Board of Health Meeting # 05-26

Public Health Sudbury & Districts

Thursday, June 18, 2026

1:30 p.m.

Boardroom

1300 Paris Street

Public Health
Santé publique
SUDBURY & DISTRICTS

AGENDA - FIFTH MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, LEVEL 3
THURSDAY, JUNE 18, 2026 – 1:30 P.M.

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

4. DELEGATION/PRESENTATION

i) More than Words: Bringing French-language Public Health Services to life

- Renée St Onge, Director, Knowledge and Strategic Services
- Natalie Philippe, Public Health Nurse, Health Promotion and Vaccine Preventable Disease

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Fourth Meeting – May 21, 2026

ii) Business Arising From Minutes

iii) Report of Standing Committees

a. Board of Health Finance Standing Committee – Unapproved Minutes dated June 10, 2026

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

a. MOH/CEO Report, June 2026

v) Correspondence

a. Membership, Board of Health for Public Health Sudbury & Districts

- Letter of Resignation by Board of Health member, Ryan Anderson, dated May 27, 2026

b. Healthy Smiles Ontario Fee Schedule and Access to Dental Care for Children and Youth

- Letter from the Board of Health for Algoma Public Health to the Minister of Health, dated May 21, 2026

c. Waterpipe Smoking Restrictions

- Resolution from Windsor-Essex County Health Unit Board of Health dated May 14, 2026

d. Enhancing Municipal Readiness for Ontario's Bring-Your-Own-Beverage (BYOB) Legislation through Public Health Engagement

- Resolution from Windsor-Essex County Health Unit Board of Health dated May 14, 2026

vi) Items of Information

None

APPROVAL OF CONSENT AGENDA

MOTION:

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

6. NEW BUSINESS

i) French Language Services at Public Health Sudbury & Districts

AFFIRMING AND ADVANCING FRENCH LANGUAGE SERVICES AT PUBLIC HEALTH SUDBURY & DISTRICTS

MOTION:

WHEREAS Public Health Sudbury & Districts serves a region with a significant Francophone population, with approximately 21% of residents identifying French as their first official language spoken;

AND WHEREAS both long-standing Francophone community members and French-speaking newcomers rely on accessible, culturally appropriate public health services to support health, safety, and integration;

AND WHEREAS the Board of Health has established a longstanding policy commitment to providing equitable, accessible, and culturally competent French-language public health services for Francophone populations;

AND WHEREAS Public Health Sudbury & Districts lives this commitment through the active offer of service, bilingual service delivery, translation of public facing materials, staff training, community partnerships, and cross-agency engagement through the Francophone Advisory Committee; these efforts collectively support equitable health outcomes

and help mitigate risks related to client safety and service quality and accessibility and;

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts

- **Affirms its commitment to equitable high-quality, culturally- and linguistically-appropriate French-language public health services for populations across Sudbury and districts in all programs and service delivery points;**
- **Supports the continued advancement of French Language Services, including the active offer of service, workforce capacity development, community partnerships, and integration of Francophone perspectives in program planning and delivery;**
- **Recognizes French Language Services as integral to health equity, accessibility, and the organization's mission to promote and protect the health of all communities served.**

ii) 2025 Audited Financial Statements

- Public Health Sudbury & Districts Audited Financial Statements for 2025
- Questions and Responses at Finance Standing Committee – 2025 Annual Financial Statements

ADOPTION OF THE 2025 AUDITED FINANCIAL STATEMENTS

MOTION:

WHEREAS the Board of Health Finance Standing Committee recommends that the Board of Health for the Sudbury and District Health Unit adopt the 2025 audited financial statements, as reviewed by the Finance Standing Committee at its meeting of June 10, 2026;

THEREFORE BE IT RESOLVED THAT the 2025 audited financial statements be approved as distributed.

7. ADDENDUM

ADDENDUM

MOTION:

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

8. IN CAMERA

IN CAMERA

MOTION:

THAT this Board of Health goes in camera to deal with personal matters about an identifiable individual, including…local board employees, and to deal with labour relations…. Time: _____

9. RISE AND REPORT

RISE AND REPORT

MOTION:

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

10. ANNOUNCEMENTS

11. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time: ____

Public Health
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SUDBURY & DISTRICTS

MINUTES – FOURTH MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, LEVEL 3
THURSDAY, MAY 21, 2026 – 1:30 P.M.

BOARD MEMBERS PRESENT

Robert Barclay	Ken Noland	Natalie Tessier
Michel Brabant	Michel Parent	Tom Trainor
Abdullah Masood	Mark Signoretti	

BOARD MEMBERS REGRET

Ryan Anderson	Natalie Labbée	Angela Recollet
Renée Carrier	Amy Mazey	

STAFF MEMBERS PRESENT

Emily Groot	Renée Higgins	Rachel Quesnel, Recorder
Jonathan Groulx	M. Mustafa Hirji	Renée St Onge

M. SIGNORETTI PRESIDING

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

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

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

The agenda package was pre-circulated.

4. DELEGATION/PRESENTATION

i) Community Drug Strategy for Greater Sudbury 2026 – Call to Action

- Josh Veilleux, Manager, Comprehensive Health Promotion, Health Promotion and Vaccine Preventable Diseases Division
- Brittany Pagnacco, Public Health Nurse, Comprehensive Health Promotion, Health Promotion and Vaccine Preventable Diseases Division

M.M. Hirji introduced the speakers noting that the Community Drug Strategy's Call to Action and 2026 priorities were released publicly May 12, 2026.

Brittany Pagnacco and Josh Veilleux presented the 2026 priorities for the Greater Sudbury Community Drug Strategy (CDS), emphasizing a collective, community-driven approach shaped by public health, community partners, and engagement with those with lived experiences, with a focus on transparency, accountability, and evidence-based action. They detailed ongoing efforts to create a fully coordinated, comprehensive, inclusive, and equitable substance use care system in Greater Sudbury, focusing on standardized referral pathways, improved access to treatment, and expanded harm reduction and outreach. An overview was provided regarding the rollout of the 2026 Community Drug Strategy for Greater Sudbury, including coordinated care, prevention, stigma reduction, and improved housing supports. The presenters outlined CDS's evaluation approach that includes an annual report card to track progress, support accountability, and communicate achievements and challenges to the public.

Comments and questions were entertained relating to substance uses addressed and roles of community partners in areas such as assessing housing models, as well as ensuring that wraparound supports are provided, including sustainable support services. Further information was provided regarding the comprehensive approach to support individuals not seeking treatment. It was clarified that the annual report card will include KPIs such as increased access to care and basic services, tracking both immediate outputs and long-term health impacts.

Dr. Hirji added that individuals affected by substance use are seeking to improve their health but often encounter barriers that prevent them from accessing care or knowing where to begin. He noted that stigma and challenges faced during transitions can be key barriers to accessing and sustaining care for which the CDS's comprehensive and community approach aims to address.

The presenters were thanked.

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. First Meeting – April 16, 2026

ii) Business Arising from Minutes

iii) Report of Standing Committees

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

a. MOH/CEO Report, May 2026

v) Correspondence

None.

vi) Items of Information

a. Public Health Agency of Canada Statement Re Andes to hantavirus situation dated May 12, 2026

26-26 APPROVAL OF CONSENT AGENDA

MOVED BY NOLAND –TRAINOR: THAT the Board of Health approve the consent agenda as distributed.

CARRIED

6. NEW BUSINESS

i) Administrative Changes to Part VIII of the Ontario Building Code: Transfer of Enforcement Authority for the Municipalities of St.-Charles, French River, Markstay-Warren, and Killarney

– Briefing Note from the Medical Officer of Health and Chief Executive Officer dated May 14, 2026

Dr. Hirji noted this item of information relates to upcoming administrative changes to Part VIII of the Ontario Building Code, noting that, at their request, enforcement authority for private sewage systems will transfer from Public Health Sudbury & Districts to the municipalities within Sudbury East municipalities, effective November 1, 2026.

He noted that the currently at Public Health Sudbury & Districts, the Part VIII program delivered across its service area operates on a cost-recovery basis, with fees paid by property owners, and that regional delivery has supported economies of scale, technical expertise, and service consistency.

The municipalities made the request last year to the Ministry of Municipal Affairs and Housing to take over the program for their area. The Minister agreed to the request confirming that effective November 1, 2026, the program is to be transferred to those municipalities to administer.

The Board was advised that the transfer will have operational and financial implications, including reduced program responsibilities and associated fee revenues, as well as the need to assess staffing impacts. Transition activities are expected to be complex and will include managing open files, coordinating inspections already underway, and transferring historical records.

Dr. Hirji noted that a Memorandum of Understanding is being developed with the affected municipalities to clarify roles and responsibilities during the transition, including records management and information sharing. He further indicated that Public Health Sudbury & Districts intends to seek provincial funding to offset one-time transition costs so that these are not borne by municipalities within the service area.

Discussion also acknowledged potential future considerations related to access to historical records for research or property transactions, and the importance of ensuring continuity of service and clear processes during the transition period.

ii) Annual Service Plan – 2026-2027 One-Time Funding Requests

- Presentation by Renée Higgins, Director of Corporate Services

Renée Higgins was invited to present the Annual Service Plan (ASP) one-time funding requests to the Ministry of Health. The ASP is the required annual submission to the Ministry of Health and aligns with the Board-approved budget, operational plans, and Ontario Public Health Standards, while also providing an opportunity to request one-time funding for capital/infrastructure needs and time-limited program capacity.

The Board received a high-level overview of the submission and a refresher on the purpose of the ASP and how one-time funding is allocated. It was noted that one-time funding is provided at the discretion of the Ministry, with consideration given to urgency and risk, the organization's ability to complete projects within required timelines, and the availability of provincial funding.

Public Health Sudbury & Districts 2026 one-time funding requests totalling approximately $2.23 million were summarized. The requests were presented within four key priority areas: protecting operations and service continuity, supporting workforce capacity, strengthening organizational resilience, and advancing Indigenous partnerships, consistent with Board-approved 2026 budget priorities.

The Board discussed risks should these one-time funding requests not be approved, including potential building failures and service disruptions, increased health and safety risks, and reduced capacity to meet Ontario Public Health Standards, along with delays in advancing workforce, Indigenous, and organizational priorities. In response to an inquiry regarding previous capital project work at 1300 Paris, clarification was provided regarding ongoing water infiltration concerns and the need to address roofing and drainage issues that were not in previous capital project scopes. It was noted that these projects are not expected to result in service closures, though minor operational impacts may occur during construction. Members also discussed alignment and impacts of proposed initiatives with

the organization's risk management priorities and controls, as well as the approach taken to prioritize and bundle certain emergency repair requests.

The Ministry will review all one-time submissions and communication of one-time funding decisions is anticipated later this fiscal year. It was clarified if we are unable to spend the one-time funding due to time constraints, any unspent funds would be returned to Ministry.

Public Health Sudbury & Districts will monitor outcomes, adjust priorities as needed, and report back to the Board on funding decisions and impacts. The Board acknowledged the strong alignment of the submission with organizational and Ministry priorities and commended the team for the quality of the proposal.

iii) Municipal Buy Ontario Procurement Directive - Phased Implementation Dates

- Briefing Note from the Medical Officer of Health and Chief Executive Officer dated May 14, 2026

M. Hirji introduced the briefing note regarding the Province's phased implementation of the Municipal Buy Ontario Procurement Directive, effective June 1, 2026. The Board was advised that the directive requires public sector entities, including boards of health, to prioritize Ontario/Canadian goods and services for certain procurements, specifically within fleet vehicles and capital infrastructure, and to maintain appropriate documentation to demonstrate compliance. Members discussed that while capital infrastructure elements—such as building repairs or renovations—could fall within scope, Public Health rarely undertakes such projects. It was noted that the anticipated impact to the organization is minimal and primarily administrative in nature. It was further noted that there are no direct incremental financial impacts identified at this time, though minor indirect impacts may arise related to documentation and procurement processes for applicable projects.

The Board received the briefing note for information.

iv) Association of Local Public Health Agencies (alPHa)

a. alPHa's 2026 Conference and Annual General Meeting, June 8-10, 2026

- Notice to Members of 2026 Annual General Meeting
- Draft Conference Program, draft as of April 7, 2026
- BOH Section Meeting Agenda dated May 12, 2026
- 2026 Resolutions for Consideration documents

Dr. Hirji provided an overview of the upcoming in-person alPHa Conference and Annual General Meeting from June 8–10, 2026, in Toronto, noting that the event brings together Public Health Units across Ontario annually and includes participation from both staff and Board members. The conference program includes sessions on navigating relationships with

the Ministry, public health funding, and emerging trends in chronic disease. Day 2 will feature Board of Health section meetings, including governance-focused discussions such as skills-based Board membership. The alPHa Annual General Meeting will include a resolution session to consider the following resolutions:

- strengthening Hepatitis B prevention in Ontario through vaccination in the first year of life;
- strengthening certified Public Health Inspector capacity to support delivery of the Ontario Public Health Standards;
- mandatory and regulated alcohol labelling on alcohol manufactured or sold in Canada; and
- enhancing the Ontario Works Benefit.

Public Health Sudbury & Districts will be represented at the alPHa Annual General Meeting by Dr. Hirji, Dr. Groot, Board member, Robert Barclay with a total of five votes allocated to PHSD. The Board was advised that the conference registrations are currently full with a waitlist; therefore, any Board members interested can be added to the alPHa waitlist.

27-26 2026 ALPHA ANNUAL GENERAL MEETING - VOTING DELEGATION

MOVED BY PARENT - TESSIER: WHEREAS the Public Health Sudbury & Districts is allocated five votes* at the Association of Local Public Health Agencies Annual General Meeting Resolution Session;

THAT the following individuals are appointed as voting delegates for the Annual General Meeting:

1) **M. Mustafa Hirji ***
2) **Emily Groot**
3) **Robert Barclay ***

***Voting delegates are permitted one proxy vote per person, as required.**

CARRIED

7. ADDENDUM

28-26 ADDENDUM

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

CARRIED

DECLARATIONS OF CONFLICT OF INTEREST

There were no declarations of conflict of interest.

i) Notification of Base Budget Increase for Healthy Babies Healthy Children Program

- Email from the Ministry of Children, Community and Social Services to Public Health Sudbury & Districts, dated May 19, 2026

M. Hirji was pleased to share that the Ministry of Children, Community and Social Services has announced that Public Health Sudbury & Districts will receive an additional $34,519 in ongoing base funding for the Healthy Babies Healthy Children Program, effective April 1, 2026. It was noted that this is only the second base funding increase for this program since 2008 and is welcomed in light of inflationary pressures and declining service capacity.

ii) Alcohol Labelling Policy (Bill S-202)

- Letter from the Board of Health Chair, District of Algoma Health Unit, to the Standing Senate Committee Chair on Social Affairs, Science and Technology dated May 15, 2026

The letter of advocacy from Algoma Public Health is shared for information.

iii) City of Greater Sudbury Council Advocacy – Public Health Funding

- Letter from City of Greater Sudbury Deputy City Clerk to Deputy Minister dated December 15, 2025
- Letter from City of Greater Sudbury Deputy City Clerk to Ontario Minister of Health dated December 15, 2025
- Letter from City of Greater Sudbury Deputy City Clerk to Premier of Ontario dated December 15, 2025

The City of Greater Sudbury had carried a motion in December 2025 noting it would write to the province to recommend it increase provincial funding to local public health agencies. We reached out to receive a copy of the letter, and it is being shared with the Board.

8. IN CAMERA

29-26 IN CAMERA

MOVED BY BRABANT–TRAINOR: THAT this Board of Health goes in camera to deal with advice that is subject to solicitor-client privilege, including communications necessary for that purpose. Time: 2:39 p.m.

CARRIED

9. RISE AND REPORT

30-26 RISE AND REPORT

MOVED BY NOLAND – MASOOD: THAT this Board of Health rises and reports. Time: 2:57 p.m.

CARRIED

It was reported that one matter was discussed in-camera to deal with advice that is subject to solicitor-client privilege, including communications necessary for that purpose and the following motion emanated:

31-26 APPROVAL OF BOARD OF HEALTH INCAMERA MEETING NOTES

MOVED BY TRAINOR – NOLAND: THAT this Board of Health approve the meeting notes of the April 16, 2026, Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the Municipal Freedom of Information and Protection of Privacy Act.

CARRIED

10. ANNOUNCEMENTS

- May 21, 2026, Board of Health meeting evaluation

Board members were invited to complete the evaluation for today's Board meeting.

- Next Board of Health Meeting

The next Bord of Health meeting will be held on Thursday, June 18, 2026, at 1:30 p.m.

11. ADJOURNMENT

32-26 ADJOURNMENT

MOVED BY TESSIER–NOLAND: THAT we do now adjourn. Time: 2:59 p.m.

CARRIED

_____ (Chair)

_____ (Secretary)

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UNAPPROVED MINUTES
BOARD OF HEALTH FINANCE STANDING COMMITTEE
THURSDAY, JUNE 10, 2026 – 1 P.M.
VIRTUAL MEETING

MEMBERS:	Michel Parent	Natalie Tessier	Mark Signoretti
REGRETS:	Renée Carrier		
EX-OFFICIO STAFF:	M. Mustafa Hirji	Rachel Quesnel	Keeley O'Neill *(delegate for R. Higgins)*
GUESTS:	Derek D'Angelo, Lead Audit Engagement Partner, KPMG Jennifer Bronicheski, Lead Audit Engagement Manager, KPMG		

M. SIGNORETTI PRESIDING

1. CALL TO ORDER

The meeting was called to order 9:30 a.m.

2. ROLL CALL

3. ELECTION OF BOARD OF HEALTH FINANCE STANDING COMMITTEE CHAIR FOR 2026

Nominations were held for the position of Board of Health Finance Standing Committee Chair for 2026. Mark Signoretti was nominated and accepted his nomination. The following was announced:

01-26 APPOINTMENT OF BOARD OF HEALTH FINANCE STANDING COMMITTEE CHAIR

MOVED BY PARENT – TESSIER: THAT the Board of Health Finance Standing Committee appoint Mark Signoretti as the Board of Health Finance Standing Committee Chair for 2026.

CARRIED

M. SIGNORETTI PRESIDING

4. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

There were no declarations of conflict of interest.

Unapproved

5. APPROVAL OF BOARD OF HEALTH FINANCE STANDING COMMITTEE MINUTES

5.1 Board of Health Finance Standing Committee Notes dated November 3, 2025

02-26 APPROVAL OF MEETING NOTES

MOVED BY TESSIER – PARENT : THAT the meeting notes of the Board of Health Finance Standing Committee meeting of November 3, 2025, be approved as distributed.

CARRIED

6. NEW BUSINESS

6.1 2025 Audited Financial Statements

a) Briefing Note from the Medical Officer of Health and Chief Executive Officer dated May 25, 2026

M.M. Hirji noted that audited financial statements are prepared annually and are important for financial planning and ensuring transparency to the public. He further indicated that the Ministry of Health requires the submission of Audited Financial Statements. Dr. Hirji also shared his awareness of a research group that uses the audited financial statements to examine the return on investments in relation to public health funding.

M.M. Hirji recapped for context that 2025 was a year in which key strategic work was launched to advance long-term sustainability through technology mobilization and strengthening organizational culture. 2025 investments for foundational work to advance its medium-term priority of leveraging technology were summarized as well as the various capital projects that were advanced and one-time funding that was received by the province.

b) Review of the 2025 Audited Finding Report and Audited Financial Statements
– Renée Higgins, Director, Corporate Services
– Keeley O'Neill, Manager, Accounting Services
– Derek D'Angelo and Jennifer Bronicheski, KPMG

On behalf of R. Higgins, K. O'Neill presented the KMPG audit team. She noted that the draft Audited Financial Statements for year ending December 31, 2025, were prepared in compliance with the Generally Accepted Accounting Principles. The financial statements provide the financial performance of the Public Health Sudbury & Districts and are based on the budget framework endorsed by the Board of Health.

Derek D'Angelo, Lead Audit Engagement Partner, and Jennifer Bronichieski, Lead Audit Engagement Manager, were welcomed. D. D'Angelo reviewed the Auditor's Audit Findings report and provided a brief overview of the intent of the notes contained in the draft Audited Financial Statements. The auditor noted that as of June 10, 2026, KPMG has completed the audit of the financial statements, with the exception of certain procedures, including completing our discussions with the Finance Committee and obtaining evidence of the Board of Director's approval of the financial statements. The auditor stated that the financial statements present the organization's financial information accurately and in alignment with Generally Accepted Accounting Standards, and that there were no matters to report or bring to the attention of the Board. The audit found consistency with a strong system of quality management.

Unapproved

K. O'Neill presented an overview of the 2025 audit of the financial statements including the statement of financial position as at December 31, 2025, statement of operations and accummulated surplus, statement of changes in net assets, statement of cash flows, and notes to the financial statements.

It was noted that the actual expenditures are higher than budgeted because it does not include one-time funding applied in year and received in year.

Questions and comments were entertained. Dr. Hirji clarified that the salaries variance reflect temporary hires to move projects forward and not an ongoing financial obligation. In response to an inquiry re: PHSD's financial position in comparison to other health units and the health care sector, it was noted that public health is underfunded. Per the *Health Protection and Promotion Act*, Boards of Health are not permitted to run a deficit and municipalities would be obligated to pay for any shortfalls. This is not a desired scenario and should there be a small deficit, the Board could pull from reserve. The result of inflation-adjusted funding decrease will therefore mean steady reduction of public health staffing and service. The approach to mitigate these financial challenges is, in the near term, to realize efficiencies with our medium term priority to invest in technology to limit reductions in services even as staffing decrease, and in the longer term, to reorient to being outcome drive including having outcome measures that can communicate the health, economic, and fiscal benefits of public health to the province and the case for funding Public Health.

In response to a question, Dr. Hirji explained that the variance from the Financial Assets in the Statement of Financial Position relates to the $4,112,197 payable to the Province of Ontario. The Ministry had provided funding that Public Health Sudbury & Districts had not spent and the Ministry had not reconciled the amount until 2025. It was clarified to another question that the operating line of credit of $500,000 is available to the health unit for emergency use.

The PHSD accounting team and members of the KPGM team were thanked and congratulated for a successful audit.

03-26 2025 AUDITED FINANCIAL STATEMENTS

MOVED BY PARENT – TESSIER: THAT the Board of Health Finance Standing Committee recommend to the Board of Health for the Sudbury and District Health Unit the adoption of the 2025 audited financial statements.

CARRIED

6.2 Year to Date Financial Statements

a) April 2026 Financial Statements

M.M. Hirji noted the statements summarize 2026 revenues and expenditures to the end April 30, 2026. The financial statements ending April 30, 2026, show a negative variance of $970,434 in the cost-shared programs. He noted that the 2026 budget is less conservative given historical budget surpluses to reduce the probability of unspent funds in 2026. With the Board's support, significant investments have been committed in technological capabilities with the goal of realizing longer term efficiencies, financial sustainability, and outcomes. It was recapped that

unapproved

these expenditures are backed by the financial reserves, but not broken out separately in the year-to-date statements; this contributes to 53% of the apparent overspend. Pre-purchasing supplies and equipment has front-loaded $360,000 in expenditures to early in the year. There is also a roughly $62,000 delay in receiving some provincial funding. In total, these three factors account for all but $32,000 of the overspend, and this $32,000 reflects the true operating deficit through April of 2026, which is a fraction of a percent of the budget to date. This will be monitored carefully to ensure no sizeable deficit by year-end.

The financial performance to within a percentage point of the budget is a measure of success of the goal to break even in the 2026 expenditures, rather than run a surplus as has occurred historically. Historically much of the surplus arose due to staffing vacancies. Measures taken in 2026 to address staffing stability, including reducing staff turnover and improving retention, including adjustments to non-union compensation, and targeted expenditures on organizational culture appear to be yielding success as vacancy-related underspending is much reduced in 2026 thus far. This reduced staff vacancy has meant less unspent salary/benefit budget which is contributing to the expenditures matching revenues and not being lower.

It was clarified that the $1,095,242 overspent variance for Corporate Services represents the entire Board-approved *organizational* vacancy rate for 2026 and has been accounted for under Corporate Services as a matter or reporting only. It was suggested that clarification regarding this variance be provided for the Board of Health.

6.3 Benefits and Insurance Update

- Presentation by Renée Higgins, Director, Corporate Services and Keeley O'Neill, Manager, Accounting Services

On behalf of R. Higgins, K. O'Neill provided an overview of the Public Health Sudbury & Districts' insurance through HIROC (Healthcare Insurance Reciprocal of Canada) and details regarding coverage were provided. Switching to HIROC (Healthcare Insurance Reciprocal of Canada) as the insurance provider as resulted in savings.

Group benefits provided to ONA, CUPE and non-union employees administered by Mosey & Mosey for a consortium under the Association of Local Public Health Agencies, and underwritten through SunLife were summarized. Overall, the group benefit decrease in 2026 is 3.7%, approximately $49,185. Higher benefit costs were seen in long term disability and dental claim increases while lower costs were seen in prescription and footwear claims, and most importantly on medical claims which is the largest driver of benefit costs.

Questions and comments were entertained. It was shared that the broker conducts a full market review approximately every five years, testing the market against a comparable basket of services to obtain updated quotes and assess competitiveness. The next review is scheduled for 2026, and the broker will be going to market later this year. It was clarified that we participate in the alPHa Consortium Plan, alongside several other public health agencies, as part of a group purchasing arrangement. In response to another question, it was explained that higher dental claim costs were driven by increase in dental fee schedules, which passed costs onto payers including insurance providers.

Unapproved

7. ADJOURNMENT

04-26 ADJOURNMENT

MOVED BY TESSIER and PARENT: THAT we do now adjourn. Time: 2:01 p.m.

CARRIED

_____ (Chair)

_____ (Secretary)

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

Words for thought

Unsafe food causes 866 million illnesses and 1.5 million deaths annually, young children at highest risk

WHO Press Release June 4 ,2026

Children aged less than five years face almost three times the risk of illness from unsafe food than older children and adults, according to new estimates released today by the World Health Organization (WHO).

Despite being just 9% of the global population, young children suffer from nearly one third of all cases of foodborne diseases, particularly diarrhoeal diseases which can be deadly for this vulnerable age group. In addition, exposure to chemical hazards such as methylmercury and lead in food can harm the developing brain and cause lifelong neurological and developmental problems in children.

WHO estimates that unsafe food causes around 866 million illnesses and 1.5 million deaths annually, many of which could be prevented with measures including improved water, sanitation and hygiene, food safety practices such as pasteurization and access to health care for vulnerable populations. Although the total foodborne disease burden has declined since 2000, major regional inequalities persist, with the greatest burden in Africa and South-East Asia.

Exposure to biological hazards, including foodborne bacteria and viruses as well as parasitic infections, caused the majority of foodborne illnesses (approximately 860 million in 2021)…

Beyond health impacts, the study estimates that in 2021 foodborne disease led to about US$ 310 billion in lost productivity (time away from work due to illness). When the economic impact was adjusted for cost-of-living differences between countries, the estimate increased to US$ 647 billion in lost productivity.

"Food safety is not an abstract issue – it touches every meal, every family, every day. Unsafe food has always been a major public health concern, but until now we lacked the bigger picture of its staggering human and economic toll. These new estimates change that." said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "For the first time, countries have their own data to see where the burden is highest. With that knowledge, governments can prioritize the actions needed to protect people's health."

…

This report from the World Health Organization is a reminder of how much infectious and other contaminants of food impact health. Globally, the study shows approximately 688 disability adjusted life years (DALYs) lost on average globally per 100 000 people, rising to over 1.5 million DALYs in central Africa. Thanks to strong food safety systems in Canada—including the critical role played by local public health at the consumer end of the food system to inspect the point of sale, as well as promote safe food handling at home—the burden of illness here is much less: under 300 DALYs per 100 000 (the lowest category in the WHO study). Nonetheless, Statistics Canada estimates that 4 million Canadians (1 in 8) are affected by foodborne illness each year, including 11 600 hospitalizations, and 238 deaths.[1]

Although food safety doesn't get as much attention as other health topics, it remains of significant importance, and is a keyway that local public health contributes to wellness in our communities. As Public Health navigates budget challenges, and is forced make changes to food safety programs (for example, reducing frequency of some inspections in the 2025 budget), such changes should be made cautiously, and with the mind that any curtailing of service is likely to have some negative impact on the health of the community as we scale back a system that sees us experiencing better health than the rest of the globe.

Source: WHO estimates of the global, regional, and national burden of 42 foodborne infectious and chemical hazards, 2000–21: an updated data synthesis - The Lancet Global Health

Date: June 4,2026

General Report

1. Medical Officer of Health and Chief Executive Officer (MOH/CEO) Performance Appraisal

Feedback regarding the MOH/CEO's performance appraisal has been received from the Board of Health members and the positions that report directly to the MOH/CEO. This feedback was reviewed by the Board of Health Executive Committee on May 21, 2026, followed by a meeting between the Board Chair and the MOH/CEO on May 29, 2026, concluding the annual MOH/CEO performance appraisal process for 2026.

2. Financial Report

As of April, cost-shared programs are slightly over budget, which is expected at this point in the year for the approved budget. Over half of the reported shortfall ($516,068 or 53%) relates to planned investments in technology-driven efficiencies funded from reserves, and the remaining operating variance ($454,366 or 47%) relates to delayed revenue from the province in the

[1] Yearly food-borne illness estimates for Canada - Canada.ca

amount of $62,000 and expensing prepaid expenses in the amount of approximately $360,000 for the year in the April financial statements. This leaves about $32,000 in true structural deficit which is 0.27% of expenditures. This is a small amount, and the expectation is that this should balance out over the course of the year. Financial performance will continue to be closely monitored and reported to the Board.

3. Strengthening Access, Coordination, and Immunization Protection Under the Child Care and Early Years Act (CCEYA)

The CCEYA aims to ensure children's health, safety, and well-being in childcare centres. Continuing the work that began last year to leverage technological efficiencies in this work-intensive process, further automation has been implemented this year (for example notification letter generating and reporting), thereby increasing consistency and timeliness.

Approximately 1,000 notices have been sent, and immunization appointments are available across PHSD sites to support timely follow-up. Primary care providers are also being supported to manage increased demand, including reminders to place vaccine orders.

Resources for parents and guardians have been updated to make immunization requirements easier to understand and to simplify how families can access and update records through the province's centralized immunization reporting system (ICON). Ongoing social media and engagement with licensed childcare centres continue to build awareness and accurate record-keeping.

These efforts are improving access to immunization services, strengthening coordination across providers, and supporting timely immunizations. Together, this contributes to safer childcare settings and protection of the broader community from vaccine preventable diseases.

4. Ebola Virus Disease

A large ebola virus disease outbreak in the Democratic Republic of the Congo (DRC) has led to significant global concern of risk and prompted proactive communications to support awareness and preparedness.

Ebola virus disease is a rare but very severe illness spread through direct contact with bodily fluids of infected individuals. The current outbreak is centred in the relatively rural eastern part of the Democratic Republic of the Congo. As of June 10, 2026, there have been 598 confirmed infections with another 138 suspected. That has led to 115 deaths with only 22 having recovered.

The global significance is that travelers from this area may carry the infection to other places. This has already occurred in Uganda, where infections have arisen linked to the DRC, but where

infection has been well-controlled from spreading extensively thanks to strong public health actions. Given the low geographic connectivity of Sudbury and districts to the eastern parts of the DRC, the risk to our area is very low.

Enhanced federal screening and monitoring measures are in place for travelers returning from affected regions. These should enable actively identifying infections. As well, locally, Public Health is doing internal preparations for the possibility of contacts of an infected person, or an infected person travelling to our area. We are also keeping local health care partners informed to ensure they are ready should the disease or risk arrive in our service area.

5. Legionella

Legionella bacteria are commonly found in freshwater environments and can pose a risk when they grow in building water systems such as cooling towers and plumbing systems. Legionnaires' disease is not spread from person-to-person and is preventable through proper system maintenance and monitoring. Seasonal patterns and activity in other jurisdictions highlight the need for ongoing vigilance. Elsewhere in Ontario, such as London, we are seeing increases in legionella infections as we head into warmer months; two infections have been detected in our service area this year.

In response to possible increasing risk, our agency has issued targeted advisory alerts to healthcare providers and stakeholders to support early detection, appropriate testing, and reporting. We continue to coordinate with provincial partners and are well positioned to respond quickly to any potential cases or exposures, supporting informed and measured public health action.

6. Hantavirus

The global hantavirus outbreak linked to a cruise ship has come to an end in Ontario. All identified contacts who were quarantining in Canada have all completed their quarantine periods, except one individual. One quarantining individual in Canada, a Yukon resident who was quarantined in British Columbia, developed illness but has now recovered. However, a person in the same household of that individual has been re-exposed and remains in quarantine. All persons quarantining in Ontario have completed their quarantine, and risk in Ontario is currently negligible. While Public Health Sudbury & Districts did not have to manage any individuals in quarantine, this is an example of good local public health work in Ontario.

7. alPHa Conference & Annual General Meeting

Dr. Hirji attended the Association of Local Public Health Agencies (alPHa) Conference and Annual General Meeting alongside Board member Bob Barclay and Associate Medical Officer of Health Dr. Emily Groot. Some highlights included

- alPHa adopted resolutions supporting hepatitis B vaccination in infancy (as this Board had advocated earlier this year), labelling of alcohol products, seeking provincial funding for more public health inspectors, and advocating for increasing Ontario Works exemptions to align with other income support policies.
- Received an update on work to model future illness in Ontario. This is work that our agency is already using to inform future planning, and Dr. Hirji is part of a panel advising on element of this work.
- Strategy Corp, a lobbying firm, again shared perspectives on the provincial government. A key take-away is that we need to demonstrate outcomes if we are to convince the current government to increase funding, and likely outcomes in areas like infectious disease where outcomes are short-term and can be realized.
- A discussion on public health budgets noted the challenges facing local public health agencies in the current environment, and the need to prioritize work and make hard choices, as well as demonstrate our value. At Public Health Sudbury & Districts, our 2025 budget began to make the hard choices proposed as we withdrew from areas of work that are less impactful or can be delivered by other partners.
- The Chief Medical Officer of Health shared his perspectives on public health's challenges. He noted great strengths in vaccination, infection prevention, and managing unusual pathogens like hantavirus and Ebola virus disease. However, he underscored the need to demonstrate good governance, accountability, and outcomes to the province to secure funding. As discussed in last month's report, consistent with our medium-term priority to "Orient towards outcomes and impact", we are engaged in an effort to develop outcome measures for our work so we can begin to demonstrate our impact in data and tell our story.
- In the meeting of medical officers of health and associates, discussion centred on the importance of doing business differently, with some discussion of how that could be approached collaboratively. Unfortunately, no next steps towards that were identified.
- Board member Bob Barkley also participated in discussions among Board of Health members across the province.

8. Procurement Policies Updated

Public Health has adopted an updated procurement policy. This new policy positions the agency to be nimbler and more innovative by re-balancing approval authority to lower levels in the management hierarchy, introducing new types of competitive procurement, and addresses how to manage procurement in emergencies. However, the policy does not weaken controls requiring competitive processes to ensure value for money. The changes to the procurement policy also address opportunities identified in the 2024 Ministry of Health audit.

In the coming months, the procurement structure is going to be strengthened further with a proposed new bylaw to ensure high level procurement principles are set by the Board of Health.

9. Employee Engagement Survey

In April/May 2026, Public Health conducted a comprehensive third-party employee engagement survey. The goal of this survey was to understand strengths and opportunities for improving engagement, given the Strategic Priority for a "Healthy and Resilient Workforce" and Medium-Term Priority for "Fostering Culture and Engagement". Engaged employees are more productive, produce higher quality work, and are subject to less turnover. In the coming months, we will be reviewing the results carefully and then working deliberately to make improvements. It is intended that ww will repeat the survey periodically to monitor our progress at improving engagement.

Activity Metrics for Public Health

Monthly and annually reported Activity Metrics for Public Health provide an overview of activities and showcase the breadth of the agency's work. The metrics highlight essential and routine efforts of Public Health that positively contribute to community well-being. Public Health's accountability monitoring and annual performance and financial reports provide additional information.

Respectfully submitted,

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

Public Health Sudbury & Districts

STATEMENT OF REVENUE & EXPENDITURES

For The 4 Periods Ending April 30, 2026

Cost Shared Programs

	Adjusted BOH Approved Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over)/under	Balance Available
Revenue:					
MOH - General Program	18,910,969	6,303,656	6,241,272	62,384	12,669,697
MOH - Unorganized Territory	1,092,500	364,167	364,180	(13)	728,320
Municipal Levies	11,800,921	3,933,640	3,933,518	122	7,867,403
Interest Earned	225,000	75,000	71,154	3,846	153,846
Total Revenues:	$32,029,390	$10,676,463	$10,610,124	$66,339	$21,419,266
Expenditures:					
Corporate Services:					
Corporate Services	5,711,223	1,972,372	3,067,614	(1,095,242)	2,643,609
Office Admin.	104,350	34,783	20,173	14,611	84,178
Espanola	131,896	43,965	40,249	3,716	91,647
Manitoulin	136,962	45,654	39,647	6,007	97,316
Chapleau	139,335	46,445	42,533	3,912	96,802
Sudbury East	17,880	5,960	6,887	(927)	10,993
Intake	385,472	128,491	128,488	3	256,984
Facilities Management	792,033	264,011	182,141	81,870	609,892
Electronic Medical Records	149,907	49,969	298,015	(248,046)	(148,108)
Total Corporate Services:	$7,569,059	$2,591,650	$3,825,746	$(1,234,096)	$3,743,313
Health Protection:					
Environmental Health - General	1,341,750	435,405	401,483	33,923	940,267
Enviromental	2,915,324	971,429	926,252	45,177	1,989,071
Vector Borne Disease (VBD)	43,708	11,071	3,112	7,959	40,597
CID	1,688,503	562,834	590,157	(27,323)	1,098,346
Districts - Clinical	250,711	83,570	2,413	81,157	248,298
Risk Reduction	53,756	17,127	4,918	12,209	48,838
Sexual Health	1,580,939	526,889	584,361	(57,472)	996,578
SFO- Local Capacity Building: Prevention and Protec	274,327	89,943	80,328	9,615	193,999
Total Health Protection:	$8,149,017	$2,698,268	$2,593,025	$105,244	$5,555,993
Health Promotion and Vaccine Preventable Diseases:					
Health Promotion and VPD- General	2,575,752	857,382	840,491	16,891	1,735,261
Comprehensive Health Promotion	3,950,589	1,331,427	1,239,415	92,012	2,711,174
Infant Feeding Clinic	645,413	215,138	215,765	(627)	429,649
Oral Health	540,421	180,407	171,313	9,094	369,109
Healthy Smiles Ontario - HSO	620,744	205,965	226,999	(21,035)	393,745
SFO- Tobacco Control Area Network	280,705	76,717	46,146	30,571	234,560
MOH - Harm Reduction Program Enhancement	191,822	63,941	13,275	50,666	178,547
VPD	2,725,683	887,820	815,549	72,271	1,910,135
MOH - Influenza	0	(0)	(25)	25	25
MOH - Meningittis	0	(0)	859	(859)	(858)
MOH - HPV	0	0	(1,318)	1,318	1,318
MOH - Northern Fruit & Vegetable Program	176,100	85,466	67,767	17,699	108,333
Total Health Promotion:	$11,707,231	$3,904,261	$3,636,235	$268,026	$8,070,997
Knowledge and Strategic Services:					
Knowledge and Strategic Services	3,457,368	1,144,954	1,175,502	(30,548)	2,281,866
Workplace Capacity Development	44,457	0	10,034	(10,034)	34,423
Health Equity Office	11,720	3,907	2,905	1,002	8,815
MOH - Special Nursing Initiative	557,232	185,744	188,903	(3,159)	368,329
Indigenous Public Health	407,705	134,701	134,615	86	273,090
MOH Local Model for Indigenous Public Health	125,601	41,867	42,482	(615)	83,119
Total Knowledge and Strategic Services:	$4,604,083	$1,511,173	$1,554,441	$(43,268)	$3,049,642
Total Expenditures:	$32,029,390	$10,705,352	$11,609,447	$(904,095)	$20,419,943
Net Surplus/(Deficit)	$(0)	$(28,889)	$(999,323)	$(970,434)	

Public Health Sudbury & Districts

Cost Shared Programs

STATEMENT OF REVENUE & EXPENDITURES
Summary By Expenditure Category
For The 4 Periods Ending April 30, 2026

		Adjusted BOH Approved Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:						
	MOH Funding	32,029,390	10,676,463	10,568,329	108,134	21,461,061
	Other Revenue/Transfers	493,475	164,492	296,603	(132,112)	196,872
	Total Revenues & Expenditure Recoveries:	32,522,865	10,840,955	10,864,932	(23,977)	21,657,932
Expenditures:						
	Salaries	19,814,870	6,607,726	7,203,432	(595,706)	12,611,438
	Benefits	7,675,019	2,558,338	2,485,586	72,752	5,189,432
	Travel	228,818	56,726	42,603	14,124	186,216
	Program Expenses	570,624	203,070	158,260	44,811	412,364
	Office Supplies	87,200	27,442	21,679	5,763	65,521
	Postage & Courier Services	90,100	30,033	23,182	6,851	66,918
	Photocopy Expenses	4,909	1,547	1,177	370	3,732
	Telephone Expenses	61,530	20,510	24,456	(3,946)	37,074
	Building Maintenance	562,416	187,472	130,436	57,036	431,980
	Utilities	190,447	63,482	61,023	2,460	129,424
	Rent	329,521	109,840	106,767	3,073	222,754
	Insurance	125,000	89,667	99,901	(10,235)	25,099
	Employee Assistance Program (EAP)	50,000	25,000	9,516	15,484	40,484
	Memberships	51,900	25,767	33,202	(7,436)	18,698
	Staff Development	158,203	29,554	23,844	5,711	134,359
	Books & Subscriptions	10,395	4,475	3,271	1,204	7,124
	Media & Advertising	55,214	10,071	4,127	5,945	51,088
	Professional Fees	697,194	232,398	253,105	(20,708)	444,088
	Translation	79,325	26,942	24,342	2,599	54,983
	Furniture & Equipment	19,267	6,145	7,977	(1,832)	11,290
	Information Technology	1,660,914	553,638	1,146,369	(592,731)	514,544
	Total Expenditures	32,522,865	10,869,844	11,864,255	(994,411)	20,658,610
	Net Surplus (Deficit)	(0)	(28,889)	(999,323)	(970,434)	

Sudbury & District Health Unit o/a Public Health Sudbury & Districts
SUMMARY OF REVENUE & EXPENDITURES
For the Period Ended April 30, 2026

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
100% Funded Programs							
LHIN - Falls Prevention Project & LHIN Screen	736	100,000	6,534	93,466	6.5%	*Mar 31/2027*	8.3%
Healthy Babies Healthy Children	778	1,725,944	108,199	1,617,745	6.3%	*Mar 31/2027*	8.3%
IPAC Congregate CCM	780	932,250	41,876	890,374	4.5%	*Mar 31/2027*	8.3%
Ontario Senior Dental Care Program	786	1,315,000	299,477	1,015,523	22.8%	*Dec 31*	33.3%
Anonymous Testing	788	64,293	-	64,293	0.0%	*Mar 31/2027*	8.3%
Total		4,289,837	456,086	3,833,751			

May 27, 2026
Board Chair and Members
Public Health Sudbury and Districts

Dear Chair and Board Members,

Please accept this letter as my formal resignation from the Board of Health, effective immediately.

It has been a privilege to serve alongside such a dedicated group of individuals committed to supporting the health and well-being of the communities across Sudbury and Districts. I am sincerely grateful for the opportunity to contribute to the important work of the Board and to collaborate with professionals and community leaders who care deeply about public health and the people we serve.

During my time on the Board, I have gained a strong appreciation for the complexity and importance of public health services, community partnerships, and long-term planning that supports healthier and stronger communities throughout the region.

This decision was not made lightly, but at this time I believe it is appropriate for me to step away from the role to focus on other commitments and responsibilities. I remain supportive of the organization's mandate and confident in the leadership and direction of the Board moving forward.

Thank you again for the opportunity to serve. I wish the Board, staff, and the communities you support continued success in the future.

Respectfully,

Ryan Anderson

Algoma PUBLIC HEALTH
Santé publique Algoma
www.algomapublichealth.com

May 21, 2026

Via Email

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

Dear Honourable Minister Jones:

Re: Healthy Smiles Ontario Fee Schedule and Access to Dental Care for Children and Youth

The Board of Health for Algoma Public Health acknowledges the Government of Ontario's demonstrated commitment to improving oral health for Ontarians. The recent introduction of the Ontario Seniors Dental Care Program reflects commitment to addressing long-standing gaps in access and demonstrates a broader commitment to prevention, health equity, and reducing avoidable pressures on the health care system.

Alongside these important investments for seniors, continued attention to publicly funded dental care for children and youth is essential to ensure equitable access to oral health services at all stages of life[1]. At its meeting on April 22, 2026, informed by a presentation on Healthy Smiles Ontario, the Board of Health for Algoma Public Health discussed ongoing barriers to care and is writing to request that the Ministry of Health update the Healthy Smiles Ontario Schedule of Dental Services and Fees. Although tooth decay is largely preventable, it affects more than half of Canadian children aged 6 to 19. The burden of oral disease is not evenly distributed, with higher rates observed among children from households experiencing socio-economic barriers to care[2,3].

Early childhood dental disease is largely preventable, yet untreated decay remains a leading cause of day surgery under general anesthesia for children under the age of 5 in Canada. Poor oral health can cause pain, disrupted eating and sleep, and difficulties with learning and school attendance, with effects that may persist into adulthood. Evidence shows that timely

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prevention and early intervention improve long-term health outcomes while reducing avoidable use of hospital services[4].

Healthy Smiles Ontario plays a vital preventive role by enabling early diagnosis and treatment, helping to prevent the progression of dental disease, and reducing demand for more intensive care. However, the program's impact is limited by its current fee structure, with reimbursement rates at approximately 40 percent of the Ontario Dental Association Suggested Fee Guide, discouraging provider participation and contributing to access challenges across the province. While some families may supplement care through the Canadian Dental Care Plan, many HSO-eligible children and youth do not qualify and continue to face unmet oral health needs.

Accordingly, our Board of Health respectfully urges the Ministry of Health to update the Healthy Smiles Ontario Schedule of Dental Services and Fees to strengthen provider capacity, improve access, and support more equitable oral health outcomes for children and youth across Ontario.

We would welcome the opportunity to contribute to this work, including sharing local perspectives on access barriers and practical considerations that could support effective implementation.

Sincerely,

Suzanne Trivers
Chair, Board of Health,
District of Algoma Health Unit

c: Dr. Kieran Moore, Chief Medical Officer of Health for Ontario
Dr. David A. Brown, Chair, Board of Directors and President, Ontario Dental Association
Bill Rosenberg, Member of Provincial Parliament, Algoma–Manitoulin
Chris Scott, Member of Provincial Parliament — Sault Ste. Marie
Ontario Boards of Health

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Windsor-Essex County Health Unit Board of Health

RECOMMENDATION/RESOLUTION REPORT – Waterpipe Smoking Restrictions

2026-05-14

ISSUE

The *Smoke-Free Ontario Act, 2017* (SFOA) prohibits the use of tobacco and vapour products in all enclosed public spaces and workplaces in Ontario. Since its introduction in 2006, the SFOA has contributed to a significant reduction in smoking in public places and exposure to second-hand smoke (Ontario Tobacco Research Unit, 2009). However, the smoking of non-tobacco products such as herbal shisha using waterpipes (e.g. hookahs) remains permitted under the Act, resulting a regulatory gap in provincial smoking legislation. The permissibility of waterpipe use for non-tobacco products creates mixed messages for the public about the safety of waterpipe smoking and diminishes its many potential health risks (Public Health Ontario, 2021). Therefore, municipal governments have the opportunity to address this legislative loophole by implementing or enforcing by-laws that are more restrictive than the SFOA that prohibit the use of waterpipes for non-tobacco products (Canadian Public Health Association, 2021; *Smoke-Free Ontario Act, 2017*).

BACKGROUND

Non-tobacco shisha that is smoked through a waterpipe is sometimes perceived as healthier than smoking or vaping because of the absence of tobacco as well as the use of water to pass smoke through. Although the smoke passes through water before being inhaled, waterpipes do not filter out toxins as they can still produce high levels of carbon monoxide and expose the person smoking to heavy metals and carcinogenic chemicals (Ottawa Public Health, 2025; Mayo Clinic, 2025). Furthermore, non-tobacco shisha products come in a variety of flavours, contributing to an image of safety and accessibility as well as youth appeal (Chappell, 2021).

Waterpipe smoking creates a plethora of health risks. The use of a hookah to smoke both tobacco and non-tobacco shisha contributes to a significantly greater risk of respiratory diseases such as lung cancer, chronic obstructive pulmonary disease (COPD), and chronic bronchitis. (Public Health Ontario, 2025; Ottawa Public Health, 2025). Waterpipe smoking is also associated with adverse cardiovascular effects including elevated heart rate, increased blood pressure, reduced exercise capacity, and coronary artery disease (Public Health Ontario, 2025; UCLA Health, 2018). Waterpipe smoking during pregnancy is associated with low birth weight, sudden infant death syndrome, and childhood respiratory, learning, and behavioural problems (Public Health Ontario, 2021; Ottawa Public Health, 2025; My Health Alberta, 2024). Furthermore, the sharing of hookah mouthpieces as well as bacteria within the pipe can contribute to infectious diseases such as hepatitis, tuberculosis, influenza, herpes, and COVID-19 (Public Health Ontario, 2021; Ottawa Public Health, 2025; My Health Alberta, 2025).

Waterpipe use also has negative health effects for those exposed to second-hand waterpipe smoke. Even when tobacco is not present, herbal shisha can worsen air quality by producing carbon monoxide and particulate matter (Public Health Ontario, 2025; Zhou et al., 2015). Because of the typically long duration of waterpipe smoking sessions (approximately one hour), individuals are exposed to greater levels of carbon monoxide and heavy metals (e.g. nickel and arsenic) using a waterpipe compared to tobacco cigarettes (Mayo Clinic, 2025; Chappell, 2021), further exacerbating health concerns for those who smoke as well as others exposed to second-hand smoke. Research from the University of Alberta finds that some hookah bars can have air quality that is similar to "being downwind from a forest fire" (University of Alberta, 2013), highlighting the importance of restricting indoor waterpipe smoking to protect the health of patrons as well as employees.

Although establishments may advertise their shisha as free of tobacco, tobacco has been found in shisha samples in Windsor and across Ontario (Chappell, 2021). Since 2024, five charges have been laid at hookah lounges in Windsor where tobacco has been found in shisha samples, representing a 50% non-compliance rate based on ten inspections conducted. Prohibiting indoor hookah use would eliminate the possibility of tobacco use indoors that persists despite current smoking legislation. Several cities throughout Ontario have banned waterpipe use within enclosed public spaces and workplaces such as Ottawa, Peterborough, Barrie, Niagara, Orillia, Toronto, and Hamilton (Public Health Ontario, 2025). Furthermore, the Canadian Public Health Association recommends that municipalities establish by-laws prohibiting hookah use in public places, as stated within their position statement *The Winnable Battle: Ending Tobacco Use in Canada* (2021).

PROPOSED MOTION

Whereas, waterpipe smoking is associated with negative health outcomes including lung cancer, chronic obstructive pulmonary disease (COPD), low birth weight, communicable diseases, and cardiovascular conditions such as high blood pressure and coronary artery disease; and

Whereas, non-tobacco smoking products (e.g. shisha) contain heavy metals, carcinogens, and carbon monoxide which are hazardous to the health of those who smoke as well as those subject to second-hand smoke; and

Whereas, the *Smoke Free Ontario Act, 2017* does not restrict the smoking of non-tobacco products indoors, providing an opportunity for municipalities to implement local by-laws which include the prohibition of waterpipe use for non-tobacco products in enclosed public spaces and workplaces;

Now therefore be it resolved the Windsor-Essex County Board of Health endorses the Windsor-Essex County Health Unit working collaboratively with area municipalities to develop, update, and enforce by-laws that restrict the use of waterpipes, including non-tobacco products, in enclosed public spaces and workplaces.

Further that, the Windsor-Essex County Board of Health supports efforts to educate the public, business owners, and municipal partners on the health risks associated with waterpipe smoking, including non-tobacco products, and the importance of protecting workers and the public from exposure to second-hand emissions in enclosed public spaces and workplaces.

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Windsor-Essex County Health Unit Board of Health

RECOMMENDATION/RESOLUTION REPORT – Enhancing Municipal Readiness for Ontario's Bring-Your-Own-Beverage (BYOB) Legislation Through Public Health Engagement

2026-05-14

ISSUE

The Province of Ontario has introduced a legislative framework permitting residents aged nineteen years and older to bring their own alcoholic beverages to municipally designated outdoor cultural and community events, effective April 30, 2026. Municipalities must pass enabling bylaws and establish local eligibility processes prior to the policy taking effect. Given the significant and well-documented burden of alcohol-related harms in Windsor-Essex, formal engagement with the Windsor-Essex County Health Unit (WECHU) is essential to ensure that any municipal implementation of the Bring-Your-Own-Beverage (BYOB) policy prioritizes public health and community safety.

BACKGROUND

The Province of Ontario will, effective April 30, 2026, expand existing alcohol permissions to allow residents aged nineteen and older to bring their own alcoholic beverages to municipally designated outdoor cultural and community events. Municipalities must first enact enabling bylaws authorizing alcohol consumption in public spaces and establish local processes to determine event eligibility prior to the issuance of permits through the Alcohol and Gaming Commission of Ontario (AGCO).

While the policy aims to support tourism, reduce event-related costs, and strengthen local economic activity, Health Canada (2024) indicates that increased visibility and normalization of alcohol at public or family-oriented events contributes to more permissive attitudes toward drinking among youth and young adults, with research among Ontarians aged 19–24 showing that alcohol is commonly perceived as an expected feature of festivals and community celebrations and associated risks are often underestimated.

In Windsor-Essex, 62% of residents report regular alcohol use, and in 2024, more than 2,000 emergency department (ED) visits were attributable to alcohol, substantially exceeding all other substance -related ED visits. Annual rates include 416.13 alcohol-related ED visits per 100,000 residents and 260 hospitalizations per 100,000 residents, both surpassing provincial averages.

Alcohol remains a predominant driver of preventable death, illness and injury locally. Increased access to alcohol has been consistently associated with higher rates of impaired driving and motor vehicle injury. Ontario and national evidence demonstrate that policy changes which increase alcohol availability are linked to increases in alcohol-related collisions, injuries, and fatalities (Callaghan et al., 2023).

Alcohol-related emergency department presentations contribute to broader system pressures in Windsor-Essex, including emergency department crowding, ambulance offload delays, and periods of reduce ambulance availability (Code Black), underscoring the region's limited surge capacity and the importance of precautionary, public-health informed approaches when considering policies that may increase acute alcohol-related demand (Public Health Ontario, 2023; Myran et al., 2024; Wan et al., 2026).

As such, any expansion of public alcohol consumption through municipal implementation of the BYOB framework should incorporate public-health-informed safeguards appropriate to the local context, including event screening, designated consumption areas, and risk-mitigation planning, to support community safety and well-being and minimize unintended health and system impacts.

PROPOSED MOTION

Whereas, the Province of Ontario will, effective April 30, 2026, authorize adults nineteen years of age and older to bring their own alcoholic beverages to municipally designated outdoor cultural and community events, contingent upon the passage of municipal bylaws permitting alcohol consumption in public spaces and the establishment of local criteria to determine event eligibility for BYOB permits;

Whereas, the implementation of the BYOB alcohol policy is not automatic and may only proceed within a municipality once the municipality has passed an enabling bylaw and developed an appropriate local approval process;

Whereas, annual local alcohol-related harms include 416.13 emergency room visits per 100,000 residents and 260 hospitalizations per 100,000 residents, exceeding provincial averages;

Whereas, an expansion of public alcohol consumption through BYOB events has the potential to exacerbate existing alcohol-related harms without robust safeguards and public health-informed oversight.

Therefore, be it resolved that, the Board of Health of the Windsor-Essex County Health Unit strongly advises municipalities within Windsor-Essex that formal consultation with the WECHU is essential prior to drafting, revising, or adopting any municipal bylaw pertaining to Ontario's BYOB alcohol policy, ensuring that public health considerations are fully integrated into local decision-making processes.

FURTHER THAT, WECHU commit to providing evidence-informed guidance and policy supports to municipal councils, including local alcohol-related harm statistics, recommendations for designated consumption areas, risk-mitigation strategies, enforcement considerations, and public-facing harm-reduction messaging.

FURTHER THAT, this resolution be circulated to all municipal councils in Windsor-Essex, the Association of Municipalities of Ontario (AMO), and the Ontario Public Health Association (OPHA) to support coordinated and health-informed implementation of the BYOB framework.

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APPROVAL OF CONSENT AGENDA

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

AFFIRMING AND ADVANCING FRENCH LANGUAGE SERVICES AT PUBLIC HEALTH SUDBURY & DISTRICTS

MOTION:

WHEREAS Public Health Sudbury & Districts serves a region with a significant Francophone population, with approximately 21% of residents identifying French as their first official language spoken;

AND WHEREAS both long-standing Francophone community members and French-speaking newcomers rely on accessible, culturally appropriate public health services to support health, safety, and integration;

AND WHEREAS the Board of Health has established a longstanding policy commitment to providing equitable, accessible, and culturally competent French-language public health services for Francophone populations;

AND WHEREAS Public Health Sudbury & Districts lives this commitment through the active offer of service, bilingual service delivery, translation of public facing materials, staff training, community partnerships, and cross-agency engagement through the Francophone Advisory Committee; these efforts collectively support equitable health outcomes and help mitigate risks related to client safety and service quality and accessibility and;

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts

- **Affirms its commitment to equitable high-quality, culturally- and linguistically-appropriate French-language public health services for populations across Sudbury and districts in all programs and service delivery points;**
- **Supports the continued advancement of French Language Services, including the active offer of service, workforce capacity development, community partnerships, and integration of Francophone perspectives in program planning and delivery;**
- **Recognizes French Language Services as integral to health equity, accessibility, and the organization's mission to promote and protect the health of all communities served.**

Financial Statements of

BOARD OF HEALTH FOR THE SUDBURY & DISTRICT HEALTH UNIT

(OPERATING AS PUBLIC HEALTH SUDBURY & DISTRICTS)

And Independent Auditor's Report thereon

Year ended December 31, 2025

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INDEPENDENT AUDITOR'S REPORT

To the Board Members of The Board of Health for the Sudbury & District Health Unit (operating as Public Health Sudbury & Districts), Members of Council, Inhabitants and Ratepayers of the Participating Municipalities of the Board of Health for the Sudbury & District Health Unit

Opinion

We have audited the financial statements of The Board of Health for the Sudbury & District Health Unit operating as Public Health Sudbury & Districts (the Entity), which comprise:

- the statement of financial position as at December 31, 2025
- the statement of operations and accumulated surplus for the year then ended
- the statements of changes in net assets for the year then ended
- the statement of cash flows for the year then ended
- and notes to the financial statements, including a summary of significant accounting policies

(Hereinafter referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Entity as at December 31, 2025, and its results of operations, its changes in net financial assets and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the ***"Auditor's Responsibilities for the Audit of the Financial Statements"*** section of our auditor's report.

We are independent of the Entity in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the Entity's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the Entity or to cease operations, or has no realistic alternative but to do so.

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Those charged with governance are responsible for overseeing the Entity's financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit.

We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion.

  The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Entity's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Entity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Entity to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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- Communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

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Chartered Professional Accountants, Licensed Public Accountants

Sudbury, Canada

May 13, 2026

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BOARD OF HEALTH FOR THE SUDBURY & DISTRICT HEALTH UNIT

(OPERATING AS PUBLIC HEALTH SUDBURY & DISTRICTS)

Statement of Financial Position

December 31, 2025, with comparative information for 2024

	2025	2024
Financial assets		
Cash and cash equivalents	$ 11,361,264	$ 14,806,939
Accounts receivable	576,051	315,050
Receivable from the Province of Ontario	132,428	51,765
	12,069,743	15,173,754
Financial liabilities		
Accounts payable and accrued liabilities	2,641,246	2,602,045
Deferred revenue	290,337	168,876
Payable to the Province of Ontario	-	4,112,197
Employee benefit obligations (note 2)	3,791,906	3,668,805
	6,723,489	10,551,923
Net financial assets	5,346,254	4,621,831
Non-financial assets:		
Tangible capital assets (note 3)	14,967,141	14,671,650
Prepaid expenses	648,277	458,156
	15,615,418	15,129,806
Commitments and contingencies (note 4)		
Accumulated surplus (note 5)	$ 20,961,672	$ 19,751,637

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See accompanying notes to financial statements.

On behalf of the Board:

_____ Board Member

_____ Board Member

BOARD OF HEALTH FOR THE SUDBURY & DISTRICT HEALTH UNIT

(OPERATING AS PUBLIC HEALTH SUDBURY & DISTRICTS)

Statement of Operations and Accumulated Surplus

Year ended December 31, 2025, with comparative information for 2024

	2025 Budget (note 10)	2025 Actual	2024 Actual
Revenue (note 9):			
Provincial grants	$ 22,924,068	$ 24,853,964	$ 24,077,037
Per capita revenue from municipalities (note 7)	11,186,768	11,186,768	10,548,731
Other:			
Plumbing inspections and licenses	317,000	417,782	251,127
Interest	300,000	443,683	568,649
Other	440,147	351,179	377,251
	35,167,983	37,253,376	35,822,795
Expenses (note 9):			
Salaries and wages	21,389,577	22,244,780	21,712,110
Benefits (note 6)	7,580,665	7,344,107	6,636,188
Administration (note 8)	3,357,436	2,777,445	2,941,588
Supplies and materials	1,014,282	816,840	935,158
Amortization of tangible capital assets (note 3)	1,111,478	1,072,422	1,111,478
Small operational equipment	1,539,430	1,527,319	838,150
Transportation	286,593	260,428	235,930
	36,279,461	36,043,341	34,410,602
Annual surplus (deficit)	(1,111,478)	1,210,035	1,412,193
Accumulated surplus, beginning of year	19,751,637	19,751,637	18,339,444
Accumulated surplus, end of year	$ 18,640,159	$ 20,961,672	$ 19,751,637

See accompanying notes to financial statements.

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BOARD OF HEALTH FOR THE SUDBURY & DISTRICT HEALTH UNIT

(OPERATING AS PUBLIC HEALTH SUDBURY & DISTRICTS)

Statement of Changes in Net Financial Assets

Year ended December 31, 2025, with comparative information for 2024

	2025	2024
Annual surplus	$ 1,210,035	$ 1,412,193
Purchase of tangible capital assets	(1,367,913)	(574,614)
Amortization of tangible capital assets	1,072,422	1,111,478
Change in prepaid expenses	(190,121)	1,336
Change in net financial assets	724,423	1,950,393
Net financial assets, beginning of year	4,621,831	2,671,438
Net financial assets, end of year	$ 5,346,254	$ 4,621,831

See accompanying notes to financial statements.

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BOARD OF HEALTH FOR THE SUDBURY & DISTRICT HEALTH UNIT

(OPERATING AS PUBLIC HEALTH SUDBURY & DISTRICTS)

Statement of Cash Flows

Year ended December 31, 2025, with comparative information for 2024

	2025	2024
Cash provided by (used in):		
Cash flows from operating activities:		
Annual surplus	$ 1,210,035	$ 1,412,193
Adjustments for:		
Amortization of tangible capital assets	1,072,422	1,111,478
Change in employee benefit obligations	123,101	(101,365)
	2,405,558	2,422,306
Changes in non-cash working capital:		
Decrease (increase) in accounts receivable	(261,001)	214,501
Increase in receivable from the Province of Ontario	(80,663)	(17,545)
Increase (decrease) in accounts payable and accrued liabilities	39,201	(167,211)
Increase (decrease) in deferred revenue	121,461	(187,776)
Increase (decrease) in payable to the Province of Ontario	(4,112,197)	3,088,070
Decrease (increase) in prepaid expenses	(190,121)	1,336
	(2,077,762)	5,353,681
Cash flows from investing activity:		
Purchase of tangible capital assets	(1,367,913)	(574,614)
Increase (decrease) in cash and cash equivalents	(3,445,675)	4,779,067
Cash and cash equivalents, beginning of year	14,806,939	10,027,872
Cash and cash equivalents, end of year	$ 11,361,264	$ 14,806,939

See accompanying notes to financial statements.

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The Board of Health for the Sudbury & District Health Unit (operating as Public Health Sudbury & Districts) (the "Health Unit") was established in 1956, and is a progressive, accredited public health agency committed to improving health and reducing social inequities in health through evidence informed practice. The Health Unit is funded through a combination of Ministry grants and through levies that are paid by the municipalities to whom the Health Unit provides public health services. The Health Unit works locally with individuals, families and community and partner agencies to promote and protect health and to prevent disease. Public health programs and services are geared toward people of all ages and delivered in a variety of settings including workplaces, daycare and educational settings, homes, health-care settings and community spaces.

The Health Unit is a not-for-profit public health agency and is therefore exempt from income taxes under the Income Tax Act (Canada).

1. Summary of significant accounting policies:

These financial statements are prepared by management in accordance with Canadian public sector accounting standards established by the Public Sector Accounting Board. The principal accounting policies applied in the preparation of these financial statements are set out below.

(a) Basis of accounting:

The financial statements are prepared using the accrual basis of accounting.

The accrual basis of accounting recognizes revenues as they are earned. Expenses are recognized as they are incurred and measurable as a result of receipt of goods or services and the creation of a legal obligation to pay.

(b) Cash and cash equivalents:

Cash and cash equivalents include guaranteed investment certificates that are readily convertible into known amounts of cash and subject to insignificant risk of change in value.

Guaranteed investment certificates generally have a maturity of one year or less at acquisition and are held for the purpose of meeting future cash commitments.

Guaranteed investment certificates amounted to $2,680,155 as at December 31, 2025 (2024 - $2,594,788) and these can be redeemed for cash on demand.

(c) Employee benefit obligations:

The Health Unit accounts for its participation in the Ontario Municipal Employee Retirement Fund ("OMERS"), a multi-employer public sector pension fund, as a defined contribution plan.

Vacation and other compensated absence entitlements are accrued for as entitlements are earned.

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1. Summary of significant accounting policies (continued):

(c) Employee benefit obligations (continued):

Other post-employment benefits are accrued in accordance with the projected benefit method pro-rated on service and management's best estimate of salary escalation and retirement ages of employees. The discount rate used to determine the accrued benefit obligation was determined with reference to the Health Unit's cost of borrowing at the measurement date taking into account cash flows that match the timing and amount of expected benefit payments.

Actuarial gains (losses) on the accrued benefit obligation arise from the difference between actual and expected experiences and from changes in actuarial assumptions used to determine the accrued benefit obligation. These gains (losses) are amortized over the average remaining service period of active employees.

(d) Non-financial assets:

Tangible capital assets and prepaid expenses are accounted for as non-financial assets by the Health Unit. Non-financial assets are not available to discharge liabilities and are held for use in the provision of services. They have useful lives extending beyond the current year and are not intended for sale in the ordinary course of operations.

(e) Tangible capital assets:

Tangible capital assets are recorded at cost, and include amounts that are directly related to the acquisition of the assets. The Health Unit provides for amortization using the straight-line method designed to amortize the cost, less any residual value, of the tangible capital assets over their estimated useful lives. The annual amortization periods are as follows:

Asset	Basis	Rate
Building	Straight-line	2.5%
Land improvements	Straight-line	10%
Leasehold improvements	Straight-line	10%
Computer hardware	Straight-line	30%
Computer software	Straight-line	100%
Website design	Straight-line	20%
Vehicles and equipment	Straight-line	10%
Equipment – vaccine refrigerators	Straight-line	20%

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1. Summary of significant accounting policies (continued):

(f) Prepaid expenses:

Prepaid expenses are charged to expenses over the periods expected to benefit from them.

(g) Accumulated surplus:

Certain amounts, as approved by the Board of Directors, are set aside in accumulated surplus for future operating and capital purposes. Transfers to/from funds and reserves are an adjustment to the respective fund when approved.

The accumulated surplus consists of the following surplus accounts:

- Invested in tangible capital assets:

  This represents the net book value of the tangible capital assets the Health Unit has on hand.

- Unfunded employee benefit obligations:

  This represents the unfunded future employee benefit obligations comprised of the accumulated sick leave benefits, other post-employment benefits and vacation pay and other compensated absences.

The accumulated surplus consists of the following reserves:

- Working capital reserve:

  This reserve is not restricted and is utilized for the operating activities of the Health Unit.

- Public health initiatives:

  This reserve is restricted and can only be used for public health initiatives.

- Corporate contingencies:

  This reserve is restricted and can only be used for corporate contingencies.

- Facility and equipment repairs and maintenance:

  This reserve is restricted and can only be used for facility and equipment repairs and maintenance.

- Sick leave and vacation:

  This reserve is restricted and can only be used for future sick leave and vacation obligations.

- Research and development:

  This reserve is restricted and can only be used for research and development activities.

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1. Summary of significant accounting policies (continued):

(h) Revenue recognition:

Revenue from government grants and from municipalities is recognized in the period in which the events giving rise to the government transfer have occurred as long as: the transfer is authorized; the eligibility criteria, if any, have been met except when and to the extent that the transfer gives rise to an obligation that meets the definition of a liability for the recipient government; and the amount can reasonably be estimated. Funding received under a funding arrangement, which relates to a subsequent fiscal period and the unexpended portions of contributions received for specific purposes, is reflected as deferred revenue in the year of receipt and is recognized as revenue in the period in which all the recognition criteria have been met.

Fees and other revenue from transactions with performance obligations, are recognized as the Health Unit satisfies a performance obligation by providing the promised goods or services to the payor. Fees and other revenue from transactions with no performance obligations, are recognized as the Health Unit has the authority to claim or retain an inflow of economic resources and when a past transaction or event is an asset. Amounts received prior to the end of the year that will be recognized in subsequent fiscal year are deferred and reported as a liability.

(i) Budget information:

Budget figures have been provided for comparison purposes and have been derived from the budget approved by the Board of Directors. The budget figures are unaudited.

(j) Use of estimates:

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of certain assets and liabilities at the date of the financial statements and the reported amounts of certain revenues and expenses during the reporting period. By their nature, these estimates are subject to measurement uncertainty. The effect of changes in such estimates on the financial statements in future periods could be significant. Accounts specifically affected by estimates in these financial statements are estimated amounts for uncollectible accounts receivable, employee benefit obligations and the estimated useful lives and residual values of tangible capital assets. Actual results could differ from those estimates. These estimates are reviewed periodically, and, as adjustments become necessary, they are reported in earnings in the year in which they become known.

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1. Summary of significant accounting policies (continued):

(k) Financial instruments:

Financial instruments are classified into three categories: fair value, amortized cost or cost. The following chart shows the measurement method for each type of financial instrument:

Financial instrument	Measurement method
Cash and cash equivalents	Cost
Accounts receivable	Amortized cost
Receivable from the Province of Ontario	Amortized cost
Accounts payable and accrued liabilities	Amortized cost
Payable to the Province of Ontario	Amortized cost

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Amortized cost

Amounts are measured using the effective interest rate method. The effective interest method is a method of calculating the amortized cost of a financial asset or financial liability (or a group of financial assets or financial liabilities) and of allocating the interest income or interest expense over the relevant period, based on the effective interest rate. It is applied to financial assets or financial liabilities that are not in the fair value category and is now the method that must be used to calculate amortized cost.

Cost

Amounts are measured at cost less any amount for valuation allowance. Valuation allowances are made when collection is in doubt.

Fair value

The Health Unit manages and reports performance for groups of financial assets on a fair-value basis. Investments traded in an active market are reflected at fair value as at the reporting date. Sales and purchases of investments are recorded on the trade date. Transaction costs related to the acquisition of investments are recorded as an expense. Unrealized gains and losses on financial assets are recognized in the Statement of Remeasurement Gains and Losses until such time that the financial asset is derecognized due to disposal or impairment.

At the time of derecognition, the related realized gains and losses are recognized in the Statement of Operations and Accumulated Surplus and related balances reversed from the Statement of Remeasurement Gains and Losses. A statement of remeasurement gains and losses has not been included as there are no matters to report therein.

1. Summary of significant accounting policies (continued):

(k) Financial instruments (continued):

Establishing fair value

The fair value of guarantees and letters of credit are based on fees currently charged for similar agreements or on the estimated cost to terminate them or otherwise settle the obligations with the counterparties at the reported borrowing date. In situations in which there is no market for these guarantees, and they were issued without explicit costs, it is not practicable to determine their fair value with sufficient reliability (if applicable).

Fair value hierarchy

The following provides an analysis of financial instruments that are measured subsequent to initial recognition at fair value, grouped into Levels 1 to 3 based on the degree to which fair value is observable:

Level 1 fair value measurements are those derived from quoted prices (unadjusted) in active markets for identical assets or liabilities.

Level 2 fair value measurements are those derived from inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly (i.e., as prices) or indirectly (i.e., derived from prices); and

Level 3 fair value measurements are those derived from valuation techniques that include inputs for the asset or liability that are not based on observable market data (unobservable inputs).

The fair value hierarchy requires the use of observable market inputs whenever such inputs exist. A financial instrument is classified to the lowest level of the hierarchy for which a significant input has been considered in measuring fair value.

(l) Asset retirement obligation:

An asset retirement obligation is recognized when, as at the financial reporting date, all of the following criteria are met:

(i) There is a legal obligation to incur retirement costs in relation to a tangible capital asset;

(ii) The past transaction or event giving rise to the liability has occurred;

(iii) It is expected that the future economic benefits will be given up; and

(iv) A reasonable estimate of the amount can be made.

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1. Summary of significant accounting policies (continued):

(l) Asset retirement obligation (continued):

A liability for asset retirement obligations has not been recorded in these financial statements. Given the nature of the assets, the age of the facilities and the remediation work completed to date it was determined there is no further legal obligation on the part of the Health Unit to complete remediation efforts.

2. Employee benefit obligations:

An actuarial estimate of future liabilities has been completed using the most recent actuarial valuation dated December 31, 2024 and forms the basis for the estimated liability reported in these financial statements. The valuation of the plan is updated from a walk forward of the December 31, 2024 results. The next full valuation of the plan will be as of December 31, 2027.

	2025	2024
Accumulated sick leave benefits	$ 514,897	$ 533,958
Other post-employment benefits	2,139,708	1,978,109
	2,654,605	2,512,067
Vacation pay and other compensated absence	1,137,301	1,156,738
	$ 3,791,906	$ 3,668,805

The significant actuarial assumptions adopted in measuring the Health Unit's accumulated sick leave benefits and other post-employment benefits are as follows:

	2025	2024
Discount	4.25%	4.00%
Health-care trend rate:		
Initial	5.67%	5.08%
Ultimate	4.00%	3.75%
Salary escalation factor	3.00%	2.75%

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2. Employee benefit obligations (continued):

The Health Unit has established reserves in the amount of $2,639,119 (2024 - $2,639,119) to mitigate the future impact of these obligations. The accrued benefit obligations as at December 31, 2025 are $3,840,723 (2024 - $2,976,939).

	2025	2024
Benefit plan expenses:		
Current service costs	$ 285,589	$ 211,182
Interest	158,988	115,061
Amortization of actuarial loss	101,864	35,912
	$ 546,441	$ 362,155

Benefits paid during the year were $403,904 (2024 - $240,432). The net unamortized actuarial loss of $1,186,118 (2024 - $1,287,982) will be amortized over the expected average remaining service period.

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3. Tangible capital assets:

Cost:

	Land	Building	Leasehold improvements	Computer hardware	Computer software	Website design	Furniture and equipment	Parking lot resurfacing	2025 Total
Balance, January 1, 2025	$ 26,938	$ 15,067,088	$ 3,617,531	$ 3,768,130	$ 423,933	$ 69,845	$ 4,603,675	$ 252,346	$ 27,829,486
Additions	-	-	943,028	77,731	43,494	48,677	254,983	-	1,367,913
Balance, December 31, 2025	$ 26,938	$ 15,067,088	$ 4,560,559	$ 3,845,861	$ 467,427	$ 118,522	$ 4,858,658	$ 252,346	$ 29,197,399

Accumulated amortization:

	Land	Building	Leasehold improvements	Computer hardware	Computer software	Website design	Furniture and equipment	Parking lot resurfacing	2025 Total
Balance, January 1, 2025	$ -	$ 4,564,171	$ 1,181,517	$ 3,672,571	$ 423,933	$ 69,845	$ 3,000,078	$ 245,721	$ 13,157,836
Amortization	-	376,679	355,257	81,270	21,747	-	234,744	2,725	1,072,422
Balance, December 31, 2025	$ -	$ 4,940,850	$ 1,536,774	$ 3,753,841	$ 445,680	$ 69,845	$ 3,234,822	$ 248,446	$ 14,230,258

Net book value:

	Land	Building	Leasehold improvements	Computer hardware	Computer software	Website design	Furniture and equipment	Parking lot resurfacing	2025 Total
At December 31, 2024	$ 26,938	$ 10,502,917	$ 2,436,014	$ 95,559	$ -	$ -	$ 1,603,597	$ 6,625	$ 14,671,650
At December 31, 2025	$ 26,938	$ 10,126,238	$ 3,023,785	$ 92,020	$ 21,747	$ 48,677	$ 1,623,836	$ 3,900	$ 14,967,141

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3. Tangible capital assets:

Cost:

	Land	Building	Leasehold improvements	Computer hardware	Computer software	Website design	Furniture and equipment	Parking lot resurfacing	2024 Total
Balance, January 1, 2024	$ 26,938	$ 15,029,052	$ 3,490,251	$ 3,757,242	$ 423,933	$ 69,845	$ 4,205,265	$ 252,346	$ 27,254,872
Additions	-	38,036	127,280	10,888	-	-	398,410	-	574,614
Balance, December 31, 2024	$ 26,938	$ 15,067,088	$ 3,617,531	$ 3,768,130	$ 423,933	$ 69,845	$ 4,603,675	$ 252,346	$ 27,829,486

Accumulated amortization:

	Land	Building	Leasehold improvements	Computer hardware	Computer software	Website design	Furniture and equipment	Parking lot resurfacing	2024 Total
Balance, January 1, 2024	$ -	$ 4,187,968	$ 906,876	$ 3,422,077	$ 423,933	$ 69,845	$ 2,794,413	$ 241,246	$ 12,046,358
Amortization	-	376,203	274,641	250,494	-	-	205,665	4,475	1,111,478
Balance, December 31, 2024	$ -	$ 4,564,171	$ 1,181,517	$ 3,672,571	$ 423,933	$ 69,845	$ 3,000,078	$ 245,721	$ 13,157,836

Net book value:

	Land	Building	Leasehold improvements	Computer hardware	Computer software	Website design	Furniture and equipment	Parking lot resurfacing	2024 Total
At December 31, 2023	$ 26,938	$ 10,841,084	$ 2,583,375	$ 335,165	$ -	$ -	$ 1,410,852	$ 11,100	$ 15,208,514
At December 31, 2024	$ 26,938	$ 10,502,917	$ 2,436,014	$ 95,559	$ -	$ -	$ 1,603,597	$ 6,625	$ 14,671,650

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4. Commitments and contingencies:

(a) Line of credit:

The Health Unit has available an operating line of credit of $500,000 (2024 - $500,000). There is $Nil balance outstanding on the line of credit at year end (2024 - $Nil).

(b) Lease commitments:

The Health Unit enters into operating leases in the ordinary course of business, primarily for lease of premises and equipment. Payments for these leases are contractual obligations as scheduled per each agreement. Commitments for minimum lease payments in relation to non-cancellable operating leases at December 31, 2025 are as follows:

No later than one year	$ 298,660
Later than one year and no later than 5 years	1,125,996
Later than five years	725,599
	$ 2,150,255

(c) Contingencies:

The Health Unit is involved in certain legal matters and litigation, the outcomes of which are not presently determinable. The loss, if any, from these contingencies will be accounted for in the periods in which the matters are resolved. Management is of the opinion that these matters are mitigated by adequate insurance coverage.

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5. Accumulated surplus:

The accumulated surplus consists of individual fund surplus accounts and reserves as follows:

	Balance, beginning of year	Annual surplus (deficit)	Purchase of tangible capital assets	Capital Infrastructure Project	Balance, end of year
Invested in tangible capital assets	$ 14,671,650	$ (1,072,422)	$ 1,367,913	$ –	$ 14,967,141
Unfunded employee benefit obligation	(3,668,805)	(123,101)			(3,791,906)
Working capital reserve	4,096,541	2,405,558	(1,367,913)	–	5,134,186
Public health initiatives	500,000	–	–	–	500,000
Corporate contingencies	500,000	–	–	–	500,000
Facility and equipment repairs and maintenance	956,272	–	–	–	956,272
Sick leave and vacation	2,639,119	–	–	–	2,639,119
Research and development	56,860	–	–	–	56,860
	$ 19,751,637	$ 1,210,035	$ –	$ –	$ 20,961,672

6. Pension agreements:

The Health Unit makes contributions to OMERS, which is a multi-employer plan, on behalf of its members. The plan is a defined contribution plan, which specifies the amount of the retirement benefit to be received by the employees based on the length of service and rates of pay.

The amount contributed to OMERS for 2025 was $2,068,863 (2024 - $2,036,224) for current service and is included within benefits expense on the statement of operations and accumulated surplus.

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7. Per capita revenue from municipalities:

	2025	2024
City of Greater Sudbury	$ 9,568,315	$ 9,022,585
Town of Espanola	297,943	280,950
Township of Sable and Spanish River	194,534	183,439
Municipality of French River	166,565	157,065
Municipality of Markstay-Warren	168,855	159,224
Township of Northeastern Manitoulin & The Islands	145,536	137,235
Township of Chapleau	135,611	127,877
Township of Central Manitoulin	116,595	109,945
Municipality of St. Charles	85,711	80,823
Township of Assiginack	54,411	51,308
Town of Gore Bay	52,468	49,475
Township of Baldwin	34,562	32,591
Township of Billings (and part of Allan)	36,436	34,358
Township of Gordon (and part of Allan)	31,994	30,170
Township of Nairn & Hyman	28,316	26,701
Township of Tehkummah	26,234	24,738
Municipality of Killarney	25,332	23,886
Township of Burpee	17,003	16,034
Township of Cockburn Island	347	327
	$ 11,186,768	$ 10,548,731

8. Administration expenses:

	2025 Budget	2025 Actual	2024 Actual
Professional fees	$ 1,279,840	$ 934,977	$ 983,441
Building maintenance	756,768	606,981	628,249
Advertising	112,500	45,382	76,077
Telephone	74,878	75,510	202,777
Rent	482,881	482,514	421,000
Utilities	198,705	206,918	176,320
Liability insurance	147,768	108,926	200,694
Staff education	155,201	192,532	113,453
Postage	90,100	69,313	86,022
Memberships and subscriptions	58,795	52,899	52,992
Strategic Planning	–	1,493	563
	$ 3,357,436	$ 2,777,445	$ 2,941,588

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9. Revenues and expenses by funding sources:

	OLHA	UIIP	Men C	HPV	Unorganized Territories	Ontario Sr. Dental Care Program	MOH/ AMOH	MCCSS: HBHC & PPNP	HIV-Aids Anonymous Testing	Non-Ministry	Sub-Total
Revenue:											
Provincial grants											
Operation	$ 18,723,802	-	-	-	-	1,098,134	270,282	1,762,537	66,255	-	$ 21,921,010
Unorganized territories	-	-	-	-	1,092,500	-	-	-	-	-	1,092,500
Municipalities	11,186,768	-	-	-	-	-	-	-	-	-	11,186,768
Plumbing and inspections	417,782	-	-	-	-	-	-	-	-	-	417,782
Interest	358,315	-	-	-	-	-	-	-	-	85,368	443,683
Other	193,444	2,415	17,620	24,922	-	4,294	-	-	-	108,484	351,179
	30,880,111	2,415	17,620	24,922	1,092,500	1,102,428	270,282	1,762,537	66,255	193,852	35,412,922
Expenses:											
Salaries and wages	18,371,475	1,980	14,443	20,428	698,524	371,681	270,282	1,309,224	53,565	65,673	21,177,275
Benefits	6,309,797	435	3,177	4,494	222,421	97,587	-	418,861	12,690	13,467	7,082,929
Transportation	145,444	-	-	-	87,425	778	-	23,218	-	-	256,865
Administration (note 9)	2,285,585	-	-	-	704	447,523	-	7,531	-	147	2,741,490
Supplies and materials	567,546	-	-	-	83,426	123,395	-	3,703	-	29,197	807,267
Small operational equipment	1,504,563	-	-	-	-	3,678	-	-	-	-	1,508,241
Amortization of tangible capital assets	1,072,422	-	-	-	-	-	-	-	-	-	1,072,422
	30,256,832	2,415	17,620	24,922	1,092,500	1,044,642	270,282	1,762,537	66,255	108,484	34,646,489
Annual surplus	623,279	-	-	-	-	57,786	-	-	-	85,368	766,433
Capital expenditures	866,525	-	-	-	-	57,786	-	-	-	-	924,311
Annual surplus, net of capital expenditures	$ (243,246)	-	-	-	-	-	-	-	-	85,368	$ (157,878)

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9. Revenues and expenses by funding sources (continued):

		2024-25 One-time Funding							2025-2026 One-time Funding						
	Sub-Total	Infection Prevention and Control Hub	COVID-19 Extraordinary Vaccine	PHI Practicuum	MOH - ISPA Vaccination Clinic Catch-up	Merger Planning	RSV	Vaccine Refrigerator	Infection Prevention and Control Hub	RSV	COVID-19 Extraordinary Vaccine	Vaccine Refrigerator	PHI Practicuum	Capital	Total
Revenue:															
Provincial grants															
Operation	$ 21,921,010	287,125	150,986	5,744	-	-	40,728	-	644,487	55,861	243,698	23,400	13,650	374,775	$ 23,761,464
Unorganized territories	1,092,500	-	-	-	-	-	-	-	-			-	-	-	1,092,500
Municipalities	11,186,768	-	-	-	-	-	-	-	-			-	-	-	11,186,768
Plumbing and inspections	417,782	-	-	-	-	-	-	-	-			-	-	-	417,782
Interest	443,683	-	-	-	-	-	-	-	-			-	-	-	443,683
Other	351,179	-	-	-	-	-	-	-	-			-	-	-	351,179
	35,412,922	287,125	150,986	5,744	-	-	40,728	-	644,487	55,861	243,698	23,400	13,650	374,775	37,253,376
Expenses:															
Salaries and wages	21,177,275	199,194	113,203	4,960	-	-	30,456	-	517,445	19,159	171,147	-	11,941	-	22,244,780
Benefits	7,082,929	44,931	36,583	537	-	-	10,272	-	105,452	7,194	54,927	-	1,282	-	7,344,107
Transportation	256,865	1,150	-	247	-	-	-	-	1,739			-	427	-	260,428
Administration (note 9)	2,741,490	22,772	600	-	-	-	-	-	12,558		25	-	-	-	2,777,445
Supplies and materials	807,267	-	600	-	-	-	-	-	7,293	1,680		-	-	-	816,840
Small operational equipment	1,508,241	19,078	-	-	-	-	-	-	-			-	-	-	1,527,319
Amortization of tangible capital assets	1,072,422	-	-	-	-	-	-	-	-			-	-	-	1,072,422
	34,646,489	287,125	150,986	5,744	-	-	40,728	-	644,487	28,033	226,099	-	13,650	-	36,043,341
															-
Annual surplus	766,433	-	-	-	-	-	-	-	-	27,828	17,599	23,400	-	374,775	1,210,035
Capital expenditures	924,311	-	-	-	-	-	-	-	-	27,828	17,599	23,400	-	374,775	1,367,913
Annual surplus, net of capital expeditures	$ (157,878)	-	-	-	-	-	-	-	-	-	-	-	-	-	$ (157,878)

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10. Budget information:

The Budget adopted by the Board of Directors on November 21, 2024, was not prepared on a basis consistent with that used to report actual results (Public Sector Accounting Standards). The budget did not include amortization of tangible capital assets. As a result, the budget figures presented in the statement of operations and accumulated surplus represent the Budget adopted by the Board of Directors on November 21, 2024 including subsequent budget amendments, with adjustments as follows:

Budget surplus for the year	$	–
Less: amortization		1,111,478
Budget deficit per statement of operations and accumulated surplus	$	(1,111,478)

11. Comparative information:

Certain comparative information have been reclassified to conform with the presentation adopted in the current year.

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Public Health
Santé publique
SUDBURY & DISTRICTS

Questions and Responses at Finance Standing Committee – 2025 Annual Financial Statements

Prepared for Board of Health – June 18, 2026

1. Why were salaries over budget in 2025? Will this have implications for future years' expenditures?

Response:
Three factors played a role in salary expenditures being higher than budgeted:

1. Due to underspending on some budget lines, temporary staff were hired in 2025 to move projects forward strategic projects at an accelerated pace.
2. We successfully applied for and received over $2 million in one-time funding which was not budgeted since receipt of these funds was not known at the time of the budget's approval. Some of this unexpected additional revenue was used to pay for staffing.
3. Public Health Sudbury & Districts implemented a non-union wage increase in 2025 that was not originally included in the approved budget. Given the organization's surplus position, the increase was made effective October 1, 2025, subsequent to the Board's endorsement of the increase in September 2025, and approval of the increase on a permanent basis on November 2025 as part of the 2026 operating budget approval.

The first of these two reasons has no implications on salary and benefits in future budgets. The third factor has been incorporated sustainability into the 2026 operating budget and will continue in future years.

2. Does the organization foresee future deficits given funding constraints?

Response:
No. Public Health is underfunded in general, however Boards of Health are not legally permitted to run a deficit per the *Health Protection and Promotion Act*. Municipalities would be obligated to pay for any shortfalls, and this is not a position that the organization wants to put municipalities in. Should funding be inadequate, services will need to be reduced to stay out of planned deficit position. However, the goal is to mitigate this (1) in the near term, by realizing efficiencies with our medium

term investments in technology and maintain services despite reduced staffing, and (2) by strengthen the case to the province for funding be reorienting to be outcome-focused, particularly by developing measures of the impact of our work on health, the economy, and the province's finances to show a large return on provincial funding of public health.

3. What explains the reduction in cash balance to $11.3 million?

Response:
Between 2020 and 2024, the Province provided excess funding totaling $4.1 million that was owed back to them. However, they only sought recovery of these funds in 2025.

The repayment of these funds reduced both:

- the Payable to Province balance to $0, and
- the organization's cash balance, as these funds were returned to the Province.

As a result, the cash balance remained unchanged with equivalent reductions in both cash on hand and on cash liabilities.

4. What is the agency's line of credit for? Has it been used? And does it cost anything?

Response:
The agency has access to an operating line of credit in the amount of $500,000, that is not currently used. Its purpose is in case of an emergency as an additional source of cash. Given the healthy cash balance currently, it is not needed and is not expected to be used outside of truly extraordinary circumstances. There is no cost to the agency when the line of credit is not used.

5. What explains the Corporate Services variance in the April 2026 financial statements?

Response:
The variance in Corporate Services reflected in the April 2026 financial statements is primarily attributable to how vacancy-related savings are budgeted and recorded.

- The vacancy rate is budgeted centrally within Corporate Services for ease of tracking, while
- The actual salary and benefit expenditures (including gapped positions) are recorded within the respective departmental budgets.

Additionally, the Corporate Services budget includes several expenditures related to the Reserve budget, which further contributes to the observed variance.

ADOPTION OF THE 2025 AUDITED FINANCIAL STATEMENTS

MOTION:

WHEREAS the Board of Health Finance Standing Committee recommends that the Board of Health for the Sudbury and District Health Unit adopt the 2025 audited financial statements, as reviewed by the Finance Standing Committee at its meeting of June 10, 2026;

THEREFORE BE IT RESOLVED THAT the 2025 audited financial statements be approved as distributed.

ADDENDUM

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

IN CAMERA

MOTION: THAT this Board of Health goes in camera to deal with personal matters about an identifiable individual, including … local board employees, and to deal with labour relations. Time:____

RISE AND REPORT

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

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