



Our Vision: Healthy People in Vibrant Communities

Board of Health Meeting Agenda

Location: 1230 Talbot Street, St. Thomas, ON

Virtual participation via MS Teams

Thursday, September 24, 2026, at 1:00 p.m.

1.0 Convening the meeting

- 1.1 Call to order (recognition of quorum, introduction of guests, board of health members and staff)
- 1.2 Approval of Agenda
- 1.3 Reminder to disclose any pecuniary interest and the general nature thereof when the item arises, including interests related to a previous meeting the member did not attend
- 1.4 Reminder that meetings are recorded for minute-taking purposes, and open session portions are publicly available for viewing for 30 days after being posted on Southwestern Public Health's website

2.0 Approval of minutes

- 2.1 Minutes from June 25, 2026

3.0 Approval of consent agenda items

- No items.

4.0 Correspondence received requiring action

- No items.

5.0 Agenda items for information, discussion, and decision

- 5.1 Medical Officer of Health's Report for September 24, 2026
- 5.2 Chief Executive Officer's Report for September 24, 2026
- 5.3 Governance Standing Committee Report for September 24, 2026

6.0 New business/other

- No items.

7.0 Closed session

Motion to move into a closed session to discuss the following matters pursuant to Section 239(2) of the Municipal Act, 2001:

- (b) personal matters about an identifiable individual, including municipal or local board employees;
- (c) a proposed or pending acquisition or disposition of land by the municipality or local Board; and
- (d) labour relations or employee negotiations.

8.0 Rising and Reporting

9.0 Future meetings and events

- Board of Health Meeting: Thursday, October 22, 2026 at 1:00 p.m.
- Location: Woodstock Site: Oxford County Administration Building, 21 Reeve Street, Woodstock, ON
- Virtual participation via MS Teams for Board meeting commencing at 1:00 p.m.

10.0 Adjournment

Accessibility:

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Board of Health Meeting

June 25, 2026



Open Session Minutes

A meeting of the Board of Health for Oxford Elgin St. Thomas Health Unit was held on Thursday, June 25, 2026, commencing at 1:00 p.m.

Present:

Ms. C. Agar	Board Member
Ms. B. Martin	Board Member (Chair)
Mr. J. Couckuyt	Board Member
Mr. J. Herbert	Board Member
Ms. K. Hobbs	Board Member
Mr. G. Jones	Board Member
Mr. D. Mayberry	Board Member
Mr. S. Molnar**	Board Member
Mr. J. Palmer	Board Member
Mr. L. Rowden	Board Member
Mr. E. Taylor	Board Member
Mr. D. Shinedling	Board Member (Vice Chair)
Mr. D. Warden	Board Member
Dr. N. Tran	Medical Officer of Health (ex officio)
Ms. C. St. John	Chief Executive Officer (ex officio)
Ms. W. Lee	Executive Assistant

Guests:

Ms. J. Austin	Public Health Promoter
Ms. J. Gordon	Administrative Assistant
Mr. P. Heywood	Program Director
Ms. S. MacIsaac	Program Director
Mr. D. McDonald	Director, Corporate Services and Human Resources
Ms. M. Nusink	Director, Finance
Ms. N. Rowe**	Manager, Communications
Ms. C. Richards	Manager, Foundational Standards
Ms. E. Robertson	Public Health Nurse
Mr. Y. Santos	Manager, IT
Mr. D. Smith	Program Director
Ms. M. Van Den Neucker	Program Manager, iHEAL
Ms. M. Van Wylie	Program Manager, CDIP
Ms. A. Vito	Public Health Promoter

Media:

Mr. R. Perry	Aylmer Express
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Note: ** indicates virtual participation

Regrets:

Mr. M. Peterson

Board Member

1.1 Call to order, recognition of quorum

The meeting was called to order by B. Martin at 1:05 p.m.

1.2 Approval of agenda**Resolution # 2026-BOH-0625-1.2**

Moved by D. Shinedling

Seconded by K. Hobbs

That the agenda for the Southwestern Public Health Board of Health meeting for Thursday, June 25, 2026, be approved.

Carried.**1.3 Reminder of conflicts of interest**

Reminder to disclose any pecuniary interest and the general nature thereof when the item arises, including interests related to a previous meeting the member did not attend.

1.4 Recording of minutes

Reminder that meetings are recorded for minute-taking purposes, and open session portions are publicly available for viewing for 30 days after being posted on Southwestern Public Health's website.

2.0 Approval of minutes**Resolution # 2026-BOH-0625-2.1**

Moved by G. Jones

Seconded by J. Palmer

That the minutes for the Southwestern Public Health Board of Health meeting for May 28, 2026, be approved.

Carried.**3.0 Consent agenda items**

No items.

4.0 Correspondence received requiring action

No items.

5.0 Agenda items for information, discussion, decision.

5.1 SWPH iHEAL Report

Emily Robertson and Mary Van Den Neucker presented the iHEAL program report and provided an overview of the program's implementation, outcomes, and ongoing research partnership with Western University examining the delivery of the program in a rural setting.

Board members commended the program and discussed participant recruitment, community awareness, and referral pathways. Staff advised that while a communications campaign was undertaken, recruitment was largely driven through one-on-one engagement with community partners. To avoid creating an unmanageable waitlist, promotion was moderated once program capacity had been reached.

Discussion included the program's reach within rural and Low-German-speaking communities, the role of trusted community partners in increasing referrals, and the importance of evidence-informed practice. Staff noted that the program has demonstrated strong uptake locally, with referrals from hospitals, primary care, community mental health organizations, and other partners. Preliminary observations suggest strong participant engagement and empowerment, with the final research report expected to provide additional findings later this year.

Board members asked questions regarding statistics cited in the report, trends in intimate partner violence, participant demographics, program capacity, and long-term sustainability. Staff explained that data referenced in the report was drawn from Statistics Canada, local violence against women organizations, and Western University researchers, and acknowledged the challenges associated with collecting comprehensive intimate partner violence data. Staff also noted that while the program primarily serves women, participants have included individuals with partners of various genders.

The Board discussed opportunities to sustain and expand the program. Staff advised that advocacy efforts are underway with regional public health partners and that additional funding opportunities, including private sector grants, are being explored. It was noted that current staffing limits the program to approximately 15–16 active participants at a time and that additional nursing resources would eliminate the existing waitlist. The Chair highlighted the importance of the program as a preventative initiative, noting its broader, long-term benefits for individuals, families, and the community, and expressed support for continued advocacy for sustainable funding. Staff also indicated that lessons learned from the project, including both quantitative and qualitative findings, will be incorporated into the final evaluation.

Resolution # 2026-BOH-0625-5.1

Moved by J. Herbert
Seconded by D. Shinedling

That the Board of Health for Southwestern Public Health receive the SWPH iHEAL Report for June 25, 2026.

Carried.

5.2 SWPH Planet Youth Report

Jessica Austin and Ashley Vito reviewed the report.

Board members commended the completion of the survey across local schools and noted the encouraging findings related to youth feeling safe and supported in their school environments. Discussion focused on substance use findings, including alcohol use, access to substances, and emerging trends. Staff advised that the survey collects information on a broad range of substances; however, results are only included in the report when response numbers meet reporting thresholds. While additional substance use data was collected, some categories did not meet the threshold for inclusion.

The Board discussed emerging concerns related to youth mental health, social media, cell phone use, and the impacts of online influences. Staff advised that research in these areas continues to evolve and that SWPH is monitoring developments, including guidance related to social media use and work occurring through community coalitions.

Discussion also focused on alcohol use among youth and broader policy considerations related to access and availability. Staff highlighted that alcohol was identified as the most commonly reported substance and noted the importance of supporting families in understanding the role of access, including the finding that some youth reported receiving alcohol from parents or caregivers. Board members discussed the need for continued education and prevention efforts, as well as broader conversations regarding alcohol policy.

Board members asked questions regarding the provincial and federal funding of the Planet Youth model, data sharing, response rates, and the role of parents and caregivers in youth substance prevention. Staff noted that the survey was distributed to all eligible students and that findings reflect consistent themes identified in other youth wellbeing research. Staff emphasized that the report demonstrates opportunities to build on existing strengths, including positive youth-parent relationships, while supporting families with strategies to promote youth wellbeing.

The Board recognized the value of the Planet Youth work and the insights gained through engaging directly with youth and communities.

Resolution # 2026-BOH-0625-5.2

Moved by J. Palmer

Seconded by G. Jones

That the Board of Health for Southwestern Public Health receive the Report on Planet Youth Oxford and Elgin-St. Thomas for June 25, 2026.

Carried.

D. Mayberry joined the meeting at 2:17pm

5.3 Medical Officer of Health's Report

Dr. N. Tran reviewed the report.

No questions were raised on the report.

Resolution # 2026-BOH-0625-5.3

Moved by D. Shinedling

Seconded by J. Herbert

That the Board of Health for Southwestern Public Health accept the Medical Officer of Health's Report for June 25, 2026.

Carried.

5.4 Chief Executive Officer's Report

C. St. John reviewed the report.

The Board discussed options related to the timing of the budget process and presentation. Members expressed support for aligning the process with the involvement of newly appointed Board members in the new year, with discussion taking into account the potential impact of municipal election results as well as the timing of Ministry funding announcements.

Discussion included clarification regarding specific budget line items. Staff explained that Lay Home Visiting services are provided by Parent Resource Workers (PRWs) who support new parents and families by providing education and assistance with positive parenting practices. Staff noted that the program has been established within the budget for several years.

Staff also clarified the Home-Based Health Care (HBHC) funding reference, advising that this relates to nurse practitioner services provided through an external arrangement with East Elgin Family Health Team and does not flow through the SWPH operating budget.

Resolution # 2026-BOH-0625-5.2-3.2

Moved by D. Shinedling

Seconded by J. Palmer

That the Board of Health approve the audited financial statements for the Healthy Babies Healthy Children Program and the Pre and Post Natal Nurse Practitioner program for the period ending March 31, 2026.

Carried.

Resolution # 2026-BOH-0625-5.4

Moved by S. Molnar
Seconded by J. Couckuyt

That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's report for June 25, 2026.

Carried.

6.0 New business

No items.

7.0 Closed session

Resolution # 2026-BOH-0625-C7

Moved by G. Jones
Seconded by J. Palmer

That the Board of Health move to closed session in order to consider the following, as outlined in the Ontario Municipal Act:

- (c) a proposed or pending acquisition or disposition of land by the municipality or local Board.

Carried.

8.0 Rising and reporting of closed session

Resolution # 2026-BOH-0625-C8

Moved by J. Palmer
Seconded by D. Shinedling

That the Board of Health rise with a report.

Carried.

Resolution # 2026-BOH-0625-C2.0

Moved by D. Warden
Seconded by L. Rowden

That the Board of Health for Southwestern Public Health accept the Special Ad Hoc Building Committee Report for June 25, 2026.

Carried.

9.0 Future meetings and events

The next official Board of Health meeting will be:

- Thursday, September 24, 2026

- Orientation at 12:00 p.m. | Meeting at 1:00 p.m.
- Location: 1230 Talbot Street, St. Thomas, ON; virtual participation via MS Teams

10.0 Adjournment

The meeting adjourned at 3:30 p.m.

Resolution # 2026-BOH-0625-10.0

Moved by J. Palmer

Seconded by J. Herbert

That the regular meeting adjourn to meet again on Thursday, September 24, 2026 at 1:00 p.m.

Carried.

Confirmed: _____

Medical Officer of Health Report



Open Session

Meeting date: September 24, 2026

Submitted by: Dr. Ninh Tran, Medical Officer of Health (written as of September 14, 2026)

Submitted to: Board of Health

Purpose: ☐ Decision
☐ Discussion
☒ Receive and file

Agenda item # 5.1

Resolution # 2026-BOH-0924-5.1

1.0 Respiratory season

1.1 Enhanced respiratory vaccine clinic access

Southwestern Public Health (SWPH) is preparing for the 2026–27 respiratory season, including the delivery of seasonal influenza, COVID-19 and RSV immunization clinics as part of a province-wide initiative directed by Ontario's Chief Medical Officer of Health, Dr. Kieran Moore.

Beginning October 20, SWPH will offer appointment-based clinics in St. Thomas, Woodstock, Aylmer, Ingersoll and Tillsonburg. The clinics will supplement vaccination opportunities available through primary care providers, pharmacies and some workplaces, with the goal of improving access to seasonal respiratory vaccines and increasing protection for individuals and populations at greater risk of serious illness.

Appointments are expected to be available through the SWPH online booking system (www.swpublichealth.ca/booking) during the week of September 14, 2026. Clinic schedules and capacity may be adjusted throughout the season in response to vaccine availability, eligibility requirements and community demand.

Final provincial direction regarding vaccine eligibility and availability is still pending. Based on current planning assumptions, high-risk populations are expected to become eligible as early as October, with broader public eligibility anticipated later in October and into November.

The clinic initiative also provides an opportunity to maintain organizational readiness and clinical capacity to scale immunization activities should a future public health need arise.

In addition to seasonal respiratory immunization activities, SWPH is preparing to deliver the provincially funded Grade 7 school immunization program. Vaccines offered through the program include Human Papillomavirus (HPV), Hepatitis B and Meningococcal ACYW.

1.2 Coordinated regional communication

To support seasonal vaccine uptake, SWPH is working with other local public health agencies across Southwestern Ontario on a coordinated regional communications approach focused on influenza, COVID-19 and RSV vaccination.

The campaign will support consistent messaging across the region, promote awareness of vaccine eligibility and availability, and encourage residents to access vaccination through the most appropriate and convenient provider.

2.0 Infectious Diseases

2.1 Supporting Community and Health System Partners

SWPH continues to work with community and health system partners to strengthen local capacity for the prevention and management of infectious diseases.

Following advocacy by SWPH, more accessible local interferon-gamma release assay (IGRA) testing is now available to support the detection of tuberculosis infection. Improved local access reduces barriers for clients and helps avoid the time and cost associated with travelling outside the area for testing.

SWPH has also provided tuberculin skin testing education to interested community partners and physicians. The sessions support appropriate screening practices and strengthen local capacity for tuberculosis prevention and follow-up. Positive feedback has been received, and opportunities to continue this education will be explored.

As part of preparations for the upcoming respiratory and outbreak season, the Infectious Diseases team and Infection Prevention and Control (IPAC) Hub will host a full-day IPAC and Outbreak Workshop on September 29 for partners from long-term care homes, retirement homes and other congregate living settings. The annual workshop will focus on current issues and emerging trends in infection prevention and outbreak management, including presentations from external academic speakers.

The IPAC Hub has also developed a mock outbreak exercise using enteric, respiratory and invasive Group A Streptococcus (iGAS) scenarios. The exercise is intended to strengthen outbreak preparedness, communication and coordination while identifying opportunities for improvement. Four long-term care homes have expressed interest in participating, with sessions scheduled for September and early October.

2.2 Ebola

SWPH continues to monitor the evolving international Ebola situation and related federal and provincial guidance.

The Government of Canada has extended its temporary border measures until September 28, 2026, in response to ongoing Ebola disease outbreaks in the Democratic Republic of the Congo, Uganda and South Sudan. The measures include requirements and restrictions for certain travellers who have recently been in affected countries.

SWPH continues to provide guidance and support to individuals returning from affected areas and works with local hospital and emergency medical services partners when notification or coordination is required.

3.0 Environmental Health Update

3.1 Extreme Heat Preparedness

SWPH is engaging community and municipal partners in discussions about strengthening local heat alert response and reducing the impacts of extreme heat on vulnerable populations.

Early discussions are underway with Oxford County to explore how Geographic Information Systems (GIS) could support coordinated extreme heat preparedness, response and recovery. Potential applications include identifying areas of increased heat risk, mapping vulnerable populations and community assets, and supporting a shared understanding of roles and available resources during extreme heat events.

Work is also underway to clarify heat-alert thresholds, communication responsibilities and emergency messaging to support a more coordinated response and alignment with Environment and Climate Change Canada.

3.2 Seasonal Environmental Health Activities

SWPH continues to monitor and respond to seasonal environmental health issues, including rabies, vector-borne diseases and recreational water safety.

The 2026 beach monitoring season has concluded following several beach postings, significant public inquiries and local media engagement.

Mosquito surveillance will continue through September. Recent surveillance has identified positive mosquito pools in Woodstock and positive bird surveillance findings in St. Thomas, reinforcing the importance of ongoing monitoring for West Nile virus activity. Fall tick surveillance, including tick dragging, is also planned to support continued monitoring of tick populations and tick-borne disease risk.

On September 11, 2026, SWPH has confirmed the first human case of West Nile Virus (WNV) in the region. While WNV-positive mosquito pools have been identified locally in recent years, this is the first human case reported to Southwestern Public Health since 2018.

Most people infected with West Nile virus do not develop symptoms. Approximately 80 per cent of infections are asymptomatic. Others may develop West Nile fever, a mild illness characterized by symptoms such as fever, headache, muscle aches, fatigue, rash, swollen lymph nodes, nausea, vomiting, diarrhea, eye pain, or sensitivity to light. Less than one per cent of infected individuals develop severe neurological illness, including meningitis, encephalitis, or acute flaccid paralysis.

4.0 Ontario Public Health Standards

The remaining draft Ontario Public Health Standards (OPHS) and associated protocols have now been shared with local public health agencies for review. SWPH is assessing the proposed

requirements and identifying any implications for programs, service delivery and organizational planning.

This work will help ensure SWPH is prepared to make any necessary adjustments as the province moves toward finalizing and implementing the updated standards and protocols.

MOTION: 2026-BOH-0924-5.1

That the Board of Health for Southwestern Public Health accept the Medical Officer of Health's Report for September 24, 2026.

Chief Executive Officer Report



Open Session

Meeting date: September 24, 2026

Submitted by: Cynthia St. John, Chief Executive Officer (written as of September 14, 2026)

Submitted to: Board of Health

Purpose:

- ☐ Decision
- ☐ Discussion
- ☒ Receive and file

Agenda item # 5.2

Resolution # 2026-BOH-0924-5.2

1.0 Program and Service Updates (Receive and file):

1.1 Association of Municipalities of Ontario Delegation – iHEAL Program

At the Association of Municipalities of Ontario (AMO) Conference on August 17, 2026, Emily Robertson (Public Health Nurse at SWPH) and I had the opportunity to meet with the Honourable Michael Parsa, Minister of Children, Community and Social Services, Associate Minister Charmaine Williams, MPP Ernie Hardimand and other Ministry officials to discuss the Intervention for Health Enhancement and Living program (iHEAL). We attended the delegation on behalf of Southwestern Public Health (SWPH), in collaboration with Middlesex-London Health Unit (MLHU) and Western University, to highlight the early impact of this evidence-based, nurse-led program supporting women and families experiencing the lasting effects of intimate partner violence and to include an ask for continued funding.

As you may recall in previous Board reports and a recent Board presentation (in June 2026), iHEAL is a trauma- and violence-informed health promotion program developed by Western University's academic iHEAL team and delivered locally by public health nurses. The program provides individualized, women-led support over several months, helping participants address safety, basic needs, health symptoms, family relationships, self-renewal, and connection to other services when needed. It does not duplicate crisis, shelter, justice, or counselling services; rather, it complements the broader system by creating another trusted and accessible door to care, particularly for women who face barriers related to rural isolation, privacy concerns, newcomer status, or limited local service availability.

During the AMO delegation, we emphasized that intimate partner violence is both a public health and human rights issue with significant and long-lasting impacts on women, children,

families, and communities. We shared that iHEAL has already demonstrated strong demand and meaningful outcomes across Southwestern Ontario. In its first nine months, the program supported more than 100 women and developed more than 90 community partnerships, including with police, shelters, hospitals, mental health providers, social services, and other community organizations. Women participating in iHEAL have reported improved safety, stronger self-advocacy, better ability to navigate health and social systems, improved mental and physical health, and renewed confidence in planning for the future.

The meeting was well received and generated constructive discussion about the value of iHEAL and its alignment with Ministry priorities related to women's safety, equality, well-being, and ending gender-based violence. We also used the opportunity to identify the urgent funding issue facing the program. While the broader research project continues until March 31, 2027, current Ministry funding for direct service delivery ends December 31, 2026. Without bridge or sustained funding, service continuity for women currently accessing or awaiting iHEAL support will be affected. Following the delegation, a letter was sent to Minister Parsa thanking him for the meeting and formally requesting \$600,000 in transitional funding to support continued service delivery from January 1 to June 30, 2027, while longer-term funding opportunities are explored.

We are encouraged by the Ministry's interest and the follow-up conversations generated through the AMO delegation. SWPH will continue working with MLHU, Western University, and government partners to pursue a sustainable funding pathway for iHEAL. The program reflects the unique contribution public health can make in addressing intimate partner violence through prevention, health promotion, equity-focused service delivery, and strong community partnerships



1.2 Annual Summary of Public-School Services

SWPH delivers mandated and evidence-informed services in public schools to support the health and well-being of children and youth. Services include universal supports for all schools and targeted supports for priority schools identified through the Ministry of Education's Educational Opportunity Index.

This report (see the attached infographic) summarizes SWPH services delivered in public schools across the region in the 2025-2026 school year.

We generate a similar school board-specific report for each board under our reciprocal data-sharing agreements.

The report aligns with SWPH strategic priorities by demonstrating population health action in schools, service excellence through partnerships and evidence-informed programming, and organizational resilience through consistent documentation, monitoring, and continuous improvement.

1.3 OSPS & CASS Let's Get Cookin'

The *Let's Get Cookin'* program supports educators and school community members in teaching students in Grades 5 to 8 to prepare and cook food over a series of 5 to 7 cooking sessions. The program focuses on developing basic food skills, such as knife safety, reading recipes, and understanding kitchen and food safety, through hands-on, experiential learning. It also aims to build students' confidence, interest, and ability to participate actively in food preparation, and to support socio-emotional development by encouraging teamwork, communication, problem-solving, patience, and responsibility.

This spring, SWPH collaborated with two Thames Valley District School Board (TVDSB) schools in Oxford County to deliver the *Let's Get Cookin'* program in a unique format. Students from a Grade 6/7 class at Oliver Stephens Public School (OSPS) participated in cooking sessions held in the culinary classroom at College Avenue Secondary School (CASS). High school culinary students served as mentors, leading cooking stations and supporting the younger students each week.

This is the first time SWPH has delivered *Let's Get Cookin'* to elementary students in a high school setting. This format strengthened inter-school and community partnerships while offering academic and social benefits for both elementary and secondary students.

Elementary students developed and applied foundational cooking skills through hands-on learning in an industrial kitchen while also building confidence, independence, and familiarity with the high school environment. They became more comfortable using kitchen tools, following recipes, and interacting with secondary students.

At the same time, high school culinary students enhanced their leadership skills and culinary knowledge by mentoring younger students and supporting safe food preparation.

Overall, the program strengthened connections between Oliver Stephens Public School and College Avenue Secondary School, fostering collaboration and a sense of belonging across age groups. A strong sense of belonging helps students feel respected, valued, and included, supporting their long-term health, well-being, and success both in and beyond the classroom. As a protective factor, belonging contributes to improved physical and mental health at the individual level while strengthening the broader community.

This approach to delivering the *Let's Get Cookin'* program was well received by students and staff at both schools and created a positive learning experience for everyone involved. SWPH plans to build on this pilot by exploring similar projects next school year and applying key learnings from this collaboration.

1.4 Strengthening Mental Health Literacy Among Parents and Caregivers

As part of a continued partnership with the TVDSB, London District Catholic School Board (LDCSB), and Middlesex London Health Unit (MLHU), SWPH participated in the *By Your Side Joint Social Media Campaign* to support parents and caregivers of children and youth (K-12). Using evidence-informed content from School Mental Health Ontario's By Your Side toolkit, the campaign increased awareness of mental health resources and shared practical information to support the well-being of children, youth, and families.

Developed through a collaborative planning process, campaign content focused on key themes related to child and youth mental health and well-being, including healthy relationships, a sense of belonging and navigating digital technology. From early May to mid June, partners shared six coordinated campaign posts weekly across their social media channels, extending the reach of mental health promotion messages and resources. The campaign reached more than 44,000 individuals and generated over 67,000 impressions across partner platforms, increasing the visibility of trusted, evidence-based mental health resources and helping parents and caregivers access practical information and strategies to support child and youth mental health and well-being across the region. An overall engagement rate of 1.36% met industry benchmarks for good performance, demonstrating meaningful audience interaction with campaign content. Lessons learned from the campaign reinforced the value of ongoing coordination among partners throughout planning and implementation, leveraging the collective reach of partner platforms to increase access to trusted mental health resources, and using campaign performance data to inform future planning and improvement. These learnings will help inform future mental health promotion initiatives, support continued collaboration with regional education and public health partners, enhance parent and caregiver engagement, increase visibility, and support ongoing performance monitoring.

The initiative highlights the value of sustained public health and education partnerships in expanding access to evidence-informed mental health information and supporting the well-being of children, youth, parents, and caregivers across the region. It also reflects SWPH's commitment to promoting mental well-being through collaborative, evidence-informed approaches and strengthened cross-sector partnerships that contribute to healthier communities.

1.5 Youth Social Media Use: Policy Developments, Emerging Evidence, and Public Health Opportunities

This update responds to the Board of Health's request for an update on youth social media use, policy developments, and public health action. The evidence suggests that age restrictions and platform regulations are emerging internationally, but early experience indicates that legislation alone is unlikely to fully protect children and youth. A comprehensive public health approach is needed, combining policy advocacy, school and community partnerships, youth and caregiver education, local data use, and investment in healthy offline opportunities for connection, recreation, and well-being. This report below summarizes recent policy developments, emerging

research, local Planet Youth findings, current SWPH work, and opportunities for public health action.

1.5.1 Updates to the Global Policy Landscape

In December 2025, the landmark Online Safety Amendment (Social Media Minimum Age) Act; came into effect in Australia, marking the first policy of its kind imposing minimum age limits for creating social media accounts.^[1,2] Since its passing, numerous countries have announced progress towards their own versions of legislation intended to moderate youth social media access. ^[3,4] Most governments appear to be pursuing policies that fall into three main silos: 1) addressing harmful content or conduct; 2) improving data and privacy protection; 3) positioning young people as unique consumers with additional consumer protections.^[3] The policy landscape on this topic is changing rapidly, so some information in this report may have changed since it was written on August 25, 2026. For instance, the United Kingdom and France have recently passed policies imposing minimum age limits for social media accounts, though the Constitutional Council ultimately struck down the French bill for infringing upon freedom of expression and communication in August 2026.^[3, 5-6] Bill C-34, the Safe Social Media Act, was introduced for first reading to the Canadian House of Commons on June 10th, 2026.^[7-8]

1.5.2 Update on Current Research

Because this policy area is novel, limited literature exists on the impacts of restrictive social media regulations for children and youth. This update is based on a review of the most recently published evidence and position statements on youth social media legislation. Politicians and researchers have eagerly awaited the release of Australian data for an initial assessment of the policy's impacts. Though it is too early to draw firm conclusions, the results from a 3-month follow-up survey have provided some interesting early insights.^[1,9] The results pointed to some modest reductions in daily social media use, though more than 85% of respondents ≤16 reported continued use of social media platforms.^[1,9] Over half of respondents continued to use their own accounts, and the most common form of age verification was self-report.^[1] Long-term impacts of these policies, such as the effects on children's mental health and well-being, or the denormalization of frequent social media use, cannot yet be understood.

Social media has been described as a core outlet for social connection, self-expression, identity formation, and leisure for adolescents.^[1,9-10] This aligns with the findings from the Local Planet Youth survey, where 65% of survey participants reported spending an average of at least 3 hours a day using social media.^[11] This local finding helps establish youth digital health as a population health issue with relevance to mental health promotion, sleep, recreation, school partnerships, and community well-being.

As part of the Planet Youth Model, "Community Coalitions" support the process and use the population-level survey data to inform collaborative action. Using the first-round survey results, coalitions identified social media use and screen time as a key priority area for further planning and consideration at the local level. This decision was based on concerning results with high reporting of insufficient sleep and poor mental health amongst youth – outcomes frequently associated with excessive screen time and social media use. Coalitions may develop interventions in this area, though action plans for the next year are yet to be finalized.^[11]

The integration of these platforms into the daily lives of youth, and their addictive designs, are major barriers to policy adherence as they create significant motivation within children to circumvent restrictions.^[1,9] Evidence from Australia suggests age restrictions alone may be

insufficient in blocking children's access to social media.[1,9] Despite limited data on restrictive laws, broader digital health literature highlights the need for a comprehensive approach to promoting children's digital safety, given the many levels of the social determinants of health and wellbeing that these platforms influence.[12-14]

1.5.3 The Role of Governments and Public Health

A comprehensive approach to improving digital safety and regulating youth social media exposure must not only restrict access, but invest in expanding recreation, leisure, and other community-building opportunities.[1,9] In a multifaceted approach, governments can wield regulatory power over tech companies by regulating age limits and verification methods, limiting addictive design features, blocking targeted advertising and profiling, establishing independent regulators, and enforcing penalties in instances of non-compliance.[1,9,12-18]

To support long-term behavioural change, public health can play a key role by partnering with community groups and educators. Promoting awareness, conducting independent research, supporting schools with device policies, and educating youth and parents on the impacts and risks of social media use are crucial, alongside strong government legislation.[1,9,12-18]

SWPH's Healthy Schools Team is already working closely with the Thames Valley District School Board and the London District Catholic School Board; the team has a Strategic Leadership Table that spans multiple departments at both boards. Earlier this year, Digital Health was identified in collaboration with Middlesex-London Health Unit (MLHU) as a new shared priority. With support from SWPH, MLHU will be leading the creation of a community table that includes academic partners, school boards, and key child and youth stakeholders. The table will be guided by the latest literature and evidence using a collective impact assessment.

As this is a developing field of policy and research, new data and opportunities for public health action are expected to emerge. Jurisdictional scans and rapid reviews are currently in progress with the National Collaborating Centre for Methods and Tools and Public Health Ontario. Southwestern Public Health will continue to monitor the issue, maintain relevant partnerships, and identify trends, community action opportunities, and policy advocacy options that can be brought forward for Board awareness, discussion, or direction as appropriate.

1.5.4 Appendix A: Summary of Policy Recommendations from Recent Position Papers and Consensus Statements

Publisher	Policy Recommendations
Council of Chief Medical Officers of Health ^[15]	- The federal government should create an independent regulator with mandate and enforcement powers to ensure online platforms and services operate in the best interests of children and youth. - Safeguard children and youth in digital spaces with policies including: - Restricting/removing addictive design features. - Moderating harmful content. - Require strict age restrictions and verifications. - Promote or mandate parental control tools. - Promote awareness and education, child and youth consultation, independent research, and collaborative solutions.

UNICEF: Children's Best Interests in Digital Policy and Practice (April 2026) ^[16]	• Ensure age-appropriate, accessible digital products and service communication. • Address risks associated with AI and emerging technologies. • Create digital platforms that support health and well-being. • Strengthen digital, especially AI, literacy for children and caregivers. • Promote inclusive, culturally responsive platform design and deployment. • Improve reporting, redress, and remedy mechanisms. • Uphold a holistic child-rights-based approach through regulation, practice, and accountability. • Conduct and consider the results of child-rights impact assessments. • Ensure government responsibility. • Include meaningful child and youth participation in strategy setting, policy design and decision-making.
American Academy of Pediatrics: Digital Ecosystems, Children and Adolescents: Policy Statement ^[17]	• Child-centred designs. • Safety and privacy to be default settings on platforms used by minors. • Limits on data collection and targeted advertising. • Increased transparency around algorithms. • Accountability for designs that amplify harmful content. • Greater investment in community resources, including libraries, recreational spaces, and nonprofit child-centred media. • Support programming that intentionally promotes strong caregiver-child relationships. • Evidence-based school phone policies with thoughtful and consistent implementation, teacher support and technology design changes. • Effective privacy-preserving age assurance should be used to prevent minors' access to illegal and harmful content. • Regulatory practices should address digital media design that recommends harmful content. • Universal erasure laws should be enacted. • Fund research.

Please note that references for Section 1.5 are listed at the end of my report.

2.0 alPHA 2026 Resolutions Update (Receive and file):

As noted in the June Board of Health report, a more fulsome summary of the resolutions approved by Association of Local Public Health Agencies (alPHA) would be provided once the final resolutions were published. The following resolutions were approved at alPHA's 2026 Annual General Meeting and are being shared with the Board for information.

2.1 alPHA Resolution A26-01 - Strengthening Hepatitis B Prevention in Ontario Through Vaccination in the First Year of Life

alPHA has written to the Ministry to consider, in consultation with relevant stakeholders, moving universal Hepatitis B vaccination from Grade 7 to the first year of life. The resolution recommends a combined vaccine administered at 2, 4, and 6 months of age to provide earlier protection against Hepatitis B and strengthen prevention of vaccine-preventable disease in young children.

2.2 aPHa Resolution A26-02 – Public Health Inspector Capacity

aPHa has requested that the Ministry implement measures to strengthen the public health inspector workforce through recruitment, education pathways, practicums, mentorship and retention. The resolution emphasizes the role of public health inspection in preventing infectious disease outbreaks and reducing environmental health hazards.

2.3 aPHa Resolution A26-03 - Mandatory and Regulated Alcohol Labelling on Alcohol Manufactured or Sold in Canada

aPHa has written to the federal Minister of Health calling for amendments to the Food and Drugs Act to require health warnings, guidance on reducing alcohol-related health risks, and standard drink information on alcohol products sold or manufactured in Canada. It also endorses the Statement from Provincial/Territorial Chief Medical Officers of Health on alcohol labelling and calls for updates to Canada's low-risk alcohol drinking guidelines based on the Canadian Centre on Substance Use and Addiction's Guidance on Alcohol and Health.

2.4 aPHa Resolution A26-04 - Enhancing the Ontario Works Benefit

aPHa has written to the Ministry to consider measures to ensure that Ontario Works income supports are sufficient to help vulnerable households meet basic needs, including food. The motion highlights the growing impact of household food insecurity on physical and mental health and notes the associated health care and economic costs to Ontario, estimated at \$5.6 billion annually.

3.0 Financial Matters (Decision):

3.1 SWPH Second Quarter Financial Statements (Decision):

At the end of quarter two, June 30, 2026, SWPH is currently underspent by approximately \$763k or 3% of the overall budget (see attached). The surplus in Q2 is primarily due to unanticipated additional funding received from various programs, including COVID-19, and iHEAL (Intervention for Health Enhancement and Living). These supplemental funds were not anticipated and/or confirmed when developing the 2026 budget, resulting in a positive variance for the quarter. This surplus provides greater flexibility moving forward and the opportunity for staff to reassess resource allocation for the remainder of the fiscal year.

All program expenses and variances are reviewed monthly. At the end of June, it was anticipated that there will be a surplus at year's end. Currently, it is too early to confirm the amount we will have at year end.

MOTION: 2026-BOH-0924-5.2-3.1

That the Board of Health approve the second quarter financial statements for the period ending June 30, 2026 as presented for Southwestern Public Health.

3.2 Charitable Status (receive and file):

I am very pleased to share that the Canada Revenue Agency (CRA) has approved the Board of Health for Oxford Elgin St. Thomas Health Unit as a registered charity under the Income Tax Act, effective January 1, 2026. The organization has been assigned a charitable registration number and designated as a Charitable Organization. The approval was granted based on the Board's governance structure under Ontario's Health Protection and Promotion Act.

Obtaining registered charity status provides Southwestern Public Health with new opportunities to support its long-term sustainability and public health mandate. In addition to allowing the organization to issue charitable donation receipts and pursue funding opportunities available only to registered charities, charitable status may also provide access to reduced-cost products and services offered through charitable discount programs. This includes likely savings on software licensing, such as Microsoft products, as well as other technology, training, and organizational resources available specifically to registered charities.

As a registered charity, SWPH will be required to comply with CRA reporting and governance requirements, including the annual filing of a T3010 Registered Charity Information Return. The first return is due by June 30, 2027, for the fiscal year ending December 31, 2026. We will establish the necessary processes to ensure ongoing compliance while exploring opportunities to maximize the benefits of charitable registration.

3.3 New Schedule C to the Public Health Funding and Accountability Agreement (receive and file):

On July 31, 2026, SWPH received an updated Schedule C, "Reporting Requirements" to our Funding and Accountability Agreement. The updated schedule includes an update to immunization and record and inventory reporting:

- Panorama Immunization Record and Inventory Reporting

The Board of Health shall make available to the Province, using Panorama or any other method specified by the Province, immunization records and inventory data under their custody and control. We are awaiting legal review of this contract and as such, we are not recommending acceptance at this time but rather receive and file until such time when we have a firm recommendation.

MOTION: 2026-BOH-0924-5.2-3.2

That the Board of Health receive and file the amended Schedule C: Reporting Requirements for Oxford Elgin St. Thomas Health Unit.

3.4 2027 Ministry Budget Increase (receive and file):

On August 24, 2026, SWPH received notification from the Ministry of Health that we may proceed to budget for a 1% increase in provincial base funding for mandatory public health programs and services for 2027.

The Ministry advised that formal funding allocations, along with any further information, will be communicated, at a later date, when the information becomes available. SWPH will continue to monitor Ministry guidance and will incorporate the confirmed funding information into the budget process.

It is helpful for SWPH to have certainty regarding the base funding increase from the Ministry of Health, especially as our organization begins to develop its 2027 draft budget for Board of Health review. Nevertheless, 1% still falls well below inflation.

I am pleased to note that alPHA responded to the Minister with the attached letter noting public health's appreciation for the base increase but also noting that provincial base funding requirements to meet public health program and service demands far exceed the 1% provincial increase.

MOTION: 2026-BOH-0924-5.2

That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's Report for September 24, 2026.

References for 1.4 Youth Social Media Use: Policy Developments, Emerging Evidence, and Public Health Opportunities

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Public Schools

**SWPH Programs & Services Report
2025/2026 School Year**

www.swpublichealth.ca



PUBLIC HEALTH STAFF

Public Health Nurses on the Healthy Schools Team :

- Provide support to all schools in the region. The team provides intensive support to Priority schools*
- Offer evidence informed programming such as Healthy Relationships Plus, Recess Programming, Let's Get Cooking and Student Leadership activities.
- Support students' individual health and wellness through one-to-one situational support sessions in our area Secondary Schools.
- Provide curriculum supports and resources for staff including consultation and response to concerns and emerging health issues.

*SWPH uses the Educational Opportunities Index to prioritize schools who require additional support. Every school has access to public health support; however, 29 elementary schools and every high school receive regular intensive school visiting support from a public health nurse.

83%

Priority schools
averaging 2 or more
interactions per
month

3426+

School Interactions

Interactions entails classroom, whole
school and school board initiatives
conducted by Public Health staff.

5

Schools received
National Healthy
Schools certification

Public health staff work alongside local educators to offer the following evidence based programs in area schools:



Active and
Safe Routes
to School



Clinical
Services



#Food4Thought



Healthy
Relationships
Plus



Healthy
Schools
Certification



Immunization



Kindergarten
Orientation
Fair



Let's Get
Cookin'



Mental
Health Lit



MindUp



Not an
Experiment



Recess
Programming



School
Assessment



SISP/
Belonging
Plan



Student
Leadership



Tower
Gardens



Use Your
Instincts



Wellness
Club

Situational Supports

Secondary school public health nurses support student's individual health and wellness needs through one-to-one situational support sessions

127
SITUATIONAL
SUPPORTS

Top Health Topics



Mental
Health



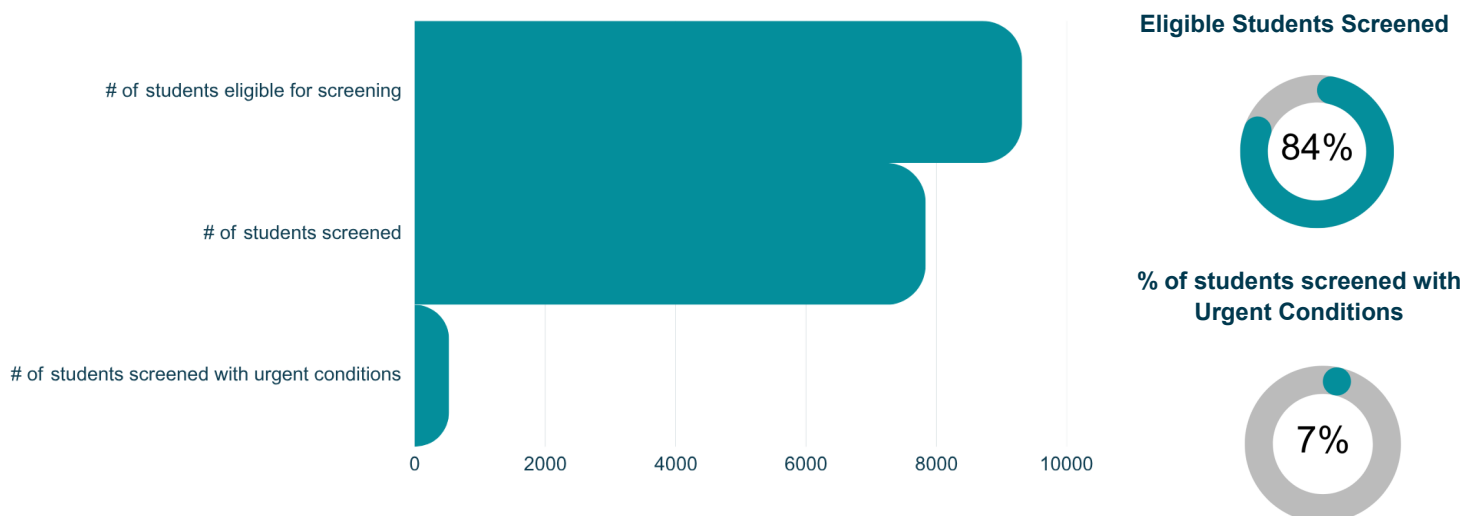
Pregnancy
testing



Healthy
Relationships

ORAL HEALTH

Oral health screening is a required program under the Oral Health Protocol, 2021. It is offered free in schools for students in JK/SK, Grade 2, and 7 to help identify students in need of dental care and connect eligible families with dental programming.



SUBSTANCE

Tobacco Enforcement Officers (TEOs) work under the Smoke Free Ontario Act, 2017, to prevent the use of tobacco and vape products on school property.



88
school offences
reported



70
warnings
issued



5
tickets
issued

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

alPHA Sections:

Boards of Health
Section

Council of Ontario
Medical Officers of
Health (COMOH)

**Affiliate
Organizations:**

Association of Ontario
Public Health Business
Administrators

Association of
Public Health
Epidemiologists
in Ontario

Association of
Supervisors of Public
Health Inspectors of
Ontario

Health Promotion
Ontario

Ontario Association of
Public Health Dentistry

Ontario Association of
Public Health Nursing
Leaders

Ontario Dietitians in
Public Health

July 21, 2026

Hon. Sylvia Jones
Minister of Health
College Park, 5th Flr,
777 Bay St
Toronto, Ontario M7A 2J3

**Re: alPHA Resolution A26-01 - Strengthening Hepatitis B Prevention in Ontario Through
Vaccination in the First Year of Life**

On behalf of the Association of Local Public Health Agencies (alPHA) and its Boards of Health Section, Council of Ontario Medical Officers of Health Section, and Affiliate organizations, I am writing to introduce the attached Resolution, which was passed by the alPHA membership at our 2026 Annual General Meeting.

This motion is asking that your Ministry consider, in consultation with appropriate stakeholders, shifting universal Hepatitis B virus (HBV) vaccination from Grade 7 to the first year of life, based on epidemiologic and economic evidence and programmatic considerations, to confer earlier protection against HBV. A combined DTaP-HB-IPV-Hib vaccine given at 2, 4, and 6 months of age is recommended to accomplish this.

A detailed rationale is outlined in the Resolution and accompanying background, and we hope you will take this information into careful consideration to further enhance protections from vaccine preventable diseases in Ontario during the earliest years of life.

We would be pleased to speak further on this matter with you and your staff. To schedule a meeting, please have your staff contact Loretta Ryan, Chief Executive Officer, alPHA, at loretta@alphaweb.org or 647-325-9594

Sincerely,



Carmen McGregor
Chair, alPHA

Copy: Dr. Kieran Moore, Chief Medical Officer of Health, Ontario
Elizabeth Walker, Executive Lead, Office of the Chief Medical Officer of Health

Encl.

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

alPHa RESOLUTION A26-01

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

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

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

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

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

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

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

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

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

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

WHEREAS a recent analysis modelling potential HBV immunization strategies for Ontario showed that providing 3 doses of the DTaP-HB-IPV-Hib vaccine (combination vaccine against 6 diseases) in infancy would lead to cost-savings compared to the current practice of administering the DTaP-IPV-Hib vaccines (combination vaccine against 5 diseases) in infancy plus the HBV vaccines in grade 7, due to reduced costs related to averted visits to healthcare providers, treatment costs, and complication costs, and noting this is also more favorable from a cost perspective than introducing birth dose HBV vaccination(10); and

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

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

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

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

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

Background

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

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

There are various Hepatitis B-containing vaccines available in Canada, alone or in combination with other vaccines that are already part of the current vaccination schedule¹.

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

Currently, the National Advisory Committee on Immunizations (NACI) does not give a specific recommendation regarding the best age for Hepatitis B vaccination. Instead, they leave it up to the provinces to make updates based on local epidemiology and specific programmatic considerations.(7)

Currently in Ontario, the Hepatitis B vaccine is routinely offered in Grade 7 (12 years of age) through the school immunization program, and a high-risk program is offered for younger age of vaccination for those most at risk. Immunization nurses visit schools twice a year to administer two doses at least 6 months apart.(5) With the current approach, most children remain unprotected from hepatitis B for the first 12 years of life.

There are two other approaches to Hepatitis B vaccination in Canada: vaccination at birth and vaccination in infancy.(11) Research shows that vaccinating children early in life is effective and safe.(4,16) Vaccination at birth² is done in New Brunswick, Northwestern Territories and Nunavut. WHO recommends universal vaccination at birth based on the evidence that mother to child transmission is the highest risk factor for Hepatitis B in childhood.(11) Vaccination in infancy³ is routinely done in British Columbia, Yukon, PEI and Quebec. Countries in Europe and the Americas have too successfully included Hepatitis B vaccine into their immunization programs in infancy.(9)

¹ ENGERIX-B-Pediatric, INFARIX hexa (DTaP-HB-IPV-Hib), RECOMBIVAX HB-Pediatric and TWINRIX Junior.

² At birth, at 1 month of age and at 6 months.

³ This can be achieved by giving a hepatitis B vaccine in addition to the current combination vaccine against five diseases (pentavalent vaccine + Hep B vaccine) or by giving one vaccine protecting against six diseases, including hepatitis B (hexavalent vaccine).

Hepatitis B vaccine is safe. There is no information suggesting that administering the vaccine at an earlier age is associated with safety concerns, the only exception being an increased risk of side effects among premature babies under 1500 g birth weight.(4) Moreover, there is no evidence that hepatitis B interferes with the immune response to any other vaccine or vice versa.(11) Likewise, there are no clinically meaningful differences in the safety profile of combination vaccines with and without the hepatitis B component.(9)

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

An Irish study found universal vaccination in infancy using a combination vaccine cost effective when compared to selective vaccination to newborns at high risk.(18) In the Ontario case, switching from the current practice of vaccination in grade seven to vaccination at birth or in infancy would prevent 37-38% of acute hepatitis B cases and 30-31% of chronic hepatitis B cases. Furthermore, birth vaccination would be cost-effective and infant immunization -involving vaccinating with a combined vaccine at 2, 4 and 6 months of age- would be cost saving.(10) This study considered costs of each vaccination modality, healthcare costs of hepatitis B disease and complications, and costs of years lost due to premature death and due to disability resulting from complications of hepatitis B infection.

In conclusion, hepatitis B and its complications are preventable with vaccination. Giving the vaccine earlier in life is safe and effective. A shift to a schedule that includes starting hepatitis B vaccination in the first year of life in Ontario would protect our children earlier and provide long-term cost-savings.

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

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

alPHa Sections:

Boards of Health
Section

Council of Ontario
Medical Officers of
Health (COMOH)

**Affiliate
Organizations:**

Association of Ontario
Public Health Business
Administrators

Association of
Public Health
Epidemiologists
in Ontario

Association of
Supervisors of Public
Health Inspectors of
Ontario

Health Promotion
Ontario

Ontario Association of
Public Health Dentistry

Ontario Association of
Public Health Nursing
Leaders

Ontario Dietitians in
Public Health

July 21, 2026

Hon. Sylvia Jones
Minister of Health
College Park, 5th Flr, 777 Bay St
Toronto, Ontario M7A 2J3

**Re: alPHa Resolution A26-02 - Strengthening Certified Public Health Inspector Capacity
to Support Delivery of the Ontario Public Health Standards**

On behalf of the Association of Local Public Health Agencies (alPHa) and its Boards of Health Section, Council of Ontario Medical Officers of Health Section, and Affiliate organizations, I am writing to introduce the attached Resolution, which was passed by the alPHa membership at our 2026 Annual General Meeting.

This motion outlines a series of measures we are asking your Ministry to consider implementing as strategies to build public health inspector (PHI) workforce capacity through recruitment, education pathways, practicums, mentorship, and retention.

A detailed rationale is outlined in the Resolution and accompanying background, and we hope you will take this information into careful consideration. Strengthening public health inspection capacity is a proven, prevention-focused approach to avoiding infectious disease outbreaks and reducing environmental health hazards, which in turn reduces pressures on emergency health-care and contributes to economic productivity.

We would be pleased to speak further on this matter with you and your staff. To schedule a meeting, please have your staff contact Loretta Ryan, Chief Executive Officer, alPHa, at loretta@alphaweb.org or 647-325-9594

Sincerely,



Carmen McGregor
Chair, alPHa

Copy: Dr. Kieran Moore, Chief Medical Officer of Health, Ontario
Elizabeth Walker, Executive Lead, Office of the Chief Medical Officer of Health
Robin Jones, President, Association of Municipalities of Ontario (AMO) Kelsie Dale, President, Canadian Institute of Public Health Inspectors (CIPHI) Ken Diplock, President, CIPHI Ontario Branch
Program Directors, CIPHI-accredited post-secondary academic institutions.

Encl.

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

alPHA RESOLUTION A26-02

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

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

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

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

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

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

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

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

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

WHEREAS The Ministry of Health has demonstrated leadership through the Ministry-led Public Health Inspector Workforce Capacity Working Group, established under the Office of

the Chief Medical Officer of Health, to inform strategies that build PHI workforce capacity across recruitment, education pathways, practicums, mentorship, and retention;

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

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

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



Backgrounder: Strengthening Certified Public Health Inspector Capacity to Support Ontario's Public Health System

Prepared by: Association of Supervisors of Public Health Inspectors of Ontario (ASPPIO)
Dominique Bremner (ASPPIO Chair)
Heidi Pitfield (alPHa Affiliate Member Representative)
Peter Heywood (ASPPIO Member)

For: alPHa Annual General Meeting & Resolutions Session

Date: June 9, 2026

Purpose

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

Background

1. Public Health Inspectors as essential public health system infrastructure

Certified Public Health Inspectors (PHIs) play a central role in delivering mandatory programs and services under the Ontario Public Health Standards (OPHS) and supporting Boards of Health in meeting requirements under the Health Protection and Promotion Act (HPPA). PHIs protect communities by preventing, identifying, and mitigating health hazards across multiple settings, including food premises, recreational water facilities, small drinking water systems, child care and congregate living settings, and other environments where preventable risks can have significant health and economic impacts.

Certified PHIs have specialized education, practicum training, and national certification, with competencies in risk assessment, infection prevention and control (IPAC), outbreak management, environmental health sciences, regulatory interpretation and enforcement, and effective public communication. This specialized training and regulatory authority supports consistent, high-quality inspection services and timely, evidence-informed decision-making.

2. Growing and evolving service demands

In recent years, PHI responsibilities have expanded in scope and complexity due to population growth, evolving regulatory requirements, emerging and novel infectious diseases, climate-related health risks, heightened IPAC expectations, and increased public expectations for transparency and timely response. PHIs are also routinely called upon to respond to urgent and emergencies, consistent with OPHS requirements for 24/7 readiness.

3. Lessons from the COVID-19 response and the need to strengthen capacity

The ASPHIO White Paper (June 2023) documents the critical contributions of PHIs to Ontario's COVID-19 response, including outbreak management in long-term care and other congregate settings; IPAC assessments and guidance; support for enforcement and Section 22 orders; and surge support for evolving public health priorities. At the same time, routine OPHS programming experienced service disruption and backlogs as PHIs were redeployed to pandemic response activities.

The White Paper also highlights workforce impacts that challenge sustainability, including burnout and mental distress, increased resignations, leaves of absence, and retirements, and reported incidents of harassment directed at PHIs. These pressures have compounded long-standing recruitment and retention challenges, particularly in northern and rural communities, and have reduced the availability of experienced staff to mentor and train new PHIs.

4. Value of prevention and the case for sustained investment

Preventive inspection and hazard prevention programs reduce the likelihood and severity of foodborne illness outbreaks, water contamination events, and IPAC lapses, and support continuity of operations for businesses and institutions. Strengthening PHI capacity helps Boards of Health deliver OPHS requirements, clear backlogs, address emerging local priorities, and maintain readiness for future public health emergencies.

Local public health agencies are currently facing challenges in meeting the required inspection frequencies outlined in the Ontario Public Health Standards (OPHS). This is primarily due to constraints in the staffing capacity of Public Health Inspectors (PHIs), which increases organizational risk for the Boards of Health that are responsible for statutory oversight. This situation highlights the critical need to address PHI staffing levels to improve compliance and support the Boards of Health in fulfilling their essential oversight responsibilities.

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

5. Building on Ministry of Health leadership and collaboration

ASPHIO recognizes and appreciates the Ontario Ministry of Health's leadership in convening the Ministry-led Public Health Inspector Workforce Capacity Working Group. The Working Group—established under the Office of the Chief Medical Officer of Health—provides a collaborative forum to

identify, assess, and prioritize PHI workforce capacity issues and opportunities, and to make recommendations to the Public Health Leadership Team.

The Working Group's Terms of Reference identify practical, professional pipeline (education – practicum - workforce) focused objectives, including: increasing enrolment in Ontario's accredited environmental health programs; exploring fast-track pathways; strengthening practicum quality and mentorship supports; partnering to attract internationally educated public health professionals; and considering targeted retention supports for northern and rural communities. This resolution is intended to complement this work by supporting timely, sustained staffing investments in PHI capacity.

6. Implementation considerations (for context)

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

The same submission recommended maintaining an annual investment of \$435,000 to enhance the PHI practicum pipeline through local public health agencies and support future workforce development.

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

Key message

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

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

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Ontario Association of
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Ontario Association of
Public Health Nursing
Leaders

Ontario Dietitians in
Public Health

July 21, 2026

Hon. Marjorie Michel
Minister of Health (Canada)
House of Commons
Ottawa, Ontario, K1A 0A6

**Re: alPHa Resolution A26-03 - Mandatory and Regulated Alcohol Labelling on Alcohol
Manufactured or Sold in Canada**

On behalf of the Association of Local Public Health Agencies (alPHa) and its Boards of Health Section, Council of Ontario Medical Officers of Health Section, and Affiliate organizations, I am writing to introduce the attached Resolution, which was passed by the alPHa membership at our 2026 Annual General Meeting.

This motion is asking that the Federal Government consider amendments to the *Food and Drugs Act* to mandate alcohol labelling to include health warnings, guidance for preventing consumption-related health risks, and standard drink sizes.

In passing this motion, our members also endorsed the [Statement](#) from Provincial / Territorial Chief Medical Officers of Health on Labelling of Alcohol Products, and are urging updates to Canada's [low-risk alcohol drinking guidelines](#) based on the Canadian Centre on Substance Use and Addiction's [Guidance on Alcohol and Health: Final Report](#).

A detailed rationale is outlined in the attached Resolution and accompanying background, and we hope you will take this information into careful consideration to strengthen Canada's alcohol-related health regulations to reflect alcohol's serious and significant health risks.

We would be pleased to speak further on this matter with you and your staff. To schedule a meeting, please have your staff contact Loretta Ryan, Chief Executive Officer, alPHa, at loretta@alphaweb.org or 647-325-9594

Sincerely,



Carmen McGregor
Chair, alPHa

Copy: Dr. Joss Reimer, Chief Public Health Officer of Canada
Dr. Kieran Moore, Chief Medical Officer of Health, Ontario
Elizabeth Walker, Executive Lead, Office of the Chief Medical Officer of Health

Encl.

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

alPHa RESOLUTION A26-03

TITLE	Mandatory and Regulated Alcohol Labelling on Alcohol Manufactured or Sold in Canada
SPONSORS	Middlesex-London Health Unit (MLHU) and Toronto Public Health (TPH)
WHEREAS	alcohol is a legal product with associated health harms and classified as a Group 1 carcinogen with a causal link to cancer (Babor, 2023; IARC, 1988; IARC, 2012; Paradis, 2023; Runggay, 2021); and
WHEREAS	alcohol caused an estimated 4,330 deaths, 22,009 hospitalizations, and 194,693 emergency department visits each year in people aged 15 and older in Ontario (Ontario Health and Ontario Agency for Health Protection and Promotion, 2023); and
WHEREAS	77% of Ontarians self-report alcohol use in the past 12 months and 33% report drinking alcohol at more than a low-risk level as per the <i>Canadian Guidance on Alcohol and Health</i> in the past week (Ontario Health and Ontario Agency for Health Protection and Promotion, 2023); and
WHEREAS	the harms due to alcohol are disproportionately carried by individuals from lower socioeconomic groups, compared to those from higher socioeconomic groups, despite often drinking less alcohol; described as the alcohol harm paradox (Bloomfield, 2020; CIHI, 2017); and
WHEREAS	many Canadians are unaware of: • alcohol’s relationship to cancer risk, especially at low levels of consumption, • what a standard drink of alcohol contains, and • guidance to reduce their alcohol risk (Government of Canada, 2024); and
WHEREAS	alcohol containers in Canada lack comprehensive health warning labels to inform consumers of the risks or ways to reduce risks; and
WHEREAS	labels are an effective tool to help consumers understand product risk (CCS, 2023; Hobin, 2022; Noar, 2016); and
WHEREAS	the membership previously carried alPHa RESOLUTION A24-03 : A Proposal for a Comprehensive Provincial Alcohol Strategy: Enhancing Public Health through Prevention, Education, Regulation and Treatment.

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

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

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

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

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

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

Background

Alcohol – No Ordinary Commodity

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

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

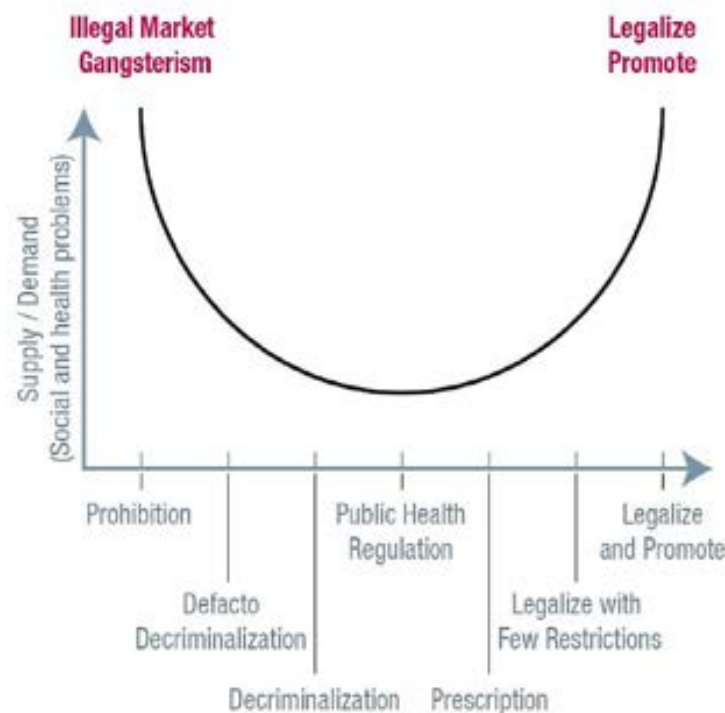
Public Health Approach to Preventing Harms from Alcohol

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

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

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

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



Rationale

Alcohol Labelling Supports Informed Choice by Consumers

In Canada, other legalized substances like commercial tobacco products and non-medical cannabis are required to display standardized labels that include health warnings and product information to inform consumers about associated health risks and have standardized packaging designed to reduce product promotion and appeal (Government of Canada, 2023; Government of Canada, 2025). While tobacco's labelling evolution took significant public health efforts to move from small text warnings in the 1970s to graphic health warnings and the plain packaging requirements that we see in Canada today, evidence confirms that these warning labels have increased awareness of health risks, reduced product appeal, and contributed to declines in smoking rates (Noar, 2016; CCS, 2023). The benefits of these tobacco

warning labels were significant enough to influence Canada's approach to packaging and labelling legalized, non-medical cannabis products in 2018, pictured below in Figure 2. Alcohol remains the outlier, as the only legalized substance that currently does not have a warning label.

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



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

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

Canadians Are Unaware of Health Harms from Alcohol

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

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

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

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

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

Alcohol Labelling and Youth Prevention

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

Summary

To address complex societal problems with significant public health burden, cooperation and collaboration between local, municipal, provincial, and federal partners are required. Impacts of alcohol consumption remain a substantial population health burden, and one that exceeds social and health care system capacity. The Middlesex-London Health Unit and Toronto Public Health support mandatory and

regulated alcohol labelling including health warnings, Canada's Guidance on Alcohol and Health, and standard drink size on all containers of alcohol manufactured and sold in Canada. It is a modest and evidence-informed policy that ensures that consumers are aware of the health harms associated with alcohol and is in alignment with Canada's approach to commercial tobacco products and the legalization of non-medical cannabis.

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

alPHa Sections:

Boards of Health
Section

Council of Ontario
Medical Officers of
Health (COMOH)

**Affiliate
Organizations:**

Association of Ontario
Public Health Business
Administrators

Association of
Public Health
Epidemiologists
in Ontario

Association of
Supervisors of Public
Health Inspectors of
Ontario

Health Promotion
Ontario

Ontario Association of
Public Health Dentistry

Ontario Association of
Public Health Nursing
Leaders

Ontario Dietitians in
Public Health

July 21, 2026

Hon. Michael Parsa
Minister of Children, Community and Social Services
7th Floor, 438 University Ave.
Toronto, ON M5G 2K8

Re: alPHa Resolution A26-04 - Enhancing the Ontario Works Benefit

On behalf of the Association of Local Public Health Agencies (alPHa) and its Boards of Health Section, Council of Ontario Medical Officers of Health Section, and Affiliate organizations, I am writing to introduce the attached Resolution, which was passed by the alPHa membership at our 2026 Annual General Meeting.

This motion is asking that your Ministry consider a series of measures to ensure that income from the Ontario Works program is sufficient to address growing household food insecurity among the province's most vulnerable families. The inability to afford basic necessities, especially food, is a strong predictor of poor physical and mental health, which in turn cost Ontario an estimated \$5.6 billion in annual health care and economic productivity costs.

A detailed rationale is outlined in the Resolution and accompanying background, and we hope you will take this information into careful consideration to ensure that all Ontarians can afford basic needs, which will make a significant contribution to your Government's stated objective to make life more affordable across the province.

We would be pleased to speak further on this matter with you and your staff. To schedule a meeting, please have your staff contact Loretta Ryan, Chief Executive Officer, alPHa, at loretta@alphaweb.org or 647-325-9594

Sincerely,



Carmen McGregor
Chair, alPHa

Copy: Hon. Doug Ford, Premier of Ontario
Dr. Kieran Moore, Chief Medical Officer of Health, Ontario
Elizabeth Walker, Executive Lead, Office of the Chief Medical Officer of Health

Encl.

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

alPHa RESOLUTION A26-04

TITLE	Enhancing the Ontario Works Benefit
SPONSORS	Middlesex-London Health Unit (MLHU), Huron Perth Public Health Unit (HPPH), Windsor-Essex County Health Unit (WECHU) and Oxford-Elgin-St. Thomas Public Health Unit (also known as Southwestern Public Health Unit, SWPH)
WHEREAS	household food insecurity (HFI), the inadequate or insecure access to food due to financial constraints, is a critical indicator of a household's financial situation, their ability to afford basic needs, and a highly sensitive measure of material deprivation;
WHEREAS	HFI is an important social determinant of health, a strong predictor of poor health, and is associated with an increased risk of a wide range of physical and mental health challenges, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress;
WHEREAS	poor diet quality costs Ontario an estimated \$5.6 billion annually in direct healthcare costs and indirect costs (e.g., lost productivity due to disability and premature mortality), with higher costs associated with more severe food insecurity;
WHEREAS	from 2020 to 2024, Ontario's food insecurity rates have significantly increased from 1 in 6 households (17.1%) to 1 in 4 households (25.3%);
WHEREAS	Ontario Works (OW) rates are inadequate for households to afford basic needs;
WHEREAS	67.2% of Ontario households reliant on OW or Ontario Disability Support Program (ODSP) were food insecure in 2021;
WHEREAS	OW income plus all eligible family and tax benefit entitlements is \$11,500-\$23,500 below Canada's Official Poverty Line and \$4,000-\$11,500 below the Deep Income Poverty threshold for various household scenarios (e.g., single person household, single parent with one child, and couple with two children);
WHEREAS	based on average provincial rent and food costs, Ontario households (e.g., single person, family of 4) receiving OW and all eligible family and tax benefit entitlements need an additional \$333-\$817 per month to afford rent and food, plus funds for all

additional expenses, and a single parent with 2 children has only \$447 remaining to pay for all additional expenses;

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

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

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

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

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

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

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

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

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

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

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

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

Statement of Sponsor Commitment

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

Background

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

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

Food Insecurity in Ontario

Household food insecurity (HFI) is the inadequate or insecure access to food due to financial constraints¹. HFI is a critical indicator of a household's financial situation and their ability to afford basic needs, and a highly sensitive measure of material deprivation¹.

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

Poor diet quality costs Ontario an estimated \$5.6 billion annually in direct healthcare and indirect costs (e.g., lost productivity due to disability and premature mortality)⁴, with higher costs associated with more severe food insecurity⁵.

Current Situation

- From 2020 to 2024, Ontario's food insecurity rates significantly increased from 17.1% (1 in 6 households) to 25.3% (1 in 4 households)⁶.
- In 2024, 4,055,000 people lived in a food insecure household in Ontario, including 33.3% of children under 18⁷.
- From 2022 to 2024, Middlesex-London's food insecurity rates significantly increased from 17.5% (1 in 6 households) to 31.3% (1 in 3 households)⁶.

Inadequacy of Ontario Works

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

- In 2021, 67.2% of Ontario households reliant on social assistance were food insecure¹.

- In 2024, Ontario Works income plus all eligible family and tax benefit entitlements was \$11,504-\$23,498 below Canada's Official Poverty Line (i.e., Market Basket Measure) and \$4,171-\$11,452 below the Deep Income Poverty threshold (i.e., Market Basket Measure – Deep Income Poverty) for various household scenarios (e.g., single person household, single parent with one child, and couple with two children)⁸.
- Based on average provincial rent and food costs, Ontario households (e.g., single person, family of 4) receiving Ontario Works and all eligible family and tax benefit entitlements (e.g., Ontario Trillium Benefit, Canada Child Benefit) need an additional \$333-\$817 per month to afford rent and food, plus funds for all additional expenses, and a single parent with 2 children has only \$447 remaining to pay for all additional expenses².
- Middlesex-London households receiving Ontario Works (e.g., single person, single parent with 2 children, family of 4) and all eligible family and tax benefit entitlements (e.g., Ontario Trillium Benefit, Canada Child Benefit) need an additional \$7-\$558 per month to afford rent and food, plus funds for all additional expenses⁹.

Ontario Works Earned Income Exemption

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

The earned income exemption was established in 2013 to encourage workforce participation¹⁰. However, the exemption has not increased since it started¹¹, while minimum wage in Ontario has increased from \$10.25 to \$17.60 per hour and cost of living, as measured by the Consumer Price Index in Ontario, has increased by 36.9% (121.3 to 166.1)¹².

In 2013, greater than 19.5 hours of minimum wage work per month resulted in a reduction in OW benefits ($\$10.25 \times 19.5 = \199.88). In 2026, greater than 11.5 hours of minimum wage work per month results in a reduction in OW benefits ($\$17.60 \times 11.5 = \202.40). Benefit reductions at the current level impact the ability to afford the cost of living and create a deterrent to workforce participation¹³. An increased earned income exemption would help households afford the cost of living and help support people working toward leaving the OW program.

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

Comparison to Ontario Disability Support Program (ODSP)

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

- ODSP rates are increased annually based on inflation, with the first inflation-based increase in 2025¹⁴.

- ODSP earned income exemption increased from \$200 to \$1,000 per month in 2023, with benefits reduced by 75 cents for every additional dollar earned¹⁵. There is no waiting period for the ODSP earned income exemption.
- Aligning OW earned income rules with those of ODSP would improve income adequacy and reduce inequities between social assistance programs.
- While the OW benefit reduction rate (50%) appears lower than ODSP's reduction rate (75%), the much lower OW earned income exemption (\$200 vs. \$1,000) means that OW recipients begin to lose benefits at far lower levels of earned income.
- As shown in Table 1, an individual receiving OW would need to earn approximately \$2,600 per month before experiencing the same \$1,200 reduction in benefits as an individual receiving ODSP. This level of earned income is unrealistic for most OW recipients, given that individuals typically qualify for OW due to significant barriers to employment, including unstable work, caregiving responsibilities, health challenges, or recent job loss.
- In practice, the current OW structure results in earlier and steeper benefit reductions, discouraging workforce participation and undermining income stability. Aligning OW earned income exemptions and reduction rates with ODSP would allow individuals to increase earnings without immediate loss of essential income supports.

Table 1. Ontario Works and ODSP Earned Income Exemption Comparison

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

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SOUTHWESTERN PUBLIC HEALTH

For the Six Months Ending June 30, 2026

STANDARD/ PROGRAM	YEAR TO DATE			FULL YEAR BUDGET	VAR	% SPENT YTD
	ACTUAL	BUDGET	VAR			
Direct Program Costs						
Foundational Standards						
Emergency Management	\$73,743	\$82,845	\$9,102	\$165,690	\$91,947	45. %
Effective Public Health Practise	162,051	169,556	7,505	339,113	177,062	48. %
Health Equity Program	101,367	124,435	23,068	248,870	147,503	41. %
Population Health Assessment	205,356	210,291	4,935	420,581	215,225	49. %
Foundational Standards Total	542,517	587,127	44,610	1,174,254	631,737	46. %
Chronic Disease Prevention & Well-Being						
Built Environment	154,085	152,184	-1,901	304,367	150,282	51. %
Healthy Eating Behaviours	54,897	56,870	1,973	113,740	58,843	48. %
Suicide Risk & Mental Health Promotion	95,235	105,302	10,068	210,605	115,370	45. %
Chronic Disease Prevention & Well-Being Total	304,217	314,356	10,139	628,712	324,495	48. %
Food Safety						
Food Safety (Education, Promotion & Inspection)	229,929	236,977	7,048	473,954	244,025	49. %
Food Safety Total	229,929	236,977	7,048	473,954	244,025	49. %
Healthy Environments						
Climate Change	116,974	122,052	5,078	244,105	127,131	48. %
Healthy Environments/Health Hazards	262,846	298,030	35,184	596,060	333,214	44. %
Healthy Environments Total	379,820	420,082	40,262	840,165	460,344	45. %
Healthy Growth & Development						
Breastfeeding	236,823	218,107	-18,716	436,214	199,391	54. %
Parenting	262,587	291,260	28,673	582,519	319,932	45. %
Reproductive Health/Healthy Pregnancies	278,375	310,435	32,059	620,869	342,494	45. %
Healthy Growth & Development Total	777,785	819,802	42,016	1,639,602	861,817	47. %
Immunization						
Vaccine Administration	82,618	82,295	-323	164,590	81,972	50. %
Vaccine Management	72,948	79,175	6,227	158,350	85,402	46. %
Immunization Monitoring and Surveillance	63,648	69,730	6,082	139,460	75,812	46. %
Respiratory Response	51,120	130,017	78,897	260,035	208,914	20. %
Immunization Total	270,334	361,217	90,884	722,435	452,101	37. %
Infectious & Communicable Diseases						
Infection Prevention & Control	1,076,704	1,156,339	79,635	2,312,679	1,235,975	47. %
Needle Syringe Program	18,264	29,000	10,736	58,000	39,736	31. %
Rabies Prevention and Control and Zoonotics	74,577	77,647	3,070	155,294	80,717	48. %
Sexual Health	544,912	596,149	51,237	1,192,298	647,386	46. %
Tuberculosis Prevention and Control	69,085	76,571	7,487	153,142	84,058	45. %
Vector-Borne Diseases	112,984	144,929	31,945	289,857	176,874	39. %
Infectious & Communicable Diseases Total	1,896,526	2,080,635	184,110	4,161,270	2,264,746	46. %
Safe Water						
Water	59,268	76,685	17,417	153,370	94,102	39. %
Safe Water Total	59,268	76,685	17,417	153,370	94,102	39. %
School Health - Oral Health						
Healthy Smiles Ontario	432,198	462,515	30,317	925,031	492,833	47. %
School Screening and Surveillance	192,415	192,897	482	385,794	193,379	50. %
School Health - Oral Health Total	624,613	655,412	30,799	1,310,825	686,212	48. %
School Health - Immunization						
School Immunization	696,237	673,885	-22,352	1,347,769	651,533	52. %
School Health - Other						
Comprehensive School Health	827,860	880,270	52,410	1,760,540	932,680	47. %
Substance Use & Injury Prevention						
Harm Reduction Enhancement	74,281	89,827	15,546	179,655	105,374	41. %
Injury Prevention	113,936	117,701	3,766	235,402	121,467	48. %
Smoke Free Ontario Strategy: Prosecution	119,346	163,785	44,439	327,570	208,224	36. %
Substance Misuse Prevention	222,965	246,747	23,782	493,495	270,530	45. %
Substance Use & Injury Prevention Total	530,528	618,060	87,533	1,236,122	705,594	43. %
TOTAL DIRECT PROGRAM COSTS	7,139,634	7,724,508	584,875	15,449,018	8,309,385	46. %
INDIRECT COSTS						
Indirect Administration	1,879,180	1,818,608	-60,572	3,637,217	1,758,037	52. %
Corporate	100,045	123,600	23,555	247,200	147,155	40. %
Board	30,104	28,775	-1,329	57,550	27,446	52. %
HR - Administration	371,067	506,930	135,863	1,013,860	642,793	37. %

SOUTHWESTERN PUBLIC HEALTH

For the Six Months Ending June 30, 2026

STANDARD/ PROGRAM	YEAR TO DATE			FULL YEAR		% SPENT YTD
	ACTUAL	BUDGET	VAR	BUDGET	VAR	
Communications	24,968	29,575	4,607	59,150	34,182	42. %
Premises	805,488	881,890	76,402	1,763,780	958,292	46. %
TOTAL INDIRECT COSTS	3,210,852	3,389,378	178,527	6,778,757	3,567,905	47. %
TOTAL GENERAL SURPLUS/DEFICIT	10,350,486	11,113,886	763,403	22,227,775	11,877,291	47. %
100% MINISTRY FUNDED PROGRAMS						
MOH Funding	58,394	62,110	3,716	124,220	65,826	47. %
Ontario Seniors Dental Care Program (OSDCP)	515,909	530,550	14,641	1,061,100	545,191	49. %
TOTAL 100% MINISTRY FUNDED	574,303	592,660	18,357	1,185,320	611,017	48. %
One-Time Funding - April 1, 2026 to March 31, 2027						
OTF Public Health Inspector Practicum Program	12,058	5,000	-7,058	20,000	7,942	60. %
OTF Infection Prevention and Control (IPAC) Hubs	100,057	103,113	3,056	412,450	312,393	24. %
OTF Woodstock Facility	99,542	300,000	200,458	1,200,000	1,100,458	8. %
Total OTF	211,657	408,113	196,456	1,632,450	1,420,793	
Programs Funded by Other Ministries, Agencies						
Healthy Babies Healthy Children	400,957	453,477	52,520	1,813,909	1,412,952	22. %
Pre and Post Natal Nurse Practitioner	34,443	34,750	307	139,000	104,557	25. %
PHAC Smoking Cessation Partnership	48,725	30,372	-18,353	121,489	72,764	40. %
HeatADAPT- Climate Change and Health Capacity Building Program	110,069	64,449	-45,620	257,797	147,728	43. %
iHEAL Program	135,624	86,647	-48,978	346,586	210,962	39. %
UW Oxford Planet Youth OTF	20	7,500	7,480	30,000	29,980	0. %
Total Programs Funded by Other Ministries, Agencies	729,838	677,195	-52,643	2,708,781	1,978,943	

Ministry of Health

Office of Chief Medical Officer of
Health, Public Health
Box 12,
Toronto, ON M7A 1N3

Fax: 416 325-8412

Ministère de la Santé

Bureau du médecin hygiéniste en
chef, santé publique
Boîte à lettres 12
Toronto, ON M7A 1N3

Téléc. : 416 325-8412

July 20, 2026

Bernia Martin
Chair, Board of Health
Oxford Elgin St. Thomas Health Unit
1230 Talbot Street
St. Thomas ON N5P 1G9

Dear Bernia Martin:

Re: Ministry of Health Public Health Funding and Accountability Agreement with the Board of Health for the Oxford Elgin St. Thomas Health Unit (the “Board of Health”) dated January 1, 2014, as amended (the “Agreement”)

To support the Immunization Repository Consolidation project and allow vaccinators to access immunization records for clinical decision-making and provision of care to their patients, the Ministry of Health (the Ministry), under the authority of the *Health Protection and Promotion Act* (HPPA), will be requiring that Boards of Health make available to the Ministry, immunization records (including personal health information) and vaccine inventory data collected and submitted in Panorama.

Under this custodianship model, the Ministry will be the single health information custodian that will disclose immunization records in Panorama to vaccinators (e.g., through the Panorama Guided Workflow). For clarity, Boards of Health will remain as custodian of the records they collect and submit into Panorama, and will continue to collect, use and disclose COVID-19 vaccine records for their provision of COVID-19 vaccines to individuals. The disclosure of data to the Ministry by Boards of Health is expected to operate similarly to the requirement under section 8 of the *Reports Regulation* under the HPPA. However, rather than Boards of Health forwarding records, the Ministry will access this information within Panorama. As a result, no physical or digital copies of Panorama records need to be shared outside of Panorama, supporting data security.

I am pleased to provide you with a new Schedule C (Reporting Requirements) that, pursuant to section 3.3 of the Agreement, shall replace the existing schedule. All terms and conditions contained in the Agreement remain in full force and effect.

We appreciate your cooperation with the Ministry in managing your funding as effectively as possible and in adhering to our reporting requirements.

Bernia Martin

Please review the new Schedules carefully. Should you require any further information and/or clarification, please contact Brent Feeney, Director, Accountability and Liaison Branch, Office of Chief Medical Officer of Health, Public Health Division, at 416-671-3615 or by email at Brent.Feeney@ontario.ca.

Yours truly,



Elizabeth Walker
Executive Lead

Attachments

C: Dr. Ninh Tran, Medical Officer of Health, Oxford Elgin St. Thomas Health Unit
Cynthia St. John, Chief Executive Officer, Oxford Elgin St. Thomas Health Unit
Monica Nusink, Director of Finance, Oxford Elgin St. Thomas Health Unit
Dr. Kieran Moore, Chief Medical Officer of Health and Assistant Deputy Minister, MOH
Brent Feeney, Director, Accountability and Liaison Branch, MOH
Robert Lerch, Director, Vaccine Policy and Programs Branch, MOH
Michael Sherar, President and Chief Executive Officer, Public Health Ontario

New Schedules to the Public Health Funding and Accountability Agreement

**BETWEEN THE PROVINCE AND THE BOARD OF HEALTH
(BOARD OF HEALTH FOR THE OXFORD ELGIN ST. THOMAS HEALTH UNIT)
EFFECTIVE AS OF THE 1ST DAY OF JANUARY 2026**

SCHEDULE C REPORTING REQUIREMENTS

The reports mentioned in this Schedule are provided for every Board of Health Funding Year unless specified otherwise by the Province.

The Board of Health is required to provide the following reports/information in accordance with direction provided in writing by the Province (and according to templates provided by the Province):

Name of Report	Reporting Period	Due Date
1. Annual Service Plan and Budget Submission	For the entire Board of Health Funding Year	March 1 of the current Board of Health Funding Year
2. Quarterly Standards Activity Reports		
Q2 Standards Activity Report	For Q1 and Q2	July 31 of the current Board of Health Funding Year
Q3 Standards Activity Report	For Q3	October 31 of the current Board of Health Funding Year
Q4 Standards Activity Report	For Q4	January 31 of the following Board of Health Funding Year
3. Annual Report and Attestation	For the entire Board of Health Funding Year	April 30 of the following Board of Health Funding Year
4. Annual Reconciliation Report	For the entire Board of Health Funding Year	April 30 of the following Board of Health Funding Year
5. MOH / AMOH Compensation Initiative Application	For the entire Board of Health Funding Year	As directed by the Province
6. Other Reports and Submissions	As directed by the Province	As directed by the Province

Definitions

For the purposes of this Schedule, the following words shall have the following meanings:

“Q1” means the period commencing on January 1st and ending on the following March 31st.

“Q2” means the period commencing on April 1st and ending on the following June 30th.

“Q3” means the period commencing on July 1st and ending on the following September 30th.

“Q4” means the period commencing on October 1st and ending on the following December 31st.

Report Details

Annual Service Plan and Budget Submission

- The Annual Service Plan and Budget Submission Template sets the context for reporting required of the Board of Health to demonstrate its accountability to the Province.
- When completed by the Board of Health, it will: describe the complete picture of programs and services the Boards of Health will be delivering within the context of the Ontario Public Health Standards; demonstrate that Board of Health programs and services align with the priorities of its communities, as identified in its population health assessment; demonstrate

SCHEDULE C

REPORTING REQUIREMENTS

accountability for planning – ensure the Board of Health is planning to meet all program requirements in accordance with the Ontario Public Health Standards, and ensure there is a link between demonstrated needs and local priorities for program delivery; demonstrate the use of funding per program and service.

Quarterly Standards Activity Reports

- The Quarterly Standards Activity Reports will provide financial forecasts and interim information on program achievements for all programs governed under the Agreement.
- Through these Standards Activity Reports, the Board of Health will have the opportunity to identify risks, emerging issues, changes in local context, and programmatic and financial adjustments in program plans.
- The Quarterly Standards Activity Reports shall be signed on behalf of the Board of Health by an authorized signing officer.

Annual Report and Attestation

- The Annual Report and Attestation will provide a year-end summary report on achievements on all programs governed under the Agreement, in all accountability domains under the Organizational Requirements, and identification of any major changes in planned activities due to local events.
- The Annual Report will include a narrative report on the delivery of programs and services, fiduciary requirements, good governance and management, public health practice, and other issues, year-end report on indicators, and a board of health attestation on required items.
- The Annual Report and Attestation shall be signed on behalf of the Board of Health by an authorized signing officer.

Annual Reconciliation Report

- The Board of Health shall provide to the Province an Annual Reconciliation Report for funding provided for public health programs governed under the Accountability Agreement.
- The Annual Reconciliation Report must contain: Audited Financial Statements; and, Auditor's Attestation Report in the Province's prescribed format.
- The Annual Reconciliation Report shall be signed on behalf of the Board of Health by an authorized signing officer.

MOH / AMOH Compensation Initiative Application

- The Board of Health shall complete and submit an annual application to participate in this Initiative and be considered for funding.
- Supporting documentation such as employment contracts must be provided by the Board of Health, as requested by the Province.
- Application form templates and eligibility criteria/guidelines shall be provided by the Province.

SCHEDULE C

REPORTING REQUIREMENTS

Panorama Immunization Record and Inventory Reporting

- The Board of Health shall make available to the Province, using Panorama or any other method specified by the Province, immunization records and inventory data under their custody and control.

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

alPHA Sections:

Boards of Health
Section

Council of Ontario
Medical Officers of
Health (COMOH)

**Affiliate
Organizations:**

Association of Ontario
Public Health Business
Administrators

Association of
Public Health
Epidemiologists
in Ontario

Association of
Supervisors of Public
Health Inspectors of
Ontario

Health Promotion
Ontario

Ontario Association of
Public Health Dentistry

Ontario Association of
Public Health Nursing
Leaders

Ontario Dietitians in
Public Health

August 20, 2026

Hon. Sylvia Jones
Minister of Health
College Park, 5th Flr,
777 Bay St
Toronto, Ontario M7A 2J3

Dear Minister Jones,

Re: Provincial Funding for Local Public Health Agencies

On behalf of the Association of Local Public Health Agencies (alPHA), including its Boards of Health Section, the Council of Ontario Medical Officers of Health Section, and our Affiliate Organizations, I am writing to acknowledge and thank you for announcing an extension of the 1% annual increase in provincial base funding for local public health units for another year.

We appreciate the Province's continued commitment to local public health and the greater certainty this provides as boards of health plan and allocate resources for the coming year.

At the same time, alPHA remains concerned that a 1% annual increase is not sufficient to maintain the current scope of provincially mandated public health programs and services. According to the Bank of Canada, inflation has averaged nearly 3.5 per cent over the past five years, and corresponding annual public health base funding increases have been well under this rate. This has contributed to ongoing pressure on local public health capacity.

Inflationary pressures have a measurable impact on local public health agencies' capacity to deliver the programs and services for which they are legally responsible under Ontario's Health Protection and Promotion Act (HPPA) and the Ontario Public Health Standards. In addition to these, they must absorb substantial costs related to collective bargaining, operating costs, technology upgrades, innovation strategies related to program and service delivery, facilities, and expenditures related to growing and changing populations.

As cost pressures outpace investments year after year, our members are experiencing increasing difficulty in maintaining capacity, service reliability, and readiness. Local public health agencies are committed to prudent financial management, pursuing efficiencies and innovation, sharing approaches, and collaborating with municipal and health-system partners. However, these measures on their own cannot fully address the growing gap between available funding for our mandate and the cost of fulfilling it.

A healthy economy is not possible without healthy people. Public health is a foundational component of Ontario's health-care system and is a critical driver of economic strength. By preventing illness, protecting communities, and promoting long-term health, public health contributes to higher productivity, reduced health-care costs, and economic prosperity. For these reasons, public health needs sufficient, predictable, and sustained funding to ensure its long-term stability.

Public health units will continue to make every effort to deliver essential services and protect the health of their communities with the resources available to them, and alPHa looks forward to continuing its constructive relationship with the Province and to working together to support strong, effective and sustainable public health services across Ontario.

We would be pleased to discuss this with you further, and welcome your staff to contact Loretta Ryan, Chief Executive Officer, alPHa, at loretta@alphaweb.org or 416-595-0006 x 222 to follow up.

Sincerely,

A handwritten signature in blue ink, reading "Carmen McGregor".

Carmen McGregor
alPHa Chair

Copy: Dr. Kieran Moore, Chief Medical Officer of Health, Ontario
Elizabeth Walker, Executive Lead, Office of Chief Medical Officer of Health

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

Governance Standing Committee Report



OPEN Session

Meeting date: September 24, 2026

Submitted by: Grant Jones, Chair (written as of September 14, 2026)

Submitted to: Board of Health

Purpose: ☒ Decision
☐ Discussion
☒ Receive and file

Agenda item # 5.3

Resolution # 2026-BOH-0924-5.3

1.0 Southwestern Public Health By-law and Policy Review

On July 15, 2026, the Governance Standing Committee completed its biennial review of Southwestern Public Health's (SWPH) Bylaws and Board of Health (BOH) policies. This fulsome review ensures our regulatory framework remains current, effective, aligned with best practices, and remains in compliance with the Health Protection and Promotion Act (HPPA), the Municipal Act, 2001, and the Municipal Conflict of Interest Act.

1.1 BY-LAW NO. 1-3 REVIEW (Decision)

Regarding By-laws No. 1-3, there are two substantive changes to note in By-law 1, highlighted in yellow in the table below:

BYLAW SECTION	PROPOSED CHANGE
Bylaw 1: Section (S. 17-27) on Meetings of the Board	RATIONALE: An explicit provision has been added to formalize the Board's commitment to open and transparent meetings in alignment with modern Ontario Ombudsman guidelines and provincial legislation. ADD: 28. Open Board Meetings. Board meetings shall be open to the public except where applicable laws otherwise permit or require. The Board shall adopt a policy with respect to closed (in-camera) meetings.

BYLAW SECTION	PROPOSED CHANGE
Bylaw 1, Section (S.66-75) on Officers	RATIONALE: The section has been amended to reflect a 2nd year term option for the Chair/Vice-Chair, removing ‘extenuating circumstances’ as the only reason for serving a consecutive year. Further, an allowance has been made for potentially serving a third consecutive term if no other nominations are received. REMOVE: “In extenuating circumstances, for which an explanation is provided to the Board, an officer may serve for a second consecutive year subject to being elected and qualified.”
	EDIT: 68. Election and Removal of the Chair and Vice Chair. Any member of the Board may serve as an officer of the Board. The Chair and Vice Chair shall be elected at the first meeting of the Board each calendar year. Nominations for Chair and Vice-Chair will be solicited at the first meeting and a majority vote will determine the election result. If more than one nomination is received for each Officer position, a secret ballot will be conducted. The ballots will be distributed by the Recording Secretary and counted by the Secretary-Treasurer. All officers shall serve for a term of one calendar year or until their successors are elected and qualified. Officers are eligible for re-election to a second consecutive one-year term. Service is limited to two consecutive terms, unless no other nominations are received. (NOTE: Numbering after this additional section to By-law 1 will be adjusted accordingly.)

Additionally, but not substantively, all By-laws and BOH policy documents will be reformatted by the start of 2027 to ensure compliance with the Accessibility for Ontarians with Disabilities Act (AODA) updates.

MOTION: 2026-GSC-0924-5.3-1.1

That the Board of Health for Southwestern Public Health approve the amendments to By-law No. 1 as presented.

1.2 BOARD POLICY REVIEW (Decision)

1.2.1 Board Policies: Proposed Updates and Revisions

Below are policies that have recommended amendments. The policies with the changes marked are attached to the meeting package. Where there have been substantial edits made to the policy, the chart below will only summarise the changes and direct you to review the entire attached document.

BOH POLICY		PROPOSED EDITS
GOVERNANCE		
1.	BOH-GOV-030 Delegation of Powers and Duties	• POLICY TITLE CHANGE TO: • BOH-GOV-030 Delegation of Authority (Powers and Duties) • The Delegation of Authority (Powers and Duties) policy has been amended to reflect current governance practices and provide greater clarity regarding the respective roles and responsibilities of the Board of Health and the Chief Executive Officer (CEO). This policy has been comprehensively revised; please review the document in its entirety. • The revised policy establishes overarching principles for the delegation of authority, identifies matters reserved exclusively to the Board, and consolidates existing delegations related to financial administration, execution of agreements, and statutory responsibilities under the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA). • A new governance continuity section has been introduced to address circumstances in which the Board is temporarily unable to achieve quorum, such as during municipal election transitions or delays in Board appointments. This section confirms the continuation of existing Board authorities and delegated CEO responsibilities, outlines caretaking principles to guide decision-making during transition periods, and establishes reporting requirements for significant actions taken until the Board is reconstituted. • The policy has also been reorganized and modernized to improve readability, strengthen accountability, and align with contemporary governance practices while preserving the Board's strategic oversight role. A clean copy of the proposed amendments has been provided alongside a version that shows the changes that have been made to the current policy.
2.	BOH-GOV-040 Recording of Board of Health Meetings	• Slight changes to wording in Items 1, 3, and 4: • 1. Notification and Consent: At the beginning of each meeting, the Chair will inform attendees, including members of the public, that the meeting will be recorded and the open session portion shall be made available on SWPH's public website. • 3. Public Access: Recordings will be made available to the public via a link on Southwestern Public Health's (SWPH) website within five business days after the meeting. • 4. Retention and Disposal: Recordings will be retained as part of the public record for a period defined by SWPH's record retention policy. After this period, recordings will be disposed of in a secure manner and in keeping with SWPH's file destruction policy, unless required for legal, audit, or archival purposes.
3.	BOH-GOV-060 Terms for Election of Officers	• This policy has been amended to align directly with By-Law No. 1, standardizing a two-term eligibility limit to promote leadership continuity while establishing a clear fail-safe to prevent a vacancy if no other nominations are received.

BOH POLICY		PROPOSED EDITS
		Edit: Current wording: The purpose is to promote continuity by ensuring members elected to be chair or vice-chair may serve for two consecutive terms. Proposed edit: The purpose of this policy is to establish clear parameters for the election and term limits of the Chair and Vice-Chair. Add: - Incumbents may be re-elected for a total of two consecutive terms before a one-year break in the role served before being re-elected for another term, in accordance with Bylaw No. 1. An incumbent may be elected to a subsequent consecutive term if no other nominations are received and that individual is subsequently elected by the Board.
HUMAN RESOURCES		
4.	BOH-HR-020 Board of Health Self-Evaluation	POLICY TITLE CHANGE TO: BOH-GOV-120 Board of Health Evaluation and Development - The Board of Health Self-Evaluation Policy has undergone substantive changes and the full policy and Competency Matrix Survey are appended for review alongside its previous version for comparison. The current policy focuses on evaluating the Board's governance practices only and does not reflect the Board Competency Matrix Survey that has since been implemented. - The proposed redeveloped policy formally recognizes both the Board Self-Evaluation Survey (renamed Board Governance: Member Evaluation) and the Competency Matrix Survey. It also clarifies the Competency Matrix Survey's distinct purpose and timing as well as confirms the Governance Standing Committee's role in reviewing competency results and recommending Board development initiatives. The revised policy will better support continuous governance improvement and align Board policy with current governance practices. - We also support that this policy (and its appendices) be reclassified from the Human Resources section to the Governance section, to better reflect its purpose and intent.
5.	Competency Matrix Survey	SURVEY TITLE CHANGE TO: BOH-GOV-120A (Appendix A): Board Competency Matrix Survey
6.	BOH-HR-020 Appendix A: Board of Health Self-Evaluation Survey	SURVEY TITLE CHANGE TO: BOH-GOV-120B (Appendix B): Board Governance: Member Evaluation Survey - Cross-references in the preamble would change accordingly.
POLICY MANAGEMENT		

BOH POLICY		PROPOSED EDITS
7.	BOH-PM-010 Policy Management	• Changes to Paragraph 3 in the Policy section: • Edit: "SWPH's Bylaws are reviewed at least every five years, or sooner as required, by the CEO or their designate to ensure applicability and the potential need for any amendments and/or additions."

MOTION: 2026-GSC-0924-5.3-1.2.1

That the Board of Health for Southwestern Public Health approve the updated policies as presented:

1. BOH-GOV-030 Delegation of Authority (Powers and Duties)
2. BOH-GOV-040 Recording of Board of Health Meetings
3. BOH-GOV-060 Terms for Election of Officers
4. BOH-GOV-120 Board of Health Evaluation and Development Policy
5. BOH-GOV-120A (Appendix A): Board Competency Matrix Survey
6. BOH-GOV-120B (Appendix B): Board Governance: Member Evaluation Survey
7. BOH-PM-010 Policy Management

1.2.2 Board Policies: No Revisions Required

Below is a list of Board of Health policies that have been reviewed and that, in our opinion, do not require any amendments other than ensuring they will be formatted in accordance with AODA recommendations by the start of 2027. These policies are not attached as they can be accessed via the links below on the Board portal for your reference.

POLICY NUMBER		POLICY NAME
GOVERNANCE POLICIES		
	BOH-GOV-010	Conflict of Interest Appendix A - Form - Written Statement of Disclosure
	BOH-GOV-020	Board Member Oath of Conduct and Confidentiality Appendix A - Form - Oath of Conduct and Confidentiality
	BOH-GOV-030	Delegation of Powers and Duties Appendix A - Delegation of Powers and Duties
	BOH-GOV-050	Accountability and Transparency
	BOH-GOV-070	Board Member Orientation
	BOH-GOV-080	Order in Council Provincial Representatives
	BOH-GOV-090	Board Member Attendance Policy
	BOH-GOV-100	Political Activities Policy
	BOH-GOV-110	Board Standing Committee Membership

POLICY NUMBER		POLICY NAME
FINANCE POLICIES		
	BOH-FIN-010	Reserve Fund
	BOH-FIN-020	Board Members' Remuneration
	BOH-FIN-030	Budgets
	BOH-FIN-040	Banking and Financing
	BOH-FIN-050	Board Member Allowable Expenses
HUMAN RESOURCES POLICIES		
	BOH-HR-030	CEO and MOH Performance Appraisals
	BOH-HR-040	Delegation of Duties of MOH & CEO
	BOH-HR-050	In Memoriam Acknowledgement
	BOH-HR-060	COVID-19 Immunization

2.0 Provincial Reappointments (Decision):

Per Board policy *BOH-GOV-080 (Order in Council (OIC) Provincial Representatives)*, the Governance Standing Committee Chair, on behalf of the Board Chair, contacted current Provincial Appointees to determine their interest in renewing their terms. The terms for David Warden (ending December 31, 2026), Catherine Agar (ending January 2, 2027), and Stephen Molnar (ending January 2, 2027) are approaching expiry. All three appointees confirmed their interest in reappointment.

Following review, the Governance Standing Committee endorsed the reappointments. To align with the Ministry of Health and Public Appointments Secretariat requirement to initiate the reappointment process 6 months prior, and noting that the Board of Health was not scheduled to meet until late September, the Board Chair and Vice-Chair approved and signed off on the application packages on behalf of the Board to ensure submission deadlines were met.

Staff worked with the three appointees to complete the necessary documentation, which has been submitted to the Public Appointments Secretariat subject to formal Board confirmation.

Motion: 2026-BOH-0924-5.3-2.0

That the Board of Health confirm and ratify the actions of the Board Chair and Vice-Chair in approving and signing off on the provincial reappointment applications for David Warden, Catherine Agar, and Stephen Molnar on behalf of the Board of Health for submission to the Public Appointments Secretariat.

Motion: 2026-BOH-0924-5.3

That the Board of Health for Southwestern Public Health accept the Governance Standing Committee Open Session Report for July 15, 2026.

CONFIDENTIAL



BY-LAWS
FOR THE BOARD OF HEALTH
FOR OXFORD ELGIN ST. THOMAS HEALTH
UNIT

BY-LAW NO. 1 - CONDUCT OF THE AFFAIRS

BY-LAW NO. 2 - BANKING AND FINANCE

BY-LAW NO. 3 - MANAGEMENT OF THE PROPERTY

PREPARED BY:

Amy C. Dale, Legal Counsel for SWPH
Cynthia St. John, Chief Executive Officer

Approved May 1, 2018

Amended September 1, 2022

Amended June 2024

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**BOARD OF HEALTH FOR THE
OXFORD ELGIN ST. THOMAS HEALTH UNIT
BY-LAW NO.1**

A by-law relating generally to the ***conduct of the affairs***
of the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT
o/a Southwestern Public Health,
including, but not limited to, the calling and proceedings at meetings.

BE IT ENACTED as a By-Law of the Board of Health for the OXFORD ELGIN
ST. THOMAS HEALTH UNIT as follows:

2.1. Interpretation

In this by-law and all other by-laws of the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT, unless the context otherwise specifies or requires:

"Act" means the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, as amended;

- a. "Board" means the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT o/a Southwestern Public Health;
- b. "By-law" means the by-law of the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT from time to time in force and effect;
- c. "Corporation" means the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT. The Act deems that the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT is a corporation, without share capital;
- d. "Municipal Act" means the *Municipal Act*, 2001, S.O. 2001, c. 25, as amended;
- e. "Regulations" means the Regulations made under the Act, as from time to time amended, and every regulation that may be substituted therefore and, in the case of such substitution, any references in the by-laws of the Board of Health for the Oxford Elgin St. Thomas Health Unit to

provisions of the Regulations shall be read as references to the substituted provisions therefore in the new Regulations;

- f. All terms which are contained in the By-laws, and which are defined in the Act or the Regulations shall have the meanings respectively given to such terms in the Act or the Regulations;
 - g. Words importing the singular number only shall include the plural and vice versa and words importing a specific gender shall include the other genders;
 - h. The headings used in the by-laws are inserted for reference purposes only and are not to be considered or taken into account in construing the terms or provisions thereof or to be deemed in any way to clarify, modify or explain the effect of any such terms or provisions; and
- ~~i.~~ The *Corporations Act*, R.S.O. 1990, c. C. 38 and the *Corporations Information Act*, R.S.O. 1990, c. C. 39 do not apply to a Board of Health.

~~h.i.~~

DESIGNATION OF HEAD

3.2. Designation of Head.

As required by the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, C. M.56, as amended, the Board thereby designates the Chair of the Board as the Head of the Oxford Elgin St. Thomas Health Unit for the purposes of that Act. The Chair of the Board shall provide for all other institutional requirements regarding access and privacy as set out in the Municipal Freedom of Information and Protection of Privacy Act and the Personal Health Information and Protection Act.

MEMBERSHIP

4.3. Duty of Board of Health.

Every board of health, shall superintend, provide or ensure the provision of the health programs and services required by this Act and the regulations made thereunder to the persons who reside in the health unit served by the board, and shall perform such other functions as are required by or under the Act or any other applicable legislation.

5.4. Numbers.

The members of the Board are appointed by the Councils of the County of Oxford, the County of Elgin, and the City of St. Thomas and by the Lieutenant Governor in Council for Ontario as provided for in the Act.

The membership of the Board shall be as follows:

- i. Four municipal members to be appointed by the Council of the County of Oxford;
- ii. Two municipal members to be appointed by the Council of the County of Elgin;
- iii. Two municipal members to be appointed by the Council of the City of St. Thomas; and
- iv. Up to three members to be appointed by the Lieutenant Governor in Council for Ontario is ideal, recognizing the Lieutenant Governor can appoint one less than the total number of municipal appointees.

~~6.5.~~ Ex-Officio Members.

The Chief Executive Officer and Medical Officer of Health are ex- officio members of the Board.

~~7.6.~~ Secretary-Treasurer.

The Chief Executive Officer shall be duly appointed as Secretary-Treasurer of the Board.

ATTENDANCE FOR THE BOARD OF HEALTH MEETINGS

~~8.7.~~ Attendance.

Members are required to attend all Board meetings. The Chief Executive Officer and Medical Officer of Health shall attend all meetings of the Board except on matters that relate to their remuneration or the performance of their respective duties.

~~9.8.~~ Directors.

Directors of the Oxford Elgin St. Thomas Health Unit shall be present at regular Board meetings, as required, to discuss agenda items related to their area(s) of responsibility.

~~10.9.~~ Recording Secretary.

The Executive Assistant to the Chief Executive Officer shall be the Recording Secretary of the Board meetings.

~~11.10.~~ Unexcused Absences.

Unexcused absences of a member from three consecutive regularly scheduled Board meetings in a calendar year shall mean that the appointing Municipal Council shall be so notified, in writing, by the Chair of the Board of the said unexcused absences and of the Board's request that the appointing Municipal Council review the member's appointment and a copy of the letter sent to the absentee Board member.

~~12.11.~~ Leave of Absence.

The Board may, upon receipt of a written request, extend to any Board member a leave of absence for a definitive period of time. During any Board approved leave of absence, paragraph 10, above, shall not apply.

BOARD MEMBERS

~~13.12.~~ Remuneration - Expenses.

The Remuneration of Board members shall be in accordance with the Act. The Board shall pay the reasonable and actual expenses of each member of the Board in accordance with the Act and the policies of the Oxford Elgin St. Thomas Health Unit.

~~14.13.~~ Term of Office.

The term of office of a municipal member of the Board continues during the pleasure of the Council that appointed the municipal member but, unless ended sooner, ends with the ending of the term of office of the Council.

The term of office of a provincial appointee of the Board continues for the duration of the appointment as outlined by the Lieutenant Governor's appointment notification.

~~15.14.~~ Disqualification.

The seat of a municipal member of the Board becomes vacant for the same reasons that the seat of a member of council becomes vacant under subsection 259(1) of the *Municipal Act*, 2001, as amended. Regardless of whether the member is municipally appointed or appointed by the Lieutenant Governor, no person whose services are employed by the Board is qualified to be a member of the Board.

~~16.15.~~ Vacancy.

Where a vacancy occurs on the Board by the death, disqualification, resignation or removal of a member, the person or body that appointed the member shall appoint a person forthwith to fill the vacancy for the remainder of the term of the member.

~~17.16.~~ Oath of Confidentiality.

Every member of the Board is required to execute an Oath of Confidentiality agreeing to uphold the privacy of personal information and personal health information that may come to their attention in the course of their being a member of the Board, whether or not such information arises inside or outside of meetings of the Board, arises in Closed Session, and regardless of what form the personal information and/or personal health information is received by the Board member.

MEETINGS OF THE BOARD

~~18.17.~~ First Meeting of the Year.

The Board shall hold its first meeting of the year not later than the first day of March.

~~19.18.~~ Number of Meetings.

Regular meetings of the Board shall be held at least eight times annually on such a day, hour and place as the Board shall determine.

~~20.19.~~ Meetings in July and August.

Meetings generally do not occur in the summer months of July and August unless at the call of the Chair.

~~21.20.~~ Special Meetings.

Special meetings may be called by the Chair or, in their absence, the Vice Chair at any time that it is deemed advisable and necessary or by a majority vote at any regular meeting at which quorum is present. The Secretary-Treasurer may call a meeting of the Board upon being petitioned, in writing, by a majority of the members to do so.

~~22.21.~~ Notice.

Members of the Board will be notified of any special meetings by email and board portal.

~~23.~~22. Omission of Notice.

The accidental omission to give notice of any meeting of the Board to, or the non-receipt of any notice by, any person shall not invalidate any resolution passed or any proceeding taken at such meeting.

~~24.~~23. Adjournment.

Any meeting of the Board may be adjourned from time to time by the chair of the meeting, with the consent of the majority of those attending the meeting, to a fixed time and place. Notice of any adjourned meeting of the Board is not required to be given if the time and place of the adjourned meeting is announced at the original meeting. Any adjourned meeting shall be duly constituted if held in accordance with the terms of the adjournment and a quorum is present thereat. The members who formed a quorum at the original meeting are not required to form the quorum at the adjourned meeting. If there is no quorum present at the adjourned meeting, the original meeting shall be deemed to have terminated forthwith after its adjournment. Any business may be brought before or dealt with at any adjourned meeting which might have been brought before or dealt with at the original meeting in accordance with the notice calling the same.

~~25.~~24. Quorum.

A majority of the members of the Board (50% plus 1) fixed under paragraph 3, hereof, shall form a quorum for the transaction of business and, notwithstanding any vacancy among the Board members, a quorum of board members may exercise all the powers of the Board. No business shall be transacted at a meeting of the Board unless a quorum of the Board members is present.

The appointed hour having been struck and a quorum being present, the Chair shall call the meeting to order. If, fifteen minutes after the appointed hour have elapsed and the Chair, or the Vice Chair, as the case may be, has not yet appeared and a quorum is present, the members may appoint one of themselves or the Secretary-Treasurer to chair the meeting until the arrival of the Chair or Vice Chair. If thirty (30) minutes after the appointed hour, a quorum is not present, then the meeting shall stand adjourned until the next regular meeting, an adjourned meeting, or a newly scheduled meeting. The Recording Secretary shall record the names of all members present and not present at the meeting.

~~26.~~25. Electronic Participation.

In a meeting which is open to the public, members of the Board may participate by means of such telephone, electronic or other communication facilities as permits all persons participating in the meeting to communicate with each other simultaneously and instantaneously, and a Board member participating in such meeting by such means is deemed for the purpose of the Act to be present at that meeting, counted in quorum and in voting.

~~27.~~26. Voting.

Questions arising at any meeting of the Board members shall be decided by a majority vote evidenced by a show of hands. The Chair and each Board member present where not otherwise disqualified from voting, shall vote on all questions.

In the case of a tie vote, the Chair of the meeting in addition to their original vote, shall not have a second casting vote and the motion will be lost. If the Chair decides to take part in any debate, he/she may leave the chair to do so, providing a member is appointed to fill the position of Chair until the question is decided.

28.27. Recorded Vote.

Any member may request a recorded vote and each member present, and not disqualified from voting by virtue of any legislation or declared conflict of interest, must then announce their vote.

To abstain or fail to vote under such circumstances is deemed to be a negative vote. When a recorded vote is requested, the names of those voted for and those who voted against the question shall be called and entered upon the minutes in alphabetical order. When a question is put and "carried" without a dissent or a call for a recorded vote, then the matter will be deemed to be carried unanimously by those present.

28. Open Board Meetings.

Board meetings shall be open to the public except where applicable laws otherwise permit or require. The Board shall adopt a policy in respect of closed (in-camera) meetings.

DECLARATION OF PECUNIARY INTEREST; CONFLICT OF INTEREST

29. Declaration of Pecuniary Interest.

Where a Board member, either on their or their own behalf or while acting for, by, with or through another, has any pecuniary interest direct or indirect in any matter and is present at a meeting of the Board at which the matter is the subject of consideration, the member,

- a. shall, prior to any consideration of the matter at the meeting disclose the interest and the general nature thereof;
- b. shall not be present or take part in the discussion of, or vote on any question in respect of the matter; and
- c. shall not attempt in any way, whether before, during or after the meeting, to influence the voting on any such question.

Where the meeting referred to above is not open to the public, in addition to complying with the requirements set forth above, the member shall forthwith leave the meeting or the part of the meeting during which the matter is under consideration.

Where the interest of a member has not been disclosed as required by reason of the member's absence from the meeting referred to therein, the member shall disclose the interest and otherwise comply with the requirements first set forth above at the first meeting of the Board attended by the member thereafter.

Every declaration of interest and the general nature thereof made by a Board member shall, where the meeting is open to the public, be recorded in the minutes of the meeting by the Recording Secretary. Where the meeting is not open to the public, every declaration of interest made by a Board member, but not the general nature of that interest shall be recorded in the minutes of the next meeting that is open to the public.

30. Registry.

The Board shall establish and maintain a registry in which it shall keep a copy of each statement filed and a copy of each declaration recorded pursuant to section 28 hereof. Access to the

registry shall be available for public inspection in the manner and during the time that the Board may determine.

31. Quorum Deemed.

Where the number of members who, by reason of the provisions of the *Municipal Conflict of Interest Act* and hereof, are disabled from participating in a meeting is such that at that meeting the remaining members are not of sufficient number to constitute a quorum, then, despite any other general or special Act, the remaining number of members shall be deemed to constitute a quorum, provided such number is not less than two.

BOARD PACKAGES, AGENDA, MINUTES, AND REPORTS

32. Board Packages.

The agenda, minutes of the previous meeting, and written reports are to be sent to Board members via electronic means approximately one week in advance of the scheduled meeting. The agenda and notice of the meeting are to be posted on Oxford Elgin St. Thomas Health Unit's website approximately one week prior to the meeting. Written reports are available at or after the Board meeting.

33. Agendas.

For all regular and special Board meetings, an agenda shall be drafted by the Secretary-Treasurer and approved by the Chair of the Board. If for any reason copies of the agenda shall not have reached members before the meeting, the member(s) will advise of such and the agenda shall be provided by the Secretary-Treasurer at the opening of the meeting.

Any member wishing to introduce business additional to that set out in the agenda must make the request during the "Agenda" portion of the agenda and must receive unanimous consent by the members present to introduce additional business. If unanimous consent is not obtained, the member may give notice of motion to discuss the business at the next regularly scheduled meeting of the Board. The motion must be seconded.

34. Minutes.

The Recording Secretary records the minutes of the meeting and submits them to the Secretary-Treasurer for review. The minutes of the previous meeting shall be circulated to the Board approximately one week prior to the next regularly scheduled meeting. At the regularly scheduled meeting, a motion will be entertained to have the minutes approved and adopted as circulated or in the case of corrections, approved and adopted as amended with the amendments specifically stated.

If the minutes of the previous Board meeting were not circulated in advance, the Secretary-Treasurer shall read them, but no motion or discussion shall be allowed on the minutes except in regard to their accuracy. Any minutes that were not circulated in advance but read by the Secretary-Treasurer in accordance with this provision shall be placed on the agenda of the next meeting of the Board for the purposes of entertaining a motion for the adoption of such minutes, either as read or in the case of corrections, approved and adopted as amended with the amendments specifically stated.

After the confirmation and adoption of the minutes, they shall be signed by the Chair. The official signed minutes of the Board shall be posted by the Recording Secretary on the Oxford Elgin St. Thomas Health Unit's website.

35. Reports.

The Chief Executive Officer's report, Medical Officer of Health's report, and any other specific reports are to be provided in writing to the Board approximately one week prior to the meeting. In some circumstances, a revised report, verbal report, or additional report may be forthcoming on a matter where the timing of such does not coincide with the preparation of the Board packages.

ORDER OF BUSINESS FOR REGULAR MEETINGS

36. Agenda.

The agenda items shall include but not be limited to:

- a. Call to Order;
- b. Agenda - amendments or corrections of, adoption of;
- c. Minutes - amendments or corrections of, adoption of;
- d. Reminder to disclose Pecuniary Interest and/Conflict of Interest, and the general nature thereof when the item arises;
- e. Reminder that meetings are recorded for minute-taking purposes and for public viewing on an electronic platform or platforms of the Board's choosing;
- f. Staff Reports/Presentations;
- g. Closed Session – motion to go into Closed Session;
- h. Rising and Reporting of Closed Session; and
- i. Adjournment.

ORDER OF BUSINESS FOR SPECIAL MEETINGS

37. Drafting the Agenda.

An agenda shall be drafted by the Secretary-Treasurer and approved by the Chair of the Board.

38. Copies of the Agenda.

If for any reason, copies of the agenda shall not have reached members before the meeting, the member(s) will advise of such and the agenda shall be provided by the Secretary-Treasurer at the opening of the meeting.

39. Additional Business.

The agenda shall not contain business other than those subjects for which the special meeting was called.

40. Agenda.

The agenda items shall include but not be limited to:

- a. Call to Order;
- b. Agenda - adoption of;
- c. Reminder to disclose Pecuniary Interest and/Conflict of Interest, and the general nature thereof when the item arises;
- d. Business – item for which the special meeting was called; and

e. Adjournment.

41. Closed Session.

It is noted that should the item of business for which the special meeting was called be a matter for Closed Session, a motion to go into Closed Session and a motion to rise and report from closed session would also be included on the agenda.

BOARD OF HEALTH MEETINGS: PROCEDURES

42. Invitation of a Non-Board Member.

Any person that wishes to address the Board, who is not a Board member, shall not be allowed to address the Board except upon invitation of the Chair and the Board members.

43. Board Member.

No member shall be allowed to speak more than once upon any question before the meeting unless expressly permitted to do so by the Chair, except the mover of the original motion who shall have the right of replying when all members choosing to speak shall have spoken. An amendment being moved, seconded, and put by the Chair, any member, even though she/he has spoken on the original motion, may speak again on the amendment. No member shall speak for more than five minutes at one time.

Members wishing to raise points of order or explanation must first obtain the permission of the Chair, and must raise the matter immediately following from when the alleged breach occurred. A member wishing to explain a material part of their speech which may have been misconstrued or misunderstood may be granted their privilege by the Chair, providing that, in so doing, they do not introduce any new matter. Any member may formally second any motion of amendment and reserve their speech until a later period in the debate.

44. Selection of Speakers.

Every member, before speaking, shall ask permission to speak and address the Chair as "Chair". The Chair, if the request is in order, shall grant permission to speak and address the member as "Member (last name)" in the case of a board member and "Staff position title and first name" in the case of a staff member. When more than one member is recognized to speak, the first to be recognized shall be given precedence, the decision resting with the Chair. Thereafter, the members shall be called upon by the Chair to speak in the order in which they were recognized.

45. Interruption.

If any member interrupts the speaker, or uses abusive language, or causes disturbance or refuses to obey the Chair when called to order, they shall be named by the Chair. They shall thereupon be expelled from the meeting and shall not be allowed to enter again until an apology satisfactory to the Board has been given. No member shall leave the meeting before its adjournment without the permission of the Chair.

46. Conduct During Board Meetings.

All members of the Board shall at all times use temperate language and conduct themselves in an appropriate manner. If, at any time, intemperate or insulting language is used against the Chair or the Board or any of its members or staff, the offending member shall respectfully apologize and retract their statement.

47. Order and Procedure.

All members shall abide by the Chair's decision or that of the Board with regard to matters of order and procedure. If any member continues to abuse their position in the Board meeting, after being named by the Chair, the Chair shall have the power to have them removed from the Board meeting until the meeting is over or until the member apologizes in full to the Chair and the members.

MOTIONS AND AMENDMENTS

48. Original Motion and Amendments.

The first proposition on any particular subject shall be known as the original motion and all succeeding propositions on that subject shall be called amendments.

49. Procedures.

Every motion or amendment must be moved and seconded by members actually present at the meeting before it can be discussed, debated or put from the Chair and wherever possible should be set forth in writing. When a motion is seconded, it shall be read by the Chair or Recording Secretary before a debate. When a question is under debate, no motion shall be received unless to commit it, to amend it, to postpone it, to adjourn it, or to move the previous question.

50. Withdrawals or Additions.

After a motion is read by the Chair or Recording Secretary, it shall be deemed in the possession of the Board, but may, with the permission of the Board, be withdrawn at any time before discussion or amendment. Any motion properly moved and seconded must be presented to the Board.

51. Amendments.

The main question may be amended only once after which the original amendment shall be voted upon and, if carried, shall stand instead of the original motion, and if lost, the main question will be recalled. A further amendment may then be put and voted upon. Every amendment submitted shall be in writing and shall be decided or withdrawn before the main question is put to the vote.

52. Reconsidering - Rescinding.

No motion to reconsider a resolution entered upon the minutes shall be received or put unless a notice of intention to introduce such rescinding motion shall have been made in writing at the previous meeting.

ADJOURNMENTS

53. Adjournments.

A motion to adjourn the Board meeting or adjourn the debate shall always be in order, but, if it is defeated, then no second motion to the same effect shall be made.

CLOSED SESSION

54. Closed Session.

A Closed Session is defined as a private session where only Board members and invited staff and professional advisors such as legal counsel are present and excludes all others, including the public and the media.

The Board may resolve to go into Closed Session if the subject matter to be considered falls within one or more of the following categories provided for in the *Municipal Act, 2001, as amended*:

- a) the security of the property of the Board;
 - b) personal matters about an identifiable individual, including Board employees;
 - c) a proposed or pending acquisition or disposition of land by the Board;
 - d) labour relations or employee negotiations;
 - e) litigation or potential litigation, including matters before administrative tribunals, affecting the Board;
 - f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
 - g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under an act other than the *Municipal Act*;
 - h) information explicitly supplied in confidence to the Board by Canada, a province or territory or a Crown agency of any of them;
 - i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the Board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;
 - j) a trade secret or scientific, technical, commercial, or financial information that belongs to the Board and has monetary value or potential monetary value; or
 - k) a position, plan, procedure, criteria, or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the Board.
-
- a) The Board shall resolve to go into Closed Session if the subject matter to be considered falls within one or more of the following categories provided for in the *Municipal Act, 2001, as amended*: a request under the *Municipal Freedom of Information and Protection of Privacy Act*, if the Board is the head of an institution for the purposes of that Act; or
 - b) an ongoing investigation respecting the Board by the Ombudsman appointed under the *Ombudsman Act*, an Ombudsman referred to in subsection 223.13 (1) of the *Municipal Act, 2001*, or the investigator referred to in subsection 239.2 (1) of the *Municipal Act, 2001*.

55. Procedural Votes.

Only procedural votes or those related to the giving of advice and direction to staff can take place in Closed Session.

56. Procedure.

When a decision to go into Closed Session is made, the Board shall state, by resolution, the following:

- a) The fact of the holding of a Closed Session;
- b) The general nature of the matter to be considered at the Closed Session; and
- c) That all matters to be considered are to be held as strictly confidential, the content of which matters, discussions, documents or related information is not to be disclosed to any persons, media, or other organizations.

57. Rules.

Rules of the Board shall be observed in the Closed Session meeting except those limiting the number of times a member may speak.

58. Quorum Voting.

The rules for quorum and voting shall be the same for the Closed Session as for the open session.

59. Questions of Order.

Questions of order arising in the Closed Session shall be decided by the Chair.

60. Agenda.

A written agenda shall be prepared by the Secretary-Treasurer for every Closed Session meeting and approved by the Board Chair.

61. Completion of the Closed Session.

The Board shall rise with a report upon completion of the Closed Session.

62. Order of Business.

The order of business for closed session meetings shall be:

- a) Reminder to disclose Pecuniary Interest and/or Conflict of Interest, and the general nature thereof when the item arises;
- b) Report from the Chief Executive Officer or Board Standing and/or Ad hoc Committee Chair regarding item(s) on the Closed Session Agenda; and
- c) Business: unfinished, new, or arising for correspondence received – listed under one of the categories of subject matter to be discussed under which a meeting may be closed.

63. Absence of the Chair.

In the absence of the Chair or whoever has been designated to chair the meeting of the Closed Session, one of the other members shall be elected to preside until the arrival of the designated Chair.

64. Confidential Notes.

Notes of meetings of Closed Session shall be recorded by the Recording Secretary and, after execution by the Board Chair, shall be maintained by the Secretary-Treasurer in a manner to protect the confidentiality of confidential personal information contained therein.

65. Breach of the Rules.

If a member disregards the rules of the Board or a decision of the Chair of a Closed Session on questions of order or practice or upon the interpretation of the rules set out, and persists in such conduct after having been called to order by the said Chair, the Chair shall forthwith put

the question with no amendment, adjournment, or debate, "that the member shall be ordered to leave their seat for the duration of the meeting".

If, following such vote by the members, the member apologizes, they may, by a further vote of the members, be permitted to retake their seat.

66. Breach of Confidentiality.

If a member of the Board disregards the rules of the Board respecting the requirement to maintain the confidentiality of matters and related information arising in a Closed Session, or disregards their own Oath of Confidentiality respecting the security of personal information and/or personal health information, the Board may call for the member to resign as a member of the Board.

OFFICERS

67. Chief Executive Officer.

The Chief Executive Officer will chair the first Board meeting of the year until a Chair has been elected.

68. Election and Removal of the Chair and Vice Chair.

Any member of the Board may serve as an officer of the Board. The Chair and Vice Chair shall be elected at the first meeting of the Board each calendar year. Nominations for Chair and Vice-Chair will be solicited at the first meeting and a majority vote will determine the election result. If more than one nomination is received for each Officer position, a secret ballot will be conducted. The ballots will be distributed by the Recording Secretary and counted by the Secretary-Treasurer.

All officers shall serve for a term of one calendar year or until their successors are elected and qualified. Officers are eligible for re-election to a second consecutive one-year term. Service is limited to two consecutive terms, unless no other nominations are received.

~~In extenuating circumstances, for which an explanation is provided to the Board, an officer may serve for a second consecutive year subject to being elected and qualified.~~

~~70.~~69. Vacancy.

Any Chair or Vice Chair vacancy shall be filled by a special election held at the next meeting following announcement of the vacancy.

~~71.~~70. Appointment of the Medical Officer of Health.

The Board shall appoint a full-time Medical Officer of Health and may appoint one or more Associate Medical Officers of Health of the Board. Where the office of Medical Officer of Health of the Board is vacant or the Medical Officer of Health is absent or unable to act, and there is no Associate Medical Officer of Health of the Board or the Associate Medical Officer of Health is absent or unable to act, the Board shall forthwith appoint a physician as Acting Medical Officer of Health, which Acting Medical Officer of Health shall perform the duties and have the authority to exercise the powers of the Medical Officer of Health of the Board.

~~72.~~71. Eligibility for Appointment.

A Medical Officer of Health or an Associate Medical Officer of Health must have the following credentials,

- a) He or she is a physician;
- b) He or she possesses the qualifications and requirements prescribed by the regulations to the Act for the position; and
- c) The Minister approves the proposed appointment.

~~73.~~72. Vacancy.

If the position of Medical Officer of Health of the Board becomes vacant, the Board and the Minister, acting in concert, shall work expeditiously towards filling the position with a full-time Medical Officer of Health.

~~74.~~73. Dismissal of Medical Officer of Health.

A decision by the Board to dismiss the Medical Officer of Health or an Associate Medical Officer of Health from office is not effective unless,

- a) the decision is carried by the vote of two-thirds of the members of the Board; and
- b) The Minister consents in writing to the dismissal.

~~75.~~74. Dismissal of Chief Executive Officer.

A decision of the Board to dismiss the Chief Executive Officer is not effective unless the decision is carried by the vote of two-thirds of the members of the Board.

~~76.~~75. Notice and Attendance.

The Board shall not vote on the dismissal of the Medical Officer of Health, an Associate Medical Officer of Health, or the Chief Executive Officer unless the Board has given to the Medical Officer of Health, Associate Medical Officer of Health, or Chief Executive Officer,

- a) Reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered;
- b) A written statement of the reason for the proposal to dismiss the Medical Officer of Health, Associate Medical Officer of Health, or the Chief Executive Officer; and
- c) An opportunity to attend and to make representations to the Board at the meeting.

~~77.~~76. Duties of Officers.

a. The Chair Shall:

- i. Preside at all meetings of the Board;
- ii. Preserve order and proper conduct during meetings;
- iii. Keep a speakers list recognizing members who wish to speak on a matter;
- iv. Issue a final ruling on any question of order and/or procedure unless challenged by way of a motion or appeal by not less than two members, and thereafter a majority of the members present shall vote in support of such challenge;
- v. Inform the members when it is the opinion of the Chair that a motion is contrary to the rules and privileges of the Board; and
- vi. Remind members of their obligations of confidentiality with respect to matters and information arising in Closed Session.

b. The Vice Chair Shall:

- i. Preside in the absence of the Chair; and
- ii. Carry out the duties of the Chair as noted.

- c. The Medical Officer of Health Shall:
 - i. Be responsible for and shall report to the Board on issues relating to the protection and the promotion of the public's health.
- d. The Chief Executive Officer Shall:
 - i. Be responsible for the day-to-day operations, policies, and directives, program and service delivery, matters of human resources and finances of the Oxford Elgin St. Thomas Health Unit, and for keeping the Board apprised of such matters.

COMMITTEES

78.77. Committees.

The Board may establish, by resolution, standing committees of the Board as it deems necessary. Special ad hoc committees may also be established, and the members appointed for a specific purpose for a specific period of time. Such committees shall be deemed to be discharged when their purpose has been achieved or when the specific period of time has lapsed. Electronic participation in such meetings is allowable, including being counted in quorum and voting.

RULES OF ORDER

79.78. Robert's Rules of Order.

The rules contained in the current edition of Robert's Rules of Order Newly Revised shall govern the Board in all cases to which they are applicable and in which they are not inconsistent with these bylaws and any special rules of order the Board may adopt.

AFFILIATION

80.79. Affiliation.

The OXFORD ELGIN ST. THOMAS HEALTH UNIT o/a Southwestern Public Health may hold membership in various agencies (i.e. Ontario Public Health Association, Association of Local Public Health Agencies, Ontario Hospital Association, Canadian Public Health Association, etc.) as needed and at the discretion of the Chief Executive Officer. The Board may be entitled to representation at meetings of various membership organizations. Should voting be required at such meetings, proxy representations with authority to vote shall be appointed and authorized by the Board whenever necessary.

ENACTED the 1st day of **May, 2018**.

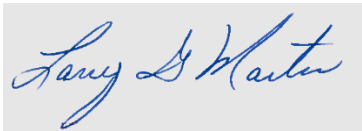


Chair, Board of Health



Chief Executive Officer

By-Laws were amended by resolution of the Board dated the 1st day of **September, 2022** (2022-BOH-0901-5.2B).

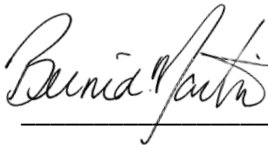


Chair, Board of Health



Chief Executive Officer

By-Law No. 1 was reviewed, amended, and approved by resolution of the Board dated the **1st day of September, 2024** (2024-BOH-0627-5.2.1).



Chair, Board of Health



Chief Executive Officer



**BOARD OF HEALTH FOR THE
OXFORD ELGIN ST. THOMAS HEALTH UNIT**

BY-LAW NO. 2

**A by-law respecting the banking and finance activities of the
Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT o/a
Southwestern Public Health.**

**BE IT ENACTED as a By-law of the Board of Health for the OXFORD ELGIN
ST. THOMAS HEALTH UNIT as follows:**

**The Board of Health for OXFORD ELGIN ST. THOMAS HEALTH UNIT enacts
the following:**

1. Interpretation.

In this by-law and all other by-laws of the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT, unless the context otherwise specifies or requires:

- a. "Act" means the Health Protection and Promotion Act, R.S.O. 1990, c. H.7, as amended;
- b. "Board" means the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT o/a Southwestern Public Health;
- c. "By-law" means the by-law of the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT from time to time in force and effect;
- d. "Corporation" means the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT. The Act deems that the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT is a corporation, without share capital;
- e. "Municipal Act" means the Municipal Act, 2001, S.O. 2001, c. 25, as amended;

- f. "Regulations" means the Regulations made under the Act, as from time to time amended, and every regulation that may be substituted therefore and, in the case of such substitution, any references in the by-laws of the Board of Health for the Oxford Elgin St. Thomas Health Unit to provisions of the Regulations shall be read as references to the substituted provisions therefore in the new regulations;
- g. All terms which are contained in the by-laws and which are defined in the Act or the Regulations shall have the meanings respectively given to such terms in the Act or the Regulations;
- h. Words importing the singular number only shall include the plural and vice versa and words importing a specific gender shall include the other genders; and
- i. The headings used in the by-laws are inserted for reference purposes only and are not to be considered or taken into account in construing the terms or provisions thereof or to be deemed in any way to clarify, modify or explain the effect of any such terms or provisions.
- j. The Corporations Act, R.S.O. 1990, c. C. 38 and the Corporations Information Act, R.S.O. 1990, c. C.39 do not apply to a Board of Health.

2. Financial Responsibility.

The Board of Health for the Oxford Elgin St Thomas Health Unit may, from time to time:

- a. Borrow money on the credit of the Board;
- b. Charge, mortgage, hypothecate, pledge or otherwise create a security interest in all or any of the currently owned or subsequently acquired real or personal, moveable or immovable property of the Board, including without limitation, book debts, rights, powers, franchises and undertakings, to secure any present or future indebtedness, liabilities or other obligations of the Board; and
- c. Delegate to such one or more of the Officers or the Chief Executive Officer of the Board as may be designated by the Board all or any of the powers conferred by the foregoing clauses of the by-law to such extent and in such manner as the Board shall determine at the time of each such delegation.

3. Designation.

All matters related to the financial affairs of the Board shall be carried out by the Chief Executive Officer or their designate.

4. Signing Authority.

The Board will maintain a formal list of names, titles and signatures of those individuals who have signing authority for the Board. Signing authority shall be given only to those persons or offices that are, from time to time, designated by the Board and in accordance with the Board's policies on such matters.

5. Duties of the Financial Designate.

The Chief Executive Officer or their designate shall:

- a. After consultation with and input from appropriate Oxford Elgin St. Thomas Health Unit staff, prepare annual budgets for submission to the Board for approval;
- b. Ensure that regular reporting of financial and operating statements is completed for the Board indicating the financial position of the board with respect to the current operations;

- c. Ensure that annual financial statements are prepared containing, but not limited to, the following content:
 - i. An annual statement of income and expenses; and
 - ii. An annual statement of assets and liabilities.
- d. Act as custodian of the books of account and accounting records of the Board as required to be kept by the laws of the Province;
- e. In conjunction with the Auditor appointed pursuant to the relevant provisions of the Municipal Act, 2001, arrange for an annual audit of all accounting books and records; and
- f. Perform other duties as the Board may direct.

6. Appointment of Auditor.

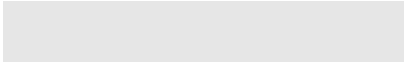
In each year, the Board shall, by resolution, appoint an auditor who shall not be a member of the Board and shall be licensed under the *Public Accounting Act*, 2004, S.O. 2004, C. 8, as amended.

7. Duties of the Auditor.

The Auditor shall:

- a. Audit the accounts and transactions of the Board;
- b. Perform such duties as prescribed by the Ministry of Municipal Affairs and Housing with respect to local boards under the Municipal Act, 2001, as amended, and the Municipal Affairs Act, R.S.O. 1990, as amended;
- c. Perform such other duties as may be required by the Board that do not conflict with the duties prescribed by the Ministry of Municipal Affairs and Housing as set out in clause (b) of this by-law;
- d. Have a right of access at all reasonable hours to all books, records, documents, accounts, and vouchers of the Board and is entitled to require from the members of the Board and from the Officers of the Board such information and explanation as in their opinion may be necessary to enable them to carry out such duties as are prescribed by the Ministry of Municipal Affairs and Housing and under the Act; and
- e. Be invited to attend any meeting of the Board and is entitled to receive all notices relating to the meeting that any member is entitled to receive and to be heard at any such meeting that they attend on any part of the business of the meeting that concerns them as auditor.

ENACTED the 1st day of **May, 2018**.



A handwritten signature in black ink, appearing to read "Brad Webb".

Chair, Board of Health

A handwritten signature in black ink, appearing to read "Cynthia St. John".

Chief Executive Officer

By-Law No. 2 was reviewed and approved by resolution of the Board dated the 1st day of **September, 2024** (2024-BOH-0627-5.2.1).

A handwritten signature in black ink, appearing to read "Brenda Puta".

Chair, Board of Health

A handwritten signature in black ink, appearing to read "Cynthia St. John".

Chief Executive Officer



**BOARD OF HEALTH FOR THE
OXFORD ELGIN ST. THOMAS HEALTH UNIT**

BY-LAW NO. 3

A by-law respecting the ***Management of the Property*** for the
Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT o/a
Southwestern Public Health.

BE IT ENACTED as a By-law of the Board of Health for the OXFORD ELGIN ST.
THOMAS HEALTH UNIT as follows:

1. INTERPRETATION.

In this by-law and all other by-laws of the Board of Health for the Oxford Elgin-St. Thomas Health Unit, unless the context otherwise specifies or requires:

- a. "Act" means the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, as amended;
- b. "Board" means the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT o/a Southwestern Public Health;
- c. "By-law" means the by-law of the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT from time to time in force and effect;
- d. "Corporation" means the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT. The Act deems that the Board of Health for the OXFORD ELGIN ST. THOMAS HEALTH UNIT is a corporation, without share capital;
- e. "Municipal Act" means the *Municipal Act*, 2001, S.O. 2001, c. 25, as amended;
- f. "Regulations" means the Regulations made under the Act as from time to time amended, and every regulation that may be substituted therefore and, in the case of such substitution, any references in the by-laws of the Board of Health for the Oxford Elgin St. Thomas Health

Unit to provisions of the Regulations shall be read as references to the substituted provisions therefore in the new regulations;

- g. All terms which are contained in the by-laws and which are defined in the Act or the Regulations shall have the meanings respectively given to such terms in the Act or the Regulations;
- h. Words importing the singular number only shall include the plural and vice versa and words importing a specific gender shall include the other genders; and
- i. The headings used in the by-laws are inserted for reference purposes only and are not to be considered or taken into account in construing the terms or provisions thereof or to be deemed in any way to clarify, modify or explain the effect of any such terms or provisions.
- j. The *Corporations Act*, R.S.O. 1990, c. C. 38 and the *Corporations Information Act*, R.S.O. 1990, c. C. 39 do not apply to a Board of Health.

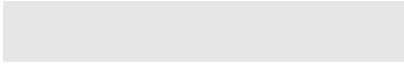
2. Responsibility

- (i) The Chief Executive Officer or their designate, shall be responsible for the care and maintenance of all properties required by the Board (where they are owned not leased), including, but not be limited to, the following:
 - a. The repair and maintenance of building systems such as heating and cooling systems, roof, structural work, plumbing, electrical systems;
 - b. The repair and maintenance of the parking areas and exterior of buildings, where applicable;
 - c. The care and upkeep of the grounds of the property, where applicable;
 - d. The cleaning, maintaining, decorating, and repairing of the interior of the buildings, where applicable; and
 - e. The maintenance of up-to-date fire and liability insurance coverage.
- (ii) Where a property required by the Board is a leased, not owned, property, the Board shall enter into a lease that addresses all maintenance, care and insurance requirements and the Chief Executive Officer shall be responsible for ensuring that the property is operated in accordance with the terms of any such lease.

3. Compliance

The Board shall ensure that all such properties comply with all applicable local, provincial and/or federal statutory requirements (i.e., building and fire codes).

ENACTED the 1st day of **May, 2018**.



A handwritten signature in black ink, appearing to read "Paul Will".

Chair, Board of Health

A handwritten signature in black ink, appearing to read "Cynthia St. John".

Chief Executive Officer

By-Law No. 3 was reviewed and approved by resolution of the Board dated the **1st** day of **September, 2024** (2024-BOH-0627-5.2.1).

A handwritten signature in black ink, appearing to read "Bernie Futo".

Chair, Board of Health

A handwritten signature in black ink, appearing to read "Cynthia St. John".

Chief Executive Officer

REFERENCES

1. *Health Protection and Promotion Act, R.S.O. 1990, c. H.7*
<https://www.ontario.ca/laws/statute/90h07>
2. *Municipal Act, 2001, S.O. 2001, c. 25*
<https://www.ontario.ca/laws/statute/01m25>
3. *Municipal Conflict of Interest Act, R.S.O. 1990, c. M.50*
<https://www.ontario.ca/laws/statute/90m50/v15?search=e+laws#BK3>
4. *Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, C. M.56*
<https://www.ontario.ca/laws/statute/90m56#BK15>
5. Robert, Henry M., III, et al. *Robert's Rules of Order Newly Revised*. 12th ed., PublicAffairs, 2020.



Board of Health

SECTION:	Governance	APPROVED BY:	Board of Health
NUMBER:	BOH-GOV-030	REVISED:	September 2026
DATE:	May 1, 2018		

Delegation of Authority (Powers and Duties)

PURPOSE:

The purpose of this policy is to establish the principles governing the delegation of powers, duties, and functions of the Board of Health for the Oxford, Elgin, St. Thomas Health Unit (OESTHU) o/a Southwestern Public Health (SWPH), including legislative and quasi-judicial powers that have traditionally been held by the Board alone.

This policy ensures the efficient administration of the organization while maintaining appropriate governance oversight and accountability and also establishes provisions to support organizational continuity during periods when the Board of Health is unable to conduct business due to vacancies, municipal election transitions, or the absence of quorum. The purpose of this policy is to establish provisions for the delegation of the powers and duties of the Board of Health for the Oxford, Elgin, St. Thomas Health Unit (OESTHU), including legislative and quasi-judicial powers that have traditionally been held by the Board alone.

POLICY:

1. GENERAL PRINCIPLES

- 1.1 The Board of Health is responsible for the governance, strategic direction, stewardship, and oversight of Southwestern Public Health.
- 1.2 The Chief Executive Officer is responsible for the day-to-day administration and management of the organization and is accountable to the Board for the exercise of all delegated authority.
- 1.3 All delegations of Board powers, duties, or functions shall be established by Board policy, Board by-law, or Board resolution.
- 1.4 Unless expressly delegated, all powers, duties, and functions remain vested with the Board.

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1.5 Delegated authority shall be exercised:

- in accordance with applicable legislation;
- in compliance with Board policies and by-laws;
- within approved budgets;
- in support of the Board's strategic priorities; and
- in the best interests of Southwestern Public Health.

~~All delegations of Board powers, duties or functions shall be effected by bylaw or policy.~~

~~Unless a power, duty or function of the Board has been expressly delegated by bylaw or policy, all of the powers, duties and functions of the Board shall remain with the Board.~~

2. MATTERS RESERVED TO THE BOARD

The following matters remain the exclusive responsibility of the Board unless otherwise provided by legislation:

- approval and amendment of Board by-laws;
- approval of governance policies;
- approval of the Strategic Plan and Board priorities;
- approval of annual operating and capital budgets;
- approval of audited financial statements;
- appointment, performance evaluation, compensation, and termination of the Chief Executive Officer;
- appointment of Board officers and committees;
- approval of borrowing where authorized by legislation;
- approval of significant real property transactions;
- approval of advocacy positions on behalf of the Board;
- any other matter reserved to the Board by the *Health Protection and Promotion Act*, applicable legislation, or Board by-law.

3.

AUTHORIZATION OF EXPENDITURES:

The Board of Health has the ultimate authority for all expenditures. The Board delegates this authority through the authorization of budgets, the procurement policy and/or by specific resolution or direction to staff.

The Board establishes financial authority through the approval of:

- annual overall operating and capital budgets;
- financial management policies;
- procurement policies;
- signing authority policies; and
- specific Board resolutions.

The CEO is authorized to administer budgets in accordance with these authorities.

The CEO may authorize expenditures provided that:

- sufficient budget has been approved;
- expenditures comply with Board policies;
- expenditures are necessary to carry out approved operations or strategic priorities; and
- delegated financial authority has not been exceeded.

~~The Board of Health has the ultimate authority for all expenditures. The Board delegates this authority through the authorization of budgets, the procurement policy and/or by specific resolution or direction to staff.~~

The Procurement Policy sets out the authority for payment of accounts and sets limits on spending levels. It also provides direction on the circumstances in which certain purchasing mechanisms are appropriate (i.e., informal quotes, formal quotes, tender submissions or requests for proposal).

4. AUTHORITY TO EXECUTE AGREEMENTS:

The Board authorizes the CEO to execute agreements and legally bind Southwestern Public Health without obtaining further Board approval where all of the following conditions are met:

- the agreement is administrative or operational in nature;
- the agreement supports an approved Board program, service, or operation;
- approved operating or capital funding exists, where applicable;
- the agreement complies with the Procurement Policy and other applicable Board policies; and
- the agreement has a term not exceeding five (5) years, unless otherwise authorized by the Board.

The CEO may delegate signing authority to employees in accordance with Board-approved policies.

5. STATUTORY DELEGATIONS

Where legislation permits the Board to delegate statutory powers or duties, such delegation shall be made by Board by-law or resolution.

~~Whereas it is desirable and expedient in the conduct of the Board's affairs to delegate certain powers and duties to staff, this policy shall authorize the CEO to enter into an agreement and shall authorize the CEO to legally bind the Health Unit by executing said agreement without approval if the following criteria are met:~~

~~The subject matter is non-financial or procured in accordance with the purchasing policy and for which approved operating or capital budget exists;~~

~~The subject matter is of an administrative or operational nature and relates to the management of the Health Unit; and~~

~~The agreement is for a term not exceeding five (5) years.~~

Municipal Freedom of Information and Protection of Privacy Act (MFIPPA):

The Board of Health as the Institution under MFIPPA legislation is responsible for the fulfilment of many of the compliance requirements for responding to Freedom of Information (FOI) requests as well as the protection of client privacy. As the majority of Board members are elected municipal officials, section 3 of this legislation requires that members of the Board of Health designate one person or committee to be appointed, by by-law, as "Head" for the purposes of the Act.

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To facilitate the timely and efficient fulfilment of obligations by OESTHU to ensure compliance with respect to responding to FOI requests from clients, other institutions, the general public and/or media, as well as ensure the protection of the client, OESTHU and third party privacy, the designated "Head" will appoint the CEO to fulfill all the responsibilities of the Head under the Act.

5.1

PROCEDURE:

- As part of the order of business for the first meeting of a newly constituted Board of Health, the members shall appoint the Chair of the Board of Health, "Head" in accordance with MFIPPA and By-Law number 1 section 2. See "BOH-GOV-030(F) – Appendix A" for template for By-Law appointing "Head" under MFIPPA.
- By motion of the Board of Health, the newly appointed "Head" will delegate the [OESTHUSouthwestern Public Health's](#) CEO as acting "Head" of OESTHU for the purpose of ensuring day-to-day fulfilment of OESTHU's compliance obligations under MFIPPA.

~~As part of the order of business for the first meeting of a newly constituted Board of Health, the members shall appoint the Chair of the Board of Health, "Head" in accordance with MFIPPA and By-Law number 1 section 2. See "BOH-GOV-030(F) – Appendix A" for template for By-Law appointing "Head" under MFIPPA.~~

~~By motion of the Board of Health, the newly appointed "Head" will delegate OESTHU CEO as acting "Head" of OESTHU for the purpose of ensuring day-to-day fulfilment of OESTHU's compliance obligations under MFIPPA.~~

6. BOARD TRANSITION AND GOVERNANCE CONTINUITY

The Board recognizes that municipal elections, provincial appointments, resignations, vacancies, or other circumstances may temporarily prevent the Board from achieving quorum.

During such periods, the following provisions shall apply.

6.1 CONTINUITY OF EXISTING AUTHORITY

All Board-approved policies, by-laws, budgets, delegations, and resolutions shall remain in effect until amended or repealed by the Board.

6.2 CEO Authority During Transition

The CEO shall continue to exercise all authority previously delegated by the Board, including authority respecting:

- administration of approved budgets;
- procurement and purchasing;
- execution of agreements;
- staffing and labour relations;
- implementation of approved programs and services;

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- public health emergency response;
- legislative compliance;
- financial administration;
- operational decision-making; and
- protection of organizational assets.

6.3 Caretaking Principles

During a transition period, the CEO shall, where reasonably possible:

- continue routine business operations;
- implement previously approved Board decisions;
- defer significant strategic initiatives until the Board has regained quorum;
- avoid commitments that would materially limit the decision-making authority of the newly constituted Board.

Nothing in this section shall prevent the CEO from taking action necessary to fulfill statutory obligations or protect the interests of Southwestern Public Health.

6.4 Urgent Matters

Where delay would reasonably be expected to:

- jeopardize public health;
- compromise employee or public safety;
- expose the organization to significant legal liability;
- result in significant financial loss;
- prevent compliance with legislation;
- materially impair the operations of Southwestern Public Health

The CEO may take such actions as are reasonably necessary to protect the organization.

Where appropriate, the CEO shall seek legal advice prior to exercising authority under this section.

6.5 Reporting

The CEO shall report all significant actions taken under Sections 6.3 and 6.4 to the Board at the earliest practical opportunity following restoration of quorum.

7. Accountability

The CEO shall maintain appropriate records respecting the exercise of delegated authority.

The Board may request information respecting any decision made under delegated authority.

Nothing in this policy limits the Board's authority to amend, suspend, or revoke delegated authority.

Delegation of authority does not diminish the CEO's accountability to the Board.

COMPLIANCE:

Non-compliance with this policy and any associated procedures may result in appropriate disciplinary measures.

REVISION DATES:

February 2019

June 2024

September 2026

SIMPLE MARK-UP VERSION



Board of Health

SECTION:	Governance	APPROVED BY:	Board of Health
NUMBER:	BOH-GOV-030	REVISED:	September 2026
DATE:	May 1, 2018		

Delegation of Authority (Powers and Duties)

PURPOSE:

The purpose of this policy is to establish the principles governing the delegation of powers, duties, and functions of the Board of Health for the Oxford, Elgin, St. Thomas Health Unit (OESTHU) o/a Southwestern Public Health (SWPH), including legislative and quasi-judicial powers that have traditionally been held by the Board alone.

This policy ensures the efficient administration of the organization while maintaining appropriate governance oversight and accountability and also establishes provisions to support organizational continuity during periods when the Board of Health is unable to conduct business due to vacancies, municipal election transitions, or the absence of quorum.

POLICY:

1. GENERAL PRINCIPLES

- 1.1 The Board of Health is responsible for the governance, strategic direction, stewardship, and oversight of Southwestern Public Health.
- 1.2 The Chief Executive Officer is responsible for the day-to-day administration and management of the organization and is accountable to the Board for the exercise of all delegated authority.
- 1.3 All delegations of Board powers, duties, or functions shall be established by Board policy, Board by-law, or Board resolution.
- 1.4 Unless expressly delegated, all powers, duties, and functions remain vested with the Board.
- 1.5 Delegated authority shall be exercised:
 - in accordance with applicable legislation;
 - in compliance with Board policies and by-laws;
 - within approved budgets;
 - in support of the Board's strategic priorities; and

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- in the best interests of Southwestern Public Health.

2. MATTERS RESERVED TO THE BOARD

The following matters remain the exclusive responsibility of the Board unless otherwise provided by legislation:

- approval and amendment of Board by-laws;
- approval of governance policies;
- approval of the Strategic Plan and Board priorities;
- approval of annual operating and capital budgets;
- approval of audited financial statements;
- appointment, performance evaluation, compensation, and termination of the Chief Executive Officer;
- appointment of Board officers and committees;
- approval of borrowing where authorized by legislation;
- approval of significant real property transactions;
- approval of advocacy positions on behalf of the Board;
- any other matter reserved to the Board by the *Health Protection and Promotion Act*, applicable legislation, or Board by-law.

3. AUTHORIZATION OF EXPENDITURES:

The Board of Health has the ultimate authority for all expenditures. The Board delegates this authority through the authorization of budgets, the procurement policy and/or by specific resolution or direction to staff.

The Board establishes financial authority through the approval of:

- annual overall operating and capital budgets;
- financial management policies;
- procurement policies;
- signing authority policies; and
- specific Board resolutions.

The CEO is authorized to administer budgets in accordance with these authorities.

The CEO may authorize expenditures provided that:

- sufficient budget has been approved;
- expenditures comply with Board policies;
- expenditures are necessary to carry out approved operations or strategic priorities; and
- delegated financial authority has not been exceeded.

The Procurement Policy sets out the authority for payment of accounts and sets limits on spending levels. It also provides direction on the circumstances in which certain purchasing mechanisms are appropriate (i.e., informal quotes, formal quotes, tender submissions or requests for proposal).

4. AUTHORITY TO EXECUTE AGREEMENTS:

The Board authorizes the CEO to execute agreements and legally bind Southwestern Public Health without obtaining further Board approval where all of the following conditions are met:

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- the agreement is administrative or operational in nature;
- the agreement supports an approved Board program, service, or operation;
- operating or capital funding exists, where applicable;
- the agreement complies with the Procurement Policy and other applicable Board policies; and
- the agreement has a term not exceeding five (5) years, unless otherwise authorized by the Board.

The CEO may delegate signing authority to employees in accordance with Board-approved policies.

5. STATUTORY DELEGATIONS

Where legislation permits the Board to delegate statutory powers or duties, such delegation shall be made by Board by-law or resolution.

Municipal Freedom of Information and Protection of Privacy Act (MFIPPA):

The Board of Health as the Institution under MFIPPA legislation is responsible for the fulfilment of many of the compliance requirements for responding to Freedom of Information (FOI) requests as well as the protection of client privacy. As the majority of Board members are elected municipal officials, section 3 of this legislation requires that members of the Board of Health designate one person or committee to be appointed, by by-law, as “Head” for the purposes of the Act.

To facilitate the timely and efficient fulfilment of obligations by OESTHU to ensure compliance with respect to responding to FOI requests from clients, other institutions, the general public and/or media, as well as ensure the protection of the client, OESTHU and third party privacy, the designated “Head” will appoint the CEO to fulfill all the responsibilities of the Head under the Act.

5.1 PROCEDURE:

- As part of the order of business for the first meeting of a newly constituted Board of Health, the members shall appoint the Chair of the Board of Health, “Head” in accordance with MFIPPA and By-Law number 1 section 2. See “BOH-GOV-030(F) – Appendix A” for template for By-Law appointing “Head” under MFIPPA.
- By motion of the Board of Health, the newly appointed “Head” will delegate the Southwestern Public Health’s CEO as acting “Head” of OESTHU for the purpose of ensuring day-to-day fulfilment of OESTHU’s compliance obligations under MFIPPA.

6. BOARD TRANSITION AND GOVERNANCE CONTINUITY

The Board recognizes that municipal elections, provincial appointments, resignations, vacancies, or other circumstances may temporarily prevent the Board from achieving quorum.

During such periods, the following provisions shall apply.

6.1 CONTINUITY OF EXISTING AUTHORITY

All Board-approved policies, by-laws, budgets, delegations, and resolutions shall remain in effect until amended or repealed by the Board.

6.2 CEO Authority During Transition

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The CEO shall continue to exercise all authority previously delegated by the Board, including authority respecting:

- administration of approved budgets;
- procurement and purchasing;
- execution of agreements;
- staffing and labour relations;
- implementation of approved programs and services;
- public health emergency response;
- legislative compliance;
- financial administration;
- operational decision-making; and
- protection of organizational assets.

6.3 Caretaking Principles

During a transition period, the CEO shall, where reasonably possible:

- continue routine business operations;
- implement previously approved Board decisions;
- defer significant strategic initiatives until the Board has regained quorum;
- avoid commitments that would materially limit the decision-making authority of the newly constituted Board.

Nothing in this section shall prevent the CEO from taking action necessary to fulfill statutory obligations or protect the interests of Southwestern Public Health.

6.4 Urgent Matters

Where delay would reasonably be expected to:

- jeopardize public health;
- compromise employee or public safety;
- expose the organization to significant legal liability;
- result in significant financial loss;
- prevent compliance with legislation;
- materially impair the operations of Southwestern Public Health

The CEO may take such actions as are reasonably necessary to protect the organization.

Where appropriate, the CEO shall seek legal advice prior to exercising authority under this section.

6.5 Reporting

The CEO shall report all significant actions taken under Sections 6.3 and 6.4 to the Board at the earliest practical opportunity following restoration of quorum.

7. Accountability

The CEO shall maintain appropriate records respecting the exercise of delegated authority.

The Board may request information respecting any decision made under delegated authority.

Nothing in this policy limits the Board's authority to amend, suspend, or revoke delegated authority.

Delegation of authority does not diminish the CEO's accountability to the Board.

COMPLIANCE:

Non-compliance with this policy and any associated procedures may result in appropriate disciplinary measures.

REVISION DATES:

February 2019

June 2024

September 2026

SECTION:	Governance	APPROVED BY:	Board of Health
NUMBER:	BOH-GOV-040	REVISED:	June 2024
DATE:	May 1, 2018		<u>September 2026</u>

Recording of Board of Health Meetings

PURPOSE:

The purpose of this policy is to ensure the creation of an accurate and comprehensive record of Board of Health (BOH) meetings, while promoting transparency and public access to the proceedings.

POLICY:

Meetings of the BOH shall be recorded and open session portions made available to the public to enhance transparency and provide a reliable record for the creation of official meeting minutes.

PROCEDURE:

- Notification and Consent:** At the beginning of each meeting, the Chair will inform attendees, including members of the public, that the meeting will be recorded and the open session portion shall be made available on the SWPH's public website. Attendance and participation in the meeting imply consent to this recording and public dissemination.
- Storage and Security:** Recordings will be securely stored by the Executive Assistant until they are made public.
- Public Access:** Recordings will be made available to the public via a link on Southwestern Public Health's (SWPH) website ~~within~~ five business days after the meeting. This timeframe allows for necessary administrative processing and quality checks. Recordings will be removed from the public website no later than the next BOH meeting, or 30 days, whichever occurs first.
- Retention and Disposal:** Recordings will be retained as part of the public record for a

period defined by SWPH's record retention policy. After this period, recordings will be disposed of in a secure manner [and in keeping with SWPH's file destruction policy](#), unless required for legal, audit, or archival purposes.

5. **Amendments to the Policy:** This policy may be revised to reflect changes in legal requirements, technological advancements, or organizational practices.

COMPLIANCE:

Non-compliance with this policy and any associated procedures may result in appropriate disciplinary measures.

REVISION DATES:

September 2022

June 2024

September 2026

SECTION:	Governance	APPROVED BY:	Board of Health
NUMBER:	BOH-GOV-060	REVISED:	June 2024
DATE:	May 1, 2018		<u>September 2026</u>

Terms for Election of Officers

PURPOSE:

The purpose of this policy is to establish clear parameters for the election and term limits of the Chair and Vice-Chair. The purpose is to promote continuity by ensuring members elected to be chair or vice-chair may serve for two consecutive terms.

POLICY:

In accordance with Section 52 of the Health Protection and Promotion Act ~~Section 52~~, at the first meeting of the Board of Health in each year, the members shall elect one member to be Cchair and one to be Vice-Chair.

In accordance with By-Law No. 1, any member of the Board of Health may serve as an Officer of the Board in the position of chair or vice-chair, provided they are elected. The term for each Officer position shall be one year.

Incumbents may be re-elected for a total of two consecutive terms before a one-year break in the role served before being re-elected for another term, in accordance with Bylaw No. 1. An incumbent may be elected to a subsequent consecutive term if no other nominations are received and that individual is subsequently elected by the Board.

REFERENCES:

- Section 52, Health Protection and Promotion Act.
- By-Law No. 1 – Southwestern Public Health

COMPLIANCE:

Non-compliance with this policy and any associated procedures may result in appropriate disciplinary measures.

REVISION DATES:

September 2022

June 2024

September 2026

DRAFT

POLICY NAME:	BOARD OF HEALTH SELF-EVALUATION & <u>DEVELOPMENT</u>
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SECTION:	HUMAN RESOURCES	POLICY NUMBER:	BBOH-HRGOV-10 20
REVISION DATE:	JUNE 2024 <u>SEPTEMBER 2026</u>	APPROVED BY:	BOARD OF HEALTH
ISSUE DATE:	MAY 1, 2018		

1.0 PURPOSE:

To establish a process for the Board of Health to periodically evaluate its governance effectiveness and assess the collective competencies of its members in accordance with the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (OPHS). The process supports continuous improvement in governance, orientation, education, and Board development. To outline the requirements of self-evaluation for board of health members in accordance with the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability.

2.0 POLICY:

The Board of Health shall undertake a comprehensive self-evaluation process at least every other year consisting of:

- a Board Governance: Member Evaluation (Appendix A) that assesses the effectiveness of the Board's governance practices, processes, and outcomes; and,
- an Individual Competency Matrix Self-Assessment (Appendix B) completed by each Board member to identify the Board's collective knowledge, skills, experience, and development needs.

2.1 Competency Matrix Survey (BOH-GOV-120 Appendix A)

Board members will complete the yearly individual assessment which aims to enhance their contribution to the board, identify skill gaps, training and development opportunities.

The annual Competency Matrix Survey shall:

- Provide Board members with an opportunity to assess their own knowledge, experience, and competencies relevant to effective governance;
- Identify the Board's collective strengths and competency gaps through aggregated results;
- Inform Board orientation, continuing education, governance development, committee succession planning, and future recruitment discussions where applicable;
- Identify opportunities for Board members to contribute their expertise in support of Board learning and committee work; and
- Not be used to evaluate the performance of individual Board members.

Individual competency assessments shall remain confidential. Only aggregated, anonymized results will be reported to the Board unless otherwise authorized by the individual member.

2.2 Board Governance: Member Evaluation (BOH-GOV-120 Appendix B)

The Board Governance: Member Evaluation may result in recommendations to strengthen Board leadership, governance effectiveness, engagement, accountability, and overall performance.

The Board Governance Member self-Evaluation process shall include consideration of whether:

1. Decision-making is based on access to supported by appropriate information with and sufficient time for deliberations;
- 1.2. The Board fulfills its legislative, fiduciary, and governance responsibilities;
- 2.3. Compliance with applicable all federal and provincial regulatory requirements is achieved;
- 1.4. Any material notice of wrongdoing or irregularities is-are responded to and addressed appropriately in a timely manner;
- 2.5. Reporting systems provide the Board with information that is timely and complete meaningful to support governance oversight;
6. Board mMembers remain abreast of major developments in governance and public health best practices, including emerging practices among peers;
- 4.7. The Board effectively oversees organizational performance, financial stewardship, enterprise risk, and accountability for programs and services;

~~2. Board discussions remain focused on strategic direction, governance, policy issues and solutions, and oversight rather than operational matters; members are actively engaged in discussing agenda items that focus on strategic results, policy issues and solutions rather than on day-to-day operational issues; and~~

~~8.~~

~~3. Board meetings, committees, orientation, and governance processes effectively support informed decision-making and member engagement. Members monitor fiscal and programs and services performance.~~

~~3-9.~~

~~3.0 Board members will complete the individual assessment portion of the tool which aims to enhance their contribution to the board, identify skill gaps, training and development opportunities.~~

PROCEDURE:

3.1 Competency Matrix Survey (BOH- GOV-120 Appendix A)

- ~~1. The CEO or designate shall distribute the Board Competency Matrix Survey to all Board members by August of the assessment year.~~
- ~~2. Board members shall complete the assessment by the established deadline.~~
- ~~3. The CEO or designate shall compile and anonymize the results to produce a collective competency profile of the Board.~~
- ~~4. The Governance Standing Committee shall review the aggregated results during the fall and may make recommendations to the Board regarding Board orientation; ongoing education; governance development initiatives; committee composition; where appropriate; and other Board development opportunities.~~

3.2 Board Governance: Member Evaluation (BOH- GOV-120 Appendix B)

1. The CEO or designate shall distribute the Board Governance Self-Evaluation to Board members following the final regular Board meeting of the calendar year.
2. Board members shall complete the evaluation by the established deadline.
3. The CEO or designate shall compile the results and prepare a summary report.

4. The Governance Standing Committee shall review the results and make recommendations to the Board, as appropriate, regarding governance practices, Board effectiveness, policies, and governance improvements.
- ~~5. The CEO or designate will forward the Board of Health and Individual Assessment form (BOH-HR-020 – Appendix A) to each Board member by July 1st of the assessment year.~~
- ~~6.—~~
- ~~7. Board members will complete the forms electronically by August 1st of the assessment year and return to the CEO.~~
- ~~8.—~~
- ~~9. The CEO will compile the results of the assessments and forward to the Board no later than September 30th of the assessment year.~~
- ~~10.—~~
- ~~11. The Board will discuss the results at a subsequent Board of Health meeting.~~

COMPLIANCE:

Non-compliance with this policy and any associated procedures may result in appropriate disciplinary measures.

CHANGES TO PREVIOUS VERSION

- September 2022
- June 2024 (addition of compliance and revision dates)
- September 2026

SIMPLE MARK-UP VERSION

POLICY NAME:	BOARD OF HEALTH EVALUATION & DEVELOPMENT
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SECTION:	HUMAN RESOURCES	POLICY NUMBER:	BOH-GOV-120
REVISION DATE:	SEPTEMBER 2026	APPROVED BY:	BOARD OF HEALTH
ISSUE DATE:	MAY 1, 2018		

1.0 PURPOSE:

To establish a process for the Board of Health to periodically evaluate its governance effectiveness and assess the collective competencies of its members in accordance with the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (OPHS). The process supports continuous improvement in governance, orientation, education, and Board development.

2.0 POLICY:

The Board of Health shall undertake a comprehensive self-evaluation process at least every other year consisting of:

- a Board Governance: Member Evaluation (Appendix A) that assesses the effectiveness of the Board's governance practices, processes, and outcomes; and,
- an Individual Competency Matrix Self-Assessment (Appendix B) completed by each Board member to identify the Board's collective knowledge, skills, experience, and development needs.

2.1 Competency Matrix Survey (BOH-GOV-120 Appendix A)

Board members will complete the yearly individual assessment which aims to enhance their contribution to the board, identify skill gaps, training and development opportunities.

The annual Competency Matrix Survey shall:

- Provide Board members with an opportunity to assess their own knowledge, experience, and competencies relevant to effective governance;

- Identify the Board's collective strengths and competency gaps through aggregated results;
- Inform Board orientation, continuing education, governance development, committee succession planning, and future recruitment discussions where applicable;
- Identify opportunities for Board members to contribute their expertise in support of Board learning and committee work; and
- Not be used to evaluate the performance of individual Board members.

Individual competency assessments shall remain confidential. Only aggregated, anonymized results will be reported to the Board unless otherwise authorized by the individual member.

2.2 Board Governance: Member Evaluation (BOH-GOV-120 Appendix B)

The Board Governance: Member Evaluation may result in recommendations to strengthen Board leadership, governance effectiveness, engagement, accountability, and overall performance.

The Board Governance Member Evaluation process shall include consideration of whether:

1. Decision-making is supported by appropriate information and sufficient time for deliberations;
2. The Board fulfills its legislative, fiduciary, and governance responsibilities;
3. Compliance with applicable federal and provincial regulatory requirements is achieved;
4. Any material notice of wrongdoing or irregularities are responded to and addressed appropriately in a timely manner;
5. Reporting systems provide the Board with information that is timely and meaningful to support governance oversight;
6. Board members remain abreast of major developments in governance and public health best practices, including emerging practices among peers;
7. The Board effectively oversees organizational performance, financial stewardship, enterprise risk, and accountability for programs and services;
8. Board discussions remain focused on strategic direction, governance, policy issues and solutions, and oversight rather than operational matters; and

9. Board meetings, committees, orientation, and governance processes effectively support informed decision-making and member engagement.

3.0 PROCEDURE:

3.1 Competency Matrix Survey (BOH- GOV-120 Appendix A)

1. The CEO or designate shall distribute the Board Competency Matrix Survey to all Board members by August of the assessment year.
2. Board members shall complete the assessment by the established deadline.
3. The CEO or designate shall compile and anonymize the results to produce a collective competency profile of the Board.
4. The Governance Standing Committee shall review the aggregated results during the fall and may make recommendations to the Board regarding Board orientation; ongoing education; governance development initiatives; committee composition where appropriate; and other Board development opportunities.

3.2 Board Governance: Member Evaluation (BOH- GOV-120 Appendix B)

1. The CEO or designate shall distribute the Board Governance Self-Evaluation to Board members following the final regular Board meeting of the calendar year.
2. Board members shall complete the evaluation by the established deadline.
3. The CEO or designate shall compile the results and prepare a summary report.
4. The Governance Standing Committee shall review the results and make recommendations to the Board, as appropriate, regarding governance practices, Board effectiveness, policies, and governance improvements.

COMPLIANCE:

Non-compliance with this policy and any associated procedures may result in appropriate disciplinary measures.

CHANGES TO PREVIOUS VERSION

- September 2022
- June 2024 (addition of compliance and revision dates)
- September 2026

Board ~~of Health~~ Governance - Member Self Evaluation Survey

Welcome to the Board of Health ~~Self-Evaluation~~ Board Governance – Member Evaluation Survey. In consideration of the significant investment of time and energy required by the Board of Health, the Ministry of Health ~~and Long-Term Care~~ has mandated that health units implement a process for evaluating board operations. BOH-~~GOVHR-1020~~ Policy, Board of Health ~~Self-Evaluation~~ and Development was developed to support this organizational standard.

This self-assessment survey aims to determine whether Board members feel that goals, objectives and deliverables are being met and to identify any potential areas for development in advance.

The survey should take about 10-15 minutes to complete.

The self-assessment is made up of five sections:

- Section 1 -Roles and Responsibilities
- Section 2 -Information Sharing
- Section 3 -Board Relations
- Section 4 -Planning Documents
- Section 5 -Personal Competencies.

There is an open-ended comment field in each section as an opportunity to provide additional detailed feedback on performance successes and suggested improvements in each area.

The results from the survey will be kept confidential. All results will be summarized in a brief summary report which will not contain information that could identify an individual.

Section 1: BOH Roles and Responsibilities

Do you agree or disagree with the following statements?

	Agree	Neutral	Disagree
1. As a BOH member, I have a clear understanding of the ROLE of the BOH at Southwestern Public Health.	☐	☐	☐
2. As a BOH member, I have a clear understanding of the RESPONSIBILITIES of the BOH at Southwestern Public Health.	☐	☐	☐

3. As a BOH member, I have a clear understanding of the role of the executive leadership team (CEO and MOH) in the Health Unit.

☐

☐

☐

Do you agree or disagree with the following statements?

Agree Neutral Disagree

4. The BOH focuses primarily on long-term issues and policy issues.

☐

☐

☐

5. The BOH steers clear of lengthy discussions of short-term administrative matters.

☐

☐

☐

6. The BOH receives adequate information to approve financial information.

☐

☐

☐

7. The BOH receives adequate information on the Health Unit's compliance with applicable legislation.

☐

☐

☐

8. The BOH is adequately prepared to oversee an emergency situation.

☐

☐

☐

9. What suggestions do you have to help clarify the roles and responsibilities of BOH members?

Section 2: BOH Information Sharing

Do you agree or disagree with the following statements?

Agree Neutral Disagree

10. I believe the staff presentations at BOH meetings are helpful in fulfilling my role.

☐

☐

☐

11. I believe the Program and Service Reports to the BOH is helpful in fulfilling my role.

☐

☐

☐

12. I believe the Medical Officer of Health Report to the BOH is helpful in fulfilling my role.

☐

☐

☐

13. I believe the Chief Executive Officer's report to the BOH is helpful in fulfilling my role.

☐

☐

☐

14. What suggestions do you have, if any, to improve information sharing with the Board of Health?

Section 3: Board Relations

Do you agree or disagree with the following statements?

Agree Neutral Disagree

15. I feel that the BOH works well as a team.

☐

☐

☐

16. There is sufficient time allocated for the full discussion of issues at the BOH meetings.	☐	☐	☐
17. BOH members have adequate opportunities to ask questions at BOH meetings.	☐	☐	☐
18. I feel comfortable raising an issue that might be unpopular.	☐	☐	☐
19. A climate of mutual trust and respect exists between the BOH and the Medical Officer of Health.	☐	☐	☐
20. A climate of mutual trust and respect exists between the BOH and the CEO.	☐	☐	☐
21. A climate of mutual trust and respect exists between the BOH and the Senior Leadership Team (Program and Service Directors).	☐	☐	☐
22. BOH members assist in developing and maintaining positive relations with key Public Health stakeholders.	☐	☐	☐

23. Are there any areas for improvement in BOH relations?

24. Are there particular strengths that should be noted in the area of BOH relations?

Section 4: Planning Documents

Do you agree or disagree with the following statements?

	Agree	Neutral	Disagree
25. I am familiar with the Health Unit's Annual Report.	☐	☐	☐
27. I am familiar with the Health Unit's Accountability Agreement with the Ministry of Health and Long-Term Care (MOHLTC).	☐	☐	☐

28. Do you have any suggestions for improving BOH work related to planning?

Section 5: Board of Health Member Personal Competencies

Do you agree or disagree with the following statements?

	Agree	Neutral	Disagree
29. I have an understanding of the skills that I bring to the BOH.	☐	☐	☐
30. I believe that I am contributing to the effectiveness of the BOH.	☐	☐	☐

31. I feel comfortable asking questions when I don't fully understand an issue.	☐	☐	☐
32. I identify and communicate my individual training needs for my role as a BOH member.	☐	☐	☐
33. I typically arrive at meetings on time and I am prepared to participate fully (to discuss, debate and make decisions).	☐	☐	☐
34. I am able to accept differences of views and opinions between BOH members.	☐	☐	☐
35. I am confident in my ability to express myself and represent my views to other Board members during discussions.	☐	☐	☐

Do you agree or disagree with the following statements?

	Agree	Neutral	Disagree
36. I believe I represent the public's interest as it relates to Public Health.	☐	☐	☐
37. I am familiar with the Health Protection and Promotion Act (HPPA) and bylaws of the organization.	☐	☐	☐
38. I am familiar with the Board of Health Bylaws and Policies/Procedures	☐	☐	☐
39. I am aware of the powers, limitations, and restrictions that I have as a Board member.	☐	☐	☐
40. I am able to interpret, analyze, and access any board information I need.	☐	☐	☐
41. I understand the role of data, measurement and evaluation in the work of the Health Unit.	☐	☐	☐
42. I enjoy being on the BOH.	☐	☐	☐
43. I feel that I have the opportunity and the skills to contribute to the success of the organization.	☐	☐	☐

44. What are some of your learning needs?

Choice 1	Choice 2	Choice 3
Please list 1-3 topics or areas in which you would like more information, training or development opportunities to help you in your role as a member of the Board of Health.		

45. Do you have any other comments or suggestions that will help the BOH increase its effectiveness?

Thank you for your time in completing this survey!

SECTION:	Policy Management	APPROVED BY:	Board of Health
NUMBER:	BOH-PM-010	REVISED:	June 2024 <u>September 2026</u>
DATE:	May 1, 2018		

Policy and Bylaws Adherence and Development

POLICY:

Southwestern Public Health's Board of Health members are responsible for adhering to all Board of Health policies and procedures and the Bylaws of SWPH.

Board of Health and non-union policies and procedures shall be reviewed every two years by the [Chief Executive Officer](#) or their designate to ensure applicability, and the potential need for any amendments and/or additions. The biennial review does not negate the possibility of an amendment to an existing and/or creation of an additional policy prior to the scheduled review.

SWPH's Bylaws are reviewed at least every five years, or sooner as required, by the CEO or their designate to ensure applicability and the potential need for any amendments and/or additions.

PROCEDURE:

1. The Executive Assistant will track when policies are required to be reviewed and prepare policies for first review.
2. The CEO will undertake a review of each policy according to the review schedule.
3. The CEO will bring forward to the Governance Committee any amendments and/or additions to Board of Health policies/bylaws.

COMPLIANCE:

Non-compliance with this policy and any associated procedures may result in appropriate disciplinary measures.

QUALITY ASSURANCE:

Amendments and or additions to Southwestern Public Health's Board of Health policies or bylaws prior to the biennial review is at the discretion of the Chief Executive Officer and will be brought to the attention of the Board of Health Governance Standing Committee, [who will in turn determine of the policy requires an amendment prior to the policy's regular review timing.](#)

LIST OF REVISIONS:

May 29, 2024:

- Additional note that the EA will prepare the relevant policies for first review; additional note that the CEO will bring forward non-union policies to the Board where appropriate.
- Addition of Compliance, Quality Assurance, and List of Revisions

[July 15, 2026:](#)

- [Added note that review of Bylaws may occur sooner than 5 years](#)
- [Minor housekeeping changes](#)

REVISION DATES:

September 2022

June 2024

[September 2026](#)