

**Board of Health for
Lakelands Public Health
MEETING AGENDA
Wednesday, May 20, 2026, 4:00 – 6:30 p.m.
LPH Lindsay Office, 108 Angeline Street South**

1. Call to Order and Land Acknowledgement

2. Welcome – Frances Gerow, Provincial Appointee

3. Declaration of Pecuniary Interest

4. Adoption of the Agenda

5. Adoption of Regular Minutes

- [Cover Report](#)
- a. [Draft Minutes, April 15, 2026](#)

6. Business Arising

7. Medical Officer of Health Update

8. Reports

8.1. Presentation: The People Behind the Numbers – Board of Health Update

- [Cover Report](#)
- a. [Presentation](#)

8.2. Presentation: Food Insecurity and Food Affordability for Lakelands Public Health, 2025

- [Cover Report](#)
- a. [Presentation](#)
- b. [Food Insecurity Dashboard](#) (*web hyperlink*)
- c. [Community-Specific Infographics](#)
- d. [Food Insecurity Webpage](#) (*web hyperlink*)

9. Consent Items

Board Members: Please identify which consent items in the following section you wish to consider separately from and advise the Chair when requested. Any items that are not pulled will be passed with one motion.

9.1. Committee Report: Indigenous Health Advisory Circle - Minutes

- Cover Report
- a. Minutes, Feb. 20, 2026

9.2. Quarterlies

- Cover Report
- a. Financial Report – Q1 2026
- b. Merger Progress Report and Dashboard – Q4 2025
- c. Ontario Public Health Standards Program Report – Q1 2026
- d. Risk Management Report – Q1 2026

9.3. Report: aLPHa Annual General Meeting Resolutions

- Cover Report
- a. Resolutions Package

10. New Business

11. In-Camera Session (nil)

12. Motions From In Camera Session (nil)

13. Date of Next Meeting

Wednesday, June 17, 2026
4:00 p.m. – 6:30 p.m.
Curve Lake First Nation

14. Adjournment

TITLE:	Meeting Minutes for Approval
DATE:	May 20, 2026
PREPARED BY:	Alida Gorizzan, Executive Assistant
APPROVED BY:	Dr. Thomas Piggott, Medical Officer of Health & CEO

Proposed Recommendation

That the Board of Health for Lakelands Public Health approve meeting minutes for April 15, 2026.

Attachments

- a. [Draft Minutes, April 15, 2026](#)

**Board of Health for
Lakelands Public Health
DRAFT MEETING MINUTES**

**Wednesday, April 15, 2026, 4:00 – 6:30 p.m.
Port Hope Office, 200 Rose Glen Road,
Meeting Rooms 1/2/3, Port Hope, ON**

In Attendance:

Board Members:

**Deputy Mayor Ron Black, Chair
Warden Bonnie Clark
Councillor Dan Joyce
Mayor Olena Hankivsky
Councillor Nodin Knott
Councillor Joy Lachica
Mayor John Logel
Dr. Ramesh Makhija
Mr. Dan Moloney
Deputy Mayor Tracy Richardson
Councillor Keith Riel
Councillor Cecil Ryall
Dr. Hans Stelzer
Councillor Kathryn Wilson (*joined at 4:05 p.m.*)**

Staff:

**Dr. Thomas Piggott, Medical Officer of Health & Chief Executive Officer
Mr. Larry Stinson, Director, Facilities, Finance & IT / Chief Transformation Officer
Julie Bromley
Ms. Alida Gorizzan, Executive Assistant (Recorder)
Ms. Michelle McWalters, Executive Assistant**

1. Call to Order and Land Acknowledgement

Deputy Mayor Black, Chair, called the meeting to order at 4:04 p.m.

2. Declaration of Pecuniary Interest

There were no declarations of pecuniary interest.

3. Adoption of the Agenda

MOTION:

That the agenda be approved as circulated.

Moved: Mr. Moloney

Seconded: Councillor Ryall

Motion carried. (2026-027)

4. Adoption of Regular Minutes

MOTION:

That the Board of Health for Lakelands Public Health approve meeting minutes for February 18, 2026.

Moved: Councillor Lachica

Seconded: Dr. Makhija

Motion carried. (2026-028)

5. Business Arising

6. Medical Officer of Health Update

Dr. Thomas Piggott provided an update that included:

- The pilot launch of the Peterborough Youth Substance Use Prevention (PYSUP) program took place on March 31 and aims to reduce substance use harms through implementation of the Icelandic Prevention Model (IPM).
- The Ministry of Health has discontinued funding for consumption treatment sites, resulting in the planned closure of the Peterborough site in June 2026.
- Collaboration continues with other merged health units to advocate for sustainable funding in light of anticipated deficits related to wage harmonization, including planning a delegation at the upcoming Association of Municipalities of Ontario conference.
- An educational session on public health is being planned for municipal candidates in early Fall 2026.
- Public engagement is underway to support the development of Lakelands Public Health's new strategic plan, with upcoming community town halls in Lindsay on May 20 and Peterborough on May 26. Dates in First Nation communities are being confirmed.

MOTION:

That the Board of Health for Lakelands Public Health receive the oral report, Medical Officer of Health Update, for information.

Moved: Mayor Logel

Seconded: Mr. Moloney

Motion carried. (2026-029)

7. Reports

7.1. Strategic & Emergency Services Division Presentation: Healthy Environments Radon Campaign - Invisible Risk. Measurable Action

MOTION:

That the Board of Health for Lakelands Public Health receive the following for information:

- Presentation: Strategic & Emergency Services Division: Healthy Environments Radon Campaign - Invisible Risk. Measurable Action
- Presenter: Julie Ingram, Manager, Emergency Services & Healthy Environments

Moved: Councillor Riel

Seconded: Councillor Lachica

Motion carried. (2026-030)

8. Consent Items

MOTION:

That the following items be passed as part of the Consent Agenda: 8.1; 8.2 a b; 8.3 a,b; 8.5.

Moved: Warden Clark

Seconded: Mayor Logel

Motion carried. (2026-031)

MOTION (8.1)

That the Board of Health for Lakelands Public Health receive Indigenous Health Advisory Circle (IHAC) minutes from its meeting held on December 12, 2025, for information.

Moved: Warden Clark

Seconded: Mayor Logel

Motion carried. (2026-031)

MOTION (8.2 a)

That the Board of Health for Lakelands Public Health receive Stewardship Committee minutes from its meeting held on November 14, 2025, for information.

Moved: Warden Clark

Seconded: Mayor Logel

Motion carried. (2026-031)

MOTION (8.2 b)

That the Board of Health for Lakelands Public Health approve Policy 02-15, Reserve Fund.

Moved: Warden Clark

Seconded: Mayor Logel

Motion carried. (2026-031)

MOTION (8.3 a, b)

That the Board of Health for Lakelands Public Health receive the following correspondence for information:

- a. Letter dated March 5, 2026 from the Board Chair to the Standing Senate Committee on Social Affairs, Science and Technology, as well as the Federal and Provincial Ministers of Health, regarding alcohol labelling and support for Bill S-202.
- b. Letter dated April 1, 2026 from the Association of Local Public Health Agencies to Dr. Joss Reimer, Canada's new Chief Public Health Officer (copied to all Ontario boards of health).

Moved: Warden Clark

Seconded: Mayor Logel

Motion carried. (2026-031)

MOTION (8.5):

That the Board of Health for Lakelands Public Health:

- receive the letter dated April 1, 2026 from the Association of Local Public Health Agencies (aLPHa) regarding 2026-27 membership; and,
- approve the 2026-27 membership fee in the amount of \$21,004.87.

Moved: Warden Clark

Seconded: Mayor Logel

Motion carried. (2026-031)

The following item was pulled from consent and amended:

MOTION (8.4)

That the Board of Health for Lakelands Public Health:

- receive the staff report, Access to Credit (RBC), for information;
- approve establishment of an Operating Line of Credit with Royal Bank of Canada (RBC) in the amount of one million eight hundred thousand (\$1,800,000);
- approve the Board of Health's Corporate Credit Card program in the amount of \$50,000 per billing cycle;
- direct that access to credit defined within these approvals complies with the approved Board Policy (as current); and,
- direct staff to conduct a review on the approved limits and report back to the Stewardship Committee, and then to the Board of Health.

Moved: Mr. Moloney

Seconded: Dr. Stelzer

Motion carried. (2026-032)

9. New Business

10. In-Camera Session

MOTION:

That the Board of Health go In Camera at 5:40 p.m. to discuss four items in accordance with the Municipal Act, 2001, Section 239(2):

(a) Security of Board property;

(b) Personal matters about an identifiable individual, including Board employees.

Moved: Mayor Hankivsky

Seconded: Mr. Moloney

Motion carried. (2026-033)

MOTION:

That the in-camera session be dissolved, and the membership return to open session at 6:43 p.m.

Moved: Mr. Moloney

Seconded: Councillor Joyce

Motion carried. (2026-034)

Dr. Makhija and Councillor Riel departed the meeting during the in camera session.

11. Motions From In Camera Session

MOTION:

That the Board of Health for Lakelands Public Health receive the following items for information:

- In Camera Meeting Minutes from February 18, 2026;
- In Camera Item 7.1 pertaining to Section 239(2)(a);
- In Camera Item 7.2, Stewardship In Camera Meeting Minutes from November 14, 2025;
- In Camera Items 7.3 and 7.4, pertaining to Section 239(2)(b).

Moved: Councillor Wilson

Seconded: Deputy Mayor Richardson

Motion carried. (2026-035)

12. Date of Next Meeting

Wednesday, May 20, 2026

4:00 p.m. – 6:30 p.m.

LPH Lindsay Office, 108 Angeline St. S., Lindsay ON

13. Adjournment

MOTION:

That the meeting be adjourned at 6:45 p.m.

Moved: Mayor Hankivsky

Seconded: Mayor Logel

Motion carried. (2026-036)

TITLE:	Presentation: The People Behind the Numbers – Board of Health Update
DATE:	May 20, 2026
PREPARED BY:	Meghan Bowman, Epidemiologist
APPROVED BY:	Fiona Kelly, Director, Quality, Planning & Epidemiology Dr. Thomas Piggott, Medical Officer of Health & CEO

Proposed Recommendation

That the Board of Health for Lakelands Public Health receive the following for information:

- Presentation Title: The People Behind the Numbers – Board of Health Update
- Presenter: Meghan Bowman, Epidemiologist

Attachments

- Presentation



Lakelands
Public Health

The People Behind the Numbers

Board of Health Update

Meghan Bowman

Epidemiologist

May 20, 2026



Outline

1. Epidemiology Team Overview
2. Special Topic: Putting Data in Perspective
 - a. The Growing Senior Population
 - b. Increased Health Complexity and System Strain
 - c. Turning Data into Action
3. Public Facing Surveillance Tools
 - a. Dashboard Demo
4. Questions

Recommendation for the Board is to receive this presentation for information.



Epidemiology Team

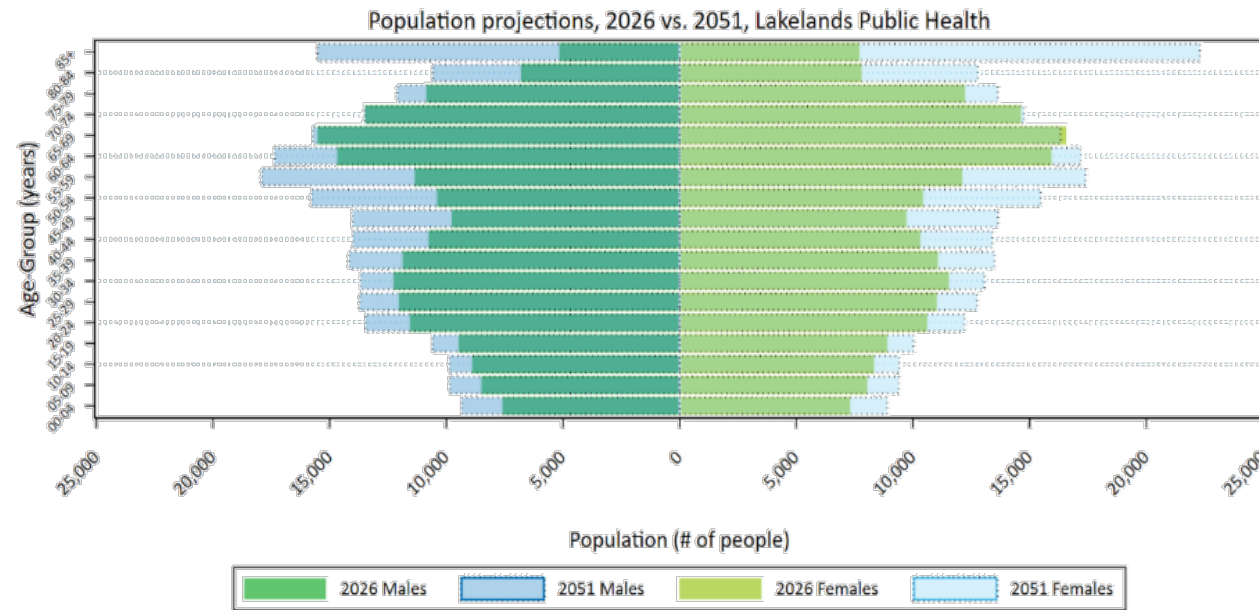
- Aim of epidemiology team: To transform raw data into actionable insights

Core responsibilities:

- Surveillance & Analysis: Monitoring disease trends, health behaviors, and population status
- Strategic Support: Developing data products, custom indicators, and support evidence-based program planning.
- Data Stewardship: Responding to internal and external requests to ensure decisions are backed by local evidence.
- Alignment with Ontario Public Health Standards:
 - Population Health Assessment & Surveillance: We fulfill the mandate to measure and report on the health of our community
- Epidemiology Team:
 - Meghan Bowman, Vidya Sunil, Andrew Harris

The Growing Senior Population

- **By 2051** 30% of the Lakelands population will be 65+.
 - Haliburton (39.2%), Northumberland (34.0%), Kawartha Lakes (32.1%), Peterborough (26.0%).
- **Lakelands Public Health** holds the highest proportion of residents aged 65+ among all Ontario Public Health Units (2026–2051).
- **Projected Growth:** An increase of 35,900 seniors over the next 25 years, reaching a total of 147,189 senior residents.



Source: Ontario Ministry of Finance, Population projections 2026–2051



Health Complexity and System Strain

- **Increased Morbidity:** By 2040, an estimated 80,000 residents (1 in 4) will live with a major illness (e.g., dementia, diabetes, hypertension).
- **Higher Acute Costs:** Average hospitalization costs in Ontario range from \$18,400 (ages 60–79) to \$23,188 (ages 80+).
- **Preventable Mortality:** In 2023, avoidable causes of death for those 65–74 were significantly higher in Lakelands than the provincial average.
- **Vulnerability:** Seniors face higher risks from environmental exposures (extreme weather), respiratory diseases (COVID-19, influenza) and injuries (falls).
 - Frequently intensified by rural health inequities and constrained resource availability.



Turning Data into Action

How surveillance Drives Decisions for an Aging Population

- Leveraging current hospitalization trends to equip program teams for the projected needs of an aging population.

Supporting the Community through Data

- Identifying where residents are falling through the cracks
- The goal is to use data to compress morbidity, ensuring the "extra years" gained by residents are spent in their homes and communities, not in acute care.



Public Facing Surveillance Tools

A suite of interactive dashboards (Chronic Disease, Injury, Demographics) designed to support decision-making.

These Dashboards allow for:

- Age filtering: provides users the ability to highlight specific populations (e.g., 65+)
- Geographic filtering: to help identify local needs
- Providing community partners, the public and internal staff the ability to make data-driven decisions.



Public Facing Surveillance Tools

Demo
(to be provided)



Lakelands
Public Health

Questions?



TITLE:	Presentation: Food Insecurity and Food Affordability for Lakelands Public Health, 2025
DATE:	May 20, 2026
PREPARED BY:	Sarah Tsang, RD, MHSc, Health Equity Coordinator Lauren Kennedy, RD, MScFN CDE, Public Health Nutritionist
APPROVED BY:	Hallie Atter, Director, Community Health Dr. Thomas Piggott, Medical Officer of Health & CEO

Proposed Recommendation

That the Board of Health for Lakelands Public Health receive the following for information:

- Presentation: Food Insecurity and Food Affordability for Lakelands Public Health, 2025
- Presenters: Sarah Tsang, RD, MHSc, Health Equity Coordinator; Lauren Kennedy, RD, MScFN CDE, Public Health Nutritionist

Background

Household food insecurity and food affordability are critical issues impacting the physical and mental health of communities served by Lakelands Public Health. Household food insecurity refers to worrying about running out of money for food. Studies show that household food insecurity is associated with a wide range of chronic conditions, including mental health disorders, higher stress and anxiety, non-communicable diseases, and infections.¹ In children, household food insecurity increases their likelihood to have poorer health, develop chronic conditions like asthma and develop mental health conditions such as depression, social anxiety and suicidal thoughts).¹ Between 2022-2024, about 22% of local households faced household food insecurity, worrying about having enough money for food.² Household food insecurity can make chronic disease management more difficult and is associated with increased hospital use and longer stays.¹

Health units are mandated to monitor food affordability by Ontario Public Health Standards.³ Monitoring food affordability is a two-step process. The first step is the costing of the Ontario Nutritious Food Basket (ONFB). The second step is to incorporate the food cost data into income scenarios to assess food affordability. Legacy HKPR and Legacy PPH have monitored food cost and food affordability for many years. Each legacy health unit costed the ONFB annually in May. The ONFB is based on Health Canada's National Nutritious Food Basket (NNFB),⁴ which includes 61 items that reflect the most recent version of Canada's Food Guide.

To support the requirement to monitor food affordability, the Ontario Ministry of Health previously developed and maintained the ONFB costing tool. The 2018 Ontario Public Health Standards included a Monitoring Food Affordability Reference Document which was not updated following release of the updated NNFB in 2019. To address this gap and

support efficiency across the province, the [Ontario Dietitians in Public Health](#) (ODPH), in partnership with [Public Health Ontario](#) (PHO), took on the role of updating and maintaining the tools required to monitor food affordability. Lakelands Public Health Dietitians are members of ODPH and have helped to lead this provincial work.

The release of 2025 data marks the start of monitoring food affordability for Lakelands Public Health as a merged health unit. Lakelands Public Health staff work actively to raise awareness about health impacts, root causes, and policy solutions for household food insecurity in collaboration with local and provincial partners.

It is also important to note that the current definition of household food insecurity is rooted in colonial frameworks and may not reflect Indigenous understandings and experiences of food systems, food access, and well-being. While discussions on the relevance of the data collected has occurred (e.g. with Hiawatha First Nation Council in 2025), Lakelands Public Health staff recognize the need for, and value of, ongoing work with First Nations and Urban Indigenous Communities to build relationships and inform future ways of assessing food insecurity together that are respectful, meaningful, and supportive of Indigenous food sovereignty.

Attachments

- a. [Presentation](#)
- b. [Food Insecurity Dashboard](#) (web hyperlink)
- c. [Community-Specific Infographics](#)
- d. [Food Insecurity Webpage](#) (web hyperlink)

Note: The attached food insecurity dashboard and community-specific infographics include unique food affordability data for City of Kawartha Lakes, Haliburton County, Northumberland County, Peterborough County, and the City of Peterborough.

References

¹ PROOF (n.d.). What are the implications of food insecurity for health and health care? Identifying Policy Options to Reduce Household Food Insecurity in Canada. Retrieved from: <https://proof.utoronto.ca/food-insecurity/what-are-the-implications-of-food-insecurity-for-health-and-health-care/>

² Public Health Ontario (2025). Household Food Insecurity Snapshot Data, Canadian Income Survey, 2022-2024 (3-year rolling average). Retrieved from: <https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Household-Food-Insecurity>

³ Ontario Ministry of Health (2018). Ontario Public Health Standards: Requirements for programs, services and accountability. Population Health Assessment, and Surveillance Protocol. Retrieved from: [Population Health Assessment and Surveillance Protocol, 2018](#)

⁴ Health Canada (2020). National Nutritious Food Basket. Retrieved from: <https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/national-nutritious-food-basket.html>



Lakelands
Public Health

Food Insecurity and Food Affordability for Lakelands Public Health, 2025

Sarah Tsang, RD, MHS, Health Equity Coordinator

Lauren Kennedy, RD, MScFN, CDE, Public Health Nutritionist

May 20th, 2026



Outline

- What is Household Food Insecurity?
- Household Food Insecurity Affects Health
- Monitoring Food Affordability
- Food Affordability for a Family on Ontario Works
- Solutions to household food insecurity
- Lakelands Public Health Actions to Address Household Food Insecurity

Recommendation for the Board is to receive this presentation for information.

🔍 Household food insecurity is:

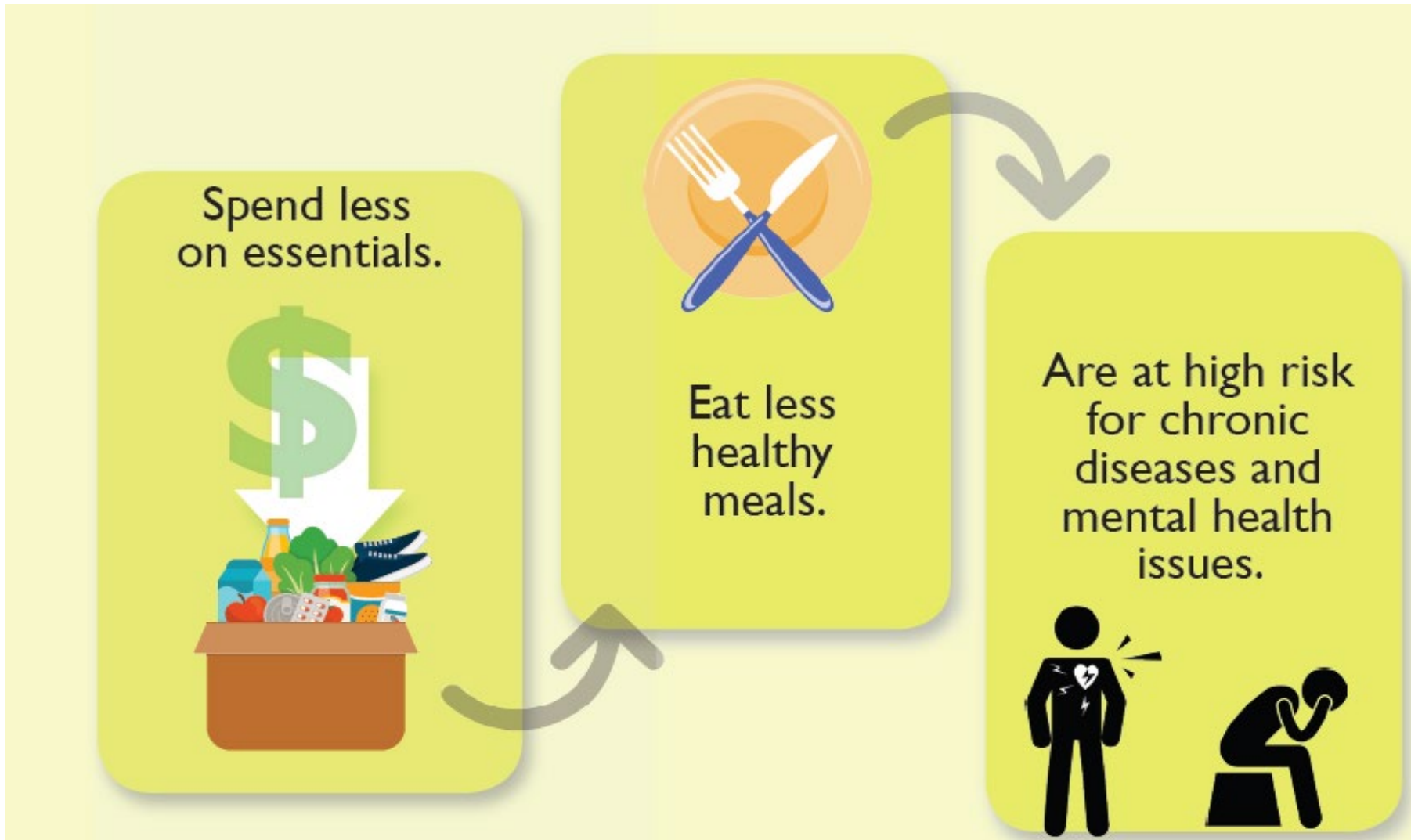


Not having enough money to afford food.

Between 2022-2024, in the Lakelands region, about **22%** of households were food insecure.



Household Food Insecurity Affects Health





Monitoring Food Affordability

Ministry of Health and Long-Term Care

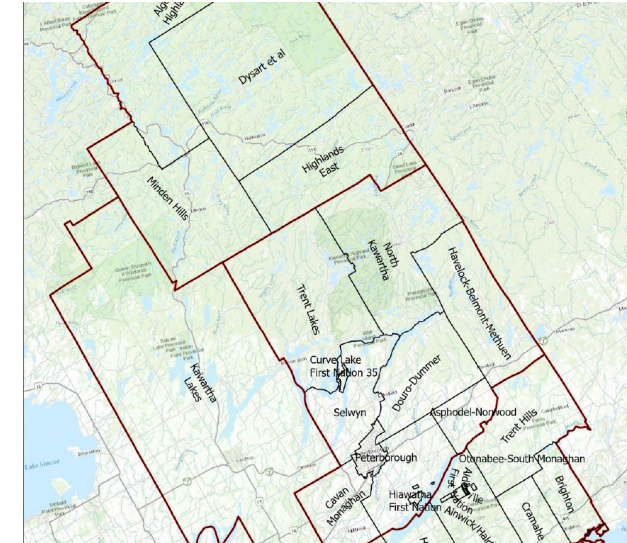
Population Health Assessment and Surveillance Protocol, 2018

Population and Public Health Division,

Mandated in the Ontario Public Health Standards.



The Nutritious Food Basket measures the cost of basic healthy eating.



2025 data presents the cost of a Nutritious Food Basket for the Lakelands area.

Scenario in Northumberland County

Family of Four
on Ontario
Works in
Northumberland
County

- **Total Income**
= \$3,013
- **Rent Cost** =
\$2,881
- **Cost of
healthy food**
= \$1,250



Money Left:
-\$1,118





Solutions to Household Food Insecurity



- Household food insecurity is not about food
- Emergency food interventions cannot solve household food insecurity
- Income-based policies can reduce food insecurity

Learn more. Get involved.
Build income solutions together.



Lakelands Public Health Actions to Address Household Food Insecurity



- ✓ Continue to monitor food affordability and report on household food insecurity.



- ✓ Raise awareness on the health impacts of household food insecurity.



- ✓ Collaborate with community partners locally and provincially.



- ✓ Have conversations with First Nation and Urban Indigenous Communities about Indigenous Food Sovereignty



Lakelands
Public Health

Questions?



References and Resources

- [PROOF, University of Toronto - Identifying Policy Options to Reduce Household Food Insecurity](#)
- [Public policy interventions to mitigate household food insecurity in Canada: a systematic review | Public Health Nutrition | Cambridge Core](#)
- [Food based interventions and household food insecurity in canada-Systematic Review.pdf](#)
- [Ontario Dietitians in Public Health Food Insecurity Resources](#)

The Cost of Eating Well in Haliburton County 2025



Household food insecurity means a family cannot always buy the food they need because money is tight.



Single Parent with 2 children over 6 years, Ontario Works

Monthly income (including benefits and credits): **\$2,776**

Percentage of income required for rent **95%**

Percentage of income required for food **34%**



I need **\$933** for healthy food but don't have enough.



We don't have any extra money for basics for our family.



\$2,633 rent for our 3-bedroom home is **95%** of my monthly income.



Research is clear:
more income =
less food insecurity.

What could help Sheena and her kids?

- ✓ Child benefits that better support low-income families.
- ✓ Ontario Works rates that match the cost of living.
- ✓ Basic Income Guarantee or Livable Basic Income.



Learn more. Get involved.
Build income solutions together.



SCAN ME!

For more information on food insecurity, scan the QR code to visit **LakelandsPH.ca/FoodInsecurity** or call **1-844-575-4567**



Household food insecurity means a family can not always buy the food they need because money is tight.



One person with a breast-fed infant on Ontario Works

Monthly income (including benefits and credits): **\$2087**

Percentage of income required for rent **94%**

Percentage of income required for food **21%**



\$1,970 for my rent takes up almost all of my monthly income.



It costs **\$442** for me to eat healthy as I breastfeed my baby.



I'm worried about how I will buy diapers and vitamin D drops for my baby.



Research is clear:
more income =
less food insecurity.

What could help Bobbi and her baby?

- ✓ Increase pregnancy and breastfeeding allowance.
- ✓ Ontario Works rates that match the cost of living.
- ✓ Child benefits adequately designed to support low-income families.
- ✓ Basic Income Guarantee or Livable Basic Income.



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Build income solutions together.



SCAN ME! 

For more information on food insecurity, scan the QR code to visit **LakelandsPH.ca/FoodInsecurity** or call **1-844-575-4567**

The Cost of Eating Well in Northumberland County 2025



Household food insecurity means a family cannot always buy the food they need because money is tight.



Family of four, Ontario Works

Monthly income (including benefits and credits): **\$3,013**

Percentage of income required for rent **96%**

Percentage of income required for food **41%**



We need **\$1,250** for healthy food but don't have enough.



We don't have any extra money for basics for our family.



\$2,881 rent for our 3-bedroom home is almost equal to our monthly income.



Research is clear:
more income =
less food insecurity.

What could help Morgan, Jesse and their kids?

- ✓ Child benefits that better support low-income families.
- ✓ Ontario Works rates that match the cost of living.
- ✓ Basic Income Guarantee or Livable Basic Income.



Learn more. Get involved.
Build income solutions together.



SCAN ME!

For more information on food insecurity, scan the QR code to visit **LakelandsPH.ca/FoodInsecurity** or call **1-844-575-4567**

The Cost of Eating Well in Peterborough County 2025



Household food insecurity means a family cannot always buy the food they need because money is tight.



Family of four, minimum wage

Monthly income (including benefits and credits): **\$5,093**

Percentage of income required for rent **63%**

Percentage of income required for food **25%**



\$3,222 rent for our 3-bedroom home is more than our monthly income.



It costs **\$1,250** for my family to eat healthy foods.



We still need to buy our kids bigger coats and boots this winter.



Research is clear:
more income =
less food insecurity.

What could help Farah, Bruno and their kids?

- ✓ Child benefits that better support low-income families.
- ✓ Minimum wage rates that match the cost of living.
- ✓ Basic Income Guarantee or Livable Basic Income.



Learn more. Get involved.
Build income solutions together.



SCAN ME! 

For more information on food insecurity, scan the QR code to visit **LakelandsPH.ca/FoodInsecurity** or call **1-844-575-4567**



Household food insecurity means a family cannot always buy the food they need because money is tight.





Pregnant person, Ontario Disability Support Program

Monthly income
(including benefits and credits): **\$1,583**


Percentage of income
required for rent **98%**

Percentage of income
required for food **29%**




After paying **\$1,547**
for rent, I have no money
left for other bills.


It costs **\$461** for me
to eat healthy during
my pregnancy.


I'm worried about
how I will pay for
childcare for my baby.



Research is clear:
more income =
less food insecurity.

What could help Rory?

- ✓ Increased pregnancy or breastfeeding allowance
- ✓ Access to a Canada Disability Benefit that meets living costs
- ✓ Ontario Disability Support Program (ODSP) rates that match cost of living
- ✓ Basic Income Guarantee or Livable Basic Income

Learn more. Get involved.
Build income solutions together.



**SCAN
ME!** 

For more information on food insecurity, scan the QR code to visit **LakelandsPH.ca/FoodInsecurity** or call **1-844-575-4567**

TITLE:	Committee Report: Indigenous Health Advisory Circle - Minutes
DATE:	May 20, 2026
PREPARED BY:	Wendy Freeburn, Executive Assistant <i>on behalf of</i> Liz Stone, Circle Chair
APPROVED BY:	Dr. Thomas Piggott, Medical Officer of Health & CEO

Proposed Recommendation

That the Board of Health for Lakelands Public Health receive the following for information:

- Indigenous Health Advisory Circle Minutes – February 20, 2026

Background

The Indigenous Health Advisory Circle (IHAC) met last on May 8, 2026. At that meeting, the Circle requested that these approved minutes come forward to the Board of Health at its next meeting.

Attachments

- IHAC Minutes - February 20, 2026

Indigenous Health Advisory Circle (IHAC)
MINUTES
Friday, February 20, 2026 – 10:30 a.m. – 12:00 p.m.
Lakelands Public Health

In Attendance:

Members:

Ms. Liz Stone, Chair
Professor David Newhouse, Vice Chair
Deputy Mayor Ron Black
Councillor Kathryn Wilson
Councillor Nodin Knott
Mayor John Logel
Ms. Ashley Safar
Ms. Courtney Taylor
Ms. Julie Bothwell
Ms. Lori Flynn
Ms. Rebecca Watts
Ms. Sarah Tsang

Staff:

Dr. Thomas Piggott, Medical Officer of Health & Chief Executive Officer
Dr. Natalie Bocking, Deputy Medical Officer of Health
Hallie Atter, Director, Community Health
Ms. Wendy Freeburn, Executive Assistant (Recorder)

Guests:

Ms. Donna Churipuy, Director, Strategic and Emergency Services, Chief Nursing Officer and Acting Privacy Officer
Ms. Julie Bromley, Manager, Emergency Services and Healthy Environments

Regrets:

Ms. Cheyanne Fisher
Councillor Joy Lachica
Ms. Samantha Roan, Manager, Indigenous Health

1. Call to Order

Dr. Thomas Piggott, Medical Officer of Health & Chief Executive Officer, called the meeting to order at 10:33 a.m.

2. Welcome, Introductions and Land Acknowledgement

3. Election of Circle Chair and Vice Chair and Terms of Reference (TOR)

A call out to all Circle members occurred prior to the meeting to determine interest in these leadership positions. The previous Circle Chair and Vice Chair, Ms. Stone and Professor Newhouse, respectively, expressed interest these positions. The Circle was fully supportive of their continued leadership for 2026.

Ms. Watts expressed interest in shadowing the Chair and Vice Chair for future succession planning and will be invited to attend IHAC planning meetings to observe and participate in development of agendas for meeting. The same opportunity is extended to all members of the Circle to gauge further interest in leadership roles.

Ms. Stone took over Chairing the meeting.

4. Confirmation of the Agenda

The agenda was approved with renumbering of Item 6.1 Regional Indigenous Health Strategy to Item 7.1 and Item 7.3 Cultural Competency Modules to Item 7.2 with Ms. Atter presenting both Items in Ms. Roan's absence.

5. Minutes of the Previous Meeting

The minutes of December 12, 2025, were approved as circulated.

Professor Newhouse suggested that, in addition to IHAC minutes being sent to the Board of Health (BOH), BOH minutes should also be shared with IHAC for reciprocity.

ACTION:

- **The minutes will be circulated to the BOH at their next meeting.**
- **Ms. Freeburn will ensure that Board of Health Minutes are circulated to all IHAC members who do not already receive them as BOH participants.**

6. Items Arising from the Minutes

6.1 Regional Indigenous Health Strategy

This item will continue as a standing item under Reports (see Item 7.1)

6.2 Update Indigenous Health Leaders Symposium Update (Liz Stone)

The Chair delivered a comprehensive report on the Indigenous Health Leaders Symposium, held on January 16, 2026, at Trent University. She outlined the event's structure and key recommendations, emphasized the importance of

avoiding repetitive or extractive consultation processes, and reaffirmed a commitment to ensuring that future gatherings build on previous work and advance toward actionable outcomes.

Seven key recommendations emerged from the Symposium that were shared with participants and the three funders of the Symposium (Peterborough Regional Health Centre, Lakelands Public Health and Trent University). They include:

- establishing an Indigenous-led health network;
- supporting Indigenous navigators and advisors;
- transforming governance structures;
- implementing Indigenous data sovereignty principles;
- developing community engagement protocols;
- ensuring comprehensive cultural safety training; and
- creating regional protocol agreements.

Deputy Mayor Black queried how to address the limited capacity of Indigenous communities to participate meaningfully in consultation processes, particularly in municipal and development-related contexts. It was agreed that discussions on potential resource supports and mechanisms to address these challenges would be pursued in an alternative forum.

ACTION: The Chair will send the final report from the Indigenous Health Leaders Symposium to all IHAC members who may not have received it.

6.3 **LPH Strategic Plan Development and Indigenous Engagement Update**

The Chair outlined the ongoing strategic planning process at Lakelands Public Health (LPH), detailing the three-phase approach led by Arising Collective, with a focus on inclusive external engagement involving Indigenous communities and leadership, and plans for community-specific sessions and interviews. The next phase (two) will include targeted sessions with IHAC, Alderville, Curve Lake, Hiawatha, and urban Indigenous communities, as well as individual interviews, including key leaders such as Chief Carr, Chief Simpson, and Chief Hockaday. The engagement methods (in-person or virtual) will be adapted to suit each group. The current process represents a significant expansion from previous strategic planning exercises, aiming for broader and deeper Indigenous participation.

6.4 **Sub-committee to Provide Cultural Advising Support to the Manager, Indigenous Health Position**

The Circle discussed and agreed to establish a sub-committee of Knowledge Keepers and Elders to support the Indigenous Health Manager and future

Indigenous staff, and to provide guidance on creating a culturally safe organizational environment. This group will draw on experiences from other institutions, with a focus on Indigenous partnerships, program advice, advocacy, and the inclusion of Indigenous knowledge, while maintaining an advisory role that does not overlap operational responsibilities.

Ms. Watts, Ms. Safar, Ms. Bothwell, and Ms. Flynn volunteered to participate on the sub-committee. It was recommended to develop a term of reference to define capacity and boundaries of the sub-committee, and to protect members' well-being, with an initial task of compiling a resource list of Knowledge Keepers and Elders in the community that can balance the group.

ACTION: Ms. Freeburn will assist in organizing an initial meeting for the newly formed Knowledge Keepers and Elders Sub-committee.

7. Reports

7.1 Regional Indigenous Health Strategy – Standing Item

Ms. Atter presented updates on the Regional Indigenous Health Strategy, including engagement principles and relationship-building with First Nations and Urban Indigenous communities with long-term commitment in all engagements.

7.2 Climate Change, Cambium Indigenous Professional Services (CIPS) Update

Deferred to the next meeting.

7.3 Cultural Competency Modules

Ms. Atter presented a review of the existing Lakelands cultural safety training modules, originally developed in partnership with the Dalla Lana School of Public Health. The review identified the need for updates and the development of enhanced cultural competency training for both staff and the Board of Health. She requested input on how best to advance cultural competency-building efforts within the organization. Future plans include mandatory training modules for all staff and board members, incorporating a blend of pre-existing materials and locally developed content.

Members of the Circle emphasized the importance of prioritizing local context and in-person learning over generic, virtual, or national level modules. Members also discussed the need to clearly distinguish between cultural competency, cultural safety, and cultural humility when designing training approaches. The Circle noted the importance of moving forward as a unified organization, ensuring a consistent foundational knowledge base rather than implementing

training differently or at different times across teams.

8. New Business

8.1 Culturally Sensitive Discussion

ACTION: Ms. Freeburn will work with the Chair, Vice Chair and Dr. Piggott to canvas and arrange a separate session for Indigenous IHAC members to discuss how culturally sensitive topics should be addressed and presented in future meetings, with the Chair and Vice Chair coordinating discussion.

8.2 IHAC 2026 Workplan

Deferred.

9. Date, Time, and Place of the Next Meeting

- Friday, May 8, 2026, 1:00 to 3:00 p.m. at the Peterborough Community Health Centre, 360 George St. N., Unit 64, Lower Level
- Friday, September 4, 2026, 10:00 a.m. to 12:00 noon, in the Boardroom, third floor, 185 King St. Peterborough
- Friday, December 4, 2026, 10:00 a.m. to 12:00 noon, in the Boardroom, third floor, 185 King St. Peterborough

10. Adjournment

On behalf of the Circle, the Chair expressed gratitude and recognition for the work, knowledge, and experience that Dr. Bocking has drawn to the Circle, not only locally, but also through her efforts in the North and across this territory.

The meeting was adjourned at 12:04 p.m.

TITLE:	Quarterly Reports
DATE:	May 20, 2026
PREPARED BY:	Senior Leadership Team
APPROVED BY:	Dr. Thomas Piggott, Medical Officer of Health & CEO

Proposed Recommendation

That the Board of Health for Lakelands Public Health receive the following items for information:

- a. Financial Report – Q1 2026
- b. Merger Progress Report and Dashboard – Q4 2025
- c. Ontario Public Health Standards Program Report – Q1 2026
- d. Risk Management Report – Q1 2026

Note: All reports represent the time period of January 1 – March 31, 2026; item b is based on the Ministry fiscal period which ends March 31, 2026.

Attachments

- a. Financial Report – Q1 2026
- b. Merger Progress Report and Dashboard – Q4 2025
- c. Ontario Public Health Standards Program Report – Q1 2026
- d. Risk Management Report – Q1 2026

Financial Update Q1 2026 (Finance Manager: Dale Bolton)

Programs Funded January 1 to December 31, 2026

	Funding Type	2026 Net Budget Approval	YTD Budget \$ Based on 2026 Submission (100%)	Year To Date Expenditures to Mar 31	Year to Date % of Budget	Year to Date Variance Under/(Over)	Comments
Mandatory Public Health Programs - all combined cost-shared	Ministry of Health (MOH) Cost Shared (CS)	32,137,600	8,034,400	7,879,114	24.5%	155,286	Year-to-date underspending from January through March based on the approved cost-shared budget for the health unit. The total funding includes MOH and local partners. The Ministry approved for 2026 includes a 1% increase over each legacy health unit's prior year cost-shared funding. Through the first quarter, expenditures net of offset revenue are \$7,879,114. Expenditures are just below budget at 24.5% based on the approved Board of Health (BOH) budget. Underspending at this time is due to some position gapping and timing of planned program spending during year. Through the balance of the year, expenditures will increase and will be on track to spend in full as program staff fulfill program harmonization and operational plans.

100% Program funded January 1 to December 31, 2026

	Funding Type	2026 Budget Approval	YTD Budget \$ Based on 2026 Submission (100%)	Year To Date Expenditures to Mar 31	Year to Date % of Budget	Year to Date Variance Under/(Over)	Comments
Ontario Seniors Dental	100%	2,083,600	520,900	359,352	17.2%	161,548	The 2026 Budget Submission of \$2,083,600 is equivalent to the prior year budget. The Year to Date expenditures are below budget at 17.2% for the first quarter. Underspending relates primarily to professional services as previous contracted dental service provider for the Haliburton area remains unfilled at this time and clinic closure for period of time in late January for period of approximately 3 weeks. Anticipate program spending will be on track through the end of the year and some of the fiscal budget will be used to support additional clinic upgrades.

100% Funding funded April 1, 2025 to March 31, 2026							
	Funding Type	2025 - 2026 Budget Approval	2025/26 YTD Budget \$ (100%)	Year To Date Expenditures to Mar 31	Year to Date % of Budget Approval	Year to Date Variance Under/(Over)	Comments
Infection Prevention and Control (IPAC) HUB - Infectious Disease	100% MOH	610,230	610,230	610,230	100.0%		- IPAC Hub budget approved by the Ministry in the amount of \$610,230 as submitted. Total program expenditures for the fiscal period equal to budget approval, thus no funds due back to the Province.
Student Practicum Program - Legacy PPH (LPPH)	100% MOH	20,000	20,000	20,000	100.0%		- Funding Public Health Inspector (PHI) Practicum Student for 16-week period. Budget approval of \$20,000 as submitted. Total program expenditures equal to budget approval, thus no funds due back to the Province.
PHI Practicum Student - Legacy HKPR (LKHKPR)	100% MOH	30,000	30,000	30,000	100.0%		- Funding PHI Practicum Students for 16-week period. Budget approval of \$30,000 as submitted. Total program expenditures equal to budget approval, thus no funds due back to the Province.
Merger - Strengthening Public Health - Year 2	100% MOH	7,682,469	7,682,469	5,103,614	66.4%	2,578,855	Year-to-date expenditures are below approved budget allocation. Through the final quarter, hired additional staff to support various initiatives, enhance program capacity and support program harmonization. Delays with planned hiring and unfilled positions contributed to overall underspending of the budget. Total expenditures includes municipal harmonization for LPPH partners for 2025 and 2026. In January 2026, the Ministry received an update on the status of the merger budget and anticipated spending through the end of March 2026, assuming planned hiring and other program activity completed.
Merger - Strengthening Public Health - Year 2: Capital Project and Building Assessment	100% MOH	800,000	800,000	482,000	60.3%	318,000	Expenses to date include minor upgrades for offices, consulting fees to complete a space needs and cost-benefit analysis for the Lindsay and Port Hope facilities, and support for capital application.

Programs funded April 1, 2025 to March 31, 2026 - Ministry of Children, Community and Social Services (MCCSS)							
	Funding Type	2025- 2026 Budget Allocation	YTD Budget Allocation \$ (100%)	Year To Date Expenditures to Mar 31	Year to Date % of Budget Approval	Year to Date Variance Under/(Over)	Comments
Infant Toddler and Development Program (LPPH)	100% MCCSS	253,283	253,283	253,283	100.0%	-	MCCSS budget approval of \$253,283. Total unaudited program expenditures equal to budget approval, thus no funds due back to the Province.
Healthy Babies, Healthy Children (LPPH)	100% MCCSS	2,107,031	2,107,031	2,065,226	98.0%	41,805	MCCSS merged budget approval of \$2,107,031. Ministry allocation based on \$1,018,064 for LPPH and \$1,088,968 for LHKPR programs. Total unaudited program expenditures \$2,065,226 are below budget due to gapping of a Community Worker and portion of a Public Health Nurse during the year. Historically the program budgets are spent in full. Upon completion of audit unspent funds will be returned to the Province as part of the settlement process.
Total - All Programs		45,724,213	20,058,313	16,802,819	36.7%	3,255,494	

TITLE:	Merger Progress Report and Dashboard – Q4 2025
DATE:	May 20, 2026
PREPARED BY:	Carolyn Doris, Manager, Project Management Sarah Gill, Manager, Change Management & Merger Communication Larry Stinson, Chief Transformation Officer
APPROVED BY:	Dr. Thomas Piggott, Medical Officer of Health & CEO

Background

This report is a point-in-time snapshot of the progress of merger implementation up to the end of the provincial Q4, or January 1 - March 31, 2026 (the fiscal year for merger funding runs from April 1st to March 31st). This report accompanies the dashboard (see attachment) for status of key deliverables in each of the four domains. It is important to note that the deliverables in the dashboard are those identified by the Ministry as common to all mergers and the timing for implementation was determined as their best estimate.

Corporate Services:

- The January 2026 cyber incident resulted in accelerating key IT project implementations. By the end of March 2026, all staff have migrated to cloud-based IT system, the on-premise environment has been decommissioned, the new tenant has been fully implemented, rehosting of SAGE accounting software into cloud-based environment has been completed, cloud-version of oral health clinic software (ClearDent) has been completed, printers are functioning, and faxes have been moved to new electronic platforms. Re-networking of all sites for internet access and firewall upgrades were also completed.
- Contract for the new Managed Service Provider has been negotiated with onboarding planned for May 2026.
- Installation of Lakelands Public Health (LPH) branded building signage completed at all office sites.
- The Facilities Review and Development Plan was presented to Board of Health in January 2026 and implementation is now underway. Work continues to move forward with a capital grant application.
- Site Manager recommendations to inform a common approach to management oversight of the four LPH office sites were approved by Senior Leadership for implementation by June 2026.
- Minor facilities retrofits at offices were completed including re-networking, lighting improvements and alarm pad upgrades.
- Labour Board ruling was received April 28th and awaiting clarification on next steps regarding bargaining unit representation and new collective agreement negotiation processes.

Governance:

- Planning for external engagement and gathering of input from community partners and the broader public, while also sharing information raising awarenesses about the changes taking place at LPH was completed. Engagement will take place in Q1 2026 (April-June).

Organizational & Programs:

- All remaining program staff using the Collaborative Health Record (CHR) were trained and onboarded in Q4. The CHR is now used by staff in the areas of Home Visiting, Sexual Health, Vaccine Preventable Diseases, Infectious Diseases, Oral Health and Community Health. Working groups will continue to support the use of CHR among teams. This work had been initiated by both legacy health units and is now harmonized.
- Harmonization of legacy policies and procedures and contracts continued.
- Program harmonization continued with progress through Playbooks. Working groups have been established across Program Divisions (Clinical Services, Environmental Health & Infectious Diseases, Strategic & Emergency Services, Community Health). Working groups, which include staff as subject matter experts and management representation from both legacy organizations, continue to move through Discovery (current state analysis), Align (future state analysis), and Action Planning activities:
 - Discovery phase has been completed by 39 programs with an additional 8 in progress.
 - Align phase has been completed by 11 programs with an additional 31 in progress.
 - Action Planning has been completed by 7 programs with 24 more in progress.
 - Eight program areas are currently in Implementation phase.

Transformation:

- Due to the cyber incident a project to migrate all staff to a modernized Microsoft Teams Phone, with improved capabilities and decreased costs, was initiated with leadership from the Transformation Team.
- Merger evaluation plan being developed in consultation with Project Sponsors and Leads.
- Year 3 Merger Budget submitted to Ministry of Health.

Attachments

[Merger Progress Dashboard](#)



Merger Progress: Year 2

Completed	In Progress	Not Started
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	Corporate Services	Governance	Organizational & Programs	Transformation
Q1	New agency emails in use	Board sub-committees, Terms of Reference completed	Program assessment / alignment reviews & integration plans completed	Change Management training for management completed
	Consolidated finance, human resources (HR) procedures	Board training needs assessment completed	Policy review initiated	Employee wellness activities initiated
	Banking transition	Board training/education plan developed	Shared service opportunities identified	Unified staff communication tools in place, utilized
	Public Sector Labour Relations Transition Act (PSLRTA) filed	Board by-laws & policies reviewed	External stakeholder consultations plan developed	CM/PM or Merger Transition Team in place
Q2	Capital/facilities/needs assessment	Board education/training activities underway	Pilot Program Harmonization	New branding developed
	Migration on contracts, memorandums of understanding (MOUs), agreements	Skill matrix tool for Board members developed, mapped to current board composition	Program consultation with external stakeholders	All-Staff event completed
	HR assessments including review or collective agreements	Interim strategic plan/guiding principles (mission, vision, values)	Partnership/Network meetings integrated (e.g. attendance, consolidation of duplicate meetings)	Staff training initiated
Q3	Capital business case (as needed)	Client Service Standards in place	Harmonization of remaining programs/service as collective agreements allow	New branding in use (website, social media, offices, signage)
	Information technology (IT), HR and operational data transfer and upgrades implemented	Self-evaluation standards in place	Harmonized medical directives, standard operating procedures	External partner communication tools/materials updated
	Procurement duplication identified and eliminated	Skill matrix used to inform Yr 3 training needs	Policy review and harmonization	Evaluation plan developed
	Non-unionized staff contracts harmonized	-	Community Health Profile	-

	Corporate Services	Governance	Organizational & Programs	Transformation
Q4	TPON registration	Strategic planning process underway for new entity	Program expansion/new program/services as collective agreements allow	Staff satisfaction/change readiness feedback
	PSLRTA vote (if applicable)	BOH orientation training	Back office/management restructuring	-
	Consolidated payroll, HR financial procedures	BOH Year 3 training plan	Staff stabilization plan	-

Updated for Q4 (2026/05/13)

TITLE:	Ontario Public Health Standards Program Report – Q1 2026 (January 1 – March 31, 2026)
DATE:	May 20, 2026
PREPARED BY:	Senior Leadership Team
APPROVED BY:	Dr. Thomas Piggott, Medical Officer of Health & CEO

Background

Section 5 of the *Health Protection and Promotion Act* (HPPA) specifies that boards of health (BOH) must superintend, provide, or ensure the provision of public health programs and services in specified areas. The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Standards) outline the minimum requirements that boards of health must meet for mandatory health programs and services.

This briefing note provides a summary of key program accomplishments and challenges for Lakelands Public Health in the first quarter of 2026 to inform the BOH about activities of the organization, monitor progress of activities, and ensure that the program requirements under the Ontario Public Health Standards (OPHS) are met.

SUMMARY OF ACHIEVEMENTS AND CHALLENGES

Achievements:

- Created an online Naloxone distribution training module for onboarding for new partners
- Final ethics approval for Peterborough Youth Substance Use Prevention (PYSUP) initiative survey; increase from 2-3 high schools to participate in survey; and, successful launch of second phase of PYSUP project.
- Initiation of harmonization action planning.
- Indigenous engagement and climate change adaptation report completed.
- Emergency response to cybersecurity incident, Colborne fire and Haliburton winter storm/power outage.
- Introduction of Enneagram and SCARF (Status, Certainty, Autonomy, Relatedness, and Fairness) model sessions to strengthen team norms, collaboration, and charter development.
- Workforce readiness & quality focus for Environmental Health & Infectious Diseases Division (EH/ID), prioritizing staff preparedness through extensive Public Health Inspector training, standardized practices, and harmonized resources to support anticipated summer surge demand.

Challenges:

- A number of short-term leaves, staff movement due to backfilling and recruitment delays due to volume have impacted teams' capacity.

- Consumption and Treatment Site closure announced; reduction in PARN outreach capacity announced; both resulting in gaps in harm reduction/needle exchange in community.
- Ongoing challenges with program harmonization influenced by PSLRTA requirements and differing team cultures and approaches.
- Significant workload in EH/ID (75 outbreaks and 145 disease investigations) alongside increased inspection activity.

BOH COMPLIANCE WITH OPHS REQUIREMENTS

Table 1 summarizes the current state of the organization’s implementation of the BOH requirements with the OPHS for the entire jurisdiction of LPH.

Table 1.

Ontario Public Health Standards	Total # BOH Requirements	# Met Q1 2026	# Partly Met Q1 2026	# Did Not Meet Q1 2026	# Met Q4 2025	# Partly Met Q4 2025	# Did Not Meet Q4 2025
Program Standard							
Chronic Disease Prevention and Well-Being	5	5			5		
Food Safety	5	4	1		4	1	
Healthy Environments	7	7			7		
Healthy Growth and Development	3	3			3		
Immunization	10	9	1		8	2	
Infectious and Communicable Diseases Prevention and Control	21	19	2		19	2	
Safe Water	8	7	1		7	1	
School Health	10	9	1		7	3	
Substance Use and Injury Prevention	4	4			3	1	

Ontario Public Health Standards	Total # BOH Requirements	# Met Q1 2026	# Partly Met Q1 2026	# Did Not Meet Q1 2026	# Met Q4 2025	# Partly Met Q4 2025	# Did Not Meet Q4 2025
Foundational Standards							
Population Health Assessment	6	6			6		
Health Equity	4	4			4		
Effective Public Health Practice	9	7	2		7	2	
Emergency Management	1	1			1		

- “Met” = can reasonably be interpreted to have achieved all of the components of the requirement. If inspections are “on track” to achieving 100%, then are considered to have “met” the requirement.
- “Partly Met” = some but not all of the stipulated requirement is being met.
- “Not Met” = none of the components of the requirement are being implemented.

Description of Requirements not Met

Effective Public Health Practice Standard

Requirements #2 and 8: This relates to organizational infrastructure to support the routine monitoring of programs and services. As noted in the Q1-Q3 report, routine monitoring to date has largely focused on compliance versus effectiveness. We continue to work on developing a culture of quality improvement, through the provision of Lean training to all levels of staff. We are planning to roll out a new Quality and Impact Framework in Q3 2026 in advance of 2027 OPHS program planning.

Food Safety Standard

Requirement #4: This articulates that the BOH shall provide all components of the Food Safety Program. Due to position vacancies (i.e. from retirements, recruitment challenges), some medium and low-risk food premises may not be inspected at intervals articulated by the *Food Safety Protocol*.

Immunization Standard

Requirement #1: The immunization status of children enrolled in licensed childcare settings, as defined in the Child Care and Early Years Act, 2014; Not met due to staffing challenges and work to meet the merger harmonization process.

Infectious and Communicable Diseases Prevention and Control Standard

Requirement # 7: This requires the BOH to use health promotion approaches to prevent and reduce exposures to sexually transmitted and blood-borne infections. While information is

available on the website and social media campaigns, dedicated health promotion work for this subject is not currently happening due to competing demands.

Requirement #14: This relates to a local Rabies Contingency Plan. A draft harmonized plan was established for finalization pending further consultation and review in 2026, and so is anticipated to be compliant by the end of the year.

Safe Water Standard

Requirement #5: While all applicable statutes and regulations to protect the public from exposure to unsafe drinking water have been implemented, LPH continues to catch-up on a backlog of small drinking water systems (SDWS) requiring an updated risk assessment. It is forecast that catch-up will be completed by mid-2026.

School Health Standard

Requirement #7: Information on vision health for children is available on our website, however, LPH is not directly providing other visual health supports or screening until assessment of OHIP data is completed to understand local need.

Board of Health for the Haliburton, Kawartha, Northumberland, and Peterborough Health Unit

2026 Standards Activity Reports

as of March 31, 2026

Risk Management

<i>Ref. #</i>	<i>Description</i>	<i>Category</i>	<i>Impact</i>	<i>Likelihood</i>	<i>Overall Risk Rating</i>		<i>Key Risk Mitigations</i>	<i>Date reported to the Board</i>
A	B	C	D	E	F = D x E		G	H
1	Due to constrained timelines for merger funding and accelerated merger implementation requirements, a diminished capacity can lead to an inability to fully meet the National Standards on Psychological Health and Safety in the Workplace. A failure to foster development of employee and organizational resilience may result, leading to risk for negative impacts on employee wellbeing and operational effectiveness with legal, financial and human resource implications.	People / Human resources	4	4	16	High	As part of the harmonization/merger process, employee health and safety is prioritized and will be part of a comprehensive Human Resource (HR) Strategy. Merger resources will be utilized to enhance capacity where feasible.	May 20, 2026 (first reported Feb. 18/26)
2	Loss of information, compromising of personal health information of clients can occur through human error, the misuse of information technology, lack of information security or through cyber-attack. There are financial and legal risks associated with loss of personal and personal health information; stakeholder/public perception risk; and re-work associated with recreating the record. Healthcare facilities are being targeted.	Privacy / Stakeholder and Public Perception / Legal	4	4	16	High	Policies and procedures and ongoing training support staff to avoid higher risk behaviours. Multi-factor authentication is required for all employees. The IT Manager and staff work with the Ministry, our insurance provider and industry leaders to ensure adequate levels of protection within our systems. A system assessment completed as part of the merger process has identified key risk reduction strategies that are being implemented independently or as part of an integrated system of a merged entity.	May 20, 2026 (first reported Feb. 18/26)
3	Boards of Health are required to provide a balanced budget annually and to operate within that budget. The current funding arrangement, under the HPPA, creates a challenge for local (municipal and First Nation) funders to cover increased costs year over year when provincial increases are inadequate. Merger funding has been able to offset the shortfall through stabilization cost eligibility, but it will only defer the funding pressure until the end of the one-time funding (March 31, 2027). A deficit is forecast in fiscal year 2027 unless changes to expenditure or funding occur. Since staffing accounts for over 80% of operating expenses, shortfalls will impact staffing and service levels.	Financial / Operational / Service Delivery	5	5	25	High	The MOH/CEO is working with the Board of Health to: advocate for adequate funding; and improve efficiency of service delivery to mitigate impacts.	May 20, 2026 (first reported Feb. 18/26)

4	Due to limited capacity some requirements under the Ontario Public Health Standards (OPHS) may be only partially or not met. A lack of compliance with OPHS can lead to relationship and reputation damage and liability for any negative health outcomes.	Operational / Service Delivery	5	3	15	High	Strategic and Operational Planning considered the impact of each intervention and the risk of de-prioritization. The Senior Leadership Team and the Board of Health continue to report on areas of non-compliance and to advocate for adequate resourcing.	May 20, 2026 (first reported Feb. 18/26)
5	The broader workforce shortage and more specifically, health service sector shortage presents potential recruitment challenges for public health.	People / Human resources	3	4	12	High	HR uses a comprehensive approach to recruitment and is developing strategies to reduce barriers based on diversity, equity and inclusion (DEI). The Our Team strategic direction from our Strategic Plan seeks to ensure LPH has a workplace that attracts the best talent.	May 20, 2026 (first reported Feb. 18/26)
6	Labour disruption or challenges—including delays in Public Sector Labour Relations Transition Act (PSLRTA) harmonization and prolonged collective bargaining processes—represent an operational risk. These challenges can create uncertainty across the organization, potentially affecting workforce morale, service delivery, and organizational timelines. Delays may also lead to inconsistencies in working conditions or expectations across different employee groups, increasing the likelihood of disputes or grievances.	People / Human resources	4	3	12	Moderate	HR maintains regular dialogue with union leaders to help build trust, reduce misunderstandings, and allows for issues to be identified and addressed early. Demonstrating respect for collective bargaining processes and adhering to all legislative and regulatory requirements further supports productive relationships, and allows the organization to navigate labour-related challenges effectively while supporting a collaborative and respectful workplace culture. Similar to emergency planning, contingency plans for workplace disruptions are under development.	May 20, 2026 (first reported Feb. 18/26)
7	A community-wide or regional public health emergency (e.g., pandemic resurgence, severe influenza season, emerging infectious disease outbreak) may occur while the organization is still engaged in harmonization activities. This could strain staff capacity, disrupt harmonization timelines, and challenge the organization's ability to deliver coordinated, consistent public health services.	Emergency	3	4	12	Moderate	Establish or update memorandums of understanding (MOUs) with partner organizations to clarify roles, resource sharing, surge capacity support, and mutual expectations during emergencies. Conduct regular scenario-based planning sessions to test emergency response capabilities while maintaining essential business continuity and ongoing harmonization activities.	May 20, 2026 (first reported Feb. 18/26)
8	Succession planning risk as part of staffing changes and end of merger funding.	Human Resources	4	4	16	High	Ongoing planning for succession and changes in resources.	May 20, 2026

*Red indicates content updates

NOTE: Formatting reflects Ministry-required template.

TITLE:	Association of Local Public Health Agencies Annual General Meeting Resolutions
DATE:	May 20, 2026
PREPARED BY:	Dr. Thomas Piggott, Medical Officer of Health & CEO
APPROVED BY:	Dr. Thomas Piggott, Medical Officer of Health & CEO

Proposed Recommendation

That the Board of Health for Lakelands Public Health support the following resolutions to be tabled at the 2026 Association of Local Public Health Agencies (aLPHa) Annual General Meeting:

- A26-01 - Strengthening Hepatitis B Prevention in Ontario Through Vaccination in the First Year of Life. The Board of Health for the District of Algoma Health Unit (Algoma Public Health); The Board of Health for the Simcoe Muskoka District Health Unit (Simcoe Muskoka District Health Unit).
- A26-02 - Strengthening Certified Public Health Inspector Capacity to Support Delivery of the Ontario Public Health Standard. Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO).
- A26-03 - Mandatory and Regulated Alcohol Labelling on Alcohol Manufactured or Sold in Canada. Middlesex-London Health Unit (MLHU) and Toronto Public Health (TPH).
- A26-04 - Enhancing the Ontario Works Benefit. Middlesex-London Health Unit (MLHU), Huron Perth Public Health Unit (HPPH), Windsor-Essex County Health Unit (WECHU) and Oxford-Elgin-St. Thomas Public Health Unit (also known as Southwestern Public Health Unit, SWPH).

Background

The aLPHa Annual General Meeting will take place on June 9, 2026. Dr. Piggott, Larry Stinson and additional staff will be in attendance. A voting registration form has been submitted for LPH.

Please note that because conference registration sold out early, board members could not be registered. This was unexpected and a number of local public health agencies were affected, likely due to space constraints related to the FIFA World Cup Event.

Attachments

- a. [aLPHa Resolution Package, June 2026](#)



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

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

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

IMPORTANT NOTE FOR VOTING DELEGATES:

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

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

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

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

Enclosures:

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



PO Box 73510, RPO Wychwood
 Toronto, Ontario M6C 4A7
 E-mail: info@alphaweb.org

**2026 alPHa Annual General Meeting
 Resolutions Session
 REGISTRATION FORM FOR VOTING**

Health Unit _____

Contact Person & Title _____

Phone Number & E-mail _____

Name(s) of Voting Delegate(s):

<u>Name and email address</u>	Proxy* (Check this box if the person requires a proxy voting card. Only one proxy is allowed per delegate.)	Is this person registered to attend the alPHa Annual Conference? (Y/N)
1.		
2.		
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* Each voting delegate may carry their own vote plus one proxy vote for an absent delegate. For any health unit, the total number of regular plus proxy votes cannot exceed the total number of voting delegates allotted to that health unit.

Please email this form to Melanie Dziengo (communications@alphaweb.org) by 4:30 pm on Friday, May 29, 2026.

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

* total number of votes for Toronto endorsed by membership at 1998 Annual Conference

**new allocation category of population >1M endorsed by membership at 2023 Annual Conference

Health Unit population statistics taken from: Statistics Canada – [2021 Census Profiles – Sorted by Health Region](#)



Resolutions for Consideration 2026

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

Resolution #	Title	Sponsor	Page
A26-01	Strengthening Hepatitis B Prevention in Ontario Through Vaccination in the First Year of Life	The Board of Health for the District of Algoma Health Unit (Algoma Public Health); The Board of Health for the Simcoe Muskoka District Health Unit (Simcoe Muskoka District Health Unit)	5
<p>NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (ALPHA) writes to the Ontario Minister of Health recommending a review in consultation with the Ontario Immunization Advisory Committee and/or the National Advisory Committee on Immunization regarding shifting universal HBV vaccination from Grade 7 to the first year of life, based on existing epidemiologic and economic evidence and programmatic considerations, in order to strengthen early protection against HBV, reduce preventable chronic infections, and advance health equity for children and families across Ontario;</p> <p>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;</p>			
<p>ALPHA’s long-standing position is that all vaccines licensed in Canada should be publicly funded and made available through Boards of Health for administration to the categories of individuals as recommended by the National Advisory Committee on Immunization (NACI). NACI has concluded that HBV vaccination in the first year of life provides long-lasting protection and that acceptable schedule options in the first year of life include either vaccination at birth or later in infancy</p> <p>Staff Recommendation: Key Strategic Direction; include in package as submitted.</p>			
A26-02	Strengthening Certified Public Health Inspector Capacity to Support Delivery of the Ontario Public Health Standards	ASPHIO	10
<p>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:</p> <ol style="list-style-type: none"> 1. Provide sustained, base funding to local public health agencies to support the hiring of up to 150 additional certified Public Health Inspectors across Ontario, to strengthen PHI staffing capacity and support consistent delivery of OPHS requirements. This estimate reflects anticipated provincial workforce gaps, emerging workload pressures, and replacement-rate forecasting for attrition and retirements; and 2. Undertake a provincial PHI workforce assessment and forecasting approach, aligned with the Ministry-led PHI Workforce Capacity Working Group, to identify current and projected workforce needs and to inform evidence-informed and equitable distribution of PHI resources; and 3. Continue to advance education, recruitment, and practicum capacity initiatives—including mentorship supports and standardized practicum approaches—in partnership with accredited 			

<p>institutions, Boards of Health, ASPHIO, and the Canadian Institute of Public Health Inspectors (Ontario Branch); and</p> <p>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</p> <p>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.</p>			
<p>One of alpha’s central purposes is to ensure boards of health can deliver their basic mandated programs under the OPHS through government commitments to sustained and adequate resources (financial, human and supportive).</p> <p>Staff Recommendation: Key Strategic Direction; include in package as submitted.</p>			
A26-03	Mandatory and Regulated Alcohol Labelling on Alcohol Manufactured or Sold in Canada	Middlesex-London Health Unit (MLHU) and Toronto Public Health (TPH)	15
<p>NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies call on the Federal Government to amend the <i>Food and Drugs Act</i> to mandate alcohol labelling including:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>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.</p> <p>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.</p>			
<p>alpha’s stated position is that Public Health has an important mandate in key areas related to the use of alcohol and other drugs, including activities in chronic disease prevention, injury prevention, substance abuse prevention and harm reduction. Comprehensive strategies to address the potential harms of substance use can only succeed through a combination of interventions: education, prevention, harm reduction, treatment and enforcement.</p> <p>Staff Recommendation: Key Strategic Direction; include in package as submitted.</p>			
A26-04	Enhancing the Ontario Works Benefit	Middlesex-London Health Unit (MLHU), Huron Perth Public Health Unit (HPPH), Windsor-Essex County Health Unit (WECHU) and Oxford-Elgin-St. Thomas Public Health Unit (also known as	24

		Southwestern Public Health Unit, SWPH)	
<p>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;</p> <p>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;</p> <p>AND FURTHER that the Association of Local Public Health Agencies reaffirm and advance its previously adopted position in Resolution A23-05, <i>Monitoring Food Affordability in Ontario and Inadequacy of Social Assistance Rates</i>, 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;</p> <p>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;</p> <p>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.</p>			
<p>aPHa has continually expressed clear positions on income-related determinants of health and this resolution builds upon these.</p> <p>Staff recommendation: Key Strategic Direction; include in package as submitted.</p>			

DRAFT RESOLUTION A26-01

- TITLE:** **Strengthening Hepatitis B Prevention in Ontario Through Vaccination in the First Year of Life**
- SPONSOR:** **The Board of Health for the District of Algoma Health Unit (Algoma Public Health)**
The Board of Health for the Simcoe Muskoka District Health Unit (Simcoe Muskoka District Health Unit)
- WHEREAS** hepatitis B virus (HBV) infection causes a substantial burden of disease globally, with chronic infection leading to cirrhosis, liver failure, and liver cancer(1), noting that in 2021 alone, 3524 cases of HBV were reported in Canada(2); and
- WHEREAS** chronic HBV infection results in high lifetime healthcare utilization and substantial costs, with increased costs related to disease severity and for patients requiring liver transplantation(3); and
- WHEREAS** infants and young children who become infected with HBV are at the highest risk of developing chronic infection, with up to 90% of infected infants becoming chronic carriers compared with fewer than 5% of infected adults(4); and
- WHEREAS** Ontario currently administers HBV vaccine routinely in Grade 7, which leaves children susceptible to infection during their first 12 years of life when they are most vulnerable to developing chronic HBV infection(5); and
- WHEREAS** surveillance data from Public Health Ontario indicate that HBV infections continue to occur among children in Ontario prior to adolescence, including Canadian-born children (139 cases before age 12 between 2003 and 2013)(1), often due to missed prenatal screening for HBV, incomplete post-exposure prophylaxis, household exposure to undiagnosed carriers, travel, or immigration from regions of higher HBV prevalence(6); and
- WHEREAS** the National Advisory Committee on Immunization (NACI) has concluded that HBV vaccination in the first year of life provides long-lasting protection(4,6,7) and that acceptable schedule options in the first year of life include either vaccination at birth or later in infancy; and
- WHEREAS** birth dose HBV vaccination is safe and highly effective(3), and jurisdictions that implemented it decades ago now show lower adult HBV prevalence and reduced long-term disease burden, supporting the population-level benefits of early immunization(8); and
- WHEREAS** infant HBV vaccination at 2, 4, and 6 months of age is a well-studied safe and effective alternative to birth vaccination which has also been implemented in many jurisdictions in Canada and globally(9); and
- WHEREAS** a recent analysis modelling potential HBV immunization strategies for Ontario showed that providing 3 doses of the DTaP-HB-IPV-Hib vaccine (combination vaccine against 6 diseases) in infancy would lead to cost-savings compared to the current practice of

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

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

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

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

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

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

Background

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

Transmission in childhood is also possible via close household contact with infected individuals (horizontal transmission), the risk being as high as 54%(13). Although rare, horizontal transmission in daycare settings is also possible (14). One of the challenges with childhood transmission is that Hepatitis B infection at an early age is mostly asymptomatic, therefore, not all cases are identified. Despite the absence of symptoms, 90% of infants infected will develop Chronic hepatitis B, and one out of four individuals with Chronic HB will die prematurely of cirrhosis or hepatocellular carcinoma.(12) There are various Hepatitis B-containing vaccines available in Canada, alone or in combination with other vaccines that are already part of the current vaccination 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 be occur among racialized children.(15)

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

There are two other approaches to Hepatitis B vaccination in Canada: vaccination at birth and vaccination in infancy.(11) Research shows that vaccinating children early in life is effective and safe.(4,16) Vaccination at 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)

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

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

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

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

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

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

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

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

References

1. Biondi MJ, Marchand-Austin A, Cronin K, Nanwa N, Ravirajan V, Mandel E, et al. Health services: Prenatal hepatitis b screening, and hepatitis b burden among children, in ontario: A descriptive study. *CMAJ*. 2020 Oct 26;192(43):E1299–305. doi:10.1503/cmaj.200290 PubMed PMID: 33106301.
2. Public Health Agency of Canada. Hepatitis B in Canada: 2021 surveillance data update. 2023.
3. Nanwa N, Kwong JC, Feld JJ, Fangyun Wu C, Sander B. The mean attributable health care costs associated with hepatitis B virus in Ontario, Canada: A matched cohort study. *Can Liver J*. 2022;5(3):339–61.
4. Public Health Agency of Canada. Hepatitis B vaccine: Canadian Immunization Guide [Internet]. 2024.
5. Government of Ontario. Publicly Funded Immunization Schedules for Ontario. 2022 Jun.
6. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Hepatitis B immunization. Toronto; 2017.
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11. World Health Organization. Hepatitis B vaccines: WHO position paper – July 2017. *Weekly epidemiological record* [Internet]. 2017 Jul 7;(27). Available from: <http://www.who.int/wer>
12. Heymann DL, editor. *Control of communicable diseases manual*. 21st ed. Washington DC: American Public Health Association; 2022.
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14. McIntosh E, Beck MD. Horizontal transmission of hepatitis B in a children’s day–care centre: a preventable event. *Aust N Z J Public Health*. 1997;21:791–2.
15. Armstrong GL, Mast EE, Wojczynski M, Margolis HS. Childhood Hepatitis B Virus Infections in the United States Before Hepatitis B Immunization [Internet]. 2001. Available from: <http://publications.aap.org/pediatrics/article-pdf/108/5/1123/893077/pe1101001123.pdf>
16. van den Ende C, Marano C, van Ahee A, Bunge EM, De Moerlooze L. The immunogenicity of GSK’s recombinant hepatitis B vaccine in children: a systematic review of 30 years of experience. *Expert Review of Vaccines*. Taylor and Francis Ltd; 2017. p. 789–809. doi:10.1080/14760584.2017.1338569 PubMed PMID: 28586278.
17. Ontario Agency for Health Protection and Promotion (Public Health Ontario). King’s Printer for Ontario. Immunization Data Tool.
18. Tilson L, Thornton L, O’Flanagan D, Johnson H, Barry M. Cost effectiveness of hepatitis B vaccination strategies in Ireland: An economic evaluation. *Eur J Public Health*. 2008;18(3):275–82. doi:10.1093/eurpub/ckm123 PubMed PMID: 18160389.

DRAFT RESOLUTION A26-02

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

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

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

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

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

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

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

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

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

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

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

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

AND FURTHER that aPHa 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.



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

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

References

Association of Supervisors of Public Health Inspectors of Ontario. (2023, June). *Highlighting the vital role of public health inspectors within a responsive and effective public health workforce* [White paper]. Canadian Institute of Public Health Inspectors (CIPHI), Ontario Branch. <https://ciphi.ca/on/documents-ontario/>

Canadian Institute of Public Health Inspectors (CIPHI), Ontario Branch. (2026, January 13). *2026 Ontario budget submission: Strengthening public health inspection capacity*.

DRAFT RESOLUTION A26-03

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

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

WHEREAS alcohol is a legal product with associated health harms and classified as a Group 1 carcinogen with a causal link to cancer (Babor, 2023; IARC, 1988; IARC, 2012; Paradis, 2023; 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 *Canadian Guidance on Alcohol and Health* in the past week (Ontario Health and Ontario Agency for Health Protection and Promotion, 2023); and

WHEREAS the harms due to alcohol are 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.

Statement of Sponsor Commitment

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

Background

Alcohol – No Ordinary Commodity

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

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

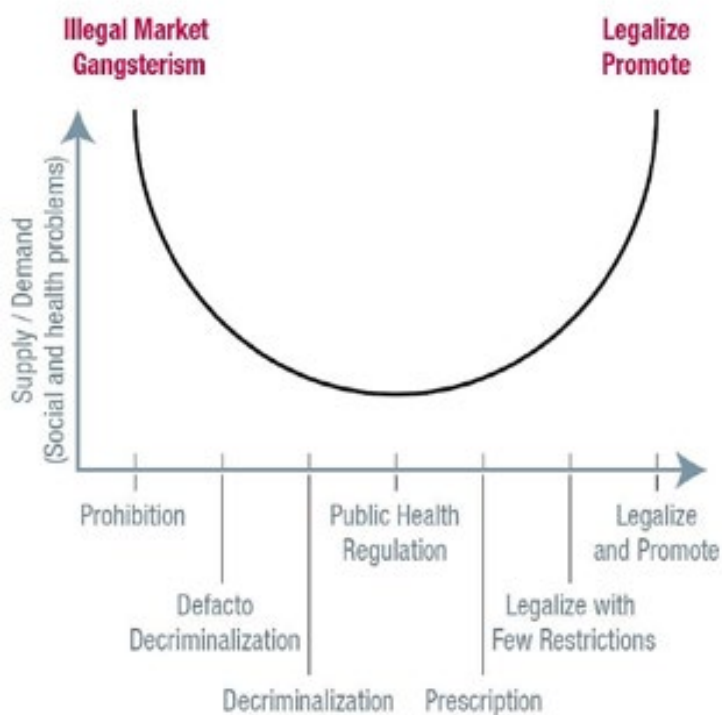
Public Health Approach to Preventing Harms from Alcohol

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

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

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

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



Rationale

Alcohol Labelling Supports Informed Choice by Consumers

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

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



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

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

Canadians Are Unaware of Health Harms from Alcohol

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

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

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

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

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

Alcohol Labelling and Youth Prevention

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

Summary

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

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DRAFT RESOLUTION A26-04

- TITLE** **Enhancing the Ontario Works Benefit**
- SPONSORS** **Middlesex-London Health Unit (MLHU), Huron Perth Public Health Unit (HPPH), Windsor-Essex County Health Unit (WECHU) and Oxford-Elgin-St. Thomas Public Health Unit (also known as Southwestern Public Health Unit, SWPH)**
- WHEREAS** household food insecurity (HFI), the inadequate or insecure access to food due to financial constraints, is a critical indicator of a household’s financial situation, their ability to afford basic needs, and a highly sensitive measure of material deprivation;
- WHEREAS** HFI is an important social determinant of health, a strong predictor of poor health, and is associated with an increased risk of a wide range of physical and mental health challenges, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress;
- WHEREAS** poor diet quality costs Ontario an estimated \$5.6 billion annually in direct healthcare costs and indirect costs (e.g., lost 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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