, that a funding approach that enables stable and predictable funding is needed so that we can adequately plan and deliver our services.

We understand that the provincial government is quite concerned by the difference in per capita funding between local public health agencies. We agree, this is something needing to be addressed, but that the goal should not be *equal* (per capita) funding across local public health agencies, but rather *equitable* funding which accounts for the circumstances of each health unit.

The following are some equity considerations that can strengthen and improve the validity of the funding approach for public health in Northern Ontario.

For clarity, our comments are intended to relate only to the base funding grants; we do not intend to make comment on the Unorganized Territories Fund, which we believe requires its own review (we welcome the opportunity for further discussion of this at a future date).

Considerations for Funding Public Health in Ontario

1. Geography

Northern Ontario has much larger service areas than in the rest of the province. Northern Ontario spans 90% of Ontario's land mass, but has only a minority of the province's population. [1] That has major implications in terms of service delivery:

- Our staff must travel long distances to deliver service. That has implications in both transportation costs as well as opportunity costs of staff time. Inflationary pressures have exacerbated these costs.

- Given some of our communities are very remote and inaccessible by roads, travel in many cases is not just by car, but by charter flight or boat. This further increases our travel costs.[1]

- Since the populations we serve in Northern Ontario are distributed over a large area, we do not benefit from the population density that facilitates economies of scale. That means we must plan and organize a service many times over. In Northern Ontario, we have 142 municipalities plus many other communities in unorganized territories, as well as First Nations communities, If delivering a vaccination program, for example, a northern local public health agency must plan, organize, travel, set-up, and deliver clinics in many locations, taking into account the lack of public transportation in and between most northern communities. These clinics will ultimately serve fewer people and cannot take advantage of the economies of scale possible in a southern Ontario city where only 2 or 3 fixed locations might be need.

- Our rural geography impacts the nature of services we must deliver as well. For example, since much more of our populations are living in rural and remote areas as compared to the rest of the province, we are much more involved with inspecting small drinking water systems and private drinking water testing. Unlike a municipality in southern Ontario that may have a few large municipal water treatment plants that aren't inspected by local public health, northern communities have a plethora of small drinking water systems that do need regular inspections. This adds significant costs to our budgets to travel to and conduct inspections as well as to transport well water samples to the lab. As well, even where a community may be on municipally treated water, these are smaller plants befitting the size of the municipalities without large public works departments operating them. Larger municipalities enjoy economies of scale

[1] While it may be argued that the Unorganized Territories Grant accounts for serving this population, and this does not impact the broader funding approach, we highlight (1) that some fly-in/boat-in communities are organized municipalities (e.g. Moosonee), and (2) in 2008, when local public health associations were asked to account for their true costs of delivering services to unorganized territories, it was concluded that costs were 99% higher than what the Unorganized Territory Grant provided [15], and so the cost-shared budget heavily supported delivery of services to these communities. Since 2008, the Unorganized Territory Fund has increased 41.3% [15] while cumulative CPI in Ontario has increased 47.1% [16], implying that the role of cost-shared funding has increased since then, especially after accounting for population growth.

from running large plants that foster expertise and sophistication, and comparably lower maintenance costs. Most northern Ontario municipalities don't enjoy these economies of scale, resulting in more common problems and interruptions to operations, and so more involvement by public health to assess risk, monitor water quality, and issue boil water advisories, and drinking water advisories.

- Technology, which may sometimes allow bridging distance through virtual delivery of services, is often not possible in Ontario's North or is very expensive to support. In 2023, the Canadian Government-sponsored Northern Ontario Broadband Report [2] found that only 26% of Northern Ontario communities met the standard of 50% of the population of the community having 10/50 Mbps internet speed. In many communities, and particularly spaces between them, mobile phone service is also spotty. The residents we serve in Northern Ontario therefore frequently do not have the ability to be served virtually.

2. Breadth, Diversity, and Complexity of Populations and Partners

The vast land area of the North also brings with it greater diversity in a few different dimensions:

- The North has 32% (142/444) of Ontario municipalities, but only 20.5% (7/34) of Ontario's health units.
- The North has 107 of the 134 First Nations Communities in Ontario (80%), and 78% of the on reserve population in Ontario (recognizing that the Census is an undercount of Indigenous population, so these numbers may underrepresent the true number). [3] Alongside these populations are Band Councils and Indigenous organizations with whom we engage to ensure we can provide services in a way that is welcome and meaningful, while navigating complex jurisdictional ambiguity.
- People in the North have much lower socio-economic standing. Between 2009 and 2018 Northern Ontario had an annual average of GDP growth [1] of 0.1% compared to 1.7% for Ontario as a whole [4]. Other social determinants of health track similarly in Northern Ontario, and so health outcomes are worse. For example, in 2021 if looking at Mortality from Avoidable Causes [5], the Northern health units had an average avoidable mortality of 323 deaths per 100,000 versus 204 for the rest of Ontario. In fact, the seven Northern health units rank in the top 8 health units for avoidable mortality, and occupy all of the top six positions. Worse social determinants of health put a greater burden on Northern local

public health agencies in terms of the number of clients needing our intervention, and the efforts we need to invest per person to mitigate inequities.

- For Indigenous populations in particular, in Ontario the median income for First Nations people living on reserve is $32,400, $44,000 for those living off reserve, and $50,400 for non-Indigenous people. [6] Similarly, "Low income" status is more prevalent among Indigenous people who live on reserve (33.7%) and off reserve (16.9%) compared to non-Indigenous people (9.9%). [7] With 78% of the on reserve Indigenous population of Ontario, this is a significant pressure on Northern local public health budgets.
- Northern Ontario has disproportionately more Francophones and French Designated Areas (Figure 1), legally obligating more resources be devoted to translation and to ensuring provision of French-language services. Public Health must also engage with Francophone communities and organizations who are numerous across the large Northern geography.

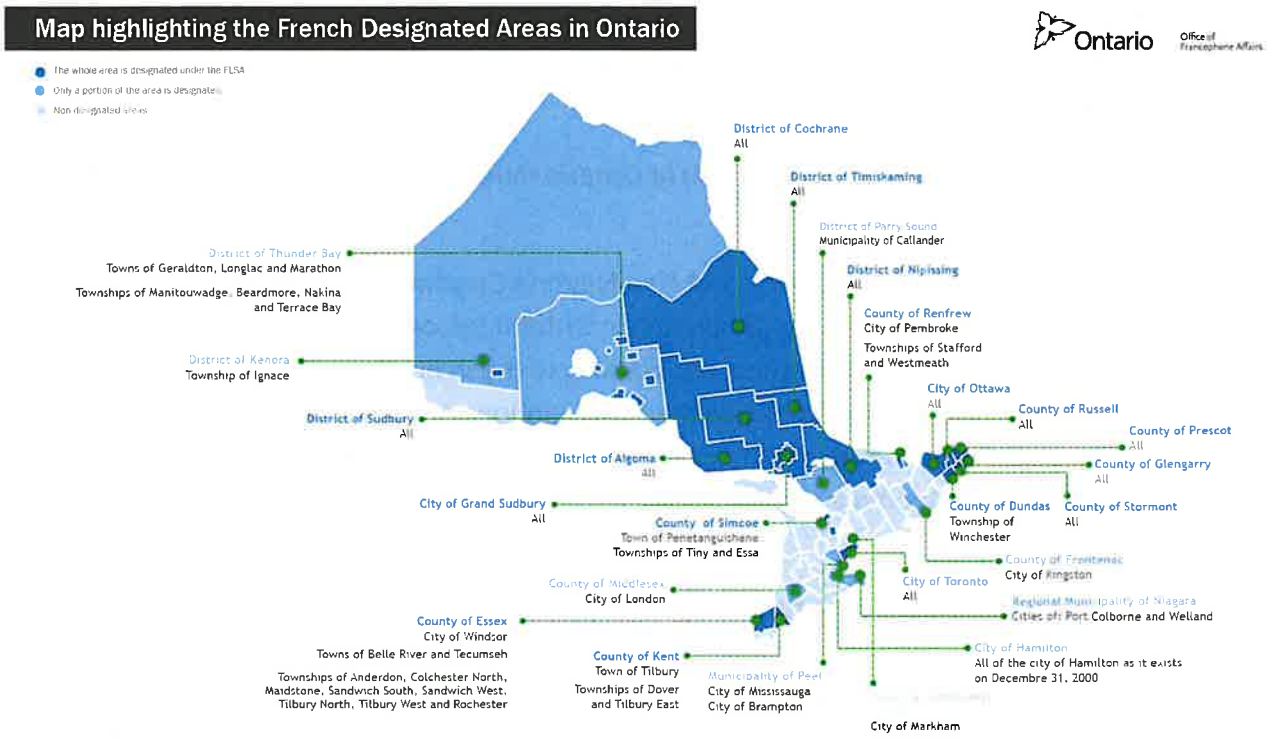

Figure 1. Designated French Language Areas in Ontario. [8]

The implication of this breadth and diversity of our populations and our partners is that it multiplies our workload: we have more municipal, Indigenous, and other partners with whom to engage; and we must meet people where they are with respect to language, Indigenous status, and social determinants of health, and invest in mitigating these. These are challenges not experienced as acutely in other parts of the province.

In addition, when attempting to work upstream, the complex patchwork of partners, many of whom are not well-funded, pose challenges to building coherent coalitions to advance advocacy or policy change for improvement of upstream health determinants.

3. Health Care Gaps

Northern Ontario is unfortunately lacking in health and dental care capacity. According to Ontario's Health Care Experience Survey for December 2019 (most recent results available) [9], 6.7% of Ontarians lacked a primary care provider, but that increased to 11.7% of residents of the North West LHIN and 11.8% of the North East LHIN. The Northern Sub-region reached as high as 29.0% of residents lacking a primary care provider.

In part, this is a function of primary care providers delivering acute care in much of Northern Ontario. In the North, family physicians routinely cover emergency departments, handle most obstetrics, are the primary surgical assists, and support long-term care, often working at multiple sites in a week.

It often falls to local public health to fill the gaps in primary care. For example, looking at the Fall 2023/24 COVID-19 vaccination program, pharmacies did not have the capacity to provide vaccinations in the North to the extent they did in the rest of the province (44.7% of vaccinations delivered by pharmacies in the North compared to 73.9% of vaccinations province-wide). Northern Public health units filled that gap, delivering 43.2% of COVID-19 vaccinations as compared to 15.7% Ontario-wide. Indeed, the six public health units with the lowest pharmacy delivery were all in Northern Ontario, and all 7 Northern Ontario PHUs were in the bottom 10 PHUs for pharmacy share of COVID-19 vaccinations. Despite the lack of pharmacy participation, Northern local public health agencies achieved above average vaccination coverage (17.9% to provincial average of 15.8%) through our efforts.

Table 1 Fall 2023/24 COVID-19 Vaccination Delivery [10] [11]

Public Health Unit	Proportion of Vaccines Delivered by Pharmacy	Proportion of Vaccines Delivered by Primary Care	Proportion of Vaccines Delivered by Public Health	Coverage Achieved
Ontario	73.9%	4.4%	15.7%	15.8%
Northern PHUs	44.7%	5.4%	43.2%	17.9%
Porcupine	21.2%	2.2%	66.0%	13.3%
Northwestern	16.2%	3.4%	71.8%	17.0%
Timiskaming	24.0%	12.3%	57.9%	17.2%
Algoma	65.4%	10.0%	18.6%	19.6%
Thunder Bay District	39.7%	8.5%	44.2%	19.9%
North Bay Parry Sound	48.8%	2.0%	43.8%	19.2%
Sudbury & Districts	54.8%	2.6%	36.9%	17.1%

Similar gaps in in primary health care capacity impact other program areas such as child health programming, sexual health programming, infectious disease programming, and rabies post-exposure prophylaxis.

Gaps in primary care can also increase rapidly with the closure of a single clinic or provider group. For example, in 2024, Sault Ste Marie experienced a dramatic announcement that 10,000 patients (8% of the entire health unit's population) would be de-rostered from their primary healthcare provider due to one provider group having difficulty recruiting primary care providers to replace retirements. [12]

There is also a lack of specialists in the North. Ontario's Health Care Experience Survey [9] shows that 65.2% of Ontarians must wait longer than 30 days for specialist care. However, that increases to 72.3% of residents in the North West LHIN and 73.8% of those in the North East LHIN. These specialist care gaps create particular challenges for public health follow-up. For example, in the follow-up and care of tuberculosis clients or syphilis infections, both of which have increased in incidence since the pandemic, most Northern communities do not have infectious disease specialists to oversee care, and primary care providers lack experience with these diseases. It falls on public health, who has some expertise from following all cases of these infections, to guide the health care system in care of such clients. This is not the norm in the rest of Ontario where greater clinical expertise exists.

4. Municipal Capacity

Just as local public health agencies struggle with the lack of economies of scale when delivering services to rural and remote populations, it should be observed that municipalities experience these same challenges with their services. Adding in the relatively lower economic opportunities in the North, Northern municipalities therefore have property tax bases that are very stretched. This makes it comparatively difficult for them to contribute to cost-shared funding of local public health. This should be considered in the obligation placed on municipalities in a new funding approach.

We believe all of the above make it more costly to deliver local public health in Northern Ontario, and that needs to be taken into account in the new funding approach.

We also wish to make a couple of comments on measures and metrics which may seem sensible to apply in the funding approach, but which have weaknesses when used for Northern geographies.

Caution on Applying Measures in Northern Ontario

1. Census Undercounting of Indigenous Populations

It is known that many Indigenous people do not complete the Canadian Census, and so the Census's counts for Indigenous population are significant undercounts throughout Northern Ontario. [12]

For example, the Health Counts Kenora project (Our Health Counts - WNHAC) used a respondent driven sampling approach and demonstrated that 76.9% of Indigenous people in the City of Kenora did not complete the 2016 census [7]. Using a conservative approach, "the Canadian Census undercounts Indigenous adults and children living in Kenora by at least 2.6 to 4.0 times." The 2016 Canadian Census reports that 3,155 Indigenous people lived in the City of Kenora; the 2021 Census reported 3,595. Both Thunder Bay and Timmins have also conducted similar counts and found significant undercounts.

As a population known to experience disproportionate health inequities, it is important that any new funding approach factor in the undercount of Indigenous peoples in the Census, and that this undercount is of a population that deserves disproportionate public health resources invested to address their health inequities.

In particular, as a new funding approach attempts to account better for population growth over time, it needs to be addressed that Northern Ontario is seeing significant growth in populations not well captured by the Census, such as Indigenous, anabaptist, and newcomer populations.

2. Inapplicability of ON-Marg in low population areas

The Ontario Marginalization Index is based on analysis at the Census dissemination area. Unfortunately, for much of Northern Ontario, there isn't sufficient population to have data for dissemination areas. For example, in Northwestern health unit, of 229 constituent dissemination areas, 101 (44%) have no data. Therefore, these areas are ignored in ON-Marg calculations. These areas that are excluded from ON-Marg calculations have many First Nation communities with low socioeconomic status and high deprivation, and so their exclusion has the impact of skewing ON-Marg metrics for Northern Ontario to appear less marginalized than is the reality.

Where dissemination areas do have data, that data is not always reliable. For example, on First Nations communities, the Low Income Measure input to ON-Marg has a flag of caution on interpretation, which means that the material deprivation dimension of ON-Marg should similarly be used in caution when looking at First Nations communities. The Northern public health units share land with 107 of the 134 First Nation communities in Ontario.

We appreciate that designing a funding approach for a diverse and complex group of local public health agencies is no easy task.

At its core, our fundamental message is that if a funding approach is to truly advance health outcomes and health equity across the province, health equity must be foundational in its design, and not be simply a variable included amongst many others. Metrics like per capita funding are attractive for their simplicity and ease of understanding. But that clarity in fact masks the complexities of serving Ontarians who are not uniform statistical units, but who live within diverse social contexts defined by countless inequities. We seek a funding approach that delivers not *equal* per capital funding, but *equitable* per capital funding.

We thank you for the consideration of the issues raised in this letter as you undertake the challenge of developing an *equitable* funding approach.

We would be very pleased to meet in the near future to discuss our perspectives further, and how we can support your team as the funding review proceeds.

And we look forward to there being an opportunity to review a funding proposal in the coming months before a final version is submitted for government approval.

Sincerely,

Lianne Catton (Aug 21, 2024 09:39 EDT)

Lianne Catton
Medical Officer of Health & CEO, Porcupine Health Unit

Janet DeMille
Medical Officer of Health & CEO, Thunder Bay District Health Unit

Kit Ngan Young Hoon
Medical Officer of Health, Northwestern Health Unit

Carol Zimbalatti (Aug 17, 2024 16:33 EDT)

Carol Zimbalatti
Medical Officer of Health & EO, North Bay Parry Sound District Health Unit

Glenn Corneil (Aug 19, 2024 08:59 EDT)

Glenn Corneil
Acting Medical Officer of Health & CEO, Timiskaming Health Unit

M. Mustafa Hirji
Acting Medical Officer of Health & CEO, Public Health Sudbury & Districts

John Tuinema (Aug 16, 2024 19:11 EDT)

John Tuinema
Acting Medical Officer of Health & CEO, Algoma Public Health

CC:

Liz Walker, Executive Lead, Office of the Chief Medical Officer of Health
Colleen Kiel, Director , Public Health Strategic Policy, Planning and Communications Branch
Brent Feeney, Director , Accountability and Liaison Branch
Fiona Kouyoumdjian, Associate Chief Medical Officer of Health
Wajid Ahmed, Associate Chief Medical Officer of Health

References

[1] Innovation, Science and Economic Development Canada, "Evaluation of the Northern Ontario Development Program (canada.ca).," January 2022. [Online]. Available: https://fednor.canada.ca/en/evaluation-northern-ontario-development-program. [Accessed 28 July 2024].

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[3] Ministry of Indigenous Relations and Reconciliation, "Indigenous peoples in Ontario | In the Spirit of Reconciliation: Ministry of Indigenous Relations and Reconciliation's first 10 years | ontario.ca," 29 March 2018. [Online]. Available: https://www.ontario.ca/document/spirit-reconciliation-ministry-indigenous-relations-and-reconciliation-first-10-years. [Accessed 2 May 2022].

[4] Ministry of Finance, "2019 Ontario Economic Outlook and Fiscal Review | Economic Data Tables," 6 November 2019. [Online]. Available: https://budget.ontario.ca/2019/fallstatement/ecotables.html#t2. [Accessed 26 July 2024].

[5] Public Health Ontario, "Potentially Avoidable Mortality Health Equity Snapshot," [Online]. Available: https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Avoidable-Mortality-Health-Inequities. [Accessed 29 July 2024].

[6] Statistics Canada, *2021 Census*..

[7] M. H. D. L. Kit Young Hoon, *Considerations for the funding formula for local health units,* Northwestern Health Unit Briefing Note, July 5, 2024.

[8] Government Services in French. Ministry of Francophone Affairs, "Map highlighting the French Designated Areas in Ontario," 31 May 2024. [Online]. Available: https://files.ontario.ca/ofa_designated_areas_map_en.pdf. [Accessed 25 July 2024].

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[10] Ministry of Health, *COVID-19 Vaccination Program: Weekly Report,* 2024.

[11] Ministry of Health, *COVID-19 Vaccination Program: Weekly Report,* 2024.

[12] "Community Update Regarding Primary Care. Group Health Centre.," 25 January 2024. [Online]. Available: https://ghc.on.ca/featured/community-update-regarding-primary-care-2/. [Accessed 9 August 2024].

[13] "Indigenous people in Toronto badly undercounted by census, but experts hopeful for change | CBC News," 30 September 2022.

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Report of the Funding Review Working Group," Ministry of Health, 2013.

[15] Statistics Canada, "Price Trends: 2014 to Today," [Online]. Available: https://www150.statcan.gc.ca/n1/pub/71-607-x/2018016/cpilg-ipcgl-eng.htm. [Accessed 14 August 2024].

Board of Health for Public Health Sudbury & Districts Summary of Board Meeting Evaluations – December 2024

After every regularly scheduled meeting, Board of Health members for Public Health Sudbury & Districts are asked to complete a post-meeting evaluation survey. Overall, the response rate for all meetings in 2024 was 63.5% compared to 46.3% in 2023. Response rates overall are lower than in past years (e.g., 74.0% in 2022). Response rates for each Board of Health meeting in 2024 are indicated in the table below.

Table 1: Board of Health Response Rate by Month, 2024

Month	Completed Evaluations	Total Attendance	Response Rate%
January	5	12	41.7
April	8	10	80.0
May	4	10	40.0
June	7	11	63.6
September	7	9	77.8
October	8	11	72.7
November	8	11	72.7

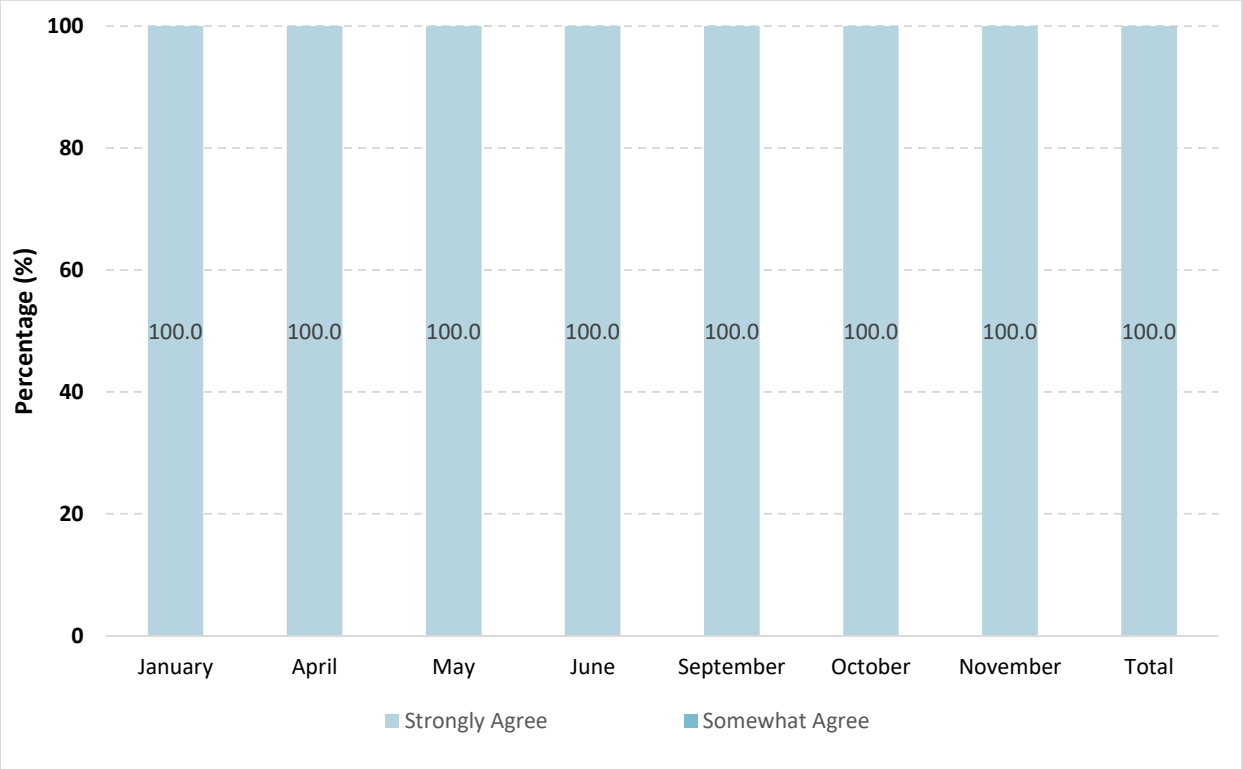
In these post-meeting evaluation surveys, Board of Health members are asked to reflect on various aspects of the meeting and to state their level of agreement or disagreement with the following statements:

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.

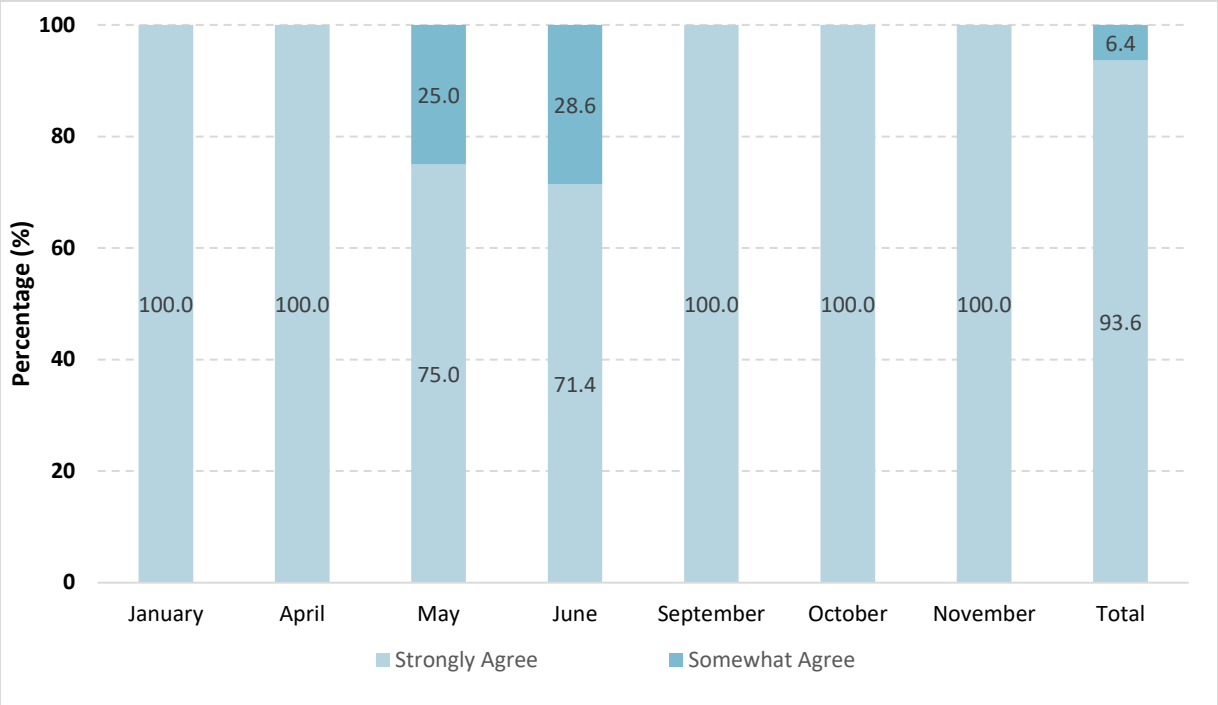
5. There is alignment with items that were included in the Board agenda package and the Public Health Sudbury & Districts' 2024-2028 Strategic Plan.
6. Board members' conduct was professional, cordial and respectful.

For the most part, Board of members mainly agreed with all statements, with some exceptions. These exceptions are highlighted in orange in the figures below.

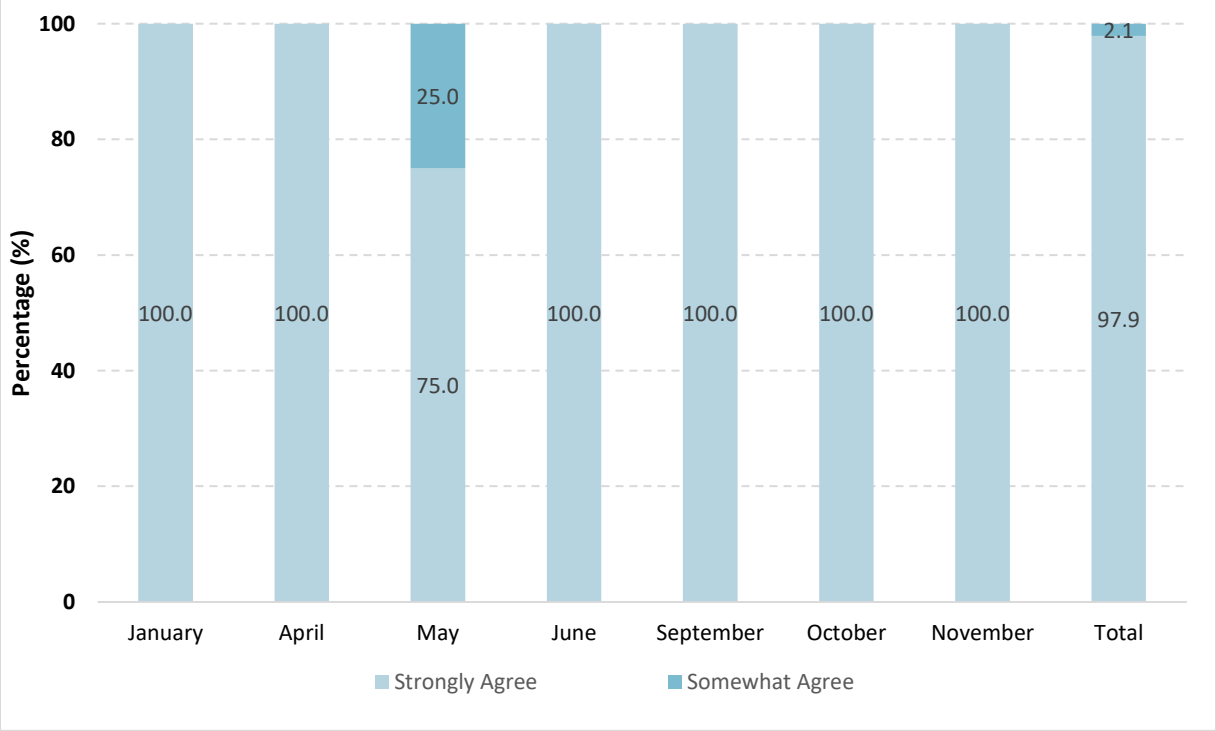
Statement #1: The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role



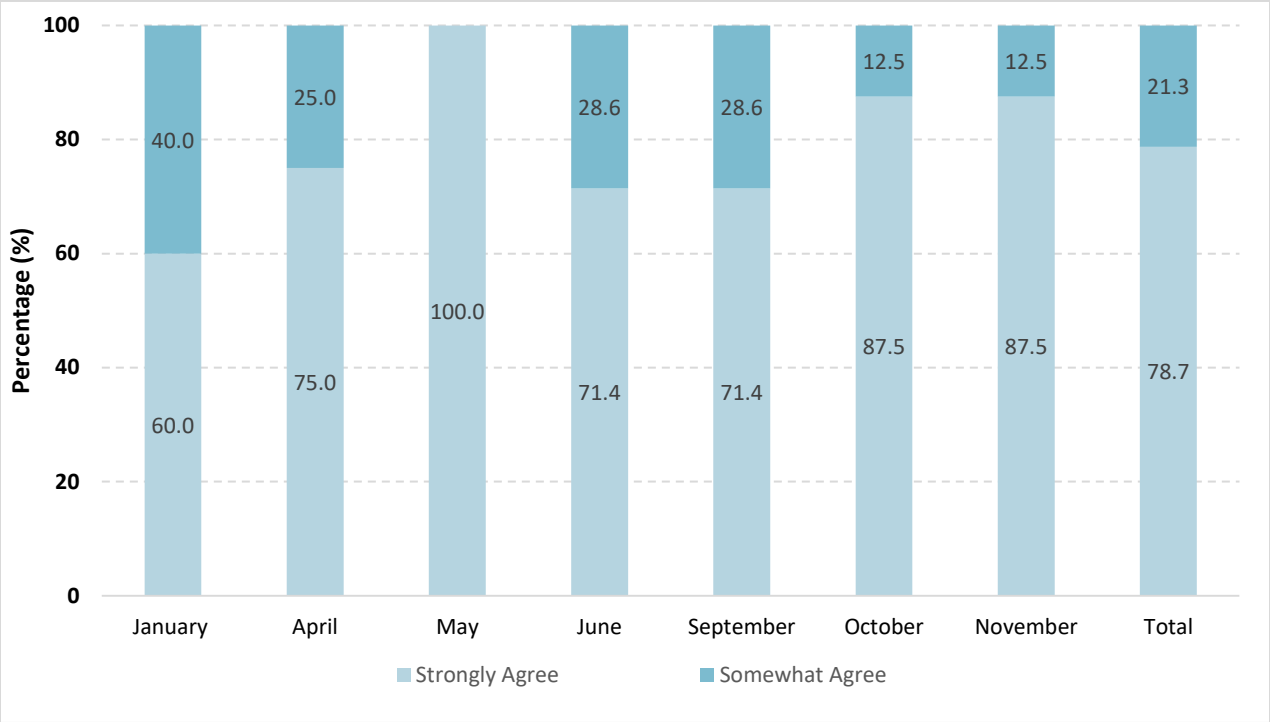
Statement #2: The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject



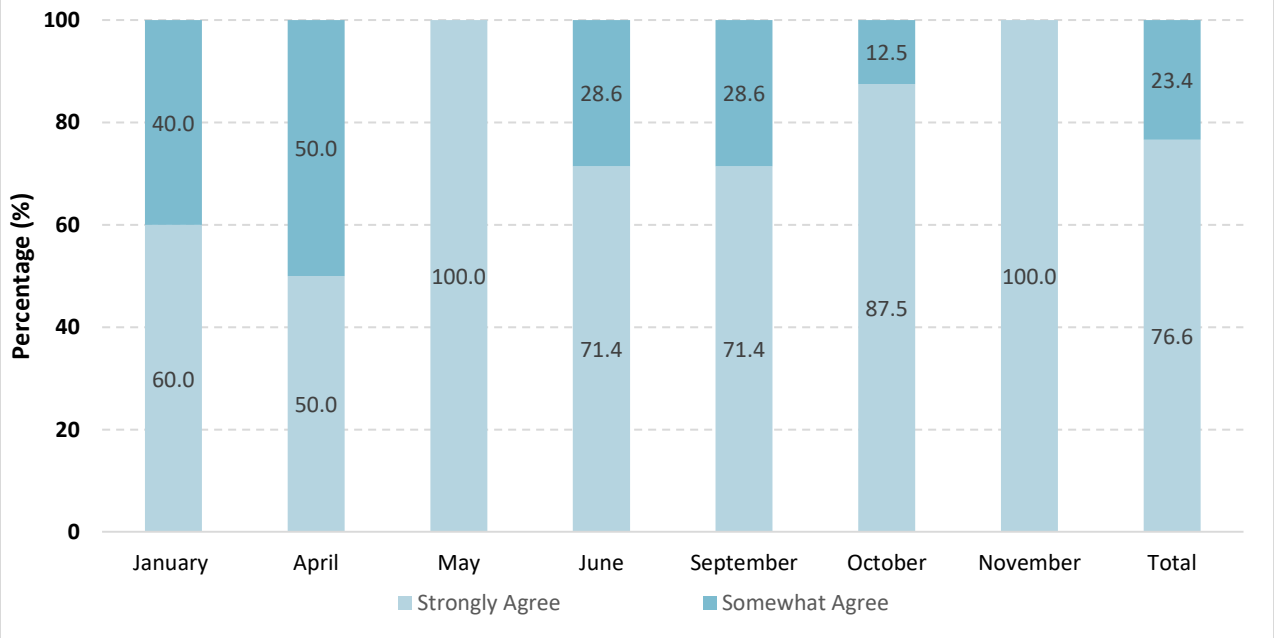
Statement #3: The MOH/CEO report was informative, timely and relevant to my governance role



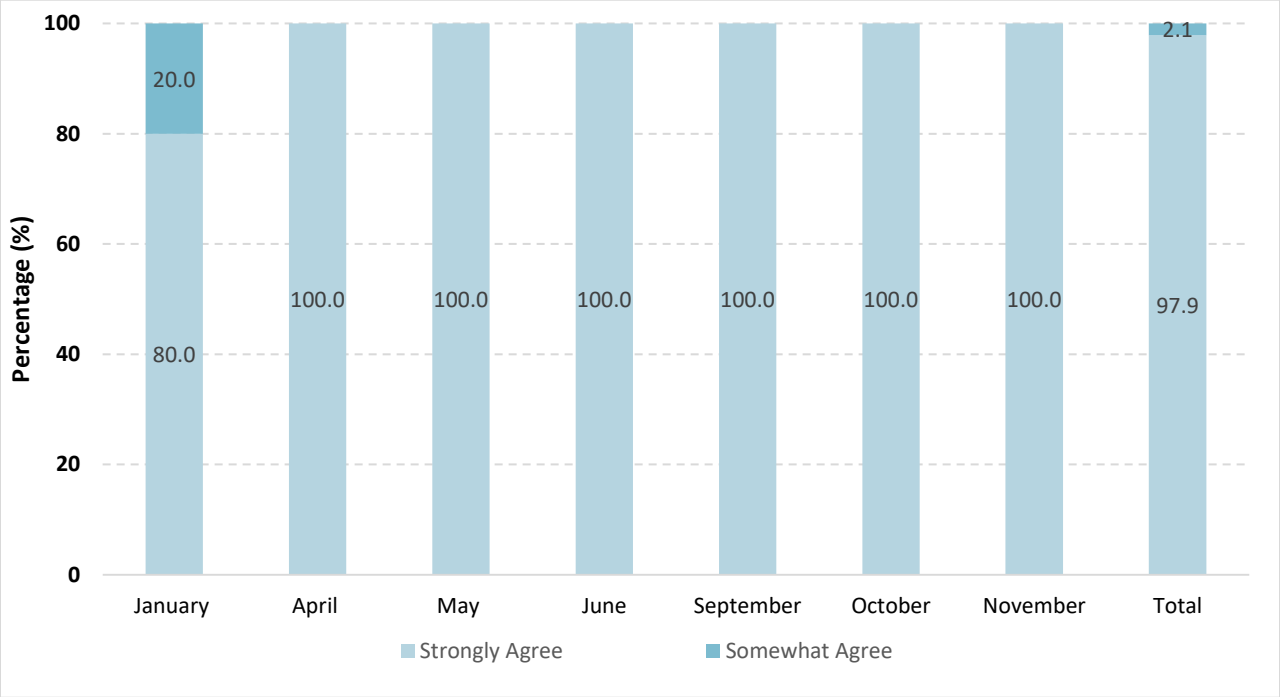
Statement #4: Overall, Board members participated in a responsible way and made decisions that further the Public Health Sudbury & Districts' Vision and Mission



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



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



Combined cumulative responses for all eight monthly Board of Health meetings are found in the table below.

Table 2: Overall (cumulative) Response to Statements

Statement	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Total Responses
1. The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.	47 (100.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	47
2. The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.	44 (93.6%)	3 (6.4%)	0 (0.0%)	0 (0.0%)	47
3. The MOH/CEO report was informative, timely and relevant to my governance role.	46 (97.9%)	1 (2.1%)	0 (0.0%)	0 (0.0%)	47

Statement	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Total Responses
4. Overall, Board members participated in a responsible way and made decisions that further the Public Health Sudbury & Districts' vision and mission.	37 (78.7%)	10 (21.3%)	0 (0.0%)	0 (0.0%)	47
5. There is alignment with items that were included in the Board agenda package and the Public Health Sudbury & Districts' 2024-2028 Strategic Plan.	36 (76.6%)	11 (23.4%)	0 (0.0%)	0 (0.0%)	47
6. Board members' conduct was professional, cordial and respectful.	46 (97.9%)	1 (2.1%)	0 (0.0%)	0 (0.0%)	47

Comments and suggestions

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

A few respondents provided suggestions, some of which are contradictory to one another. These include the following:

- Include the implementation of the strategic plan in the agenda
- Ensure the Chair has better control of the conversations to avoid repeating comments
- Encourage all board members to be present at the meetings
- Encourage a broader input and participation from all members to hear the full spectrum of BOH member opinions, ideas, and perspectives
- Extend the meeting duration to enable a more complex examination of the meeting materials and to allow more time for discussion on agenda attachment materials
- Shorten the meeting
- Give an update on the recruitment efforts to fill vacant positions at Public Health

Meeting highlights

- The great discussions and questions from board members
- The roll call to introduce themselves to the new board member
- Giving all members a chance to ask questions or make comments

- The level of professionalism and professional atmosphere, overall coordination of meetings, and protocols in place
- The hard work by Dr. Hirji and team
- The easy to understand and follow presentation on the budget and the overall level of information shared at meetings
- The interesting presentation on mental health and addictions

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.

ATTENDANCE
2024 BOARD OF HEALTH MEETINGS

Date of Meeting	01/18/24	BOH Special 02/15/24	02/20/24	04/18/24	05/16/24	06/20/24	09/19/24	10/17/24	11/21/24	Total	%
Anderson, Ryan	√	√ (virtual)	√	√ (virtual)	regrets	√	√ (virtual)	√ (virtual)	√	8/9	89%
Barclay, Robert	√	√	√	√	√	√	√	√	√	9/9	100%
Brabant, Michel *(started Sept. 3/24)*							√	√	√	3/3	100%
Carrier, Renée	√ (virtual)	√ (virtual)	√ (virtual)	√	√	√ (virtual)	regrets	√ (virtual)	√	8/9	89%
Despatie, Guy	√ (virtual)	√ (virtual)	√ (virtual)	√	√	√	regrets	√ (virtual)	√ (virtual)	8/9	89%
Pauline Fortin *(started April 18/24)*				√	√	√ (virtual)	√ (virtual)	√	√ (virtual)	6/6	100%
Lapierre, René, *Chair*	√	√	√	√	√	√	√	√	√	9/9	100%
Leduc, Bill *(resigned March 21/24)*	√ (virtual)	√ (virtual)	absent							2/3	67%
Masood, Abdullah	√	√	√	√	√	regrets	regrets	√	√	7/9	78%
Noland, Ken	√	√	√	√	√ (virtual)	√	√	√ (virtual)	√	9/9	100%
Parent, Michel	√ (virtual)	regrets	√	regrets	√ (virtual)	√ (virtual)	√	√	regrets	6/9	67%
Signoretti, Mark	√	√	√	√	√ (virtual)	√	√	regrets	√	8/9	89%
Sizer, Al *(resigned Sept 3/24)*	√	√	√	absent	absent	√				4/6	67%
Tessier, Natalie	√	√	√ (virtual)	√	√ (virtual)	√ (virtual)	√ (virtual)	√	√ (virtual)	9/9	100%

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: Chair, Board of Health for Public Health Sudbury & Districts

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

Date: January 9, 2025

Re: Board of Health Support for Immunization Registries

☐ For Information ☐ For Discussion ☒ For a Decision

Issue:
Currently, neither Ontario nor Canada has a reliable, complete or timely way to record immunization information for the population. Therefore, immunization records for residents are stored in a variety of locations such as primary health care providers offices, public health agencies, and pharmacies. Many individuals still rely on paper-based records (yellow immunization cards) to document their vaccine history.

Recommended Action:
That the Board of Health endorse the establishment and implementation of an Immunization Registry for Ontario.

That the Board of Health also support a pan-Canadian immunization registry that would integrate with provincial registries.

Alternative Actions:
To make no recommendation.

Background:
An immunization registry for Canadians has been a longstanding desire of public health practitioners in Canada. It was a major recommendation to strengthen public health after SARS in order to improve preparedness and the ability to respond to future public health emergencies. As of 2025, Canada and Ontario continue to have no comprehensive immunization registry.

In September of 2024, the Ontario Immunization Advisory Committee (OIAC) released a position statement[1] urging the Ontario Ministry of Health to develop and implement a provincial immunization registry. The position statement includes seven recommendations on what is needed in Ontario to implement an immunization registry.

2024–2028 Strategic Priorities

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

An immunization registry would help to address some of the current challenges, including

- Eliminating the need for parents to report vaccinations to local public health agencies
- Reducing the risk of inaccurate information being reported and documented
- Helping to easily identify individuals who are overdue on their immunizations
- Preventing the duplication of immunizations
- Reducing the resources required to enter data
- Lowering school suspension rates during the enforcement of the *Immunization of School Pupils Act* (ISPA)
- Enabling evaluation of immunization programs

An immunization registry would also provide benefits to a variety of users such as individuals, health care providers, public health agencies and researchers. Some of these including protecting people from vaccine-preventable diseases, providing more efficient and accessible health care, improving efficiencies within the health system, and monitoring and evaluation vaccine uptake, safety and effectiveness.

Most importantly, in addressing public health infectious risks, or responding to future pandemics by enabling easy assessment of vaccination coverage, identifying at-risk groups and areas due to lower vaccination, and informing vaccination efforts to groups in need of greater attention. A pre-established registry would also prevent a repeat in a future pandemic of the scramble during 2020 to design data systems to track COVID-19 vaccinations.

A national immunization registry would be particularly valuable given that infectious disease threats do not respect provincial borders, and particularly in a pandemic or national pubic health emergency, it would be critical to track immunizations across the country.

Peterborough Public Health (Motion 9.3.6) and Wellington-Dufferin-Guelph Public Health (Resolution 32) have also passed motions and sent correspondence to the province to support a provincial immunization registry.

Financial Implications:
N/A

Ontario Public Health Standard:
OPHS Program Standard: Immunization

Strategic Priority:
Equal Opportunities for Health
Excellence in public health practice

Contact:
Stacey Gilbeau, Director, Health Promotion and Vaccine Preventable Diseases Division and Chief Nursing Officer.

[1] Ontario Agency for Health Protection and Promotion (Public Health Ontario), Ontario Immunization Advisory Committee. Position statement: a provincial immunization registry for Ontario. Toronto, ON: King's Printer for Ontario; 2024. Available at https://www.publichealthontario.ca/-/media/Documents/O/24/oiac-position-statement-provincial-immunization-registry.pdf?&sc_lang=en#:~:text=Health%20care%20providers%20and%20public,appropriately%20across%20the%20health%20system.&text=1.&text=registry%20that%20captures%20all%20immunizations,immunization%20providers%20in%20all%20settings.

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

November 29, 2024

Hon. Sylvia Jones
Deputy Minister / Minister of Health
Government of Ontario
sylvia.jones@ontario.ca

Dear Minister Jones:

Re: PPH Board of Health Support for a Provincial Immunization Registry

I am writing on behalf of the Board of Health for Peterborough Public Health to indicate its strong support for the Ontario Immunization Advisory Committee's recommendation to establish an Immunization Registry for all residents of Ontario.

Immunizations registries are centralized electronic systems that hold immunization information of residents. They facilitate "timely, accurate recording of all relevant immunization information, regardless of where and by whom vaccines are administered."[1] Currently, the immunization records for residents of Ontario may be stored at a wide variety of locations including physician offices, clinics, public health agencies, and pharmacies, to name a few.

In September, 2024, the Ontario Immunization Advisory Committee (OIAC) released a position statement strongly urging that Ontario Ministry of Health develop a provincial immunization registry. The OIAC recommends that such a registry include vaccination records for all residents and ensure real-time access to everyone, including their health care providers. The OIAC position statement also outlines seven recommendations on what is needed for Ontario to implement an immunization registry[2] that meets the "need of diverse populations and ensure timely and equitable access to individual immunization records."[3]

An Ontario-wide immunization registry would address many of the challenges with the current system, including:

- eliminate the need for parents to report vaccinations to local public health agencies;
- reduce the risk of inaccurate information being reported;
- help identify individuals who are overdue on their immunizations;
- prevent duplication of immunizations;
- reduce resources needed to enter data;
- lower school suspension rates; and
- enable evaluation of immunization programs.

We respectfully request that the Ministry employ the powerful and efficient technology that is now available to develop a provincial Immunization Registry that will ease administrative burdens, increase the efficiency and effectiveness of the health care system and meet the needs of all Ontarians.

Sincerely,

Original signed by

Councillor Joy Lachica
Chair, Board of Health

cc: Local MPPs
Peterborough Family Health Team
Peterborough Ontario Health Team
Peterborough Regional Health Centre
Association of Local Public Health Agencies
Ontario Boards of Health

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[1] Immunization records: Canadian Immunization Guide - Canada.ca
[2] OIAC Position Statement: A Provincial Immunization Registry for Ontario (publichealthontario.ca)
[3] Ibid.

SUPPORT FOR IMMUNIZATION REGISTRIES

MOTION:

WHEREAS neither Ontario nor Canada currently have a reliable, complete or timely way to record immunization information for residents;

WHEREAS a national immunization registry has been a longstanding recommendation for strengthening public health in Canada;

WHEREAS in September 2024, the Ontario Immunization Advisory Committee released a position statement[i] strongly urging the Ontario Ministry of Health to develop a provincial immunization registry; and

WHEREAS Peterborough Public Health (Motion 9.3.6) and Wellington-Dufferin-Guelph Public Health (Resolution 32) have also passed motions to support a provincial immunization registry;

THEREFORE BE IT RESOLVED THAT the Board of Health endorses the establishment and implementation of an Immunization Registry for Ontario;

AND THAT the Board of Health supports the establishment of a pan-Canadian immunization registry that integrates with any provincial registries.

[i] Ontario Agency for Health Protection and Promotion (Public Health Ontario), Ontario Immunization Advisory Committee. Position Statement: a provincial immunization registry for Ontario. Toronto, ON: King's Printer for Ontario; 2024.

Briefing Note

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

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

Date: January 9, 2025

Re: Amendment to Section 22 of the *Health Protection & Promotion Act*

☐ For Information ☐ For Discussion ☒ For a Decision

Issue:
As part of *Bill 231 2024 An Act to enact or amend various Acts related to health care*, there is a proposed amendment to the *Health Protection & Promotion Act*'s section 22, subsection 5.0.1 concerning class orders. The amendment would require that before any section 22 class order could be issued by a medical officer of health or associate medical officer of health, notice must be provided to the Chief Medical Officer of Health, and written approval of the order must also be received.

This change would compromise the original goals of section 22 orders and would reduce local autonomy and ability to address local public health threats.

A public comment period to this amendment is currently open until January 31, 2025.

Recommended Action:
That the Board of Health submit comment outlining concerns with the proposed amendment, and advocate for a more thorough review of this provision.

Alternative Actions:
The Board of Health make no comment.

Background:
The provision class orders under section 22 arose in 2003 after the first wave of SARS. In 2004, then Chief Medical Officer of Health Sheila Basrur, and former Medical Officer of Health of Toronto during SARS, outlined the rationale as follows:

> One of the elements that arose during SARS was our inability to issue orders on anything but a person-by-person, one-at-a-time kind of basis. There was an instance wherein we had an entire group of people who needed to be put into quarantine on a weekend. It was physically and logistically impossible to issue orders person to person on a Saturday afternoon n for 350 people who happened to live in three or four different health units all at once, each with their own

> MOH, their own solicitors and so on. So now there is an amendment to the Act. Again, that was processed even between phases one and two of the SARS outbreak. So things can happen fast when the will is there, but also when the need is apparent, such that orders can be issued against a class of persons. In a future pandemic or other wide-scale emergency, that will be a very helpful provision so we can issue mass orders if necessary and if warranted under the circumstances.

Class orders were used to address targeted, and localized health risks until 2020, when a novel definition of class was used to define the entire population of a health unit. Given the expanse of this power, there are reasons to increase checks and balances on it. However, there are concerns with respect to the proposed amendment along a few lines:

1. While provincial approval of a class order may have justification for a class order applied during a province-wide health emergency, and where that order applies to the entire population of a health unit, it makes much less sense for a localised health risk. In particular, provincial approval would slow down the rapid response class orders were designed to permit, as outlined by Dr. Basrur above.
2. This amendment would reduce the historic local autonomy boards of health and medical officers of health have had to protect the local population under their responsibility.
3. Even in a broad application of a section 22 class order, provincial review could significantly delay implementation. There should be consideration of timelines on the CMOH to complete the review and/or allow orders to go into effect, and the CMOH to instead rescind them after the fact rather than veto them before the fact.
4. Many issues arose regarding section 22 orders and class orders through the Campbell Commission post-SARS which have never been addressed. Reviewing all the issue and comprehensively amending the legislation would seem advisable at this opportunity.

The proposed recommendation to the Board of Health is to share these concerns, and advocate for a detailed, thorough review of the section 22 provision before making any amendment.

Financial Implications:
There are no financial implications to the recommendation in this report.

Ontario Public Health Standard:
N/A

Strategic Priority:
N/A

Contact:
M. Mustafa Hirji, Acting Medical Officer of Health & CEO

RESPONSE TO PROPOSE AMENDMENT OF SECTION 22 OF THE *HEALTH PROTECTION & PROMOTION ACT*

MOTION:

WHEREAS Class Orders under Section 22 of the *Health Protection & Promotion Act* were created in 2003 in the wake of the first wave of SARS to better equip local public health to respond to time-sensitive and severe public health emergencies;

WHEREAS Class Orders were used in novel ways during the COVID-19 pandemic response, ways that were much broader in scope than likely intended in 2003;

WHEREAS additional checks and balances on Class Orders are reasonable give the novel use of these orders to ensure they do not inappropriately impact public freedoms;

WHEREAS *Bill 231, More Convenient Care Act, 2024* proposes an amendment to the *Health Protection & Promotion Act* that would require provincial review and approval for any Class Order;

WHEREAS seeking provincial review and approval would create significant time delays with issuing Class Orders contrary to the need identified during the SARS response;

WHEREAS provincial review and approval of a local medical officer of health's actions to deal with local outbreaks and local health risks would represent an unusual infringement on local autonomy and independence in dealing with local concerns;

WHEREAS there are many recommendations that have arisen around improving the use of Section 22 orders dating back to SARS, many of which have not been implemented;

THEREFORE BE IT RESOLVED THAT the Board of Health recommends that the Legislative Assembly of Ontario that amending section 22 of the *Health Protection & Promotion Act* warrants more careful study, and that a dedicated task force to review this provision is recommended prior to any amendments; *Health Protection & Promotion Act;*

AND THAT the Board of Health recommends that any amendment of Section 22 Class Orders should distinguish between the original use of Class Orders which were narrowly targeted to small groups concerning time-sensitive risk of a local nature, and the novel use of Class Orders which area applied across an entire health unit on a risk diffuse throughout the province.

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

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

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

Date: January 9, 2025

Re: Endorsement of the Recommendations of the Walport Report, and Support for Continued focus on Public Health Emergency & Pandemic Preparedness

☐ For Information ☐ For Discussion ☒ For a Decision

Issue:
The federal government recently released an assessment and recommendations on evidence and science based on the experience of the COVID-19 pandemic response. The report, *The Time to Act is Now: Report of the Expert Panel for the Review of the Federal Approach to Pandemic Science Advice and Research Coordination* (aka *The Walport Report*) lays out 12 key recommendations and two broader recommendations for future pandemic preparedness.

Many recommendations after SARS were not acted upon, and the Walport Report again recommends some of those. There is a risk that recommendations will not be implemented again as time from the pandemic response increases, and attention to pandemic preparedness wanes.

Previously the Ontario Chief Medical Officer of Health released his 2022 Annual Report, *Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics*. Thusfar, many recommendations of that report have not been implemented, including the recommendation for an annual report to the Ontario Legislature on preparedness activities.

Recommended Action:
The Board of Health endorse the Walport Report and encourage its deliberate implementation, along with the ongoing implementation of the 2022 Chief Medical Officer of Health of Ontario annual report.

Alternative Actions:
The Board of Health make no endorsement nor recommendation.

Background:
After the SARS emergency, there were several major reports completed both nationally and provincially on improving public health preparedness. Thusfar, there has not been the appetite to learn from the COVID-19 pandemic response in order to prepare for the future. Welcome exceptons have been the 2022 Ontario Chief Medical Officer of Heath report and the recently released Walport Report, at the federal level.

The recommendations of the Walport Report are outlined below. These are thorough, and reflect challenges experienced by Public Health Sudbury & Districts in its response. These recommendations are worthy of support.

A distinct risk from these reports is that the motivation for change and improvement wanes as time passes from the emergency. Indeed, many recommendations after SARS were never implemented and are again made in the Walport Report. Similarly, the 2022 Chief Medical Officer of Health report has seen many recommendations seemingly go unfulfilled, most critically, an annual report to the provincial legislature which would in part provide the transparency if any action is occurring on those recommendations.

Endorsing the Walport Report and encouraging ongoing implementation of these learnings from the pandemic response can help indicate ongoing support for pandemic preparedness and hopefully spur the ongoing action needed to see implementation of recommendations.

The recommendations of the Walport Report are as follows:

Recommendation 1: Put in place a comprehensive national health risk management system

a. Develop a national health risk register and preparedness plan including mitigation, response, and recovery elements. This should encompass the health implications of environmental, zoonotic, chemical, biological, radiological, nuclear, and other natural hazards and human threats that could originate domestically or internationally. It should be updated regularly based on horizon scanning, and an external version should be published at least annually. The Health Portfolio should lead this process in coordination with Public Safety Canada and other departments and agencies as required. The plan should be developed in collaboration with provincial/territorial public health agencies and health departments.

b. Incorporate the health risk register and preparedness plan within broader national emergency protocols, clearly outlining the roles and responsibilities of relevant departments and agencies. Plans should be rehearsed and refined through regular table-top simulations and exercises.

c. Establish a standing health risk assessment and planning advisory body to inform the health risk register and preparedness plan. This should include a dedicated standing expert advisory committee on infectious diseases and pandemic preparedness.

Recommendation 2: Ensure that surveillance systems adequately support real-time assessment and public health security

a. Provide sufficient long-term funding for clinical, public health, and laboratory surveillance networks and infrastructure for emerging infectious diseases and risks to public health, accompanied by the underpinning technical infrastructure, in coordination with provincial/territorial governments and First Nations, Inuit, and Métis partners.

b. Systematically provide the results of all federally managed and funded public health surveillance efforts to provincial/territorial, local, and Indigenous health agencies and pursue reciprocal sharing agreements.

Recommendation 3: Establish a science advisory system for emergencies

a. Create a central federal mechanism that is designed to immediately activate a specialized expert advisory group in response to a health emergency to provide the best independent scientific advice directly to Cabinet. This system should be co-led by the Privy Council Office and the Health Portfolio, in collaboration with the Office of the Chief Science Advisor, Public Safety Canada, and other departments and agencies as required.

b. Ensure that this mechanism is ever-ready by establishing a standing interdepartmental government secretariat with sufficient ongoing and surge capacity. The secretariat should have knowledge mobilization and communications expertise, and access to all required intelligence. It should maintain a roster of experts relating to key health risks (as per the proposed health risk register in recommendation 1). Preparedness work should include training the roster of experts, secretariat members, and government decision makers on best practices for providing, receiving and communicating evidence; as well as simulations and exercises.

c. Designate the activated expert advisory group as the main federal science advisory body for health emergencies. This group should typically be convened jointly by the Chief Public Health Officer and Chief Science Advisor. Members should be assembled based on the nature of the emergency, drawing from the roster of experts, standing advisory committees, and elsewhere as required. The majority of members should be independent experts, chosen solely for their expertise. Expertise should be diverse with health, social, behavioural, humanities, and applied sciences as required, and cut across sectors, including intramural, extramural, industry, health equity, Indigenous health, and other relevant experts. Other relevant senior government officials should participate as liaisons. Supporting sub-groups and task forces should be formed as required.

d. Embed this advisory system in overall government emergency protocols; establish strong links with other domestic health advisory bodies, federal-provincial-territorial health and emergency networks, and international emergency advisory systems; and invite provincial/territorial governments and Indigenous partners to name liaisons.

e. Expand this advisory system over time to cover all emergencies, not just health emergencies.

Recommendation 4: Improve external communication of advice from federal advisory bodies

a. Stipulate in terms of reference that during an emergency, advisory bodies should publicly release evidence and advice briefs in a timeframe commensurate with the urgency of the situation, typically within days of their provision to government unless there are extenuating circumstances.

b. Develop corresponding internal emergency communications protocols that accelerate and streamline release processes to achieve releases in this timeframe.

c. Include provisions to protect sensitive and confidential information, and require that the level of uncertainty of evidence and advice is clearly communicated in all outputs.

Recommendation 5: Improve national guidance for the use of diagnostics, non-pharmaceutical interventions, and therapeutics in response to an emergency

a. Put in place sufficient emergency capacity and protocols to develop and release timely clinical and community guidance in these areas as reliable evidence emerges, in a similar fashion to the National Advisory Committee on Immunization's role on vaccines.

Recommendation 6: Improve pan-Canadian coordination of health emergency-related research

a. Establish a central interdepartmental mechanism within the federal government to work with other levels of government, academia, industry, First Nations, Inuit, and Métis health experts, and international partners to identify research priorities relating to the preparation for, and response to, health emergencies, and coordinate with provincial health research funders. This mechanism should be led by the Health Portfolio in collaboration with federal research granting councils and other departments and agencies.

b. Use the proposed new national health risk register and response plan, including the standing health risk assessment and planning advisory body (in recommendation 1), to inform this research prioritization during periods of stability. In response to an emergency, the activated special scientific advisory group for that emergency (as per recommendation 3) should take the lead advisory role in supporting the prioritization of new research questions as these arise in real time.

c. Establish a mechanism (linked to the above) for the prioritization of medical countermeasure research and development, working closely with industry and other relevant groups, informed by supply chain intelligence and coordinated with international allies.

Recommendation 7: Enhance the readiness of research and clinical trial networks and infrastructure

a. Create and maintain domestic and international research networks during inter-emergency periods. Some of these networks can be maintained in the form of "sleeping protocols", capable of rapid activation in the event of an emergency, while others should operate continuously and be used to address ongoing health priorities. These networks should put in place, as much as possible, the required inter-organizational agreements and ethical and other approvals, considering what may be required in response to potential future health emergencies including those identified in the proposed national health risk register (in recommendation 1).

b. Ensure that critical intramural and external health research infrastructure and human capacity are available and can operate during the next health emergency through sufficient and sustained funding. This should include creating an inventory of relevant assets, establishing protocols for the operation of federal facilities during an emergency, and publishing guidance for external labs.

c. Continue to increase the speed, scale, and inclusiveness of clinical trial infrastructure and processes by ensuring sufficient funding for the human capacity and necessary infrastructure required across the country.

Recommendation 8: Strengthen the emergency preparedness of the federal research granting councils

a. Put in place processes and protocols so that granting councils operate collectively in an emergency, with rapid decision making, streamlined review processes, and processes to facilitate collaboration on projects that are of sufficient scale to address national priorities. Funding conditions should include the timely completion of new inter-institutional agreements between collaborating research institutions as required, and the timely release of research data and results where appropriate.

b. Facilitate interdisciplinary research by removing subject-matter boundaries currently specified in very fine detail between the granting councils, and through capacity building where necessary.

c. Remove barriers to intramural and extramural research collaboration including federal funding eligibility restrictions for provincial and territorial intramural researchers. Operating funding envelopes for federal intramural researchers collaborating with recipients of grants and contributions should also be put in place.

Recommendation 9: Increase investments in research on actions required to better support and prioritize the needs of groups disproportionately impacted by health emergencies

a. Provide sufficient funding for research on the implementation of public health, government policy, and other interventions to mitigate inequities and address the underlying health needs of priority groups, including those in poverty or experiencing homelessness, Black and other racialized communities, and residents and employees of long-term care facilities. This research should be developed and conducted in concert with affected communities.

b. Establish a standing science advisory body of independent experts on health equity, supported by a secretariat within the Health Portfolio, to inform government policies and public health measures in this area.

Recommendation 10: Increase investments to advance research on actions required to improve Indigenous health outcomes

a. Co-develop health priorities with First Nations, Inuit, and Métis health experts and communities and provide sufficient funding for research on actions to address these priorities. This should include increased investments to advance Indigenous-led research and training in areas including epidemiology.

b. Cultivate and invest in the development of expertise in the coordination and funding of Indigenous health research, in and among federal departments and agencies.

Recommendation 11: Resolve the longstanding issue of the non-availability and fragmentation of essential public health and clinical data

a. Accelerate dedicated efforts with the provinces and territories to establish data standards, interoperable data systems and data sets, and provide access to data that are essential for assessing and managing public health between and during emergencies, reducing the health disparities between sociodemographic groups, and enabling the conduct of innovative and important research. This should include the systematic collection and availability of de-identified routinely collected health data, including vaccination data, across the country.

b. Provide sufficient resources to the Public Health Agency of Canada, the Canadian Food Inspection Agency, other relevant departments and agencies, and federally funded health data research networks to build and maintain interoperable data systems and data sets and make these available to provinces and territories, Indigenous health authorities, and researchers.

Recommendation 12: Continue efforts to meaningfully engage with Indigenous Peoples and their communities to support their respective health data strategies and advance shared digital health and health data priorities

a. Support and collaborate with First Nations, Inuit, and Métis communities and authorities across the country to bring their health data systems in line with the most robust systems in Canada, while preserving Indigenous data sovereignty and ensuring data integration and interoperability with provincial/territorial and federal systems, further to the commitment in the *Pan-Canadian Health Data Charter*.

Broader recommendation A: Pursue legislation to formalize the role of the Chief Science Advisor of Canada

This should include defining the role in preparation for and response to health and other emergencies.

Broader recommendation B: Create a new Deputy Chief Public Health Officer position that is fully dedicated to Indigenous health

This role should be held by an Indigenous person and have the mandate to ensure that First Nations, Inuit, and Métis health issues are integrated into the priorities and processes of the Public Health Agency of Canada. It should interface with other areas of the Health Portfolio, Indigenous Services Canada, and other departments and agencies as required.

Financial Implications:
There are no financial implications to Public Health Sudbury & Districts from these recommendations.

Ontario Public Health Standard:
The recommendations in this report help to advance the Emergency Management Standard as well as the Effective Public Health Practice standard and the Health Equity Standard.

Strategic Priority:
These recommendations support the Strategic Priorities for Excellence in Public Health Practice as well as Equal Opportunities for Health.

Contact:
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November 27, 2024

Hon. Sylvia Jones
Deputy Minister / Minister of Health
Government of Ontario
sylvia.jones@ontario.ca

Hon. Mark Holland
Minister of Health
Government of Canada
hcminister.ministresc@hc-sc.gc.ca

Dear Honourable Ministers:

Re: PPH Board of Health Support for the Walport Report and Sustained Investment and Reporting on Provincial Emergency Preparedness

On November 13, 2024, the Board of Health (BOH) for Peterborough Public Health expressed its support for the recommendations in the Health Canada report, *The Time to Act is Now: Report of the Expert Panel for the Review of the Federal Approach to Science Advice and Research Coordination*. The BOH also confirmed its belief that annual reporting on emergency preparedness activities is an essential mechanism for ensuring continued work and development of emergency preparedness capacity and exhorts the Ontario Ministry of Health to ensure that the legislature is kept informed of the status of emergency preparedness of the Province.

It has been five years since we learned of the outbreak in China that preceded the declaration of a global pandemic. We have learned significantly in public health and more broadly from these experiences and several reports have been authored summarizing the learnings and calling for sustained investment in emergency preparedness.

In 2022, the Office of the Chief Medical Officer of Health (CMOH) published the *2022 Annual Report - Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics* that included findings at the provincial level and a need for ongoing vigilance and reporting to the Ontario provincial legislature on pandemic readiness on an annual basis.

More recently, Health Canada published *The Time to Act is Now: Report of the Expert Panel for the Review of the Federal Approach to Science Advice and Research Coordination*, which takes a similar, yet higher level call to sustained investment and commitment to emergency preparedness including coordination of research and scientific advice across the country and close attention to addressing inequities and determinants of health.

...2

As noted in the report, "The pandemic exposed and exacerbated the weaker elements of Canada's health research and science advisory systems. It also highlighted severe shortcomings of health data systems and an inability to conduct timely and adequate observational studies, including infectious disease surveillance, and clinical trials."[1]

Major findings of the Expert Panel Report (also referred to as the "Walport Report" after Panel Chair, Sir Michael Walport) include:

- Canada must act now to be prepared for the next health emergency;
- Greater pan-Canadian coordination of research and science advice is required;
- A greater focus needs to be placed on equity and addressing social and structural determinants of health;
- Indigenous health expertise must be embedded in research coordination and science advice processes.[2]

The 2022 CMOH report recommended annual reports, however, to date public health reporting to the Province has not changed and to the best of our knowledge the legislature has not yet received a report on preparedness activities for 2023 and 2024. Failing to implement the recommendation for ongoing reporting to the legislature on pandemic readiness would be a significant setback for both the public and public health.

Furthermore, the federal Walport Panel's recommendations, which emphasize the need to improve and sustain emergency preparedness in advance of future crises, underscore the importance of transparent, consistent reporting. Without this essential accountability, Ontario risks falling behind in its readiness for future emergencies, which could have dire consequences for public health and safety.

Respectfully,

Original signed by

Councillor Joy Lachica
Chair, Board of Health

cc: Dr. Kieran Moore, Ontario Chief Medical Officer of Health
Local MPPs
Local MPs
Association of Local Public Health Agencies
Ontario Boards of Health

[1] Walport Report, p. 7
[2] Ibid, p. 7-8

ENDORSEMENT OF THE RECOMMENDATIONS OF THE WALPORT REPORT, AND SUPPORT FOR CONTINUED FOCUS ON PUBLIC HEALTH EMERGENCY & PANDEMIC PREPAREDNESS

MOTION:

WHEREAS for the past two decades, there have been Public Health Emergencies of International Concern approximately every two years, several of which have impacted Canada;

WHEREAS in a world that is increasingly more complex, interconnected, and uncertain, future public health emergencies maybe more impactful and difficult to manage;

WHEREAS the are opportunities to learn lessons from the COVID-19 pandemic response, both of around successes and areas for improvement;

WHEREAS The Time to Act is Now: Report of the Expert Panel for the Review of the Federal Approach to Pandemic Science Advice and Research Coordination (aka The Walport Report) is one detailed effort to learn lessons from the COVID-19 pandemic response;

WHEREAS The Ontario Chief Medical Officer of Heath's 2022 Annual Report Being Ready: Ensuring Public Health Preparedness for Infectious Outbreaks and Pandemics presented a laudable path forward to be better prepare for future public health emergencies;

THEREFORE BE IT RESOLVED THAT the Board of Health endorses the Walport Report and its 12 recommendations;

AND THAT the Board of Health encourages both the Federal government and the government of Ontario to act with deliberate resolve in implementing the Walport Report as well as the 2022 Chief Medical Officer of Health report, respectively.

CHANGE IN BOARD OF HEALTH MEETING DATE

MOTION:

WHEREAS the Sudbury & District 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 2025 Association of Local Public Health Agencies Annual (alPHa) in-person Conference and General Meeting will be held from June 18 to 20, 2025;

THEREFORE BE IT RESOLVED THAT this Board of Health agrees that the June 19, 2025, regularly scheduled Board of Health meeting date be changed to Thursday, June 12, 2025 at 1:30 p.m.

ADDENDUM

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

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