Algoma
PUBLIC HEALTH
Santé publique Algoma

September 23, 2026

BOARD OF HEALTH MEETING

SSM Algoma Community Room

294 Willow Avenue

Sault Ste. Marie

www.algomapublichealth.com

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APH Land Acknowledgement

The land on which we are gathered is in the traditional territories of the Anishinabek (Aw-nish-naw-bek), Ililiwak (I-lil-i-wuk) [Cree], and Wiisaakoodewiwiniwok (We-saw-coe-day-win-in-i-wuk) [Métis Nation].

Algoma Public Health delivers services and programs within some of the Robinson-Huron Treaty, Robinson-Superior Treaty, and Treaty 9 territories, specifically within the traditional territories of the Michipicoten, Missanabie-Cree, Batchewana, Garden River, Thessalon, Mississauga, Serpent River, and Sagamok First Nations.

Algoma Public Health also delivers services and programs within the traditional territory of the Huron-Superior Regional Métis Community, represented by the Historic Sault Ste. Marie Métis Council and the North Channel Métis Council as part of the Métis Nation of Ontario.

We say miigwech (me-gwech) to thank Indigenous Peoples for continuing to take care of this land from time immemorial. We are all called to treat this sacred land, its plants, animals, stories and its Peoples with honour and respect. We commit to the shared goal of Truth and Reconciliation

Board of Health Meeting
AGENDA

Wednesday, September 23, 2026 - 5:00 pm
SSM Algoma Community Room | Videoconference

	BOARD MEMBERS	APH MEMBERS
PRESENT:	Sally Hagman Donald McConnell - 2nd Vice-Chair Luc Morrissette Beverly Nantel Sonny Spina Sonia Tassone Suzanne Trivers - Board Chair Jody Wildman - 1st Vice-Chair Natalie Zagordo	Dr. Jennifer Loo - Medical Officer of Health & CEO Dr. John Tuinema - Associate Medical Officer of Health & Director of Health Protection Dr. Lyall Pacey – Resident Physician Kristy Harper - Director of Health Promotion & Chief Nursing Leslie Dunseath - Acting Director of Corporate Services & Manager of Accounting Services Trina Mount - Executive Assistant
REGRETS:		

1.0 Meeting Called to Order *S. Trivers*
- **a. Land Acknowledgment**
- **b. Roll Call**
- **c. Declaration of Conflict of Interest**

2.0 Adoption of Agenda *S. Trivers*

RESOLUTION

THAT the Board of Health agenda dated September 23, 2026, be approved as presented.

3.0 Adoption of Minutes of Previous Meeting *S. Trivers*

RESOLUTION

THAT the Board of Health meeting minutes dated June 24, 2026, be approved as presented.

4.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Reports *Dr. Loo*

MOH Report - September 2026

RESOLUTION

THAT the report of the Medical Officer of Health and CEO for September 2026, be accepted as presented.

b. Finance and Audit

i. Finance and Audit Committee Chair Report *J. Wildman*

RESOLUTION

THAT the September 16, 2026, report of the Finance and Audit Committee Chair be accepted as presented.

ii. Policy 02-05-065 - Algoma Board of Health Reserve Fund *J. Wildman*

RESOLUTION

THAT the Board of Health approves the revised, Policy 02-05-065 - Algoma Board of Health Reserve Fund, as presented.

iii. Briefing Note: Options for 2025 Public Health Cost-Shared Surplus *J. Wildman*

RESOLUTION

THAT the Board of Health accepts the recommendation of the Finance and Audit Committee to approve allocation of the 2025 Public Health Cost-Shared Surplus to reserve funds in accordance with Board policy.

iv Unaudited Financial Statements ending July 31, 2026. *J. Wildman*

RESOLUTION

THAT the Board of Health accepts the Unaudited Financial Statements for the period ending July 31, 2026, as presented.

c. Governance *D. McConnell*

i. Governance Committee Chair Report

RESOLUTION

THAT the September 15, 2026, report of the Governance Committee Chair be accepted as presented.

ii. **Briefing Note: Applying an Indigenous Health Equity Lens to the BOH Skills Matrix** *D. McConnell*

RESOLUTION

THAT the Board of Health accepts the recommendation of the Governance Committee to approve the briefing note and the resulting revisions following the application of an Indigenous health equity lens to the BOH Skills Matrix (Appendix A), as presented.

iii. Policy 02-05-001 - Composition and Accountability of the Board of Directors *D. McConnell*

RESOLUTION

THAT the Board of Health approves the revised, Policy 02-05-001 - Composition and Accountability of the Board of Directors, as presented.

vi. Policy 02-05-002 - Procurement *D. McConnell*

RESOLUTION

THAT the Board of Health approves the revised Policy 02-05-002 - Procurement, as presented.

v. Briefing Note: Temporary delegation of Board of Health authority during the 2026 municipal election transition *D. McConnell*

RESOLUTION

THAT the Board of Health accepts the above-noted briefing note recommended by the Governance Committee as presented and proceed with the recommended actions within.

vi. Policy 02-05-020 - Travel Policy *D. McConnell*

RESOLUTION

THAT the Board of Health approves the revised, Policy 02-05-020 - Travel, as presented.

vii. Policy 02-05-035 - Continuing Education for Board Members *D. McConnell*

RESOLUTION

THAT the Board of Health approves, Policy 02-05-035 - Continuing Education for Board Members as presented.

viii. Policy 02-05-055 - Board of Health Self-Evaluation *D. McConnell*

RESOLUTION

THAT the Board of Health approves the revised, Policy 02-05-055 - Board of Health Self-Evaluation as presented.

ix. Policy 02-05-060 - Meetings and Access to Information *D. McConnell*

RESOLUTION

THAT the Board of Health approves the revised, Policy 02-05-060 - Meetings and Access to Information as presented.

x. Bylaw 06-02 - Ontario Building Code Appointments *D. McConnell*

RESOLUTION

THAT the Board of Health approves the revised, Bylaw 06-02 - Ontario Building Code Appointments as presented.

xi. Bylaw 95-1 - To Regulate the Proceedings of the Board *D. McConnell*

RESOLUTION

THAT the Board of Health approves the revised, Bylaw 95-1 - To Regulate the Proceedings of the Board as presented.

5.0 Correspondence - for action *S. Trivers*

a. Letter from MPP Robin Lennox, regarding Bill 121, Save a Life Act (Naloxone Kit Registration and Public Access), 2026, dated July 23, 2026 with Bill 121 attachment

b. Briefing Note: Endorsement of Bill 121 - Save a Life Act *S. Trivers*

RESOLUTION

c. Letter from Thunder Bay District Health Unit, regarding Improving Highway Safety in Northern Ontario, dated July 20, 2026 *S. Trivers*

d. Briefing Note: Improvement to Safety on Algoma Highways *S. Trivers*

RESOLUTION

6.0 Correspondence - for information

a. Letter from Lakelands Public Health, regarding Healthy Smiles Ontario Schedule of Dental Services and Fees, dated July 16, 2026

b. Email from alPHa, regarding Governance Continuity & Fiduciary Obligations During Municipal Election Transition, dated July 27, 2026

b. Email from alPHa, regarding Provincial Funding for Local Public Health Agencies, dated August 20, 2026

d. Email from alPHa, regarding 2026 Ontario Municipal Elections Resources, dated September 8, 2026

e. Letter from Lakelands Public Health, regarding Endorsement of Bill 121, Save a Life Act (Naloxone Kit Registration and Public Access), 2026, dated September 17, 2026

7.0 Addendum *S. Trivers*

8.0 In-Camera *S. Trivers*

For discussion of labour relations and employee negotiations, matters about identifiable individuals, adoption of in camera minutes, security of the property of the board, litigation or potential litigation, information supplied in confidence to the Board of Health by the Province / Ministry of Health.

RESOLUTION

THAT the Board of Health go in-camera.

9.0 Open Meeting *S. Trivers*

Resolutions resulting from in-camera meeting.

RESOLUTION

10.0 Announcements / Next Committee Meetings: *S. Trivers*

National Day for Truth and Reconciliation
Wednesday, **September 30, 2026** - 2:00-3:30 pm

Finance and Audit Committee Meeting
Wednesday, **October 14, 2026** @ 5:00 pm
SSM Algoma Community Room | Video Conference

Board of Health Meeting
Wednesday, **October 21, 2026** @ 5:00 pm
SSM Algoma Community Room | Video Conference

11.0 Adjournment *S. Trivers*

RESOLUTION

THAT the Board of Health meeting adjourns.

Algoma
PUBLIC HEALTH
Santé publique Algoma

September 23, 2026

Report of the

Medical Officer of Health / CEO

Prepared by:
Dr. Jennifer Loo and the
Leadership Team

Presented to:
Algoma Public Health Board of Health

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APH AT-A-GLANCE

From Strategy to Stories

Since the Board approved our Strategic Plan in June, the focus has shifted from planning to action.

The first step was helping leaders and teams see themselves in the plan. In June, APH's leadership team spent two days exploring the pillars, goals, and strategic actions that will guide our work over the next three to five years. They identified where their current work already supports the plan, where new efforts will be needed, and what resources teams will require to succeed. Building on that work, the Foundations and Strategic Support Team (FASST) met with teams across the organization to answer an important question: What will it take for us to bring this plan to life? Teams shared what strengths they can build on, where they see opportunities to contribute, and what support they will need along the way. Those conversations are revealing quick wins and priorities for our first year of implementation.

Just as importantly, employees told us how they want to stay connected to the journey. As a result, we are planning an organization-wide launch event and establishing a regular rhythm of updates, celebration of milestones, cross-team learning, and reflection so that people can see progress and learn from one another as the work unfolds. The launch event will also mark the introduction of our refreshed APH brand. More than a visual update, the brand refresh is intended to support clearer, more accessible and more consistent communication across APH's work, while aligning the organization's visual identity with its renewed strategic direction.

With the implementation roadmap taking shape, our next step is to define how we will measure progress. FASST has begun developing strategic plan indicators and will engage teams across APH to ensure the measures reflect the work happening throughout the organization. What stands out most from this phase of the journey is the energy people are bringing to it. Across APH, teams are identifying opportunities, sharing ideas, and looking for ways to contribute. We have a strong foundation to build from and are growing momentum as we work toward health for all, together.

Connecting with Communities on Upstream Prevention

Planet Youth Algoma implementation continued to advance over the summer, with several key milestones achieved and ongoing engagement with community partners across the district. A key milestone was reached with the signing of a five-year agreement with Planet Youth, providing APH with access to the training, tools, technical expertise, and ongoing support to implement the Planet Youth model in Algoma. The inaugural meeting of the Planet Youth Algoma Central Steering Committee was held on August 31, bringing together representatives from key sectors to provide strategic guidance and support coordinated implementation across the district.

Engagement with school boards and secondary schools continues in preparation for survey administration later this fall. To support continued engagement, APH and community partners

have begun establishing five Local Action Teams with representation across the district. These teams will serve as local coalitions for community-level planning and action based on evidence, data, and local needs. Their role will be to engage community partners, identify local priorities, and guide the implementation of strategies to improve youth well-being. Additional outreach with municipalities, Indigenous partners, youth, and community organizations continues to strengthen local partnership networks and build the foundation for long-term, community-led prevention efforts across Algoma.

Towards Truth and Reconciliation – from Frontline to Governance

September 30 is the National Day for Truth and Reconciliation. On this day, and every day, Algoma Public Health stands in solidarity with First Nations, Inuit, and Métis Peoples. We honour Residential School Survivors, their families, as well as the children who never returned home. We recognize that the impacts of colonial policies and practices continue to be felt today, and that Truth & Reconciliation requires ongoing listening, learning, reflection, and action.This September 30, with guidance from Indigenous Knowledge Carriers, APH will launch our Truth & Reconciliation Strategy.

Our Strategy reflects our commitment to becoming a culturally safer, trauma-informed, anti-racist, and culturally humble public health organization that honours Indigenous rights, knowledge systems, cultures, languages, leadership, and ways of being. Through three interconnected Truth & Reconciliation directions, *Hearts and Minds, Spaces and Places,* and *Connecting and Collaborating,* our Strategy builds on ongoing efforts and helps guide future action to strengthen organizational capacity, enhance public health environments, and build meaningful relationships and partnerships that contribute to Indigenous health and well-being in Algoma, now and for the next seven generations. We will continue to build and strengthen relationships with local Indigenous health partners and Knowledge and Language Carriers. Recent examples of actions include formalizing Indigenous Cultural Safety learning requirements within employee onboarding through our **Hearts and Minds** direction, and bringing forward a proposed expansion of the Board of Health Skills Matrix through our **Connecting and Collaborating** direction to incorporate equity considerations, including Indigenous representation and perspectives at the governance level.

Algoma Board of Health Reserve Fund

REFERENCE #: 00-05-065

APPROVED BY: Board of Health

SECTION: Policies

DATE: Original: Jun 17, 2015
~~Revised: Jun 24, 2017~~
~~Reviewed: Apr 24, 2019~~
Reviewed: Mar 27, 2024
Revised: tbd

PURPOSE:

To provide guidance on the establishment, maintenance, and use of a reserve fund. The reserve fund serves as a financial safeguard to ensure continuity of operations during periods of unexpected financial hardship, revenue shortfalls, emergencies, or other unforeseen circumstances. This policy also establishes a target and maximum reserve contribution limit to ensure that excess funds are appropriately directed toward Algoma Public Health's (APH) mission and strategic objectives.

SCOPE:

This policy applies to all unrestricted operating surpluses and cash reserves held by APH.

Donations, grants, and funds designated for specific purposes by donors or external parties are excluded from this policy unless otherwise approved by the Board ~~of Directors~~.

POLICY & BACKGROUD:

The Board of Health for the Algoma Public Health has established reserves as follows:

~~BACKGROUND:~~

The Health Protection and Promotion Act (the "Act") requires, in section 72(1), that the expenses incurred by or on behalf of a Board of Health and the Medical Officer of Health/Chief Executive Officer (MOH/CEO) in the performance of their functions and duties under the Act or any other act shall be borne and paid by the Municipalities in the health unit served by the Board of Health.

Section 72(5) (1) of the Act requires the Board of Health to cause the preparation of an annual estimate of expenses for the next year. Such estimate of expenses may from time to time be too high or too low, resulting in an excess or a shortfall respectively of funds paid by the Municipalities.

The Board of Health considers it prudent and expedient to establish reserve funds, which include reserves, into which, inter alia, any excess funds received in any year be paid to be applied to cover any shortfall of funds in future years.

Section 417(1) of the Municipal Act empowers the Board of Health in each year to provide in its estimate of expenses for the establishment or maintenance of a reserve fund for any purpose for which it has authority to expend funds.

Section 417(2) of the Municipal Act only requires the approval of the Councils of the majority of the Municipalities in a health unit for the establishment and maintenance of a reserve fund if the Board of Health is required to obtain such approval for capital expenditures.

Section 52(4) of the Act only requires the Board of Health to seek the approval of the Councils of the majority of Municipalities in a health unit for capital expenditures made to acquire and hold real property.

To obviate the need to seek the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit to establish and maintain a reserve fund, the reserve fund will contain a restriction that the funds therein shall not be used for capital expenditures to acquire real property without first obtaining the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit as required by section 52(4) of the Act.

PROCEDURE:

1. The Board of Health forthwith establish and maintain a reserve funds for ~~W~~working ~~C~~capital, ~~L~~land ~~C~~control, ~~H~~human ~~R~~resources ~~M~~management, ~~P~~public ~~H~~health ~~i~~initiatives and ~~R~~response, ~~C~~corporate ~~C~~contingencies, and ~~F~~facility and ~~E~~equipment ~~R~~repairs and ~~M~~maintenance; and,
2. The reserve funds shall be used and applied only to pay for expenses incurred by or on behalf of the Board of Health and the Medical Officer of Health in the performance of their functions and duties under the Health Protection and Promotion Act or any other Act; and,
3. None of the reserve funds shall be used or applied for capital expenditures to acquire and hold real property unless the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit have been first obtained pursuant to section 52(4) of the Act; and,
4. The Board of Health in each year may provide in its budget estimates for a reasonable amount to be paid into the reserve funds provided that no amount shall be included in the estimates which are to be paid into the reserve funds when the cumulative balance of ~~all~~ the reserve funds in the given year exceeds 15 percent of the regular operating revenues for the Board of Health approved budget for the mandatory cost-shared programs and services; and,

~~5. All lease revenues received by the Board of Health under leases of part of its premises, in excess of the actual operating costs attributable to the leased premises, shall be paid annually into the reserve funds; and,~~

5. Any over-expenditures in any year shall be paid firstly from the reserve funds, and only when the reserve funds shall have been exhausted will the Board of Health seek additional funds from the Municipalities to pay for such over-expenditures; and
6. The reserve fund shall not be used to fund recurring operating deficits without a documented recovery plan approved by the Board; and,
7. Any excess revenues in any year resulting from an overestimate of expenses shall be paid into the reserve funds; and,
8. The MOH/CEO shall, with Board approval, in each year, direct the allocation of excess funds to ~~such~~ the reserve fund ~~or funds as the MOH/CEO shall decide~~; and,

   ~~The MOH/CEO shall be entitled to transfer funds from one reserve fund to another reserve fund at any time and from time to time.~~

9. The approval of the Board of Health shall be required for any transfers from the Board's reserve that constitute part of the annual budget approval process or that are in excess of $100,000 per transaction.
10. The MOH/CEO shall be responsible for the management of the reserve in accordance with respective Board of Health motions and By-law 15-01 To Provide for the Management of Property.

RESERVE FUND TARGET AND MAXIMUM FUND LIMIT:

APH shall strive to achieve and maintain a reserve fund equal to a minimum of three (3) months and a maximum of six (6) months of the Board approved operating budget for cost-shared mandatory public health programming.

Once the reserve fund reaches this maximum level:

- No additional unrestricted operating surpluses shall be automatically transferred to the reserve fund.
- Excess surpluses may be allocated by Board approval toward items such as strategic initiatives, capital expenditures, program expansion, debt reduction, special projects aligned with APH's mission or other Board designated reserve.

The Board may approve a temporary increase above the maximum limit where a specific future obligation, capital project, or identified financial risk justifies a higher level of reserve funds.

INVESTMENT AND CUSTODY:

Reserve fund assets shall be held in secure and liquid financial instruments, separate from APH's day-to-day operating funds. Preservation of capital and liquidity shall be prioritized over investment return.

~~The MOH/CEO shall be responsible for the management of the reserves in accordance with respective Board of Health motions and By-law 15-01 To Provide for the Management of Property.~~

~~The approval of the Board of Health shall be required for any transfers from the Board's reserves that constitute part of the annual budget approval process or that are in excess of $50,000 per transaction.~~

Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

To: Board of Health

From: Leslie Dunseath – Manager of Accounting Services and Acting Director of Corporate Services

Date: September 23, 2026

Re: Options for 2025 Public Health Cost-Shared Surplus

☐ For Information ☐ for Discussion ☒ for a Decision

KEY MESSAGES:

- A $199,229 municipal surplus from 2025 mandatory cost-shared programs is currently being held in APH's operating account.
- Based on the review of current interest rates, management recommends contributing the 2025 municipal surplus dollars to the APH reserve fund.

ISSUE & BACKGROUND:

The 2025 audited financial statements and settlement to the province are complete. Algoma Public Health (APH) reported a municipal surplus in mandatory cost-shared programs in the amount of $199,229 in 2025. Currently the surplus dollars are being held in APH's operating account.

APH's Board of Health established a Reserve Fund Policy in June of 2015. The purpose of the establishment of a reserve fund is to be better prepared to:

- meet any unexpected costs that may arise in the future;
- help offset one-time and/or capital expenditures;
- help offset any revenue shortfalls;
- mitigate against fluctuations in funding;
- help manage cash flows and;
- avoid application of additional levies to municipalities in the event of any cash shortfalls.

APH's current reserve fund policy states that "any excess revenues in any year resulting from an overestimate of expenses shall be paid into the reserve funds." Furthermore, we note that alongside this briefing note, the APH team is also providing recommended edits to the current reserve policy that establishes target and maximum thresholds for the reserve fund.

Historically, APH has contributed to the reserve fund based on recommendations by the Board. APH has not needed to use any of the reserve fund since the development of the policy in June 2015. As of July 31, 2026, the balance of the reserve fund is $2,361,003,

which represents between one and a half and two months of operations of cost-shared mandatory public health programming based on the 2026 Board approved budget (vs. the target of a minimum of three months per recommended revised reserve fund policy provided alongside this briefing note).

APH's lowest daily liquidity position in the operating account within the past six months was $1.4M. Details regarding current interest rates are as follows (as of July 31, 2026, subject to change):

- Reserve Fund – Royal Bank of Canada Premium Investment Account currently earning interest at 2.50% on balances between $1.0M - $5.0M.
- Business Account - currently earning interest on balances over $1.0M at the Royal Bank Prime Rate less 2.00% - or currently 2.45%

OPTIONS FOR CONSIDERATION:

Option 1: Contribute 100% of municipal surplus dollars to the reserve fund

Consistent with the Board of Health's risk management strategy over the past number of years and contributes toward achieving target reserve fund balance per recommended changes to the reserve policy.

Option 2: Apply a lump sum payment to outstanding term debt

APH's current loan agreement with TD Bank allows for pre-payment up to 10% of the loan's original value, in any given year, without penalty. This option would contribute to a faster payback of APH's term debt and, based on current rates, would save APH approximately $20K in interest over the 5-year term; however, APH would forfeit approximately $26K in interest earned within the reserve account.

RECOMMENDED ACTION:

Management recommends option #1 – to contribute the 2025 municipal surplus dollars to the reserve fund to support continued growth of the financial strength and reliability of the organization given ongoing funding concerns, capital projects and budget constraints.

CONTACT:

Leslie Dunseath, Manager of Accounting Services and Acting Director of Corporate Services

Algoma Public Health

Statement of Operations

July 2026

(Unaudited)

Public Health Programs (Calendar)

Description	Current YTD	Current YTD Budget	YTD Budget Variance	Annual Budget	Variance % Act to Bud	Variance YTD Act to Bud
Public Health Funding, Total	7,533,555	7,399,438	-134,117	12,642,892	2%	102%
Other Funding, Total	0	0	0	0		
Levies, Total	3,956,881	3,956,880	-1	5,275,840	0%	100%
Fees & Recoveries, Total	268,722	326,491	57,770	549,410	-18%	82%
Other Revenue, Total	39,380	0	-39,380	0		
TOTAL REVENUE	**11,798,537**	**11,682,809**	**-115,728**	**18,468,142**	1%	101%
Salaries & Wages, Total	6,332,554	6,630,152	297,597	11,360,155	-4%	96%
Benefits, Total	1,768,322	1,853,444	85,122	2,978,820	-5%	95%
Office Expenses, Total	21,530	29,167	7,637	50,000	-26%	74%
Program Expenses, Total	802,999	621,327	-181,672	1,052,002	29%	129%
Professional Development, Total	49,296	42,603	-6,693	73,033	16%	116%
Travel Expenses, Total	99,588	91,423	-8,165	156,726	9%	109%
Fees & Insurance, Total	208,992	225,264	16,272	353,310	-7%	93%
Telecommunications, Total	147,273	140,982	-6,291	241,684	4%	104%
Program Promotion, Total	19,895	10,908	-8,986	18,700	82%	182%
Debt Management & Amortization, Total	266,829	266,829	0	467,000	0%	100%
Computer/IT Services, Total	455,128	464,243	9,115	795,846	-2%	98%
Facilities Expenses, Total	861,662	537,172	-324,491	920,866	60%	160%
TOTAL EXPENSES	**11,034,069**	**10,913,514**	**-120,555**	**18,468,142**	1%	101%
SURPLUS/DEFICIT	**764,468**	**769,296**	**4,827**	**0**		

Healthy Babies Healthy Children (Fiscal)

Description	Current YTD	Current YTD Budget	YTD Budget Variance	Annual Budget		
TOTAL REVENUE (MCCSS)	380,254	386,472	6,218	1,163,565	-2%	98%
TOTAL EXPENSES	375,019	390,022	15,003	1,163,565	-4%	96%
SURPLUS/DEFICIT	5,235	-3,550	-8,785	0		

Fiscal Programs (Non-Public Health)

Description	Current YTD	Current YTD Budget	YTD Budget Variance	Annual Budget		
PROVINCIAL GRANTS	80,584	80,584		166,754	0%	100%
OTHER FUNDING	38,723	38,724	1	177,447	0%	100%
TOTAL REVENUE	**119,307**	**119,308**	**1**	**344,201**	0%	100%
CAPC	24,505	25,816	1,310	77,447	-5%	95%
Nurse Practitioner	57,421	55,585	-1,836	166,754	3%	103%
Stay on Your Feet	40,790	33,333	-7,457	100,000	22%	122%
TOTAL EXPENSES	**122,716**	**114,734**	**-7,983**	**344,201**	7%	107%
SURPLUS/DEFICIT	**-3,409**	**4,574**	**7,984**	**0**		

Fiscal Programs (Public Health)

PROVINCIAL GRANTS	210,762	210,750	-12	632,250	0%	100%
TOTAL EXPENSES	223,510	212,635	-10,875	632,250	5%	105%
SURPLUS/DEFICIT	-12,748	-1,885	10,863	0		

NOTE: Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months and variances of 10% and $10,000 occurring in the final 6 months.

Algoma Public Health

Statement of Revenue

July 2026

(Unaudited)

Description	Current YTD	Current YTD Budget	YTD Budget Variance	Annual Budget	Variance % Act to Bud	Variance YTD Act to Bud
MOH Program Funding - Public Health	5,962,795	5,962,720	-75	10,221,806	0%	100%
MOH Program Funding - 100%	1,368,342	1,378,116	9,774	2,362,484	-1%	99%
MOH Program Funding - One Time	202,418	58,602	-143,816	58,602	245%	345%
Public Health Funding, Total	**7,533,555**	**7,399,438**	**-134,117**	**12,642,892**	2%	102%
Levies - Sault Ste. Marie	2,752,063	2,752,063	0	3,669,417	0%	100%
Levies - District	1,204,817	1,204,817	0	1,606,423	0%	100%
Levies, Total	**3,956,880**	**3,956,880**	**0**	**5,275,840**	0%	100%
Program Fees	24,095	20,416	-3,679	35,000	18%	118%
Land Control Fees	108,645	137,000	28,355	210,000	-21%	79%
Immunization Recoveries	32,030	61,667	29,637	126,000	-48%	52%
Recoveries from Programs	37,835	24,864	-12,971	36,910	52%	152%
Interest Revenue	66,118	82,544	16,426	141,500	-20%	80%
Other Revenue	39,380	0	-39,380	0	#DIV/0!	#DIV/0!
Fees & Recoveries, Total	**308,103**	**326,491**	**18,388**	**549,410**	-6%	94%
TOTAL REVENUE	**11,798,538**	**11,682,809**	**-115,729**	**18,468,142**	1%	101%

Variance	1	-	(1)	-

Algoma Public Health

Comparative Balance Sheet

July 2026

(Unaudited)

	Current Balance	December 31, 2025
Cash and Investments, Total	4,839,006	3,655,860
Accounts Receivable, Total	835,532	663,904
Other Assets, Total	443,115	371,829
Fixed Assets, Total	16,806,250	16,806,250
TOTAL ASSETS	22,923,903	21,497,842
Accounts Payable - Province, Total	1,335,973	314,954
Accounts Payable, Total	1,249,371	1,174,880
Accrued Liabilities, Total	3,092,427	3,496,032
Long-term Liabilities, Total	2,498,653	2,498,653
Other Liabilities, Total	281,460	315,622
TOTAL LIABILITIES	8,457,885	7,800,141
TOTAL ACCUMULATED SURPLUS	14,466,019	13,697,700
TOTAL LIABILITIES AND EQUITIES	22,923,904	21,497,841

Glossary

Expense Category	Definition
Salaries & Wages	salaries and wages for management, non-union, CUPE and ONA staff (includes stand-by pay for on call rotation for those applicable)
Benefits	CPP, OMERS, EI, EHT, WSIB and Non-Statutory benefits (group health benefits and insurance)
Office Expenses	office supplies and equipment leases
Program Expenses	program materials and supplies; health & safety; purchased services inlcuding physician/dentist feees
Professional Development	professional development
Travel Expenses	mileage; food and lodging; agency owned vehicle leases; vehicle maintenance
Fees & Insurance	board expenses and honoraria; bank charges; audit fees; legal fees; subscriptions & memberships; insurance
Telecommunications	internet; phones; efax; answering services
Program Promotion	program promotion; communications & media; recruitment
Debt Management & Amortization	principal and interest payments on term debt
Computer/IT Services	computer equipment purchased; computer software; computer support services
Facilities Expenses	utilities; building repairs and maintenance; security; janitorial; rent

Notes to Financial Statements – July 2026

Reporting Period

The July 2026 financial reports include seven months of financial results for Public Health programming. All other non-funded public health programs are reporting four months of results from the operating year ending March 31, 2027.

Statement of Operations

Summary – Public Health and Non-Public Health Programs

APH has not yet received the 2026 Amending Agreement from the province identifying the approved funding allocations for public health programs. The annual budget for public health programs has been updated to reflect the Board approved budget as presented at the November 2025 Board of Health Meeting.

As of July 31, 2026, Public Health calendar programs are reporting a $5K negative variance – which is driven by a $116K positive variance in revenues and a $121K negative variance in expenditures.

Public Health Revenue

Our Public Health calendar revenues are within 1% variance to budget for 2026.

For the 2026 calendar year, the province instructed public health units to plan for base funding growth of 1%. These anticipated changes are reflected within the Board of Health approved 2026 budget and cashflow payments from the Ministry have been updated to reflect the same as of late June 2026.

Contributing to a variance in one-time Ministry funding for calendar programming, is payments related to Northern Ontario Fruit and Vegetable (NOFV) Program Expansion funding that was approved for APH for the 2025/2026 fiscal year to support scoping the program for inclusion of additional schools across the district (programming is currently only provided in elementary schools). Although discussions are ongoing, formal confirmation regarding continuation of funding for this program expansion beyond March 31, 2026 has not yet been received. Further contributing to one-time Ministry funding variance is COVID-19 Vaccine Program funding that was unbudgeted for, yet approved for the period of April 2025 through March 2026.

Other revenues reported at July 31, 2026 include two quarterly installments ($12.5K) from United Way and various municipal contributions ($9.5K) towards the Planet Youth initiative. Additionally, APH has received $17.4K in one-time donations/sponsorships to support Nurturing Algoma and district wide dental screening initiatives.

In March 2024, the Ministry confirmed that IPAC Hub funding would continue in the 2024-25 fiscal year and in the years following, with ongoing formal planning and funding meetings to continue. This funding has been provided to hubs across the province in order to enhance IPAC practices in identified congregate care settings. In November 2025, APH received confirmation of 100% committed base funding for the IPAC Hub in the amount of $632K through the 2029-2030 fiscal year (previously funded by 50% committed base and 50% one-time funding). This funding is reflected in the public health fiscal programs. APH

submitted other one-time funding requests totaling $763K alongside the 2026 Annual Service Plan, however response to these requests is not anticipated until later in the year.

Public Health Expenses

Salaries and Benefits

There is a positive variance of $383K associated with salaries and benefits based on ongoing position vacancies. Recruitment and retention strategies continue to be at the forefront of APH management priorities and workforce planning initiatives are reviewed monthly at the executive level.

Program Expenses

There is a $182K negative variance associated with program expenses which is largely driven by the first annual billing associated with the Planet Youth contract. As discussed in detail via briefing note provided at the June 2026 Board of Health meeting, this expense is to be financed via committed contributions from community partners across the district resulting in minimal overall impact to APH's cost-shared programming budget.

Facilities Expenses

There is a negative variance of $324K associated with facilities expenses due to $19K in additional snow removal that was required during Q1 of 2026, as well as $274K related to progress billings for the lighting and building automation projects approved by the Board. It is to be noted that APH has requested one-time capital funding from the Ministry related to these two projects. Should this funding be approved, these expenses will be re-aligned from cost-shared public health programs to associated capital funding. We anticipate a response to this request later in the year.

Financial Position - Balance Sheet

APH's liquidity position continues to be stable and the bank has been reconciled as of July 31, 2026. Cash includes $2.3M in reserve funds.

Long-term debt of $2.5 million is held by TD Bank @ 1.80% for a 60-month term (amortization period of 120 months) and matures on September 1, 2026. $146K of the loan relates to the financing of the Elliot Lake office renovations, which occurred in 2015 with the balance, related to the financing of the 294 Willow Avenue facility located in Sault Ste. Marie. There are no material accounts receivable collection concerns.

Governance Committee Report

September 15, 2026

Attendees:

Don McConnell

Suzanne Trivers

Regrets:

Sonia Tassone

APH Members:

Dr. Jennifer Loo – Medical Officer of Health & CEO

Kristy Harper – Director of Health Promotion & Chief Nursing Officer

Leslie Dunseath – Acting Director of Corporate Services & Manager of Accounting Services

Trina Mount – Executive Assistant

Guests:

Corina Artuso, Indigenous Engagement Facilitator

Jasmine Bryson, Manager of Effective Public Health Practice

Minutes

- The Minutes of the Governance Committee meeting of May 5, 2026, were approved.

Business Arising from Minutes

- Applying an Indigenous Health Equity Lens to the BOH Skills Matrix - The Committee agreed that applying a health equity lens should be a core skill required for all Board Members and that it would be advantageous to have at least one Board Member with an Indigenous background. It was noted that considering Indigenous representation at the governance level is part of our commitment to achieve consistency with the Truth and Reconciliation Commission Report. The committee thanked Corina and Jasmine for their excellent work in developing this briefing note.

  The Committee recommends that the Board of Health approve the briefing note concerning the application of an Indigenous Health Equity Lens to the BOH skills matrix.

New Business

- Policy 02–05–001 – Composition and Accountability of the Board of Directors – The proposed additions concerning applying a health equity lens to the Board Member skills matrix were reviewed and are recommended for Board of Health approval.

  It was also agreed to further review the BOH skills matrix for compliance with provincial and good governance guidelines. Staff were asked to help increase awareness of municipal appointment opportunities as part of APH's communications infrastructure.

- Policy 02–05–002 – Procurement Policy – Following review, the Committee agreed to increase the MOH/CAO's spending authority from $100,000 to $125,000. A number of procurement processes were deleted from the policy as these are more appropriate in an administration manual. The Committee also requested that the new Director of Corporate

Services undertake a comprehensive review of the procurement policy to ensure that it aligns with provincial guidelines and best practices.

The Governance Committee recommends that the Board of Health approve the revised procurement policy.

- Temporary Delegation of Board of Health Authority during the 2026 Municipal Election Transition – The 2026 municipal election transition will create a three-month gap during which the Board of Health will not have quorum and will not be scheduled to meet. The Governance Committee reviewed the briefing note on ensuring smooth operations during this time and agreed with the recommendations.

  The Governance Committee recommends that the Board of Health approve the proposed delegation of financial and contractual signing authority to the Medical Officer of Health from November 14, 2026 until the new Board of Health can be convened subject to the conditions and restrictions contained in the briefing note.

- Policy 02–05–020 – Travel Policy – The travel policy was reviewed and is recommended without changes for Board of Health approval.

- Policy 02–05–035 – Continuing Education for Board Members – This policy was reviewed and is recommended without changes for Board of Health approval.

- Policy 02–05–055 – Board of Health Self-Evaluation Policy – This policy was reviewed and is recommended without changes for Board of Health approval.

- Policy 02–05–060 – Meetings and Access to Information – This policy was reviewed and is recommended with minor editorial changes for Board of Health approval.

- Policy 02–05–080 – Performance Evaluation for MOH/CEO – After review, the Committee agreed that this policy does not effectively support the Board's or senior staff needs. A new policy will be developed next year based on the recently approved Strategic Plan and subsequent action plans. Accordingly, the current policy is not being brought forward to the Board for approval.

- Bylaw 06–02 – Ontario Building Code Appointments – This bylaw was reviewed and is recommended with minor changes for Board of Health approval.

- Bylaw 95–01 – To Regulate the Proceedings of the Board – This bylaw was reviewed and is recommended with minor changes to improve clarity for Board of Health approval.

- 2026-27 Risk Management Model – The Governance Committee has reviewed and recommends the Board of Health approve the 2026–27 Risk Management Model.

Next Meeting

The timing of the next governance committee meeting will be determined in early 2027 following the initial meeting of the new Board of Health.

Briefing Note

To: The Board of Health

From: Foundations and Strategic Support Team (FASST)

Date: September 23, 2026

Re: Applying an Indigenous Health Equity Lens to the BOH Skills Matrix

☐ **For Information** ☒ **For Discussion** ☒ **For a Decision**

PURPOSE

To seek Board of Health (BOH) endorsement to add equity considerations to the current BOH Skills Matrix. Appendix A contains a copy of the current BOH Skills Matrix, with the addition of the proposed equity considerations.

KEY MESSAGES

- The BOH Skills Matrix identifies core skills and specific areas of expertise desired for BOH members to support effective governance.
- Following the "Indigenous Membership and/or Representation at the Governance Level at Algoma Public Health" briefing note (May 2026), one of the opportunities for including Indigenous representation and/or membership at the APH BOH was to broaden the APH BOH Skills Matrix to include health equity considerations, as it currently does not.
- With that in mind, we ask the APH BOH to consider expanding the BOH Skills Matrix to support health equity and Indigenous membership and/or representation at the governance level.
- As the municipal election is on October 26, 2026, it is a timely opportunity to include these considerations to the BOH Skills Matrix in anticipation of new municipal appointments to the BOH.

RECOMMENDED ACTIONS

- That the APH BOH receives this briefing note for discussion and a decision.
- That the APH BOH expand the BOH Skills Matrix by:
    - Adding "Applying a Health Equity Lens" as a core skill for all BOH members.
    - Adding "Health Equity: First Nations, Métis and/or Inuit Ways of Knowing" as specific expertise for 1 or more BOH members.
    - Adding the inclusion of First Nations, Métis and/or Inuit individual(s) to "Other Representation Considerations".

CONSIDERATIONS

Context

The BOH Skills Matrix is used as part of the current BOH member self-evaluation and is included in APH communications to municipalities when APH is seeking appointments of its BOH members at the

beginning of a new municipal term. It outlines core skills required for all board members (page 1) and specific expertise required for 1 or more board members (page 2).

While the matrix identifies several important competencies, there is an opportunity to further strengthen the representation of skills, knowledge, and experiences related to health equity, which are essential to APH's commitment to advancing Truth and Reconciliation and improving health outcomes across Algoma.

Applying a Health Equity Lens

Broadly, all BOH members should possess, or actively develop, skills related to health equity, positionality, cultural humility, and ongoing self-reflection. These skills help foster inclusive governance practices and support informed decision-making that reflects the diverse needs and experiences of communities across the Algoma district. The table below outlines potential enhancements to the current skills matrix for consideration.

Table 1: Addition of the core skill "Applying a Health Equity Lens", required for all BOH members.

Core Skills		
Skills/Experience	**Description**	**Number of Directors Requiring Skill**
Applying a Health Equity Lens	• Understanding of how systemic and structural oppression (e.g. racism, sexism, colonialism, ableism, and other forms of discrimination)[1,2] create inequitable (i.e., unfair, modifiable and avoidable)[1] negative health outcomes that disadvantage equity-deserving communities and individuals. • Recognition of and respect for the distinct inherent rights of Indigenous Peoples as the original Peoples of our lands[3]. • Awareness of how your own identities, experiences, values, social position, biases, and professional role influence perspectives and decision-making. • Commitment to ongoing self-reflection, learning, and accountability to support cultural safety and advance health equity.	All

Health Equity: First Nations, Métis and/or Inuit Perspectives

Strengthening APH's commitment to the shared goal of Truth and Reconciliation includes supporting Indigenous representation and/or membership at the governance level. One of several approaches is to identify First Nations, Métis, and/or Inuit perspectives as a specific area of expertise within the Board of

Health Skills Matrix, outlined in Table 2. Indigenous representation and/or membership at the governance level will support Truth and Reconciliation, inform culturally safer decision-making, and help advance the journey to ensure Indigenous perspectives are meaningfully reflected in priorities and actions that affect communities across Algoma.

Appreciating that Truth and Reconciliation and Equity, Diversity, and Inclusion (EDI) are integral to health equity, it is important to clarify the difference between them. EDI focuses on addressing barriers and promoting inclusion for diverse populations, while Truth and Reconciliation is grounded in the distinct rights of Indigenous Peoples, including inherent rights, Treaty relationships, and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). As such, Indigenous perspectives should be recognized and represented as distinct from broader EDI considerations[3].

Table 2: Addition of specific expertise related to "Health Equity: First Nations, Métis and/or Inuit Perspectives", required for 1 or more BOH members.

Specific Expertise with the 15-member Board (one or more)		
Specific Expertise	**Description**	**Number of Directors Requiring Skill**
Health Equity: First Nations, Métis and/or Inuit Ways of Knowing	• Brings knowledge of Indigenous health, wellness, cultural safety, Truth & Reconciliation, and distinctions-based approaches to governance and decision-making.	1 or more

Other Representation Considerations

As part of APH's commitment to Truth and Reconciliation, it is important to consider Indigenous representation and/or membership at the BOH governance level, as seen in Table 3.

Given that 14.3% of the population within the Algoma region self-identifies as Indigenous, including First Nations (8.8%), Métis (5.0%), and Inuit (0.05%) individuals[5], Indigenous Peoples make up a significant portion of the communities served by APH. With that in mind, including Indigenous representation and/or membership within the BOH ensures that decision-making reflects the population APH serves.

Table 3: Addition of First Nations, Métis and/or Inuit individual(s) to the "Other Representation Considerations" for BOH members, noted within square brackets.

OTHER REPRESENTATION CONSIDERATIONS	
Other	• As much as possible, given the requirements above, the board will aspire to promote gender balance, cultural, and linguistic diversity. [In particular, as part of the BOH's commitment to Truth and Reconciliation, the board will strive to support the inclusion within its membership of First Nations, Métis and/or Inuit individual(s) who maintain meaningful, accountable, and ongoing relationships with Indigenous communities and/or organizations within Algoma.]

NEXT STEPS

As part of APH's ongoing journey towards Truth and Reconciliation, the Foundations and Strategic Support Team (FASST) will propose a cultural safety training plan that will support BOH members in applying anti-racist, trauma-informed, culturally humble practices that respond to the impacts of colonialism and systemic oppression within their local public health governance role.

OPHS STANDARDS

The Ontario Public Health Standards (OPHS) are under review, and updated standards are to be released for 2027 implementation. Drafts for the updated OPHS indicate stronger direction and more prescriptive language for health equity work, particularly for Indigenous Communities and Organizations. That said, the OPHS (2021) requirements are included below.

OPHS (2021), Health Equity Requirement 3: The board of health shall engage in multi-sectoral collaboration with municipalities and other relevant stakeholders in decreasing health inequities in accordance with the Health Equity Guideline, 2018 (or as current). Engagement with Indigenous communities and organizations, as well as with First Nation communities striving to reconcile jurisdictional issues, shall include the fostering and creation of meaningful relationships, starting with engagement through to collaborative partnerships, in accordance with the Relationship with Indigenous Communities Guideline, 2018 (or as current)[4].

OPHS (2021), Good Governance and Management Practices Domain Requirement 10: The board of health shall engage in relationships with Indigenous communities in a way that is meaningful for them[4].

STRATEGIC PILLARS

- **OUR COMMUNITY: Creating Meaningful Connection**
  - We will strengthen our trusted presence and increase our recognition across Algoma communities through relation building, community engagement, and collaborative action.
- **OUR APPROACH: Focusing on Upstream Pathways**
  - We will advance upstream approaches to population health through a health equity lens that strives to improve systemic and social conditions for better health outcomes across Algoma.

REFERENCES

[1]National Collaborating Centre for Determinants of Health. (2023). *Let's Talk: Health equity* (2nd ed.). Antigonish, NS: NCCDH, St. Francis Xavier University.

[2]National Collaborating Centre for Determinants of Health. (2024). *Let's Talk: Determinants of health*. Antigonish, NS: NCCDH, St. Francis Xavier University.

[3]Indigenous Primary Health Care Council. EDI vs. Reconciliation – We Are a Distinct Nation. Available from: https://iphcc.ca/wp-content/uploads/ninja-forms/2/IPHCC-Guiding-Document-EDI-vs-Reconciliation.pdf

[4]Ontario Ministry of Health and Long-Term Care. Ontario Public Health Standards: Requirements for Programs, Services, and Accountability. 2018.

[5]Algoma Public Health. Algoma's Community Health Profile 2024. Available from: https://www.algomapublichealth.com/media/drihnyko/aph-community-health-profile-sept-18-2024.pdf.

APPENDIX A

ALGOMA PUBLIC HEALTH

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BOARD MEMBER SKILLS MATRIX

(15 member Board – 8 Municipal Members and 7 Provincial Members)

PREAMBLE:

In addition to the legislative requirements for the composition of the Board of Health (BOH), the Board Member Skills Matrix is a tool that identifies core skills and specific areas of expertise which are desirable for a skills-based board. This tool is designed to support the APH BOH in seeking municipal and provincial appointees who would be capable of supporting the BOH's governance functions and the mission and vision of APH.

SKILL / EXPERIENCE	DESCRIPTION	NUMBER OF DIRECTORS REQUIRING SKILL
Core Skills		
Analytical and Critical Thinking	• The ability to think analytically and critically, to evaluate different options, proposals and arguments and make sound independent decisions.	All
Inter-personal Communications	• The ability to effectively communicate their ideas, positions, and perspective to their peers, as well as understand the ideas, position, and perspective of their peers and facilitate resolutions of differences in the common interest.	All
Creative and Strategic Vision/Planning	• The ability to envision and define future goals and objectives that provide improved benefits for the groups and individuals on whose behalf the organization acts. (For example, experience with strategic planning, performance measurement, business planning, etc.)	All
Understanding of the board's governance role	• Understanding of the appropriate roles, group processes, protocols and policies that form the systems of board governance, including those related to the legal (fiduciary) obligations of directors and a requirement to work in the best interests of the APH and those it serves. • Demonstrated judgment and integrity in an oversight role. • Experience serving on a board of directors or governance committee and/or senior level experience working with other strategic or policy boards preferred. • Determination to act in one's own independent deliberative judgment with confidence and persistence in order to ask appropriate, relevant and necessary questions.	All
Financial Literacy	• The ability to read and have a layman's understanding of financial statements, including budgets, income statements, balance sheets and cash flow projections.	All
Community Knowledge	• Knowledge of the community (fabric; particular needs) and more broadly knowledge of the needs of the Algoma District at large.	All

REFERENCE: 02-05-001.1

Commitment to Mandate	• Strong understanding and commitment to the organization's mandate, including an awareness and commitment to working in the best interests of APH and those it serves to protect public health.	All
Applying a Health Equity Lens	• Understanding of how systemic and structural oppression (e.g. racism, sexism, colonialism, ableism, and other forms of discrimination) create inequitable (i.e. unfair, modifiable and avoidable) negative health outcomes that disadvantage equity-deserving communities and individuals. • Recognition of and respect for the distinct inherent rights of Indigenous Peoples as the original Peoples of our lands. • Awareness of how your own identities, experiences, values, social position, biases, and professional role influence perspectives and decision-making. • Commitment to ongoing self-reflection, learning, and accountability to support cultural safety and advance health equity.	All

Specific Expertise with the 15 member Board (one or more)		
Financial	• Expertise and experience (preferably with a designation) in financial accounting and reporting and corporate finance. • Comprehensive knowledge of internal financial controls, financial operational planning and management in an organization that includes expertise in auditing, evaluating and analyzing financial statements. • Knowledge of best practices in procurement and contract management an advantage.	1 or more
Communications / Public Relations Practices	• Expertise and experience (preferably with a designation) with the planning, design, implementation and evaluation of strategic communications, and/or stakeholder relations initiatives.	1 or more
Risk Management	• Expertise and experience or consulting in analyzing exposure to risk in the private, public or not-for-profit sector and successfully determining appropriate measures to manage such exposure.	1 or more
Education	• Expertise and experience in the education sector, particularly, as it relates to subjects of relevance to public health programs and services.	1 or more
Legal	• Expertise and experience in the law (preferably with a designation), particularly, as it relates to subjects of relevance to public health programs and services.	1 or more
Health Service Delivery	• Expertise and experience in one or more aspects of health care delivery. Knowledge and/or experience in aspects of public health service delivery an advantage.	1or more

Human Resources	• Expertise and experience in human resources (preferably with a designation) particularly in the areas of compensation, labour relations, change management, organizational development and leadership.	1 or more
Information Management / Information Technology	• Expertise and experience in IT/IM, particularly as it relates to systems and policies for data security and protecting privacy.	1 or more
Health Equity: First Nations, Métis and/or Inuit Ways of Knowing	• Brings knowledge of Indigenous health, wellness, cultural safety, Truth & Reconciliation, and distinctions-based approaches to governance and decision-making.	1 or more
OTHER REPRESENTATION CONSIDERATIONS		
Other	• • As much as possible, given the requirements above, the board will aspire to promote gender balance, cultural, and linguistic diversity. In particular, as part of the BOH's commitment to Truth and Reconciliation, the board will strive to support the inclusion within its membership of First Nations, Métis and/or Inuit individual(s) who maintain meaningful, accountable, and ongoing relationships with Indigenous communities and/or organizations within Algoma.	

Composition and Accountability of the Board of ~~Directors~~Health

REFERENCE #: 02-05-001

DATE: Original: May 4, 1995
~~Revised: May 27, 2020~~
~~Revised: Mar 24, 2021~~
~~Reviewed: Sep 28, 2022~~
Reviewed: Sep 25, 2024
Revised: TBD

APPROVED BY: Board of Health

SECTION: Policies

KNOWLEDGE:

The Board of Health for the District of Algoma Health Unit is the governing body of Algoma Public Health and is established by the provincial public health legislation, the Health Protection and Promotion Act, RSO 1990, (HPPA) and regulations.

Boards of Health are the governing bodies and policymakers of public health units. Boards of Health monitor all operations within their health unit and are accountable to the community and to the Ministry of Health.

All Boards of Health have a legislated duty to ensure that the public health programs and services required by the HPPA are provided to people who live in the health unit jurisdiction. Public health programs and services are intended to prevent the spread of disease and to promote and protect health.

The Ontario Public Health Standards: Requirements for Programs, Services and Accountability or its most current revision, published by the Ministry of Health, set out the minimum requirements for fundamental public health programs and services for boards of health.

Section 1 of Regulation 559 to the HPPA states that the Board of Health for the District of Algoma Health Unit shall have eight municipal members. Section 49 (3) of the HPPA states that the Lieutenant Governor in Council *may* appoint one or more persons as members of a Board of Health, but the number of members so appointed shall be less than the number of municipal members of the Board of Health. Therefore, the maximum size of the board **may be fifteen (15) members** (eight (8) municipal members + seven (7) provincial members).

The distribution of board membership for the Board of Health for the District of Algoma Health Unit is as follows:

Zero (0) to Seven (7) Members:	appointed by the Lieutenant Governor to represent the Province of Ontario (currently two (2) provincial members);
Three (3) Members:	appointed by the Council to represent the City of Sault Ste. Marie;
One (1) Member:	appointed by the Municipal Councils representing the Municipality of Wawa, Township of White River and Dubreuilville;
One (1) Member:	appointed by the Municipal Councils representing the Town of Blind River and the Township~~s~~ of the North Shore and ~~Shedden~~the Town of Spanish (formerly known as the Township of Shedden);

One (1) Member:	appointed by the Municipal Councils representing the Town of Thessalon and Municipality of Huron Shores;
One (1) Member:	appointed by the Municipal Councils representing the Town of Bruce Mines, Village of Hilton Beach and the Townships of Hilton, Jocelyn, Johnson, Laird, Macdonald, Meredith and Aberdeen Additional, Plummer Additional, Prince, St. Joseph and Tarbutt;
One (1) Member:	appointed by the Municipal Council representing Elliot Lake;
Maximum Membership:	fifteen (15) members.

The appointment of members of municipal council(s) shall be for the term of the council(s). Council(s) may have internal policies that further refine this term of appointment.

Provincial appointees are for a three-year term that may be renewed.

It is the accountability of the Chair of the Board of Health to communicate vacancies, resignations or changes to the Board when they occur.

Note: The City of Sault Ste. Marie has an internal policy that appointments of members by the municipal council representing the City of Sault Ste. Marie is for a two-year term but may end sooner with the ending of the term of office of the council.

REFERENCES:

02-05-001.1 Algoma Public Health Board Member Skills Matrix

Procurement ~~Policy~~

REFERENCE #:	02-05-002	**DATE:**	Original: Feb 13, 1996 ~~Revised: Jun 26, 2019~~
APPROVED BY:	Board of Health		~~Revised: Nov 25, 2020~~ ~~Revised: Jun 28, 2023~~
SECTION:	Policies		Revised: Oct 23, 2024 Revised: TBD

1.0 PURPOSE

The purpose of this policy is:

a. To ensure that Algoma Public Health (APH) utilizes fair, reasonable, and efficient methods to procure quality goods and services required to execute the Board of Health for the District of Algoma Health Unit's (the Board's) programs and services.

b. To ensure APH aims to be accountable and transparent when procuring goods and services while safeguarding the assets of the agency.

c. To protect the financial interest of APH while meeting the needs of its programs and services it offers within the district of Algoma.

d. To promote and ensure the integrity of the procurement process and to ensure the necessary controls are present for a public institution.

2.0 POLICY ACCOUNTABILITY AND RESPONSIBILITIES

The Board is accountable to ensure that APH uses fair, reasonable and efficient methods to procure quality goods and services required to execute the Board's programs and services. The Board delegates responsibility to APH employees as outlined below:

Medical Officer of Health/Chief Executive Officer (MOH/CEO)

a. Ensures the Leadership Team is aware of and follows the Procurement Policy.

b. Ensures that an adequate system of internal controls is in place related to APH's Procurement Policy.

c. Ensures changes to the Procurement Policy are implemented.

d. Reports to the Board on any liability incurred as a result of the policy not being followed.

Leadership Team

a. Ensures all staff know and follow policy directions for the procurement of goods and services.

b. Considers price, quality and timely delivery of the product or service being procured rather than only the lowest invoice price.

c. Considers the total acquisition cost.

d. Monitors expenses on a regular basis to ensure that they are within the approved budget.

3.0 SCOPE OF APH PROCUREMENT POLICY

3.1 Government Procurement Direction

Nothing in this policy will supersede legislated or government-prescribed procurement direction/guidance.

3.2 Exemptions

This policy applies to the procurement of goods and services for APH. The following are excluded from this policy except for sections 4, 8 and 9 of the Procurement Policy.

a. Training and education
   i. Registration for conferences, conventions, courses, workshops, and seminars
   ii. Magazines, subscriptions, books, and periodicals
   iii. Memberships and association fees
   iv. Guest speakers for employee development

b. Refundable employee expenses
   i. Meal allowances
   ii. Travel expenses
   iii. Kilometre and other incidental expense reimbursement

c. Employer's general expenses
   i. Payroll and honoraria remittances
   ii. Government license fees
   iii. Insurance premiums
   iv. Employee benefits
   v. Damage and insurance deductible claims
   vi. Petty cash replenishment
   vii. Tax remittances

viii. Loan payments
ix. Bank fees and charges
x. Payments pursuant to agreements approved by the Board

d. Professional and special services
e.
~~i.~~ Special tax, accounting, actuarial and audit services and advice from the Board-approved auditor

~~ii.~~i. Legal fees and other professional services related to litigation, potential litigation or legal matters
~~iii.~~ii. Clinical services that are required to meet a community need and for which there are a limited number of professionals willing to provide these services
~~iv.~~iii. Confidential items (i.e., investigations, forensic audits)
~~v.~~iv. Honoraria
~~vi.~~v. Warranty work resulting from contractual obligations
~~vii.~~vi. Group benefits and employee assistance programs
~~viii.~~vii. Agency insurance

f. Advertising services required by APH on or in but not limited to radio, television, online, newspaper and magazines

g. Bailiff or collection agencies

h. Software licensing renewals

i. Ongoing maintenance agreements

j. Vaccine purchases

k. A situation where APH staff are incurring the cost of a service (i.e., exercise class on APH premises)

l. Real property interests
i. All real estate transactions

m. A situation where a competitive process could interfere with APH's ability to maintain security or order or to protect human, animal or plant life or health

n. Emergency goods and services where an unforeseen situation or urgency exists, and the goods or services cannot be obtained through a competitive process. Purchase of these emergency items must be authorized by the Director of Corporate Services or the MOH/CEO. The Chair of the Board or designate must be notified. An unforeseen situation of emergency does not occur where APH has failed to allow sufficient time to conduct a competitive process.

o. Goods and services where there is only one supplier available and no alternative or substitute exists.

4.0 FORM OF COMMITMENT BY ROLE /SIGNING AUTHORITY

4.1 Signing authority to make purchases

The delegation of signing authority to make purchases on behalf of the agency is based on the dollar amount of the expenditure and the role which the employee occupies within the agency.

Expenditure $ Amount	Required Approval
$0 - $5,000	Executive Assistants and HR Assistants
$0 - $10,000	Supervisors and Managers
$0 - $~~6~~33~~0~~0,000	Any Director or Manager of Accounting Services
$0 – $~~10~~66~~0~~0,000	Associate MOH or Director of Corporate Services
$0 - $~~25~~100125,000	MOH / CEO
Greater than $ $125,000~~100~~,000	Board of Health

Commented [JL1]: @KristyHarper - is this reasonable?

The delegation of signing authority for the Execution of Documents is defined by APH Bylaw 95-1 – To Regulate the Proceedings of the Board of Health, clause 13, Execution of Documents.

Note: When the Associate MOH (AMOH) is functioning in the capacity of the MOH, the signing authority will reflect that of the MOH noted above.

4.2 General Guidelines

When assessing what dollar value the purchase falls within, the following conditions are considered:

a. The spending authorization limits noted above and throughout this policy are before applicable taxes.

b. The goods or services purchased must be taken in their entirety and not broken down into component parts in an attempt to circumvent this policy.

c. The cumulative value of those goods or services over a calendar year.

d. The total value of the contract that will be awarded to the same individual/company over the term of that contract, whether for a single or multiple years.

5.0 QUOTATION PROCEDURE

5.1 Requests for Bids/Quotations/Proposals/Tenders and Dollar Thresholds

Requests for bids, quotations and proposals are mandated for the purchase of all goods and services according to the following guidelines:

a. $1 – $10~~6~~,000: single quote (purchase order) is required. Multiple quotes are recommended.

b. $~~6~~10,000 – $302~~0~~,000: two (2) written bids, quotations, and/or proposals are required.

c. $302~~0~~,000 to $1006~~0~~,000: three (3) written bids, quotations, and/or proposals are required.

d. For purchases greater than $1006~~0~~,000, a formal Request for Quotation (tender/proposal) must be adhered to. Board approval is required for purchases greater than $125~~100~~,000.

e. The time frames for soliciting this information are generally done in a timely manner, depending on the complexity and value of the request.

The submission of split requisitions in an attempt to circumvent the bidding policy is not allowed.

Written bids, quotations and/or proposals must go through APH administration.

Administration may, at their discretion, secure other competitive bids regardless of the dollar thresholds listed at any time. Furthermore, administration may, at their discretion, conduct negotiations with more than the apparent low bidder when it is deemed to be in APH's best interest to do so.

5.2 Confidentiality of Proposals

In accordance with fair and best business practice, all information supplied by vendors in their bid, quotation or proposal must be held in strict confidence by the employee(s) evaluating the bid, quotation or proposal and may not be revealed to any other vendor or unauthorized individual. Failure to do so may result in termination.

5.3 Late Proposals

a. All bids, quotations and proposals are to be date and time-stamped to ensure that they are received prior to the deadline for submission. It is the responsibility of the vendor to ensure that their bids are received by the responsible person no later than the appointed hour of the bid closing date as specified on the request for bid.

b. Late submissions will not be considered.

5.4 Errors in Bids/Quotations/Proposals

a. Vendors are responsible for the accuracy of their quoted prices. In the event of an error between a unit price and its extension, the unit price will govern. Quotations may be amended or withdrawn by the bidder up to the bid opening date and time, after which, in the event of an error, bids may not be amended but may be withdrawn prior to the acceptance of the bid.

b. After an order has been issued, no bid may be withdrawn or amended unless administration considers the change to be in APH's best interests.

5.5 Sole Source Procurement and Justification

The director, in consultation with the applicable manager, shall initiate sole source purchases provided that any of the following conditions apply:

a. where there is only one known source

b. where the compatibility of a purchase with existing equipment, facilities, or services is a paramount consideration.

c. when competition is precluded because of the existence of patent rights, copyrights, trade secrets.

d. where the procurement is for electric power or energy, gas, water, or other utility services.

e. where it would not be practical to allow a contractor other than the utility company itself to work upon the system.

f. where a good is purchased for testing or trial use.

g. when the procurement is for technical services in connection with the assembly, installation, or servicing of equipment of a highly technical or specialized nature.

h. when the procurement is for parts or components to be used as replacements in support of equipment specifically designed by the manufacturer.

i. the extension or reinstatement of an existing contract would be more cost-effective or beneficial to APH.

6.0 VENDOR SELECTION

As APH strives to provide the best quality of program offerings and services, the lowest price received in the bid and RFQ/RFP process may not always be accepted. In such cases, justification for choosing an alternative bid or RFQ/RFP must accompany the package of bids or RFQs. In some cases, the required number of formal bids may not be possible (i.e., potential vendors decide not to bid). In such cases, evidence of solicitation of the required number of bids as outlined in this policy must be maintained. If there is evidence to support that a vendor's actions or values are in stark contrast with that of public health, then APH reserves the right to exclude the vendor from the RFQ/RFP.

Purchasing decisions are based on price, quality, availability, and suitability.

6.1 Vendor of Record

The use of a Vendor of Record (VOR) from the Ministry of Government Services website precludes the need to go to a public bid solicitation process since this process was already done by that Ministry. Examination of the pricing should be done against local/current suppliers of the same product or service to ensure that the health unit is obtaining the best price, quality, availability and suitability before engaging a VOR.
Sole sourcing from a vendor of record that has been approved by the Ontario Education Collaborative Marketplace (OECM) or a similar government agency is permitted.

6.2 Cooperative Purchasing

The health unit shall participate with other government agencies or public authorities in cooperative purchasing where it is in the best interests of the health unit to do so.

The Director of Corporate Services, in conjunction with the MOH/CEO, has the authority to participate in arrangements on a cooperative or joint basis for purchases of goods and/or services where there are economic advantages to do so, purchases comply with the principles of this policy, and the annual expenditures are expected to be less than $125~~100~~,000.

If the annual expenditure is expected to be greater than $125~~100~~,000, Board of Health approval for the purchase will be required.

The policies of the government agencies or public authorities calling the cooperative tender are to be the accepted policy for that particular tender.

7.0 SPECIAL PROCUREMENT POLICIES

7.1 CONTRACTS/LEASES

Signing authority to enter into a contract/lease will follow the limits set out in section 4.1 of this policy. In addition;

The Board must approve contracts where:

a. Irregularities preclude the award of a contract to the lowest bidder in the tending and Request for Quotation process, and the 'total acquisition cost' exceeds $10060,000.

b. A bid solicitation has been restricted to a single source supply, and the 'total acquisition cost' of such goods or services exceeds $100125,000.

c. The contract/lease is for multiple years and exceeds $100125,000 per year.

7.2 Consulting Services

Consulting Services are provided by an individual or company with expertise or strategic advice. The individual is working under a contract relationship rather than an employee relationship.

The acquisition of consulting services must be sought through a competitive process ~~when the total expenditure for the service is greater than $20,000~~. The limits for the competitive process for consulting services are as follows:

Commented [LD2]: per broader public sector procurement directive

~~a. $0 - $20,000: negotiation with the prospective consultant to acquire consulting services~~

~~b.~~a. ~~$20,00~~0 – $~~60~~100,000: Three (3) written bids, quotations, and/or proposals are required.

~~c.~~b. For purchases greater than $10060,000, a formal Request for Proposal must be adhered to.

All contractual agreements with consultants up to $125~~100~~,000 must be approved by the MOH/CEO **and** Director of Corporate Services. Consulting contracts for more than $125~~100~~,000 requires the approval of the MOH/CEO **and** the Board of Health.

Consulting services do not include services in which the physical component of an activity would be prevailing. For example, services for the operation and maintenance of a facility.

7.3 Approvals for Construction and Alterations to Physical Space

~~d.~~c. All requisitions for construction, renovation, or alteration to physical space at APH under $125~~100~~,000 require the review and prior written approval of the Director of Corporate Services and the MOH/CEO. All requisitions for construction, renovation, or alteration to physical space at APH over $~~100~~125,000 require authorization of the Board of Health.

~~e.~~d. Detailed specifications, drawings, and/or blueprints, if appropriate, should accompany the Purchase Requisition. Requisitions submitted to Accounts Payable without prior written approval will not be processed.

7.4 Equipment and Equipment Screening

a. APH has established a policy governing the acquisition, control, and disposition of APH equipment.

b. It is the policy of APH to ensure that every effort is made to avoid the purchase of unnecessary or duplicate equipment.

c. The purchasing authorization levels by role defined in the policy will govern equipment purchases.

8.0 PROHIBITIONS

8.1 Conflicts of Interest

Employees shall not place themselves into positions where they could be tempted to prefer their own interests or the interest of another over the interest of the public that they are employed to serve. Whenever employees, during the discharge of their duties, become exposed to or involved in actual/or potential conflicts of interest, they must disclose the situation to their manager /director /MOH/CEO /Board of Health (as may be appropriate) and shall abide by the advice given.

8.2 Gifts, Gratuities, and Kickbacks

APH policy prohibits all employees from accepting gifts, gratuities, or kickbacks of any value from vendors or service providers. Items of a very minimal value which are of an advertising nature only and available to other customers may be accepted (e.g. pens, hats, coffee cups, etc.). Any questions an APH employee may have as to the appropriateness of the value of the item must be communicated to the employee's manager/ director/ MOH/CEO/Board of Health (as may be appropriate).

8.3 Personal Purchases

The purchase of any goods or services for personal use by or on behalf of any APH employee for purposes other than the bona fide requirements of APH is strictly prohibited.

8.4 Division of Contracts

The division of a contract to avoid the requirements of this policy is prohibited.

8.5 Local Preference

No local preference shall be shown or taken into account in acquiring goods and services on behalf of APH. Consideration will be given to local/regional products and services which are considered equal in quality and price and have a level of performance acceptable to the Board of Health.

8.6 Prohibited Classes of Vendor

APH shall not acquire goods and/or services from any of the following:

a. Board of Health members;

b. Employees of the health unit at or above the level of supervisor;

c. Businesses in which the individuals in (a) or (b) above hold a controlling interest.

9.0 General Information

9.1 The Accessibility for Ontarians with Disabilities Act (AODA)

In deciding to purchase goods or services through the procurement process for the use of itself, its employees or the public, APH, to the extent possible, shall have regard to the accessibility for persons with disabilities to the goods or services, except where it is not practical to do so, APH shall provide, upon request an explanation.

9.2 Environmental Considerations

The Board of Health will endeavour, whenever possible, to purchase and utilize products that support environmentally sound practices from the manufacturing process through to final delivery and disposal. Priority consideration will be given to products that espouse environmentally friendly sound practices.

Consideration will be given to recycled and other environmentally responsible products which are considered equal in quality and price and have a level of performance acceptable to the Board of Health. Potential for indirect savings will be considered when choosing a product that is environmentally friendly.

9.3 Disposal of Surplus Goods

The disposal of surplus and obsolete equipment shall be evaluated on a case-by-case basis.

The Director of Corporate Services, in conjunction with the MOH/CEO, shall have the authority to sell, exchange, or otherwise dispose of Goods declared as surplus needs of APH, and where it is cost-effective and in the best interest of APH to do so. Items or groups of items may:

a. Be offered for sale to other health units, affiliates or other government agencies or public authorities; or

b. Be sold by external advertisement, formal request, auction, or public sale (where it is deemed appropriate, a reserve price may be established); or

c. Be donated to a not-for-profit agency; or

d. Be recycled; or

e. In the event all efforts to dispose of goods by sale are unsuccessful, these items may be scrapped or destroyed if recycling is unavailable.

No disposition of such good(s) shall be made to employees, elected officials, or their family members, with the exception of electronic assets that have been fully depreciated. The disposition of electronic assets would be at the discretion of the Director of Corporate Services in conjunction with the MOH/CEO as appropriate; the Manager of Accounting Services and/or the Director of Corporate Services shall record the disposition of tangible capital assets.

9.5 Consulting Services Requirements

All consultants working on behalf of APH who will have direct access to APH financial records, bank accounts, or employee records as per the terms of their contract are required to provide a current police information check (PIC). This includes but is not limited to any consultant or licensed professional who will serve in the capacity of APH's Director of Corporate Services, Manager of Accounting Services, Manager of Human Resources, or Information Technology support.

All consultants or service providers working on behalf of APH who will interact with children, youth, or vulnerable persons as per the terms of their contract are required to provide a current police vulnerable sector check (PVSC). If the service provider is required to provide a criminal reference check to their regulatory college as part of the annual licensure process, an attestation from the service provider along with a copy of their current licensure will be accepted.

Provision of the required criminal record search is required prior to the commencement of any consulting work with APH. All offers for consulting services are conditional on receipt of satisfactory criminal reference checks.

All consultants are required to provide the names and contact information of at least two (2) references for which similar services were recently provided.

Positive references are required prior to the commencement of any consulting work with APH. All offers for consulting services are conditional on receipt of satisfactory reference checks.

10.0 Review and Evaluation

The effectiveness of this policy will be evaluated and reviewed every two (2) years by the Board of Health or more frequently as required. This review will include both legislative requirements and best practices.

~~11.0 PROCUREMENT PROCEDURES~~

~~The purchasing cycle includes the following steps to be made within the confines of this policy:~~

~~a. Authority to purchase goods and services through the Board of Health approved budget and delegation of purchasing authority by the Board to the MOH/CEO~~

~~b. The MOH/CEO delegates authority to purchase goods and services to other employees based on roles defined within the agency.~~

~~c. Quotation procedure and vendor selection.~~

~~d. A purchase requisition/purchase order approval or executed service contract.~~

~~e. Receipt of goods/services (bill of lading) and invoice.~~

~~f. Payment made to vendor.~~

~~All goods and services necessary to support APH programs and services must be authorized and follow the appropriate purchasing procedures. Note: any purchase that is noted as an exception in this policy does not require a purchase order (i.e., utility expense).~~

~~11.1 Purchase Requisition/Purchase Order.~~

~~For the purposes of this policy, an APH purchase order will serve as the request to purchase a good or service (purchase requisition) by staff. Requisitions may be initiated at any level, but only the above-named positions can bind a purchase order through the authorization levels as defined by the dollar amounts noted above. A purchase order serves as the legal offer to buy products or services from a vendor. Once a vendor accepts a purchase order from APH, a contract now exists to purchase the goods or services.~~

~~a. The purchase requisition/purchase order is used to request a vendor or purchasing authority to acquire materials, parts, supplies, equipment, or services.~~

~~b. All quotations and correspondence from the vendor and supporting documentation (e.g., written bids, letters of justification and/or sole source justification) must be maintained for a minimum of three years.~~

c. Administration reserves the right to seek additional bids from other qualified sources as it deems appropriate.

d. Petty cash purchases are not required to provide a purchase order.

11.2 Change Order – Cancellation or Modification of a Purchase Order

Changes to purchase orders must be amended and returned to the original approvers for review and re-approval.

11.3 Blanket Purchase Orders

A blanket purchase order is any contract for the purchase of goods or services which will be required frequently or repetitively but where the exact quantity of goods or services required may not be precisely known or the time period during which the goods or services are to be delivered may not be precisely determined. A Blanket Purchase Order is often negotiated to take advantage of predetermined pricing. It is normally used when there is a recurring need for expendable goods (i.e., birth control pills, vaccines, etc.). Blanket purchase orders are often used when APH buys large quantities of a particular good and has obtained special discounts as a result of bulk purchasing.

Request to enter into a blanket purchase order must be approved by the Director of Corporate Services or Manager of Accounting Services. A blanket purchase order generally should not exceed one year. The associated manager and their reporting director must approve the blanket purchase order.

11.4 Cheque Requisition

For miscellaneous or non-competitive purchases, payment for goods and services may be initiated by completing a cheque requisition. A cheque requisition is completed by the department making the request and is authorized and signed by the employee's manager. cheque requisitions require the approval of the appropriate signing authority.

11.5 Petty Cash

Petty cash may be used for immediate needs such as stationery or miscellaneous program material supply purchases of $200 and under. Petty cash may not be used for travel expenses, personal loans, consultant fees or any other type of personal service payments, salary advances or the cashing of personal cheques.

Disbursements from the petty cash fund must be properly documented with original itemized receipts approved by the employee's manager or a director and include the appropriate cost center (including account and program number) as to where the charges should be expensed to. Receipts should include a description of the business purpose of the transaction, goods or services purchased and the date. (See petty cash procedures for further guidance).

11.6 Use of Corporate Credit Card

~~The Board of Health has authorized the use of corporate credit cards to carry out approved business transactions. The MOH/CEO or designate will approve employees who require a corporate credit card to execute needs of the health unit. Purchases made via a corporate credit card must follow the guidelines as set out in this policy and the health unit's Corporate Credit Card Policy. Specifically, the delegation of signing authority noted above will govern individual credit card purchases. In situations where a credit card has been issued to an employee who has not been designated signing authority, an approved purchase order signed by the appropriate signing authority is required for each purchase. In situations where an employee has been issued a corporate credit card and where the specific expenditure exceeds their signing authority, an approved purchase order signed by the appropriate signing authority is required for each purchase.~~

~~**11.7 Custody of Documents**~~

~~The Director of Corporate Services, or designate, shall be responsible for the safeguarding of original purchasing and contract documentation for the contracting of goods, services or construction and will retain documentation in accordance with the records retention policy.~~

Commented [JL3]: Consider removal and transitioning to procedure

Glossary of Roles Noted within Algoma Public Health Procurement Policy

Administration – consists of any position within APH, including and above the role of supervisor in the following departments: Finance & Accounting, Human Resources, Payroll, Corporate Services, Communications, and Operations.

Board of Health for the District of Algoma Health Unit - is the governing body of APH and is established by the provincial public health legislation, the Health Protection and Promotion Act, RSO 1990 (HPPA) and regulations.

Chair of the Board – is the highest officer of APH. The individual holding this position is elected by members of the Board of Health for the District of Algoma Health Unit.

Consultant – is an individual or company that provides expertise or strategic advice to APH. The individual is working under a contract relationship rather than an employee relationship and is paid through the submission of invoices.

Executive Team – consists of the MOH/CEO, the AMOH, and directors.

Leadership Team – consists of any position within APH, including and above the role of supervisor.

Staff/Employee – a person who is hired to provide services to a company on a regular basis in exchange for compensation and who does not provide these services as part of an independent business.

Vendor – the party in the supply chain that makes the goods or services available or sells something to APH.

Related Procedure: Procurement Procedure ## - ## - ###

Algoma PUBLIC HEALTH
Santé publique Algoma
www.algomapublichealth.com

Briefing Note

To: The Board of Health

From: Medical Officer of Health & CEO

Date: September 23, 2026

Re: Temporary delegation of Board of Health authority during the 2026 municipal election transition

☒ **For Information** ☒ **For Discussion** ☒ **For a Decision**

PURPOSE

- To provide information and context regarding the upcoming disruption to Board of Health (BOH) continuity during the 2026 municipal election transition.
- To provide recommended actions to enable management to continue carrying out operational responsibilities during a temporary disruption in the BOH's ability to meet.

KEY MESSAGES

- The 2026 municipal election transition will create a three-month gap during which the BOH will not have quorum and will not be scheduled to meet.
- Planning for governance continuity is essential to meet statutory and fiduciary requirements, and to mitigate against the risk of operational disruption.
- During this period, the BOH is recommended to delegate temporary authority to the Medical Officer of Health/CEO, with operational oversight and co-authorization from the BOH's provincial appointee/second vice-chair.

RECOMMENDED ACTIONS

1. That the Board of Health delegates temporary financial and contractual signing authority to the Medical Officer of Health/CEO (MOH/CEO) from November 14, 2026 until the next formal meeting of the BOH, scheduled for January 27, 2027. For greater certainty, if the BOH has not regained quorum by January 27, 2027, this delegation shall continue, without further BOH action, until the earlier of the date on which quorum is restored or the date the BOH otherwise resolves to end it.
2. That the BOH directs the MOH/CEO to bring to the attention of the current provincial appointee, who is also the second vice-chair, any time-sensitive matter normally requiring BOH approval for review and co-authorization during the period from November 14, 2026 until the next formal meeting of the BOH.

3. That the BOH confirms the authority and responsibility of the second vice-chair to assume the role and duties of the Chair of the Board of Health in their absence, as per BOH policy 02-05-089 Chair Roles and Responsibilities.
4. That, notwithstanding the delegation of financial and contractual signing authority above, the MOH/CEO shall not, during the delegation period: approve borrowing, capital projects or significant asset acquisitions or disposals; or enter into agreements creating material long-term obligations beyond existing BOH direction.
5. That the good-faith immunity provided under HPPA s.95 extends to actions taken in good faith under this delegation by the MOH/CEO and the co-authorizing second vice-chair of the BOH.

BACKGROUND: IMPLICATIONS OF THE 2026 ELECTION TRANSITION FOR BOH AND OPERATIONAL CONTINUITY

- APH BOH composition is prescribed under the Health Protection and Promotion Act[1] (HPPA), and Regulation 559[2] under the HPPA, and is further described in BOH policy 02-05-001, Composition and Accountability of the Board of Directors[3].
    - Notably, as per the HPPA, "the term of office of a municipal member of a board of health continues during the pleasure of the council that appointed the municipal member but, unless ended sooner, ends with the ending of the term of office of the council" (R.S.O. 1990, c. H.7, s.49(7))[1].
- Quorum is defined in APH BOH by-law 95-1 To Regulate the Proceedings of the Board of Health[4] as a majority of the current members of the board and that there must be at least five current members of the board.
- With the municipal terms of council ending on November 14, 2026, all eight municipal appointees to the APH Board of Health will be vacant and there will remain one active provincial appointee on the Algoma Public Health BOH, until new members are appointed by Algoma municipalities.
    - The current APH BOH provincial appointee is also the second vice-chair.
- The last BOH meeting in 2026 is scheduled for October 21, 2026, and the subsequent meeting would be scheduled for January 27, 2027. This creates:
    - a three-month gap during which the BOH will not have quorum and will not be scheduled to meet
    - a two-and-a-half-month gap during which there will be no elected BOH Chair.
- Although most matters of governance may be deferred during this period, emergent operational matters may arise requiring timely decision-making, which may include approval at the BOH level. As per the BOH Procurement Policy 02-05-002[5], examples of operational expenditures requiring BOH authorization include:
    - An expenditure of over $100,000 related to the purchase of goods and/or services;
    - Entering into a multiyear contract or lease of over $100,000 per year;
    - A requisition for construction, renovation, or alteration to physical space at APH that exceeds $100,000.
- From time to time, the signing authority of the BOH Chair is also required for routine operations, such as the completion of annual and other reports to the provincial Ministry of Health. The

timing of these reports is not expected to overlap with the period between November 14, 2026 and January 27, 2027 when there will not be an elected BOH Chair.

EVIDENCE/ ANALYSIS

- As highlighted in the briefing note sent to all boards of health from the Association of Local Public Health Agencies (alPHa), "Governance Continuity & Fiduciary Obligations – During Municipal Election Transition Period[6]" and confirmed through legal counsel, the BOH's fiduciary and legislative obligations continue uninterrupted regardless of municipal election cycles. Governance continuity is required for the BOH to meet its statutory and fiduciary obligations under the HPPA.
- In recent history, the APH BOH has not taken any proactive measures or delegated authority in advance of municipal election transition periods.
- During the previous municipal election period, some delays in the appointment of municipal appointees led to the first meeting of 2023 to be delayed to February 8, 2023.
- Due to differing governance structures and local contexts, Ontario boards of health vary in their approaches to the municipal election transition period. A number of Northern Ontario health units, who face similar continuity gaps and their potential operational challenges, are preparing for this period by delegating authority to the MOH/CEO or CEO.

ASSESSMENT OF RISKS AND MITIGATION

1. To mitigate against the risk of disruption and delays to routine procurement and operations,
    a) Proposed revisions to the BOH Procurement Policy 02-05-002 are being presented separately to the BOH to increase the expenditure thresholds, which have not been adjusted in a number of years and have not kept pace with inflation.
    b) This briefing note recommends the temporary delegation of BOH financial and contractual signing authority to the MOH/CEO.
2. To maintain governance-level oversight of operational decision-making during the temporary delegation of authority, it is recommended that the BOH's remaining provincial appointee, who is also the second vice-chair, review and co-authorize any decision normally requiring BOH approval under legislation, by-law, or BOH policy.
3. To avoid unnecessary delays in the resumption of routine BOH meetings, APH staff will
    a) proactively reach out to Algoma municipalities to provide the expected date of the first meeting in 2027 and to support the timely appointment of municipal members and their onboarding.
    b) proceed to resume regular meetings of the BOH as scheduled on January 27, 2027, provided quorum is met.
4. Legal counsel has been consulted on the recommended actions presented in this briefing note to help ensure that the APH BOH is appropriately meeting its legislative requirements, carrying out its fiduciary and governance responsibilities, and maintaining operational oversight.

FINANCIAL IMPLICATIONS

None.

OPHS STANDARDS

OPHS (2021), Good Governance and Management Practices Domain Requirement 5: The board of health shall comply with the governance requirements of the *Health Protection and Promotion Act* (e.g., number of members, election of chair, remuneration, quorum, passing by-laws, etc.), and all other applicable legislation and regulations[7].

OPHS (2021), Common to All Domains Requirement 4: The board of health shall have a formal risk management framework in place that identifies, assesses and addresses risk[7].

REFERENCES

[1]Health Protection and Promotion Act, R.S.O. 1990, c. H.7. Available from: https://www.ontario.ca/laws/statute/90h07

[2]Designation of Municipal Members of Boards of Health, R.R.O. 1990, Reg 559 (Health Protection and Promotion Act, RSO 1990, c H.7). Toronto: King's Printer for Ontario. Available from: R.R.O. 1990, Reg. 559 DESIGNATION OF MUNICIPAL MEMBERS OF BOARDS OF HEALTH | ontario.ca

[3]Algoma Public Health. Policy 02-05-001: Composition and Accountability of the Board of Directors. Sault Ste. Marie (ON): Algoma Public Health; [2024].

[4]Algoma Public Health. By-law 95-1: To Regulate the Proceedings of the Board of Health. Sault Ste. Marie (ON): Algoma Public Health; [2024].

[5]Algoma Public Health. Policy 02-05-002: Procurement Policy. Sault Ste. Marie (ON): Algoma Public Health; [2024].

[6]Association of Local Public Health Agencies. Governance continuity & fiduciary obligations – during municipal election period. Toronto (ON): alPHa; 2026. Available from: alPHa_BOH_Governance_Continuity_Fiduciary_Obligations_Municipal_Elections_2026.pdf

[7]Ontario Ministry of Health. Ontario public health standards: requirements for programs, services, and accountability. Toronto (ON): King's Printer for Ontario; 2018. Available from: https://www.ontario.ca/page/ontario-public-health-standards-requirements-programs-services-and-accountability

Travel ~~Policy~~

REFERENCE #:	02-05-020	**DATE:**	Original: Mar 1991 ~~Revised: Mar 22, 2023~~ ~~Revised: Jun 28, 2023~~ ~~Revised: May 22, 2024~~ Revised: Nov 27, 2024 Revised: TBD
APPROVED BY:	Board of Health		
SECTION:	Policies		

1. PURPOSE

The purpose of this document is to ensure that employees and board members understand the policy and procedures for Algoma Public Health (APH) business travel.

APH will reimburse employees and board members for all reasonable and necessary expenses while travelling on authorized APH business. APH assumes no responsibility to reimburse employees and board members for expenses that are not in compliance with this policy.

2. ACCOUNTABILITY AND RESPONSIBILITIES

2.1. APH's Travel Policy must be followed, and the **Travel Expense Report** completed if any of the following conditions are true:

- **a.** An employee or board member travels outside the district of Algoma.
- **b.** An employee or board member requires accommodation within the district for at least one night.
- **c.** An employee or board member travels more than 250 km within one day.

2.2. Travel not meeting the above criteria may be eligible for compensation through the **Kilometre Reimbursement Policy 01-03-002.**

3. EXAMPLES

The below scenarios will serve as a guide:

Scenario One

An employee/board member travels between Sault Ste. Marie and Elliot Lake and spends one night in the destination location.
Departure time is 1:00 pm and return to Sault Ste. Marie at 3:00 pm the next day. Admissible meal expenses include:

- Dinner the night of travel
- Breakfast the next day (assuming not provided at the hotel)
- Lunch the next day

Scenario Two
An employee/board member travels between Elliot Lake and Blind River and returns to origin the same day (114 total km).

- No admissible meal expenses are permitted.

Scenario Three
An employee/board member travels from Sault Ste. Marie to Toronto for a conference or seminar and will spend two nights in Toronto.

Departure time is 5:30 pm on Monday and return home is Wednesday at 5:00 pm. Admissible meal expenses include:

- Dinner the night of travel
- Breakfast the next day (assuming it is not provided by the hotel/conference/seminar)
- Lunch the next day (assuming it is not provided by the conference/seminar)
- Dinner the next day (assuming it is not provided by the conference/seminar)
- Breakfast the second day (assuming it is not provided by the hotel/conference/seminar)
- Lunch the second day (assuming it is not provided by the conference/seminar)

Scenario Four
An employee/board member travels between Blind River and Sault Ste. Marie and returns to the original location the same day (284 total km). Admissible meal expenses include:

- Lunch for that day
- Dinner for that day only if the employee arrives home after 6:30 pm.

Scenario Five
An employee/board member travels more than 250 km within one day while conducting APH business. Departure time is 8:30 am. Return home by 4:30 pm the same day. Admissible meal expenses include:

- Lunch for that day

Scenario Six
An employee/board member travels from Sault Ste. Marie to Toronto for a meeting and will return on the same day. Departure time is before 7:00 am. Return home is after 6:30 pm the same day. Admissible meal expenses would include:

- Breakfast for that day
- Lunch for that day
- Dinner for that day (if the return flight is after 6:30 pm)

4. TRAVEL AUTHORIZATION

4.1. All employees/board members who travel outside the district of Algoma must be pre-approved.
4.2. Employee travel must be pre-approved by their respective Manager.
4.3. Manager travel outside the district of Algoma must be pre-approved by their respective Director.
4.4. Director travel outside the district of Algoma must be pre-approved by the MOH/CEO or designate from the Executive team.
4.5. Travel by the MOH/CEO or Board Chair requires prior approval from the other if the destination is more than 200 km outside Ontario.
4.6. Board member travel must be pre-approved by the Board Chair or designate.
4.7. Given the level of responsibility, MOH/CEO / Board Chair travel does not require prior authorization unless the destination is more than 200 km outside Ontario; however, any expenses related to MOH/CEO travel must be approved by the Chair of the Board or Vice-Chair of the Board or designate.
4.8. Board Chair travel expenses must be approved by the Vice-Chair or Board designate.

5. METHOD OF TRAVEL

Employees/board members are responsible for making travel arrangements that account for safety and convenience and should take the most economical method of transportation. Where available, agency fleet vehicles should be selected as a preferred economical method of transportation.
If an employee chooses to take a more expensive mode of travel based on personal preference, APH will cover the cost of the most economical rate to that location, and the employee will be required to pay any additional costs. If the employee chooses this option, it must be preapproved by the employee's manager.

5.1. Air Travel

a. When booking air travel, the employee must engage an APH Clerical/Executive Assistant to book the flight on the employee's behalf. Reservations should be made several weeks in advance to ensure flight availability and acquire reasonable pricing. Economy flights are to be booked. Board members will work with the Secretary of the Board to book travel via air.

b. APH will reimburse employees/board members for the first checked baggage fee charged by certain airlines. APH will not reimburse employees/board members for additional checked baggage fees or fees associated with overweight bags.

c. APH will reimburse employees/board members for airport parking or taxi services to and from the airport if it is more economical or practical.

5.2. Personal Automobiles

Per-kilometre, reimbursement for employees will be provided at the most recently posted Canada Revenue Agency reasonable per-kilometre allowance rate and updated annually on April 1 of each year. Distance should be calculated using the quickest route using route internet maps (e.g. Google Maps).

For reference, the following is provided:

Round Trip Kilometres (as per Google Maps)

From/To	294 Willow Avenue, Sault Ste. Marie	9 Lawton Street, Blind River	302-31 Nova Scotia Walk, Elliot Lake	18 Ganley Street, Wawa
294 Willow Avenue, Sault Ste. Marie	N/A	284	396	450
9 Lawton Street, Blind River	284	N/A	114	734
302-31 Nova Scotia Walk, Elliot Lake	396	114	N/A	844
18 Ganley Street, Wawa	450	734	844	N/A

5.3. Car Rental

If required and economically prudent, employees/board members may rent vehicles while on APH business with management approval. Mid-sized vehicles must be reserved unless a larger vehicle is required to accommodate the number of travellers sharing the vehicle.

APH has special rates for car rentals with a preferred provider in Sault Ste. Marie. The Manager of Accounting Services will notify APH employees of our preferred provider on an annual basis. Preferred providers bill APH directly.

Note: Employees/board members will not be reimbursed for any traffic or parking tickets resulting from business travel.

6. ACCOMMODATIONS

6.1. Employees/board members are expected to stay in a standard-type room in a good-standing hotel. The employee/board member is entitled to an individual room.

6.2. Hotel reservations will be made by the travelling employee. For board members, the Secretary to the Board will make hotel reservations. Where possible, the accommodation chosen should be a government-approved hotel offering government rates or the host hotel of the conference or seminar. Employees/Board Secretary should inquire about the possibility of obtaining a government rate.

6.3. Algoma Public Health has secured corporate rates with a number of hotels within the District of Algoma. Employees will be provided with a list of preferred providers annually by the Manager of Accounting Services. Preferred provider hotels bill APH directly and employees should first attempt to book rooms from the preferred providers list.

6.4. The travelling employee or a clerical employee may prepare a purchase order on behalf of the travelling employee. When completing the Travel Expense Report, employees are required to populate Section (B) CHARGED TO COMPANY as it relates to their respective hotel stay.

6.5. When travelling to all other locations, employees/board members (excluding those employees with a corporate credit card) must pay hotel expenses using a personal credit card. The employee/board member will subsequently be reimbursed by APH when submitting their expense form by populating Section (A) REIMBURSABLE EXPENSES as it relates to their respective hotel stay. If an employee has been issued a corporate credit card, it may be used to pay for hotel expenses. When completing the Travel Expense Report, populate Section (B) CHARGED TO COMPANY as it relates to the respective hotel stay.

7. CANCELLATIONS

It is the responsibility of the employee/Executive Assistant to cancel a hotel reservation in the event of a change. To avoid charges, the employee/Executive Assistant should be familiar with the hotel's cancellation policy. The employee/ Executive Assistant should record the cancellation number in case of a billing dispute.

8. MEALS & OTHER EXPENSES

Alcohol is not a reimbursable expense.

Original itemized receipts are required for allowable expenses, such as parking, taxis, and buses in order to be eligible for reimbursement. Original itemized receipts must state the date, place and cost (credit card receipts that do not identify the items will not be accepted). If an itemized receipt cannot be provided (i.e. the itemized receipt is misplaced), a written explanation reviewed and approved by the employee's direct manager must be submitted to

explain why the receipt is unavailable, and a description itemizing and confirming the expenses must be provided.

Reimbursement for meal expenses will be on a per diem basis based on the rates set out in the chart below. These rates include taxes and gratuities. No receipts are required.

Meals	Travel Per Diem
Breakfast	$15.00
Lunch	$25.00
Dinner	$35.00

If meals are provided at the event or part of the hotel booking, the employee will not be eligible for per diem reimbursement (i.e. if breakfast is provided at the hotel or conference, the employee will not be eligible to submit expenses for breakfast on the date of the conference).

APH will be responsible for the expenses incurred by an APH employee/board member only.

As meals are reimbursed on a per diem basis, APH credit cards should not be used for meals during business-related travel.

9. TIPS/GRATUITIES

Employees/board members may be reimbursed for reasonable gratuities for taxis (15-18%). Keep a record of gratuities paid.

10. TRAVEL ADVANCES

APH will not provide travel advances.

11. EXPENSE REPORTS

Employees/board members must submit an expense report within 15 business days of the completion of each trip. Any expenses submitted after that time may not be reimbursed by APH.
Expense reports must be approved by the employee's Manager. Managers have their expense report approved by their Director. Directors have their expense report approved by the MOH/CEO. The MOH/CEO must have expenses approved by the Chair of the Board or

Vice-Chair of the Board. Board members must have expenses approved by the Chair of the Board/ Vice-Chair of the Board. The Chair of the Board must have expenses approved by the Vice-Chair.

Original itemized receipts must be attached to the expense report. Expense reports are to be submitted to the clerical in Accounts Payable. Employees/board members will be reimbursed for expenses via the cheque run to ensure prompt reimbursement.

12. TRAVEL REIMBURSEMENT THROUGH MINISTRY/THIRD PARTY

APH recognizes there are times when an employee/board member will be travelling, and the expenses incurred are to be submitted to the Ministry/Third Party for reimbursement. When such a situation arises, the employee/board member is expected to follow the rules outlined in the Ministry/Third Party Travel Policy.

The Ministry/Third Party travel policy will supersede APH's travel policy regarding allowable reimbursable expenses and dollar amounts. Any travel considered reimbursable through the Ministry/Third Party must be approved at the Director level or above.

In order to keep track of costs and ensure no duplication of employee/board member reimbursement, APH should be reimbursed by the Ministry/Third Party directly. Under no circumstance should an employee/board member receive a cheque from the Ministry/Third Party directly.

In situations where the employee/board member is travelling, and the Ministry/Third Party will reimburse APH, the following must be adhered to:

- The Ministry/Third Party expense report is to be completed with a copy submitted to the clerical in Accounts Payable (Director to ensure both the original expense report and the copy are identical prior to any report being submitted to the Ministry/Third Party and APH Accounts Payable).

- The Ministry/Third Party expense report and original itemized receipts will be submitted to the Ministry/Third for APH to be reimbursed (this expense report must include expenses incurred by both the employee/board member and APH).

- The Ministry/Third Party expense report and copies of itemized receipts will be submitted to APH for employee/board members to be reimbursed. This is the only circumstance where copies of itemized receipts will be accepted by APH. Expense reports must be submitted within 15 business days after each trip.

- APH will reimburse the employee/board member.

- APH will be reimbursed by the Ministry.

NOTE: Flights are to be booked through APH's preferred provider as prescribed by the Manager of Accounting Services. Hotels are to be paid using the employee's personal credit card in this circumstance

13. REFERENCE

- Kilometre Reimbursement 01-03-002
- Travel Expense Report
- Ministry/Third Party expense report

Continuing Education for Board Members

REFERENCE #:	02-05-035	**DATE:**	Original: Jan 20, 2010 ~~Revised: Nov 28, 2018~~ ~~Reviewed: Sep 23, 2020~~ ~~Reviewed: Sep 28, 2022~~ Reviewed: Sep 25, 2024 Reviewed: tbd
APPROVED BY:	Board of Health		
SECTION:	Policies		

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1. POLICY

Algoma Public Health encourages and supports board members to attend and participate in training, workshops, seminars, meetings, and conferences related to public health and governance issues.

The Medical Officer of Health / Chief Executive Officer shall bring programs, seminars or conferences relevant to the work of the board to the attention of the board. Board members may also identify learning and development opportunities designed to enhance their competence and knowledge throughout their mandate. These may include seminars or workshops sponsored by other community service groups or those sponsored by health associations or government departments.

Board members shall receive approval by the chair of the board to attend as a representative of the board and to receive financial support for expenses and remuneration. The chair of the board shall receive approval from the first chair. If they are not available, then the second chair will give approval. The member shall submit a brief written report to the board highlighting the information/ knowledge/ skills presented.

Board members, approved by the board chair for a professional development activity, shall be reimbursed for all expenses incurred as per policy 02-05-025 Board Member Remuneration

Board of Health Self-Evaluation ~~Policy~~

REFERENCE #: 02-05-055

APPROVED BY: Board of Health

SECTION: Policies

DATE: Original: May 20, 2015
~~Reviewed: Jun 28, 2017~~
~~Revised: Nov 28, 2019~~
~~Revised: Sep 22, 2021~~
Revised: Sep 27, 2023
Reviewed: tbd

1. POLICY

The Board of Health shall have an annual self-evaluation of its governance practices and outcomes that is implemented every year and may result in recommendations for improvements in leadership excellence, board effectiveness, engagement and performance. The Board may also supplement its evaluation tools by seeking evaluation by key partners and/or stakeholders and/or governance consultants when issues are identified in its self-evaluation that require further investigation,

2. ANNUAL SELF EVALUATION ~~Annual Self-Evaluation~~

The self-evaluation process shall include consideration of whether:

a. Decision-making is based on access to appropriate information with sufficient time for deliberations.

b. Compliance with all federal and provincial regulatory requirements is achieved.

c. Any material notice of wrongdoing or irregularities is responded to in a timely manner.

d. Reporting systems provide the Board with information that is timely and complete.

e. Members remain abreast of major developments in governance and public health best practices, including emerging practices among peers.

f. The Board members are actively engaged in discussing agenda items that focus on strategic results, policy issues and solutions rather than on day-to-day operational issues.

g. The Board monitors fiscal and program and services performance.

3. BI-ANNUAL MEETING EVALUATION

The Board of Health shall have an evaluation process that will result in improved Board of Health meeting effectiveness. Board members are encouraged to complete the electronic evaluation biannually.
Meeting evaluation results will be reviewed by the Board of Health Chair and presented to the Board of Health two times a year at the January and June Board meetings.

The Board of Health will maintain a record of its members' attendance. The summary will be reviewed by the Board of Health Chair on an annual basis, as noted in the Board's annual work plan.

4. ANNUAL SELF-EVALUATION PROCESS

Board of Health Member:

- Complete the Board of Health Self-Evaluation Survey including board member name at the June Board meeting.

Board Secretary

- Compile evaluations into a report and present at the September Board meeting as noted in the Board's annual work plan.

5. BI-ANNUAL BOARD MEETING EVALUATION PROCESS

Board of Health Member:

- Complete the Board of Health Meeting Evaluation Survey after the November and May Board meetings.

Board Secretary:

- Compile evaluations and forward to the Board Chair to review
- Results will be included in the Board of Health meeting package at the January and June Board meetings

6. KNOWLEDGE

a. Board Member Self-Evaluation of Performance Template
b. Board Monthly Meeting Evaluation Template
~~**c.**~~

7. REFERENCES

~~7.~~8.

~~8.~~ The following are tools used by the Board of Health to complete evaluation surveys:

Board of Health Meeting Evaluation

Board of Health Annual Self Evaluation

Meetings and Access to Information

REFERENCE #: 02-05-060

APPROVED BY: Board of Health

SECTION: Policies

DATE: Original: Oct 28, 2015
~~Revised: Mar 28, 2018~~
~~Reviewed: Jun 24, 2020~~
~~Revised: Sep 28, 2022~~
Revised: Sep 25, 2024
Revised: tbd

1. PURPOSE

~~As reflected in the Algoma Public Health Strategic Plan the Board of Health strongly supports the principles of accountability and transparency.~~ This policy regarding Meetings and Access to Information instructs the board, and informs the public as to:

- how meetings of the board will be held;
- how the public can access information from board meetings;
- how information from board meetings will be disseminated;
- the terms under which a meeting or part of a meeting may be closed to the public in accordance with Section 239 of the *Municipal Act.*

2. POLICY

Board of Health meetings are open to the public and the board will conduct its meetings subject to Section 239 of the Municipal Act.

The Chair of the Board of Health, in collaboration with the Medical Officer of Health/CEO, will prepare an agenda for each regular and special Board of Health meeting for distribution to the members of the Board of Health.

The chair of each committee, in collaboration with the Medical Officer of Health/CEO, will prepare an agenda for each committee meeting.

The Medical Officer of Health/CEO or designate will provide briefing notes that outline an issue, recommended course of action, alternative courses of action, background and analysis, and financial implications on matters for which the Board of Health will be required to make a decision.

At each Board of Health regular meeting, the Medical Officer of Health/Executive Officer or designate may provide the following information:

- Minutes from the previous Board of Health meeting
- Report of the Medical Officer of Health to address key issues since the last report that may include:
    - Updates on the implementation of public health programs and services
    - Updates on emerging provincial public health issues
    - Updates on community-based public health issues or actions

- Descriptions of new or ongoing corporate initiatives
- Information on policy and procedure issues
- Target Indicators
- Biannual updates on progress related to the Strategic Plan
- Other information items of relevance to the Board of Health

Minutes of Board of Health, Finance Committee and Governance Committee meetings will be posted on Algoma Public Health's website and emailed to each municipal clerk in Algoma Public Health's catchment area with the exception of the in-committee minutes.

Copies of board records in the possession or under the control of the board secretary may also be made available to members of the public and shall be processed in accordance with the ~~General Administrative Manual (GAM)~~ policy for information requests.

Municipal Freedom of Information and Protection of Privacy Act does not apply to a record of a meeting closed under subsection (3.1). 2006, c. 32, Sched. A, s. 103 (3) of the *Municipal Act*.

In the event that APH receives a complaint relating to a closed Board of Health meeting, APH will utilize the services of the Ombudsman Ontario as the investigator when required in accordance with s.239 of the *Municipal Act*. (reference 03-08).

The Secretary to the Board of Health will ensure that members of the media covering board meetings have access to relevant information.

In accordance with Section 239 of the *Municipal Act,* which also applies to local boards or committees of local boards, a meeting or part of a meeting may be **closed** to the public if the subject matter being considered is:

- the security of the property of the municipality or local board;
- personal matters about an identifiable individual, including municipal or local board employees;
- a proposed or pending acquisition or disposition of land by the municipality or local board;
- labour relations or employee negotiations;
- litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;
- advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
- a matter in respect of which a council, board, committee or other body may hold a closed meeting under another act;

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

- a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the municipality or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;

- a trade secret or scientific, technical, commercial or financial information that belongs to the municipal local board and has monetary value or potential monetary value; or

- a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board. 2001, c. 25, s. 239 (2); 2017, c. 10, Sched. 1, s. 26.

- A meeting is held for the purpose of educating or training the members, and at the meeting, no member discusses or otherwise deals with any matter in a way that materially advances the business or decision-making of the council, local board or committee.
  2006, c. 32, Sched. A, s. 103 (1).

- Biannual updates related to the Accountability Agreement performance.

A meeting shall be closed to the public if the subject matter relates to the consideration of a request under the *Municipal Freedom of Information and Protection of Privacy Act* if the council, board, commission or other body is the head of an institution for the purposes of that act.
(1990, c. 25, s. 239 (3))

Before holding a meeting or part of a meeting that is to be closed to the public, a municipality or local board or committee of either of them shall state by resolution,

a. the fact of the holding of the closed meeting and the general nature of the matter to be considered at the closed meeting or

b. in the case of education or training sessions, the fact of the holding of the closed meeting, the general nature of its subject-matter and that it is to be closed under article 239 subsection 3.1 of the *Municipal Act.*

Ontario Building Code Appointments Bylaw

REFERENCE #:	06-02	**DATE:**	Original: Apr 19, 2006 ~~Revised: May 23, 2018~~ ~~Reviewed: Jun 24, 2020~~ ~~Revised: Sep 28, 2022~~ Revised: Nov 27, 2024 Revised: tbd
APPROVED BY:	Board of Health		
SECTION:	Bylaws		

Being a Bylaw of the Board of Health of Algoma Public Health to appoint a Chief Building Official and Inspectors for the purposes of the enforcement of the Ontario Building Code (OBC) Act respecting sewage systems.

WHEREAS the Building Code Act, S.O. 1992, Chapter 23, provides that a Board of Health appoints a Chief Building Official and such inspectors as are necessary for the purpose of enforcement of the Act;

AND WHEREAS the Board of Health of Algoma Public Health deems it desirable to appoint a Chief Building Official and inspectors for the enforcement of the Building Code Act for the purposes of sewage systems, in the jurisdiction of Algoma Public Health;

AND WHEREAS the Building Code Act, S.O. 1992, Chapter 23, Section 7.1. requires the establishment and the enforcement of a code of conduct for the Chief Building Officials and Inspectors;

NOW THEREFORE THE BOARD OF HEALTH OF ALGOMA PUBLIC HEALTH HEREBY ENACTS AS FOLLOWS:

a. The Manager of Environmental Health shall be appointed as the Chief Building Official (CBO).

b. In the absence of the CBO, at the manager level, an Ontario Building Code-trained staff member~~ inspector~~ with CBO designation shall be appointed~~ by the Manager of Environmental Health~~ as ~~their~~ a temporary alternate (Temporary Acting CBO). ~~The chair~~Chair of the Board of Health ~~will be notified of this temporary alternate appointment.~~ Any dispute arising during the absence of the CBO can be heard by the Temporary Acting CBO. The Chair of the Board of Health will be notified if a Temporary Acting CBO is not able to be appointed in the absence of the CBO.

c. The CBO or Temporary Acting CBO shall have all the powers and duties as set out in Section 1.1(6) of the Building Code Act, S.O. 1992 for CBO.

d. The CBO or Temporary Acting CBO shall meet the qualifications and registration as required in Section 3.1.2, Division C, Part 3 of the Ontario Building Code and register annually on the Ministry of Housing and Municipal Affairs Quarts website for the duration that they are appointed as CBO.

e. OBC trained inspector(s) that meet the qualifications under Part 8 of the Building Code shall register annually on the Ministry of Housing and Municipal Affairs Quarts website. OBC inspectors are appointed under Section 3.1.4, Division C, Part 3 of the Ontario Building Code to carry out duties for Part 8 - Sewage Systems on behalf of Algoma Public Health.

f. The CBO and CBO-trained staff ~~inspectors~~ shall act in accordance with the policies and procedures governing employees at APH, including the Code of Conduct.

Enacted and passed by the Algoma Health Unit Board on this 16th day of April 2006

Original signed by
G. Caputo, Chair
A. Northan, MOH

Revised and passed by the Algoma Public Health Board on this 27th day of November 2024

S. Hagman, Chair

L. Morrisette, 1st Vice Chair

To Regulate the Proceedings of the Board of Health Bylaw

REFERENCE #:	95-1	**DATE:**	Original: Dec 13, 1995 ~~Reviewed: Nov 20, 2019~~ ~~Revised: Sep 22, 2021~~ ~~Revised: Sep 28, 2022~~ Revised: Nov 27, 2024 Revised: tbd
APPROVED BY:	Board of Health		
SECTION:	Bylaws		

The Board enacts as follows:

1. Interpretation

In this By-law:

a) "Act" means the Health Protection and Promotion Act. R.S.O. 1990, Chapter H.7 as amended;

b) "Board" means THE BOARD OF HEALTH FOR THE DISTRICT OF ALGOMA HEALTH UNIT, as prescribed;

c) "Chair" means the person presiding at the meeting of the Board;

d) "Chair of the Board" means the Chair elected under Section 57 of the Act which reads:

At the first meeting of the Board of Health each year, the members of the Board shall elect one of the members to be Chair and one to be Vice-Chair of the Board for the year;

e) "Committee" means a committee of the Board but does not include the Committee of the Whole;

f) "Committee of the Whole" means all the members present at a meeting of the Board sitting in Committee;

g) "Conflict of Interest" as per A.P.H. policy 02-05-015: Conflict of Interest.

h) "Meeting" means a meeting of the Board;

i) "Member" means a member of the Board;

j) "Quorum" means a majority of the current members of the Board (MOHLTC Communication 2016) and that there must be at least five current members of the Board;

k) "Secretary" means the Secretary of the Board of Health;

l) Words that indicate singular masculine gender only shall include plural and/or feminine gender.

2. General

a) The Board shall hold the first meeting each year not later than the first day of February. At the first meeting of the Board in each year, members of the Board shall elect one member to be Chair, one member to be First Vice-Chair and one member to be Second Vice-Chair of the Board for the year. The First Vice-Chair shall chair the Finance and Audit Committee, and the Second Vice-Chair shall chair the Governance Committee.

b) The Board shall consist of the members as prescribed under the Act.

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

d) In all the proceedings at or taken by this Board, the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board and in the Committee(s) thereof.

e) Except as herein provided**, *Robert's Rules of Order* s**hall be followed for governing the proceedings of the Board and the conduct of its members.

f) A person who is not a member of the Board shall not be permitted to address the Board except upon invitation of the Chair subject to written request to the Secretary at least two weeks prior to the scheduled meeting.

g) In unusual circumstances, persons who have not requested in writing to address the Board may address the Board, provided two-thirds of the Board's members are in agreement.

3. Meetings

a) Regular Meetings:

i. The regular meetings shall be held at a date and time determined by the board annually at the first meeting of the year;

ii. The Board may, by resolution, alter the time, day or place of any meeting;

iii. It is expected that commitments to regularly scheduled Board meetings be honoured by the Board members;

iv. Three consecutive absences from regular Board meetings by a member of the Board will be reviewed by the Chair of the Board with the member in question, following which notification may be forwarded to the appropriate municipality, council or the province.

b) Special Meetings:

i. A special meeting of the Board shall not be called for a time which conflicts with a regular meeting previously called of (participating) council(s) or municipality(s).

ii. A special meeting may be called by the Chair of the Board of Health.

iii. The Secretary shall call a special meeting upon receipt of a petition signed by the majority of Board members, for the purpose and at the time mentioned in the petition.

4. Notice of Meetings:

a) The Secretary shall give notice of each regular and special meeting of the Board and of each Committee to the members thereof and to the heads of departments concerned with such meetings.

b) The notice shall be accompanied by the agenda and any other matter, so far as is known, to be brought before such meeting.

c) The notice for a regular meeting shall be delivered or sent by electronic means or courier to the residence or place of business of each member so as to be received no later than three working days prior to the day of the meeting.

d) The notice for a special meeting may be sent by telephone or by electronic means, with the Secretary confirming receipt.

e) No errors or omissions in giving such notice for the meeting shall invalidate it or any action taken.

f) The notice calling a special meeting of the Board shall state the business to be considered at the special meeting, and no business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

5. Preparation of the Agenda:

a) The Secretary shall have prepared for the use of members at the regular meetings the Agenda as follows:

i. Call to Order

ii. Declaration of Conflict of Interest

iii. Adoption of Agenda

iv. Delegations / Presentations

v. Adoption of Minutes of Previous Meeting

vi. Business Arising from Minutes

vii. Report of Medical Officer of Health

viii. Reports of Committees

ix. New Business / General Business

x. Correspondence requiring action

xi. Correspondence for information

xii. Addendum

xiii. In-Camera

xiv. Open Meeting

xv. Announcements / Next Committee Meetings

xvi. Adjournment

b) For special meetings, the agenda shall be prepared when and as the Chair of the Board may direct or, in default of such direction, as provided in the last preceding section so far as is applicable.

c) The business for each meeting shall be taken up in the order in which it stands upon the agenda unless otherwise decided by the Board.

6. Commencement of Meetings:

a) As soon as there is a quorum after the hour fixed for the meeting, the Chair of the Board or First Vice-Chair of the Board, if the Chair is not present or the Second Vice-Chair if the First Vice-Chair is not present, shall take the Chair and call the members to order.

b) If the Chair or Vice-Chairs are not present or their duly appointed representative, but a quorum is otherwise achieved, the Secretary shall call the members to order, and a presiding officer shall be appointed by the Secretary to preside during the meeting or until the arrival of the person who ought to preside.

c) If there is no quorum within 15 minutes after the time appointed for the meeting, the Secretary shall call the roll and take down the names of the members then present. If an absence of an expected quorum occurs ~~due to a health emergency or to weather conditions~~ and business must be expedited, the Board shall have the privilege of designating items of business as essential to be expedited at that meeting. Under these conditions, the Board shall have the privilege of conducting the necessary items of business but such items shall be confirmed at the next meeting of the Board.

7. Rules of Debate and Conduct of Members of the Board

a) The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on point of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

b) Each deputation will be allowed a maximum of one speaker for a maximum of 5 minutes, but a member of the Board may introduce a deputation in addition to the speaker or speakers.

Normally, a deputation will not be heard on an item unless there is a report from staff on the item or upon agreement of two-thirds of the Board present.

c) Every member, prior to speaking to any question or motion, shall be acknowledged by the Chair.

d) When two or more members ask to speak, the Chair shall name the member who, in his opinion, first asked to speak. The Chair shall develop a speakers list when more than one member wishes to address each item.

e) A member may speak more than once on a question but, after speaking, shall be placed at the foot of the list of members wishing to speak.

f) A motion for introducing a new matter shall not be presented without notice unless the Board, without debate, dispenses with such notice by a majority vote and no report requiring action of the Board shall be introduced to the Board unless a copy has been placed in the hands of the members at least one day prior to the meeting, except by a majority vote, taken without debate.

g) Every motion presented to the Board shall be written.

h) Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair but may, with permission of the Board, be withdrawn at any time before amendment or decision.

i) When a matter is under debate, no motion shall be received other than a motion:

   i. to adopt,

   ii. to amend,

   iii. to defer action,

   iv. to refer,

   v. to receive,

   vi. to adjourn the meeting or

   vii. that the vote be now taken.

j) A motion

   i. to refer or defer shall take precedence over any other amendment or motion except a motion to adjourn.

   ii. to refer shall require direction as to the body to which it is being referred and is not debatable.

   iii. to defer must include a reason and a time period for the deferral and is not debatable.

k) When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and if carried by a majority vote of the members present, the motion and any

amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

l) Any member, including the Chair, may propose or second a motion, and all members, including the Chair, shall vote on all motions except when disqualified by reasons of interest or otherwise; a tie vote shall be considered lost. When the Chair proposes a motion, he shall vacate the Chair to one of the Vice-Chairs during debate on the motion and reassume the Chair following the vote.

8. Duties of the Secretary for the Board

It shall be the duty of the Secretary:

a) to attend or cause an assistant to attend all meetings of the Board;

b) to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of by-laws and resolutions passed by it; and

c) to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same.

d) to give all notices required to be given to the members.

9. Appointment and Organization of Committees

a) At the first meeting in any year, the Board shall appoint the members required by the Board to standing committees(s) (Finance and Audit Committee, Governance Committee). When a new member(s) join the Board after the first meeting of the year, the Board shall appoint the new member(s) to one of the standing committees.

b) The Board may appoint committees from time to time to consider such matters as specified by the Board.

10. Conduct of Business in Committees

a) The rules governing the procedure of the Board shall be observed in the Committees insofar as applicable.

b) It shall be the duty of the Committee:

i. to report to the Board on all matters referred to them and to recommend such action as they deem necessary;

ii. to report to the Board the number of meetings called during a year, at which a quorum was present, and the number of meetings attended by each member of the Committee; and

iii. to forward to the incoming Committee for the following year any matter undisposed of.

11. Procedures of the Board Covered by other By-laws

The procedures of the Board with respect to:

a) incurring of liabilities and paying of accounts;

b) authority for expenditures;

c) audits;

d) budgets and settlements;

shall be in accordance with the By-laws #95-2 and #95-3.

12. Short Name

The Board will use the short name Algoma Public Health for signage, communications and, promotional messaging and other matters as warranted.

13. Execution of Documents

a) The Board may, at any time and from time to time, direct the manner in which and the person or persons who may sign on behalf of the Board any particular contract, arrangement, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, conveyances, mortgages, obligations or documents.

b) In general, unless changed by a resolution of the Board, the following applies:

i. Budgets and Settlement Forms will be signed by the combination of Board member(s) and staff of the agency as required by Ministry specifications;

ii. Leases for real estate, mortgages or other loan documents will be signed by ~~the Chair of the Board and by~~ the Medical Officer of Health/ CEO, and, where indicated in the Procurement Policy 02-05-002, by the Chair of the Board of Health

iii. Leases or purchase agreements for vehicles, as approved in budgets, will be signed by the ~~Senior Financial Leader of A.P.H.~~Director of Corporate Services and/or the Medical Officer of Health or a Senior Administrative Leader (should two signatures be necessary);
/

iv. Purchase of service agreements with service providers for programs will be signed by the MOH/CEO and by the appropriate program Director.

v. Purchase of service agreements with service providers for financial, building and corporate services will be signed by the Medical Officer of Health/CEO or ~~Senior Financial Leader of APH.~~Director of Corporate Services or Senior Administrative Leader.

14. Duties of Officers

a) The Chair of the Board shall:

i. preside at all meetings of the Board;

ii. represent the Board at public or official functions or designate another Board member to do so;

iii. be ex-officio a member of all Committees to which he has not been named a member;

iv. complete performance appraisals according to Policy #02-05-080 of the Medical Officer of Health/CEO using input from the Medical Officer of Health/CEO as well as the members of the Board, with the results of this appraisal being shared with the Board members in-camera;

v. perform such other duties as may from time to time be determined by the Board.

b) The First Vice-Chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of the Chair of the Board, together with such powers and duties, if any, as may be from time to time assigned by the Board. The Second Vice-Chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of both the Chair of the Board and the First Vice-chair, together with such powers and duties, if any, as may be from time to time assigned by the Board.

15. Amendments

The Board shall consist of the members as prescribed under the Act; Any provision contained herein may be repealed, amended or varied, and additions may be made to this By-law by a majority vote of members present at the meeting at which such motion is considered to give effect to any recommendation contained in a Report to the Board, and such report has been transmitted to members of the Board prior to the meeting at which the report is to be considered. No motion for that purpose may be considered unless notice thereof has been received by the Secretary two weeks before a Board meeting, and such notice may not be waived, and in any event, no bill to amend this By-law shall be introduced at the same meeting as that at which such report or motion is considered.

16. Dismissal of Medical Officer(s) of Health

a) A decision by the Board of Health to dismiss a Medical Officer of Health from office is not effective unless:

i. the decision is carried by the vote of two-thirds of the members of the Board; and

ii. the minister consents in writing to the dismissal. R.S.O. 1990 c.H7, s.66(1)

b) The Board of Health shall not vote on the dismissal of a Medical Officer of Health unless the Board has given to the Medical Officer of Health:

i. reasonable written notice of the time, place and purpose of the meeting at which the

dismissal is to be considered;

ii. a written statement of the reason for the proposal to dismiss the Medical Officer of Health; and

iii. an opportunity to attend and to make representation to the Board at the meeting. R.S.O. 1990, c.H7, S.66(2)

17. Reporting of Medical Officer of Health/CEO to the Board of Health

a) The Medical Officer of Health/CEO of a board of health reports directly to the Board of Health on issues relating to public health concerns and to public health programs and services under this or any other Act. The Medical Officer of Health of a Board of Health is responsible to the Board for the management of the public health programs and services under this or any other Act. (HPPA, s.67(1) and (3))

b) The Medical Officer of Health/CEO of a board of health is entitled to notice of and to attend each meeting of the Board and every Committee of the Board, but the Board may require the Medical Officer of Health/CEO to withdraw from any part of a meeting at which the Board or a Committee of the Board intends to consider a matter related to the remuneration or the performance of the duties of the Medical Officer of Health/CEO (HPPA, s70).

Enacted and passed by the Algoma Health Unit Board this 13th day of December 1995.

Original signed by
I. Lawson, Chair
G. Caputo, Vice-chair

Revised and passed by the Algoma Public Health Board on this 27th day of November 2024

S. Hagman, Chair

L. Morrisette, 1st Vice Chair

Robin
LENNOX
Member of Provincial Parliament for Hamilton Centre

July 23, 2026

RE: Bill 121, Save a Life Act (Naloxone Kit Registration and Public Access), 2026

Dear Members of Algoma Board of Health,

What if naloxone kits were co-located with AEDs and in other critical public spaces across Ontario?

MPP Dr. Robin Lennox, Hamilton Centre and her colleagues MPP France Gélinas, MPP Lisa Gretzky, and MPP Lise Vaugeois have recently introduced Bill 121: *Save a Life Act, 2026*, and are requesting the support of your Board of Health as we confront the toxic drug crisis in Ontario.

The Save a Life Act would ensure that naloxone is available in public spaces where opioid poisonings may occur. Currently, Ontarians' lives are saved by automated external defibrillators (AEDs) which are housed in community centres and other public spaces. This legislation will ensure that naloxone is equally accessible and available to save lives.

Expanding access to naloxone in public spaces has the potential to save lives by enabling rapid intervention during opioid poisonings, even before emergency responders arrive. Paramedic responses to opioid poisonings are rising in Ontario. Across Ontario, EMS calls for opioid toxicity rose from 604 (Q1 2025) to 739 (Q2 2025) to 1,024 (Q3 2025).

Ontario's health-care system continues to face considerable pressures, particularly within emergency medical services, emergency departments, and critical care units. Community-based interventions to respond to opioid poisonings could reduce the demand on already strained acute care resources.

Considering these public health benefits, we respectfully request that your Board of Health pass a motion endorsing Bill 121, Save a Life Act, and forward a copy of the motion to the Premier of Ontario and the Minister of Health in support of this important initiative.

Sincerely,

Robin Lennox, MD, CCFP
MPP Hamilton Centre

QUEEN'S PARK OFFICE
Room N202, Main Legislative Building
Queen's Park, Toronto, ON M7A 1A8
416-325-1796 RLennox-QP@ndp.on.ca

COMMUNITY OFFICE
630 Main Street East,
Hamilton ON L8M 1J7
905-544-9644 RLennox-CO@ndp.on.ca

Private Member's Bill	Projet de loi de député
MOTION FOR FIRST READING	MOTION DE PREMIÈRE LECTURE
MPP R. Lennox	Député(e) R. Lennox
I move that leave be given to introduce a Bill entitled	**Je propose** qu'il soit permis de déposer un projet de loi intitulé
"An Act to enact the Save a Life Act (Naloxone Kit Registration and Public Access), 2026"	«Loi édictant la Loi de 2026 visant à sauver des vies (accès public aux trousses de naloxone et leur enregistrement)»
and that it now be read the first time.	et que ce texte soit maintenant lu une première fois.

…….
Bill no. — N° du projet de loi

…….
First Reading Date — Date de la première lecture

…….
Clerk's Signature — Signature du greffier

Co-sponsors:	Coparrains :
MPP R. Lennox	Député(e) R. Lennox
MPP F. Gélinas	Député(e) F. Gélinas
MPP L. Gretzky	Député(e) L. Gretzky
MPP L. Vaugeois	Député(e) L. Vaugeois

Save a Life Act (Naloxone Kit Registration and Public Access), 2026

EXPLANATORY NOTE

The *Save a Life Act (Naloxone Kit Registration and Public Access), 2026* is enacted. The Act imposes certain requirements respecting the installation, maintenance, testing and availability of naloxone kits at designated premises. Designated premises include any premises at which a defibrillator is installed and any publicly accessible premises that are designated by the regulations.

The Act also requires naloxone kits at designated premises to be registered with the registrar within specified time periods, and requires prescribed persons to be notified of the registrations. Regulations may be made under the Act setting out details relating to the requirements under the Act.

Bill **2026**

An Act to enact the Save a Life Act (Naloxone Kit Registration and Public Access), 2026

CONTENTS

Preamble

Each year, more than 2,000 Ontarians die from opioid poisoning. Data indicates that for every opioid toxicity death, roughly 15 non-fatal overdoses may occur that require intervention with tools such as naloxone. Naloxone can safely be administered by bystanders to reverse opioid toxicities as they are occurring. Many opioid toxicity events are occurring in public places. Ensuring that naloxone kits are available to members of the public may prevent tragedies from occurring.

Therefore, His Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

Definitions

1. In this Act,

"Minister" means the member of the Executive Council to whom responsibility for the administration of this Act is assigned or transferred under the *Executive Council Act*; ("ministre")

"naloxone kit" has the same meaning as in section 25.2 of the *Occupational Health and Safety Act*; ("trousse de naloxone")

"regulations" means the regulations made under this Act; ("règlements")

"prescribed" means prescribed by the regulations. ("prescrit")

Designation of registrar

2. The Minister may designate a registrar for the purpose of this Act.

Designated premises

3. (1) The following are designated premises for the purpose of this Act:

1. Subject to any prescribed exceptions, any premises at which a person is required by law to ensure that a defibrillator is installed.

2. Subject to any prescribed exceptions, any premises at which a person elects to install a defibrillator.

3. Any other publicly accessible premises that are designated by the regulations.

Installation, etc., of naloxone kits

(2) Every person who owns or operates designated premises shall,

(a) ensure that naloxone kits are installed at the premises in accordance with the regulations;

(b) ensure that any naloxone kit installed at the premises is available for use in locations that facilitate easy access to the naloxone kit, as described in the regulations;

(c) ensure that the location of a naloxone kit at the premises is appropriately indicated with signs in accordance with the regulations;

(d) ensure that any naloxone kit installed at the premises is maintained and tested in accordance with the manufacturer's guidelines and with any other guidelines as may be prescribed; and

(e) ensure that training is undertaken by prescribed persons for the use of a naloxone kit, according to the prescribed training and education guidelines.

Registration of naloxone kit

4. (1) Every person who owns or operates designated premises at which a naloxone kit is installed shall register the naloxone kit with the registrar,

(a) within 30 days after it is installed; or

(b) if, on the day this subsection comes into force, the naloxone kit has already been installed, no later than 30 days after that day.

Naloxone kit moved or removed

(2) Subject to the regulations, if a naloxone kit registered with the registrar is moved to a different location at the designated premises, or is removed from the premises for any reason, the owner or operator of the premises must notify the registrar in accordance with the regulations.

Notification re naloxone kit

5. The registrar must, in accordance with the regulations, notify the prescribed persons about,

(a) the registration of a naloxone kit under section 4; or

(b) the subsequent moving of the naloxone kit to a different location within the premises or its removal from the premises.

Inspectors

6. (1) The Minister may appoint inspectors for the purposes of this Act.

Inspection

(2) An inspector may, without warrant and without notice, enter any premises that is not a dwelling at any reasonable time and conduct inspections for the purpose of determining compliance with the requirements under this Act.

Identification

(3) An inspector conducting an inspection shall produce, on request, evidence of his or her appointment.

Powers of inspector

(4) An inspector conducting an inspection may,

(a) examine and make copies of a document or other thing that is relevant to the inspection;

(b) search for or demand the production for inspection of a document, in a readable format, or other thing, that is relevant to the inspection;

(c) remove a document or other thing that is relevant to the inspection for the purpose of making a copy, and return the document or other thing as promptly as reasonably possible; and

(d) question a person on matters relevant to the inspection.

Copy admissible in evidence

(5) A copy of a document or other thing that purports to be certified by an inspector as being a true copy of the original is admissible in evidence to the same extent as the original and has the same evidentiary value as the document or other thing itself without proof of the signature or official character of the person appearing to have certified the copy.

Obstruction

(6) No person shall obstruct, hinder or interfere with or attempt to obstruct, hinder or interfere with an inspector conducting an inspection or refuse to answer questions on matters relevant to the inspection.

False information, etc.

(7) No person shall provide an inspector with information that the person knows to be false or misleading, or conceal or destroy anything that is relevant to an inspection.

Offence

7. (1) A person is guilty of an offence if the person,

(a) contravenes a provision of this Act;

(b) obstructs, hinders or interferes with or attempts to obstruct, hinder or interfere with an inspector conducting an inspection contrary to subsection 6 (6); or

(c) provides false or misleading information to an inspector or conceals or destroys anything that is relevant to an inspection contrary to subsection 6 (7).

Penalty, individual

(2) An individual who is convicted of an offence under subsection (1) is liable to the prescribed fine.

Penalty, corporation

(3) A corporation that is convicted of an offence under subsection (1) is liable to the prescribed fine.

Same, officers and directors

(4) An officer or director of a corporation who authorizes or permits the corporation to commit an offence under subsection (1) is guilty of an offence and on conviction is liable to the prescribed fine.

Crown bound

8. This Act binds the Crown.

Regulations

9. The Lieutenant Governor in Council may make regulations,

(a) designating publicly accessible premises for the purposes of section 3;

(b) governing the registration of naloxone kits;

(c) prescribing and governing any matter that this Act describes as being prescribed, done in accordance with the regulations or provided for in the regulations;

(d) governing the powers and duties of inspectors appointed for the purposes of this Act, the obligations of other persons in respect of inspections conducted by an inspector and the admissibility in court of evidence procured by the inspector;

(e) respecting any matter necessary or advisable to effectively carry out the purposes of this Act.

Commencement

10. This Act comes into force six months after the day it receives Royal Assent.

Short title

11. The short title of this Act is the *Save a Life Act (Naloxone Kit Registration and Public Access), 2026*.

Loi de 2026 visant à sauver des vies (accès public aux trousses de naloxone et leur enregistrement)

NOTE EXPLICATIVE

La *Loi de 2026 visant à sauver des vies (accès public aux trousses de naloxone et leur enregistrement)* est édictée. La Loi prévoit certaines obligations en matière d'installation, d'entretien, de mise à l'essai et de mise à disposition des trousses de naloxone dans les lieux désignés. Les lieux désignés comprennent les lieux où un défibrillateur est installé ainsi que les lieux accessibles au public qui sont désignés par règlement.

La Loi exige également que les trousses de naloxone installées dans des lieux désignés soient enregistrées auprès du registrateur dans des délais précisés et que les personnes prescrites soient avisées des enregistrements. Les détails des exigences prévues par la Loi peuvent être précisés par règlement.

Loi édictant la Loi de 2026 visant à sauver des vies (accès public aux trousses de naloxone et leur enregistrement)

SOMMAIRE

Préambule

Chaque année, plus de 2 000 Ontariens et Ontariennes meurent d'une intoxication aux opioïdes. Les statistiques montrent que pour chaque décès par intoxication liée aux opioïdes, environ 15 surdoses non mortelles peuvent survenir, lesquelles nécessitent le recours à certains instruments comme la naloxone. La naloxone peut être administrée de façon sécuritaire par des passants afin de renverser les effets d'une surdose d'opioïdes en cours – un grand nombre desquelles se produisent dans des lieux publics. En mettant des trousses de naloxone à la disposition du public, de nombreuses tragédies pourraient être évitées.

Pour ces motifs, Sa Majesté, sur l'avis et avec le consentement de l'Assemblée législative de la province de l'Ontario, édicte :

Définitions

1. Les définitions qui suivent s'appliquent à la présente loi.

«ministre» Le membre du Conseil exécutif à qui la responsabilité de l'application de la présente loi est assignée ou transférée en vertu de la *Loi sur le Conseil exécutif*. («Minister»)

«prescrit» Prescrit par les règlements. («prescribed»)

«règlements» Les règlements pris en vertu de la présente loi. («regulations»)

«trousse de naloxone» S'entend au sens de l'article 25.2 de la *Loi sur la santé et la sécurité au travail*. («naloxone kit»)

Désignation de registrateurs

2. Le ministre peut désigner un registrateur pour l'application de la présente loi.

Lieux désignés

3. (1) Les lieux suivants sont désignés pour l'application de la présente loi :

1. Sous réserve des exceptions prescrites, tout lieu où une personne est tenue par la loi de veiller à ce qu'un défibrillateur soit installé.

2. Sous réserve des exceptions prescrites, tout lieu où une personne choisit d'installer un défibrillateur.

3. Les autres lieux accessibles au public qui sont désignés par règlement.

Installation, accès et entretien des trousses de naloxone

(2) Le propriétaire ou l'exploitant d'un lieu désigné s'assure que :

a) des trousses de naloxone sont installées dans le lieu conformément aux règlements;

b) les trousses de naloxone installées dans le lieu sont situées à des endroits facilement accessibles conformément aux règlements;

c) les endroits où se trouvent les trousses de naloxone sont indiqués de façon adéquate à l'aide de panneaux conformément aux règlements;

d) les trousses de naloxone installées dans le lieu sont entretenues et mises à l'essai conformément aux lignes directrices du fabricant et aux autres lignes directrices prescrites, le cas échéant;

e) les personnes prescrites suivent une formation sur l'utilisation d'une trousse de naloxone conformément aux lignes directrices prescrites en matière de formation et d'instruction.

Enregistrement

4. (1) Le propriétaire ou l'exploitant d'un lieu désigné où une trousse de naloxone est installée enregistre la trousse de naloxone auprès du registrateur :

a) dans les 30 jours suivant l'installation de la trousse de naloxone;

b) si la trousse de naloxone est déjà installée le jour de l'entrée en vigueur du présent paragraphe, au plus tard 30 jours après ce jour.

Déplacement ou enlèvement

(2) Sous réserve des règlements, si une trousse de naloxone enregistrée auprès du registrateur est déplacée dans le lieu désigné où elle est située ou est enlevée du lieu pour une raison quelconque, le propriétaire ou l'exploitant du lieu doit en aviser le registrateur conformément aux règlements.

Avis

5. Le registrateur doit aviser les personnes prescrites, conformément aux règlements, de ce qui suit :

a) l'enregistrement d'une trousse de naloxone en application de l'article 4;

b) le déplacement subséquent de la trousse de naloxone dans le lieu où elle est située ou son enlèvement du lieu.

Inspecteurs

6. (1) Le ministre peut nommer des inspecteurs pour l'application de la présente loi.

Inspection

(2) L'inspecteur peut, sans mandat ni préavis, pénétrer à toute heure raisonnable dans tout lieu qui n'est pas un logement et y effectuer des inspections afin de déterminer si les exigences prévues par la présente loi sont respectées.

Identification

(3) L'inspecteur qui effectue une inspection produit, sur demande, une preuve de sa nomination.

Pouvoirs de l'inspecteur

(4) L'inspecteur qui effectue une inspection peut :

a) examiner des documents ou toute autre chose se rapportant à l'inspection et en tirer des copies;

b) chercher des documents, sur support lisible, ou toute autre chose se rapportant à l'inspection, ou en demander formellement la production;

c) enlever des documents ou toute autre chose se rapportant à l'inspection pour en tirer des copies et les remettre aussi promptement que raisonnablement possible;

d) interroger des personnes sur toute question se rapportant à l'inspection.

Copies admissibles en preuve

(5) Les copies de documents ou de toute autre chose qui se présentent comme étant certifiées conformes aux originaux par l'inspecteur sont admissibles en preuve au même titre que les originaux et ont la même valeur probante que ceux-ci, sans qu'il soit nécessaire de prouver l'authenticité de la signature ou la qualité officielle de la personne qui semble les avoir certifiées.

Entrave

(6) Nul ne doit gêner ni entraver le travail de l'inspecteur qui effectue une inspection, ou tenter de le faire, ni refuser de répondre à des questions se rapportant à l'inspection.

Faux renseignements

(7) Nul ne doit fournir à l'inspecteur des renseignements qu'il sait faux ou trompeurs ni dissimuler ou détruire quoi que ce soit se rapportant à l'inspection.

Infraction

7. (1) Est coupable d'une infraction quiconque, selon le cas :

a) contrevient à une disposition de la présente loi;

b) gêne ou entrave le travail de l'inspecteur qui effectue une inspection, ou tente de le faire, contrairement au paragraphe 6 (6);

c) fournit à l'inspecteur des renseignements qu'il sait faux ou trompeurs ou dissimule ou détruit quoi que ce soit se rapportant à l'inspection, contrairement au paragraphe 6 (7).

Peine : particulier

(2) Le particulier qui est déclaré coupable d'une infraction prévue au paragraphe (1) est passible de l'amende prescrite.

Peine : personne morale

(3) La personne morale qui est déclarée coupable d'une infraction prévue au paragraphe (1) est passible de l'amende prescrite.

Idem : dirigeants et administrateurs

(4) Le dirigeant ou l'administrateur d'une personne morale qui autorise ou permet la commission par la personne morale d'une infraction prévue au paragraphe (1) est coupable d'une infraction et passible, sur déclaration de culpabilité, de l'amende prescrite.

Obligation de la Couronne

8. La présente loi lie la Couronne.

Règlements

9. Le lieutenant-gouverneur en conseil peut, par règlement :

a) désigner des lieux accessibles au public pour l'application de l'article 3;

b) régir l'enregistrement des trousses de naloxone;

c) prescrire et régir tout ce que la présente loi mentionne comme étant prescrit, fait conformément aux règlements ou prévu par règlement;

d) régir les pouvoirs et fonctions des inspecteurs nommés pour l'application de la présente loi, les obligations d'autres personnes par rapport aux inspections effectuées par les inspecteurs et l'admissibilité devant un tribunal des preuves obtenues par les inspecteurs;

e) traiter de tout ce qui est nécessaire ou souhaitable pour réaliser efficacement l'objet de la présente loi.

Entrée en vigueur

10. La présente loi entre en vigueur six mois après le jour où elle reçoit la sanction royale.

Titre abrégé

11. Le titre abrégé de la présente loi est *Loi de 2026 visant à sauver des vies (accès public aux trousses de naloxone et leur enregistrement)*.

Algoma PUBLIC HEALTH
Santé publique Algoma
www.algomapublichealth.com

Briefing Note

To: The Board of Health

From: Hilary Gordon, Manager Community Wellness & School Health

Written by: Dr. Lyall Pacey, Resident Physician

Date: 9/23/2026

Re: Endorsement of Bill 121 – Save a Life Act

☒ **For Information** ☐ **For Discussion** ☒ **For a Decision**

PURPOSE

MPP Robin Lennox requests the Algoma Board of Health's endorsement of Bill 121, which would ensure placement of naloxone kits in the same public places as Automated External Defibrillators (AEDs). This is in response to rising calls to EMS and accompanying pressure on health care resources.

KEY MESSAGES

- Compared to Ontario, Algoma carries a greater burden of deaths, health harms, and use of resources related to opioids.
- Naloxone can reverse opioid poisoning, and naloxone availability in public places can allow trained members of the public to potentially help save a life.
- Bill 121 proposes to make naloxone kits available at the same locations as AEDs throughout the province.

RECOMMENDED ACTIONS

- That the Board of Health consider a motion to endorse Bill 121, as requested in the correspondence from MPP Robin Lennox.
- That the Board of Health continue to provide strong support for the work of Algoma Public Health (APH) and community partners as we, in alignment with strategic priorities and prevailing provincial direction:
    - Continue to improve local naloxone access broadly across Algoma;
    - Implement upstream strategies that prevent or delay harms associated with substance use; and
    - Embed this work in trauma and violence-informed approaches, which decrease stigma and increase safety, control, and resilience for people who use drugs who are seeking services.

BACKGROUND

- Ontario's **Bill 121, *Save a Life Act (Naloxone Kit Registration and Public Access), 2026*** would require naloxone kits at premises where an AED is legally required or voluntarily installed. Owners/operators would have to ensure accessible placement, signage, maintenance, training and

registration of the kits, with compliance subject to inspection and offences; as of September 2026, the bill passed first reading in May 2026 and is awaiting second reading. [1]

- In 2025, Algoma residents died from opiate toxicity at a rate typically twice that of the average Ontarian, at 20.8 deaths per 100,000 people in the population. Though some are intentional, Algoma ED opioid poisoning visits are over 84% unintentional.[2]
    - The majority (77%) of drug-related deaths since 2022 occurred in private residences; 1% occur in shelters, 1% in public buildings, with somewhat more in outdoor spaces (5%), and hotels (6%). Personal naloxone kits can continue to protect against in-resident deaths, whereas public placement of kits may help protect people without kits in public.[3]
- The health services in Algoma face substantial resource demand from opioid-related issues, including 242 calls to EMS for suspected opioid poisonings and 124 per 100,000 visits to the ER in 2025 (vs. 55 per 100,000 in Ontario) in 2025.[2]
- The Ontario Naloxone Program (ONP) provides naloxone to members of the public at pharmacies and at strategic locations throughout the district. These nasal naloxone kits can be used by any person to help recover from harmful / fatal effects of opioid poisoning, such as stopped breathing or choking.
    - APH is the lead for naloxone distribution across Algoma; we have onboarded 41 community partners for distribution, including locations in Elliot Lake, Blind River, Central Algoma, Sault Ste. Marie, Wawa, and White River.
    - In Algoma, 4,474 and 15,626 kits were distributed at pharmacy and community sites respectively in 2025.[2]
- Through the ONP, APH ensures provision of naloxone to all eligible applicant agencies, which includes:
    - Health and social service agencies who work directly with individuals at risk of experiencing opioid-related harms; and
    - Police, fire, and first-on-scene emergency responders.
- In Ontario, AEDs are already a requirement in community centres, recreation facilities, schools, government buildings, large retail spaces, and certain construction sites.[1,4,5]

EVIDENCE & ANALYSIS

- Public access to naloxone is supported in academic literature:
    - An Alberta study found that every additional 10,000 publicly distributed naloxone kits in circulation were associated with a 23.9% reduction in opioid-related deaths.[6]
    - Direct public-access is effective, with 98% of untrained bystanders correctly administered naloxone from a simulated public station.[7]
    - A Metro Vancouver study of 14,089 opioid poisonings noted that take-home naloxone covered about 35% of cases, adding public placement (including at existing AED locations) to chain business (up to 22%) and transit sites (up to 53%) could provide substantial geographic coverage of poisoning events.[8]
- Several Ontario municipalities have already implemented similar programs:
    - Barrie, London, Brantford, and Kingston include publicly-accessible naloxone kits in AED cabinets at some or all municipal facilities.[9-12]
- Internally at APH, we already have naloxone placed with AEDs. Beyond the cost of additional signage indicating presence of naloxone, we already inspect our AEDs routinely, therefore minimal additional worker time is incurred by the addition of naloxone.

- Should Bill 121 receive royal assent, Algoma communities may see an increase in naloxone availability in public spaces that are required to have AEDs, including municipal recreation facilities/community centres (if not already included), large retail spaces, and government buildings.
- Though a valuable tool, naloxone is the most "downstream" intervention available. In addition to improving naloxone access in Algoma, APH also works to build understanding about substance use and addiction; build the safety, skills, and resilience of those using drugs; and prevent drug use through "upstream" community approaches, such as Nurturing Algoma and Planet Youth.

OPHS STANDARDS

Substance Use Prevention and Harm Reduction Guideline (2018): The board of health shall support the implementation of the Ontario Harm Reduction Program Enhancement which includes implementing or support the implementation of opioid overdose early warning systems and serving as naloxone distribution leads, and providing training and other supports, to eligible community organizations.[13]

STRATEGIC DIRECTIONS

- Our Community: Creating Meaningful Connection
  - *Broaden community outreach, digital presence, and low-barrier engagement opportunities*
- Our Approach: Focusing on Upstream Pathways
  - *Build capacity to strengthen community action, create supportive environments and promote local healthy public policy with community partners*
  - *Work at the systems level to better support people facing inequities*

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Health Unit

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TBDHU.COM

July 20, 2026

The Right Honourable Mark Carney, Prime Minister of Canada
80 Wellington Street Ottawa, ON K1A 0A2
Sent via email: PM@pm.gc.ca

The Honourable Doug Ford, Premier of Ontario
Legislative Building Queen's Park
Toronto, ON M7A 1A1
Sent via email: Premier@ontario.ca

Re: Improving Highway Safety in Northern Ontario

Dear Prime Minister Carney and Premier Ford,

On June 17, 2026, at a regular meeting of the Board of Health (the Board) for the Thunder Bay District Health Unit (TBDHU), the Board considered a letter from Northeastern Public Health (NEPH), which calls upon Federal and Provincial governments to improve highway safety in Northern Ontario with investments in infrastructure, considerations for equity, and proactive safety measures. The Board also received an update on Ontario's commitment to improve safety measures along the Highway 11/17 corridor, including increased enforcement, infrastructure improvements, and better support for commercial traffic.

The Trans-Canada Highway is a critical lifeline for residents of Northern Ontario, providing essential access to health care, education, employment, and other vital services. However, communities in the Thunder Bay District face significant threats to safety due to inadequate highway infrastructure and challenging road conditions. These risks are compounded by the region's long distances between communities, severe weather, heavy commercial traffic, and wildlife hazards.

Within the TBDHU region, land transport incidents (LTIs) are a cause of concern as they account for the third highest category (6.9%) of all emergency department visits for unintentional injuries. There are typically 1.5 times more LTIs in the TBDHU region compared to provincial rates.

With respect to provincial highways, Ontario Road Safety Annual Report data from 2015-2022 show that provincial highways consistently produced the largest share of roadway deaths in Thunder Bay District. While municipal roads generated many lower severity collisions, highway crashes were far more likely to result in fatal outcomes. This pattern reflects the unique transportation realities of Northwestern Ontario, where residents depend on long stretches of high-speed highways for work, health care, education, and essential services.

Several municipalities and unorganized areas experienced notable increases in collision activity over the 2015-2022 time period. Areas such as Greenstone and Oliver Paipoonge showed growth in reported collisions, reflecting increasing transportation pressures along major highway corridors.

Given the impact of land transport incidents in our catchment area, the TBDHU Board of Health endorses the letter and recommendations put forward by NEPH, and urges swift action on measures to improve safety along the Highway 11/17 corridor in Northern Ontario, a critical segment of the Trans-Canada Highway.

Sincerely,

James McPherson
Chair, Board of Health
Thunder Bay District Health Unit

cc:

The Honourable Steven MacKinnon, Minister of Transport
The Honourable Prabmeet Sarkaria, Minister of Transportation
Marcus Powlowski, MP – Thunder Bay – Rainy River
Patty Hajdu, MP – Thunder Bay- Superior North
Kevin Holland, MPP – Thunder Bay – Atikokan
Lise Vaugeois, MPP – Thunder Bay – Superior North
Northern Ontario Boards of Health
TBDHU District Municipalities

Northeastern
PUBLIC HEALTH
SANTÉ PUBLIQUE
du Nord-Est

January 14, 2026

The Right Honourable Mark Carney, Prime Minister of Canada
80 Wellington Street Ottawa, ON K1A 0A2
Sent via email: PM@pm.gc.ca

The Honourable Doug Ford, Premier of Ontario
Legislative Building Queen's Park
Toronto, ON M7A 1A1
Sent via email: Premier@ontario.ca

Dear Prime Minister Carney and Premier Ford

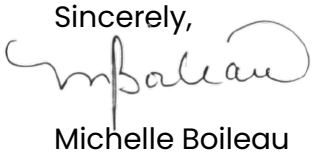
Re: Highway Safety in Northern Ontario

Highway safety in Northern Ontario has been a long-standing concern for Northern communities with tremendous tragic losses of beloved community members, impacts on local economies with frequent inability to access to work, education and necessary social and health care services. In addition, the Board of Health for the Northeastern Health Unit has seen the negative impacts and delays in emergency response systems during public health emergencies across the region. Please find enclosed a resolution along with a Briefing report outlining issues, impacts to public health, evidence and key recommended interventions for the improved development of Northern highways.

The Board of Health respectfully requests careful and urgent consideration of options to address highway safety and accessibility. While ensuring the same standards are available at minimum for residents of Northern Ontario would be preferred with four lane highways that are consistently cleared, FONOM's letter *A Nation-Building Case for a 2+1 Highway for enhanced east-west Canadian trade* issued by the Federation of Northern Ontario Municipalities (FONOM), shared important options for consideration. The Northern population already experiences poorer health outcomes on most indicators compared to the rest of the province, and prioritizing highway safety and accessibility across Northern Ontario is critical to protecting and preserving the health of our communities.

On behalf of the Board of Health, thank you for the attention that you will give to this report.

Sincerely,



Michelle Boileau
Chair, Board of Health
Northeastern Public Health

Copies to:
Right Honourable Mark Carney, Prime Minister of Canada
The Honourable, Steven Mackinnon, Minister of Transportation
Honourable Doug Ford, Premier of Ontario
Honourable Prabmeet Sarkaria, Minister of Transportation
Honourable Jill Dunlop, Minister of Emergency Preparedness and Response
Honourable Sylvia Jones, Minister of Health
Honourable Paul Calandra, Minister of Education
Honourable Michael S. Kerzner, Solicitor General
Honourable George Pirie, Minister Northern Economic Development and Growth, Member of Provincial Parliament – Timmins
Guy Bourgoin, Member of Provincial Parliament – Mushkegowuk – James Bay
John Vanthof, Member of Provincial Parliament – Timiskaming - Cochrane
Bill Rosenberg Member of Provincial Parliament – Algoma – Manitoulin
Dr. Kieran Moore, Chief Medical Officer of Health (CMOH)
NEPH member municipalities
Commissioner Thomas Carrique, Ontario Provincial Police
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)
Board of Health for the Northeastern Health Unit

Encl: Northeastern Public Health Resolution BOH – 2025-R-51 Improving Highway Safety and Equity in Northern Ontario Early
Northeastern Public Health Briefing Note – Northern Highways
Federation of Northern Ontario Municipalities A Nation Building Case for a 2+ 1 Highway for Enhanced east-west Canadian Trade

October 23, 2025

SUBJECT: Improving Highway Safety and Equity in Northern Ontario

At the October 23rd meeting, the Board of Health for the Northeastern Health Unit, supported this motion to highlight the need to address Northern highway safety.

The following motion was read:
MOVED BY: Andrew Marks
SECONDED BY: Jeff Laferriere

Board of Health Resolution #BOH-2025-R-51

WHEREAS Highway safety is a critical public health issue in Northern Ontario, where long distances between communities, severe weather, heavy commercial transport traffic, and wildlife hazards increase risks for residents, service providers, and emergency responders. Spanning more than 11,000 kilometres, Highways 11, 17, 101, and 144 serve as lifelines, connecting Northeastern communities to the rest of the province (2). These routes are vital links in the Trans-Canada Highway system, providing essential access to health care, education, employment, and basic services (1,2); and,

WHEREAS From 2018 to 2022, emergency department visits for motor vehicle collisions in the Northeastern Public Health (NEPH) region were consistently 1.6 to 2.0 times higher than the Ontario average, highlighting both the region's elevated collision risk and its heavy reliance on these critical corridors (8); and,

WHEREAS The Northern region records the highest rate of large-truck collisions in Ontario - 94% higher than the next highest region and over three times higher than the lowest – as well as the highest fatality rate from motor vehicle collisions, 27.8% above the next highest region and 15.5 times higher than the lowest (7,8).; and, serious and fatal collisions along with prolonged road closures, hinder access to goods and essential services, delay emergency response and jeopardize the well-being and safety of Northern Ontaria

WHEREAS Northern communities, including Indigenous and First Nation communities and Francophone populations (32.8% Francophone, 17.5% Indigenous), face significant barriers to health care that are intensified by highway closures, isolating residents from emergency care and essential services. These inequities are further exacerbated for First Nations and Indigenous peoples, rooted in historical trauma and reflected in ongoing disparities in access to care, essential services, and overall health outcomes (3,4,5). Unsafe and unreliable highways deepen these inequities, threaten community well-being, and widen gaps in overall health and quality of life; and,

WHEREAS Limited access to primary care and medical specialists further compounds the challenge. In 2022–2023, more than 170,000 Northern Health Travel Grants were issued to assist 66,000 residents with travel and accommodation for medical needs, demonstrating the region's dependence on long-distance highway travel for essential health care (6); and,

WHEREAS Each year, Northern Ontario roads experience increasing numbers of drivers and collisions, traveling on highways that are substandard, outdated, and unsafe (1). Every day, more than 8,400 trucks transport over $200 million in goods across these same routes, which have limited passing lanes, inadequate shoulders, and numerous high-collision zones (10). Current highway designs lack sufficient median separation, safe passing lanes, and refuge zones, increasing the risk of head-on collisions and dangerous overtaking, especially under winter conditions; and,

WHEREAS Investing in safer Northern Ontario highways is a matter of health equity(10). Residents of Northern Ontario and First Nation communities deserve the same level of safety, accessibility and opportunity as those in southern regions, and the continued loss of life on unsafe roads is unacceptable (9, 10).

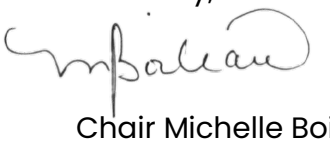
WHEREAS FONOM and Northern municipalities propose the 2+1 upgrade on Highways 11 and 17, including *North Bay to Cochrane* and *Renfrew to Sudbury* in Phase 1, and *Cochrane to Nipigon*, *Thunder Bay to Kenora*, and *Sault Ste. Marie to Sudbury* in Phase 2 recognizing this alternating passing lane design with a crash-rated median barrier is proven, safe and cost-effective fit for Northern Ontario, and reducing fatal crashes by up to 76% (10);

NOW THEREFORE BE IT RESOLVED THAT The Board of Health for the Northeastern Health Unit calls upon the Government of Ontario and Canada to prioritize highway safety and equity across Northern Ontario by:

1. Committing to the full, phased implementation of the 2+1 highway model along Highways 11, 144 and 17 as a priority investment in safety and health equity
2. Collaborating with northern Municipalities, First Nation communities and urban First Nation, inuit and Metis partners to ensure infrastructure planning incorporates health, safety and equity considerations.
3. Designating high-collision and high-risk zones for safety upgrades, with priority for sections that affect emergency response, health-care access, and the delivery of essential goods and services.

CARRIED AS PRESENTED

Sincerely,



Chair Michelle Boileau,
Board of Health for the Northeastern Health Unit

Copies to: Right Honourable Mark Carney, Prime Minister of Canada
The Honourable, Steven Mackinnon, Minister of Transportation
Honourable Doug Ford, Premier of Ontario
Honourable Prabmeet Sarkaria, Minister of Transportation
Honourable Jill Dunlop, Minister of Emergency Preparedness and Response
Honourable Sylvia Jones, Minister of Health
Honourable Paul Calandra, Minister of Education
Honourable Michael S. Kerzner, Solicitor General
Honourable George Pirie, Minister Northern Economic Development and Growth, Member of Provincial Parliament – Timmins
Guy Bourgoin, Member of Provincial Parliament – Mushkegowuk – James Bay
John Vanthof, Member of Provincial Parliament – Timiskaming - Cochrane
Bill Rosenberg Member of Provincial Parliament – Algoma – Manitoulin
Dr. Kieran Moore, Chief Medical Officer of Health (CMOH)
NEPH member municipalities
Commissioner Thomas Carrique, Ontario Provincial Police
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)
Board of Health for the Northeastern Health Unit

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Briefing Note:
Northern Highways

Issue

Northern Ontario highways pose serious risks. Dangerous single lane designs, narrow winding roads, unpaved shoulders, harsh winters, and limited emergency access (i.e. poor cellular service, intermittent patrols, few exits and rest stops). Northern highways carry heavy-load commercial vehicles and residents who rely on them for specialized and life-saving medical care, amenities, employment and education (1, 2). Alongside serious and fatal collisions, prolonged road closures and delays hinder timely access to goods and essential services, slow emergency response time with concern for timely life saving measures and overall well-being of Northern Ontarians.

Background

Road safety is not just a concern – it is a critical public health issue. Every year, Northern Ontario roads see more drivers, and more collisions (1). Northern Ontario highways span over 11, 000 km, with highways 11, 17, 101 and 144 serving as lifelines connecting Northeast communities to the rest of the province (2). These highways are crucial links in the Trans-Canada highway and essential routes for residents who need access to healthcare, education and basic services.

The Impact on Public Health:

During the COVID-19 pandemic and a blastomycosis outbreak in a remote First Nation community, Northern Ontario's single-road access to remote communities failed. A three-day highway closure delayed critical healthcare and access to supplies. Throughout the pandemic, vaccine shipments were constantly at risk from road conditions, and healthcare workers faced dangerous commutes to reach isolated communities.

- The Northeastern region is shared with 11 First Nations, many without road access (3, 4).
- **Rural and Vulnerable Populations:** Higher rates of residents who identify as Francophone (32.8% vs. 3.3% Ontario), Indigenous (17.8 % vs. 2.9% Ontario) (4). The Northeastern Public Health (NEPH) area has a larger rural population (32.9%) compared to the province (13.3%) (17, 18).
- **Poorer Overall Health:** Elevated rates of chronic disease and preventable deaths (associated factors such as smoking and substance use, increased cost of living, and lack of affordable nutritious foods) (5).

- **Lack of Healthcare Services:** 2.5 million in Ontario do not have a family doctor (16). In 2022-2023, about 170,000 Northern Health Travel Grants were issued for 66,000 residents' travel and accommodation needs (6).
- **Increase Use:** In just one year, the number of licensed drivers increased by 170, 877 individuals with a staggering total of 10, 877, 259 driving on Ontario roads in 2021 (1).

Current Status

The Ministry of Transportation has made some initial investments in Northern Ontario's highways, but it is not enough. These efforts are a start, but fall short to the actions needed:

- Expanding parts of Highways 11/17 and 69 (2).
- Piloting a 2+1 passing lane model on highway 11 (7).
- Improvements to and addition of rest areas (2, 8).
- Enhancements the Cochrane by-pass, 11 to 652 (2).

Winter highway clearing is inadequate. The MTO strives for 90% bare pavement, but in Northern Ontario, this translates to subpar standards that fall short of those in other areas of the province. In Northern Ontario, minor highways (servicing 401-800 vehicles per day) only require the center lanes to be cleared within 24 hours after a storm. For local highways (service an average 400 vehicles per day), the standard permits for snow-packed driving surfaces within 24 hours post-storm.

Minor improvements have been announced, yet none address the need for adequate clearing times to meet bare pavement standards, leaving safety compromised:

- 14 new Road Weather Information System (RWIS) stations for winter crews.
- Enhanced use of anti-icing liquids for highway snow clearing.
- Upgrades to the Ontario 511 app (limited cellular service restricts access to this app) (8).

Key Considerations

Human behaviour inevitably increases the risk of highway injuries and deaths with distracted driving, high speeds, substance impairment, and fatigue as major factors (9). In 2022, the Northern region led in motor vehicle collisions due to each of these causal factors: alcohol/drugs, distraction, seatbelt non-use, speed. The Northern region was higher by 2.5 to 4.6 times compared to other regions (10).

The Evidence

- **Injury Rates:** From 2018 to 2022, Northeastern ED visits due to motor vehicle collisions consistently exceeded the Ontario rate – 1.6 to 2.0 times higher than the Ontario average (2018-2022) (11).
- **Truck Collision:** The Northern region reported the highest rate of large trucks collisions in Ontario - 94% higher than the next highest region and 3.1 times higher than the lowest region (11).

- **Cost of Transport-Related Injuries:** In 2019, transport-related injuries in Ontario cost over $1.3. billion annually, with motor vehicle collisions accounting for the highest cost, even before pedestrian and cycling collisions (12).
- **Fatalities:** Between 2018 and 2022 the Northern region recorded the highest fatalities from motor vehicle collisions - 27.8% above the next highest region and 15.5 times higher than the lowest (10, 11).
- **Impact on Emergency Response:** Poor highway conditions and closures have repeatedly prevented paramedics from reaching their regional bases, jeopardizing emergency response:

"Ensuring our highways are properly maintained, especially in Northern Ontario, is critical for the safety of all road users. Improved highway cleaning and maintenance can significantly reduce the risk of motor vehicle collisions, which have devastating consequences for families and communities. Additionally, highway closures not only cost lives but also hinder our ability to respond to emergencies and assign paramedics where they are needed most. Keeping our highways clear is essential for saving lives and ensuring that emergency services can reach those in need without delay." *Marc Renaud, Chief (A) of Cochrane District Paramedic Service*

- **Essential Services Perspective:** Luc Mignault, a local business owner and tow truck operator, highlighted how lengthy highway closures severely impact safe, timely travel across Northern Ontario. Northern Ontario highways require commercial drivers to navigate unique challenges, including rapidly changing weather and remote, single-lane routes. To address these specific risks, additional training and education for drivers of heavy-load vehicles are essential, equipping them to respond safely to Northern Ontario's demanding conditions.
- Public Concern: A 2021 national survey found that road safety to be a top 5 priority of Canadians, yet fewer than half feel safe on our roads (39% vs 46%) (13).

Options

Vision Zero has cut road mortality by 68% in Sweden from 2000 to 2019 and by 50% in Edmonton between 2015 and 2021. A zero-tolerance approach to road injuries demands a system-wide commitment from policy makers, law enforcement, road users and roadway designers (14).

Key interventions are recommended for the improved development of Northern highways:

1. **Target High-Risk Areas:** Assess collision prone sites in the Northeast, especially where vulnerable road-users are at risk (15).
2. **Overhaul Winter Maintenance Standards:** Prioritize timely, effective winter clearing, especially in rural and remote areas and align Northern Ontario's bare pavement standards with the rest of the province. **Equitable standards across Ontario are essential to ensuring safe, accessible roads for all residents, no matter where they live.**
3. **Expand Emergency and Law Enforcement Presence:** Enhanced presence of emergency respondents and law enforcement, for effective intervention.
4. **Strengthen Road Safety Education:** Implement targeted education for both commercial and residential road-users, addressing specific risks on Northern Highways.
5. **Revise Emergency Response Plans:** Update plans for motor vehicle collisions where closures are expected to exceed 8-12 hours, ensuring readiness for extended incidents.

6. **Expand Cellular Coverage:** Commit to improving cellular infrastructure to ensure travelers can access emergency services and real-time updates.
7. **Implement 2+1 Road Designs:** Expand the piloting of 2+1 highway model with alternating passing lanes on major Northern routes to reduce head-on collisions and allow safer passing in high-traffic areas.
8. **Increase Lighting and Signage:** Install better lighting and clear, reflective signage on high-risk stretches to improve visibility, especially in winter conditions.
9. **Install Safety Measures:** Install safety features (i.e., barriers, rumble strips), to prevent vehicles from veering off-road and to reduce the severity of collisions.
10. **Expand and Enhance Rest Stops and Road Shoulders:** Increase the number of safe and accessible rest stops to reduce driver fatigue and support commercial and long-distance drivers. Improve road shoulders to provide essential space for emergency stops and safer travel. Appropriately maintained rest stops.

Conclusion

The built environment has direct impact on preventable road injuries and deaths. Moving to a Vision Zero framework requires action from policy makers and influencers to enact meaningful change. With increasing numbers of vulnerable road users in the Northeast, urgent improvements in infrastructure, highway maintenance, emergency response, and management of highway closures and delays are essential. **Northern Ontario's road safety crisis demands immediate, decisive action.**

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FONOM

Federation of Northern Ontario Municipalities

July 15, 2025

The Right Honourable Mark Carney Prime Minister of Canada

80 Wellington Street Ottawa, ON K1A 0A2

SENT BY EMAIL: PM@pm.gc.ca

The Honourable Doug Ford Premier of Ontario

Legislative Building, Queen's Park

Toronto, ON M7A 1A1

SENT BY EMAIL: Premier@ontario.ca

Dear Prime Minister Carney and Premier Ford,

Subject: *A Nation-Building Case for a 2+1 Highway for enhanced east-west Canadian trade*

in Alignment with Prime Minister Carney's Five Criteria

Purpose

This briefing presents a compelling case for federal investment in upgrading Northern Ontario's Highway 11 and Highway 17, utilizing **the proven 2+1 highway model.** Supported by evidence in infrastructure policy, safety, economic performance, and national security, the proposal aligns directly with the **five nation-building criteria** set out by Prime Minister Carney under the ***Building Canada Act*.**

We propose a two-phase approach:

- **Phase 1**
  - Construct 2+1 on **Highway 11 segments from North Bay to Cochrane**
  - Construct 2+1 on **Highway 17 from Renfrew to Sudbury**

- **Phase 2**
  - Extend the 2+1 **configuration from Cochrane to Nipigon on Highway 11**
  - Construct the 2+1 **configuration from Thunder Bay to Kenora on Highway 11 and 17**
  - Construct 2+1 on **Highway 17 from Sault Ste. Marie to Sudbury**

This initiative is far more than a regional infrastructure upgrade—it is a nation-building investment. It will strengthen Canada's internal connectivity, improve transportation resilience, and contribute to long-term economic growth, safety, and sovereignty.

Background

With the **Building Canada Act** in place, the Government of Canada is proceeding with consultations with provinces, territories and Indigenous rights-holders to determine the initial list of national interest projects. This proposal presents a project deemed of national interest.

The **Building Canada Act** focuses on creating a unified Canadian economy that promotes enhanced trade between the east and west within Canada. It also focuses on the development of major nation-building projects that will likely involve the transportation of large industrial materials for building. With a vast land area and diverse geography, an efficient transportation network is crucial for connectivity and facilitating the movement of materials.

While air and rail form part of Canada's transportation network, **highways and trucking are the backbone of Canada's transportation system**, connecting major cities, towns and rural communities. Trucking companies and drivers rely on governments to ensure a well- connected transportation network, including highways, major routes, border crossings, and ports, for efficient and safe operations. In turn, knowing the most efficient and safe highways and routes helps truckers save time, fuel, and operational costs.

The Trans-Canada Highway itself—of which Highways 17 and 11 are a vital part—is the **longest continuous national highway in the world**, connecting all ten provinces and three territories. During the Great Depression, the federal government funded the highway's early development as a job-creation initiative and a strategic investment in national cohesion. Over $19 million was allocated to the provinces to construct a continuous road, enabling Canadians to travel across the Dominion without entering the United States. **That same nation-building spirit is now needed once again in Northern Ontario.**

Proposal

Except for Newfoundland, Prince Edward Island, and Ontario, most of the routes used by truckers crossing Canada are four-lane highways. In Ontario, truckers heading east from Manitoba or west from Quebec can choose to cross the province via Highway 17, the Trans-Canada Highway, or Highway 11, and what is now known as the **Northern Trans- Canada Route.** Truckers travelling from Toronto to western Canada can choose to take either 1) Highway 69 to Highway 17, then join the **Northern Route** of Highway 11 via West Nipissing and King's Highway 64, or 2) Highway 11 to North Bay, then the **Northern Route**. Almost all sections of Highways 17 and 11 between the Manitoba border and Renfrew in eastern Ontario are two lanes, except for ongoing highway

twinning projects near Nipigon and west of Thunder Bay, as well as a small, complete section east of Sault Ste. Marie. A small section of twinning has also been completed at Arnprior.

With Ontario being Canada's busiest province for truck traffic, these vital highways, which are linked to much of the country's economic activity, need to be considered for continued expansion beyond their existing two-lane profile. From their early days, they have formed part of Canada's **critical national corridor,** from playing a foundational role in connecting Canada's frontier communities to enable economic development and assert national sovereignty across the North. Unfortunately, road safety and infrastructure conditions in northern Ontario are deteriorating, according to the Ontario Trucking Association. Their primary concern is the danger of passing other vehicles. In turn, the Truckers for Safer Highways association recently stated: "People and truckers are dying on these highways!" That is why the Federation of Northern Municipalities, an organization representing 110 cities, towns and municipalities, has been a consistent and vocal advocate for the adoption of the 2+1 highway model in Northern Ontario. This cost-effective, safety-enhancing design has proven successful in many countries, including Sweden, Finland, and Australia. A 2+1 highway expands on a 2-lane road by implementing continuously alternating passing lanes and separates opposing directions of traffic with a crash-rated median barrier, resulting in safety outcomes that are equal to fully twinned highways.

The Government of Ontario is responding and has announced two pivotal initiatives that mark a turning point for Highway 11, offering a clear opportunity for federal collaboration. First, a **pilot project** is scheduled to commence in 2026 on a 2+1 highway segment between **North Bay and Temagami**. Second, the province committed to extending the 2+1 configuration further north, from **Temiskaming Shores to Cochrane**. These two segments lay the groundwork for a scalable, long-term corridor strategy—a shared infrastructure vision well-suited to a federal-provincial nation-building partnership that would see a phased approach to northern Ontario's highway development.

Data from Statistics Canada (see Appendix A) highlights that a five-year average from 2013 to 2017, over 925,000 truck shipments were made between Western Canada and the Toronto/Montreal region via two-lane highways in Northern Ontario. By comparison, 960,005 between Toronto and Montréal, 206,574 between Toronto and Hamilton and 96,607 between Toronto and Windsor — routes served by four-lane highways. Put simply, there is as much transport traffic on Highway 17 and 11 as on the Highway 401 corridor—but it is forced to spread over narrower, less safe roads.

Priority should be given to Highway 11, as it offers a **preferred westward route** for commercial carriers. Compared to Highway 17, it is less hilly reducing fuel consumption and is not subject to frequent closures caused by Lake Superior's weather systems. In short, Highway 11 is more reliable and increasingly indispensable to national logistics and supply chains. Highway 11 will also be critical to the rapidly expanding mining and agriculture sectors in the north that depend on a safe and efficient transportation corridor.

Ministry of Transportation **Annual Average Daily Traffic (AADT)** volumes from 2021 confirm this importance:

- **Near Temiskaming Shores**: 7,800
- **Near Englehart**: 6,100
- **Between Kirkland Lake and Cochrane**: 3,200 to 5,500

These figures **meet or exceed international thresholds** for 2+1 highway justification. In fact, Ontario's Ministry of Transportation and Swedish transport authorities both find 2+1 highways are effective and safe at volumes of up to **18,000–20,000 AADT**, which is well above the current corridor levels of 3,200–7,800. This places Highway 11 within the model's ideal "sweet spot"—not only today, but for decades to come.

Moreover, these traffic counts were gathered during the COVID-19 pandemic, when private vehicle use was depressed. Actual normalized volumes are likely even higher.

Despite this high usage and strategic importance, Highway 11 faces challenges stemming from decades of underinvestment. These include:

- **Substandard Road Geometry**
- **Insufficient passing opportunities**
- **Above-average collision and fatality rates**
- **Regular closures due to weather and accidents**

These weaknesses not only endanger lives but also **disrupt freight movement**, **delay goods**, and **increase costs** for industries that depend on timely delivery. The **2+1 model, featuring a crash-rated median barrier and alternating passing lanes every few kilometres, significantly improves safety and traffic flow at a substantially reduced cost compared to** traditional four-lane twinning. This makes it the ideal design for long rural corridors with steady but moderate traffic, such as Highway 11.

Alignment with Prime Minister Carney's Five Nation-Building Criteria

1. **Strengthen Canada's Autonomy, Resilience, and Security**

- **Strategic Defence Logistics**: Highways 17 and 11 support access to key military and NORAD infrastructure, including CFB North Bay. It also offers critical redundancy should either highway become compromised.
- **Nuclear Waste Transport**: The Nuclear Waste Management Organization has identified these highways for the secure transport of used nuclear reactor rods to a planned long-term storage site in Northwestern Ontario. Enhanced road safety is essential.
- **Emergency and Climate Resilience**: These roads play a vital role in wildfire evacuations and emergency response functions that will only grow more urgent with climate change.
- **Critical Minerals Access**: As Canada builds out its critical minerals sector, Highways 17 and 11 are essential for transporting the tools, supplies, and workforce needed to unlock Northern resource potential.

2. **Deliver Economic Benefits and Support Growth**

- **Economic Resilience and Supply Chain Reliability**: Highways 17 and 11 are a lifeline for national industries such as mining, forestry, agriculture, and manufacturing. Collisions and closures in this corridor disrupt supply chains, delay shipments, and raise costs—undermining productivity and competitiveness. A safer, more reliable route will protect against these losses and help sustain Canada's industrial and export performance, particularly as interprovincial trade barriers ease and east-west commercial traffic increases.
- **Workforce Access and Regional Efficiency:** Improved traffic flow enhances access for workers, goods, and services, strengthening regional economies and making it easier for businesses to attract and retain talent.
- **Job Creation and Indigenous Participation:** Construction and long-term maintenance will create employment opportunities, with strong potential for Indigenous training, contracting, and equity partnerships.
- **Tourism and Local Business Vitality:** As the primary transportation artery for dozens of rural communities, Highways 17 and 11 support tourism, retail, and service sectors. Safer, faster routes help keep these towns economically viable and socially connected.
- **High Return on Investment:** According to the Northern Policy Institute, the proposed 2+1 pilot for Highway 11 delivers a benefit-cost ratio of **1.0 at 20 years**, rising to **3.6 at 60 years**—clear evidence of enduring value.

3. **High Likelihood of Successful Execution**

- **Shovel-Ready Projects**: Ontario's North Bay–Temagami pilot is fully designed and poised to go to tender
- **Provincial Commitment Already Secured**: The province has also announced plans to extend the 2+1 model northward between Temiskaming Shores and Cochrane.
- **Proven Design Model**: The 2+1 design has achieved fatality reductions of up to 76% in countries like Sweden, Finland, and Australia. It offers a practical model for safe, efficient travel across long rural corridors. Ontario's projects benefit from this international evidence.
- **Faster Cheaper Delivery**: By leveraging existing roadbeds, 2+1 roads require less land acquisition and construction time, avoid delays from environmental permitting, and can be implemented in phases. Ontario's own pilot designs incorporate global best practices from around the world.
- **Expandable by Design**: 2+1 highways can be converted to 2+2 highways in the future when traffic volumes warrant it, making 2+1 roads a flexible and cost- efficient steppingstone, ideal for future-proofing national transportation infrastructure.

4. **Advance the Interests of Indigenous Peoples**

- **Early and Ongoing Engagement:** Highways 17 and 11 intersect the traditional territories of several Indigenous Nations. Their early and ongoing involvement ensures meaningful participation and long-term benefits.
- **Pathways to Economic Reconciliation**: Indigenous-led training, employment, and equity stakes can be prioritized into project delivery, creating generational value. With designs that are modular, the Proposal also supports phased contracting models.
- **Improved Safety for Remote Access**: Both Highways are a lifeline for many Indigenous communities, enabling access to healthcare, food, education, and evacuation routes. Safer highways are a matter of equity.

5. **Contribute to Clean Growth and Climate Objectives**

- **Lower Emissions from Freight**: Improved traffic flow reduces idling, braking, and congestion, directly cutting greenhouse gas emissions. Infrastructure for electric vehicle (EV) charging can be integrated into the design.
- **Sustainable Construction Practices**: Ontario's design process is already integrating lower-emission materials and recycled aggregates to help Canada reach its climate goals.
- **Reduced Environmental Footprint**: Compared to full twinning, 2+1 highways use less land, preserve wildlife corridors, and prevent overbuilding—balancing transportation needs with environmental stewardship.

Conclusion

Transforming the Trans-Canada's Highway 17 and its Highway 11 Northern Route into 2+1 corridors is not simply a matter of regional equity—it is a strategic investment in Canada's future. It safeguards our autonomy, strengthens our supply chains, advances reconciliation, and supports economic growth—while reinforcing the vital national bond between northern and southern Canada. FONOM believes this project reflects the values and vision of a confident, resilient country—one that invites its northern regions to be equal partners in prosperity. **We now call on the provincial and federal government to build a Trans-Canada Highway worthy of our national ambitions—modern, safe, autonomous, and truly coast-to-coast.**

Sincerely,

Danny Whalen President Federation of Northern Ontario Municipalities

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Appendix A

Number of Truck Shipments by Routes Note 1						**# of lanes in Ontario**
	2013	**2014**	**2015**	**2016**	**2017**	
Truck shipments to and from major destinations in western Canada to Toronto and Montreal	1,019,899	927,405	986,136	924,682	767,998 **NOTE: 5 year average 2013 to 2017= 925,224**	2 lanes northern Ontario / 4 lanes southern and eastern segments
Truck shipments to and from Toronto and Montreal	867,321	894,068	1,237,732	916,433	884,474 **Note: 5 year average = 960,005**	4+ lanes
Truck shipments to and from Toronto and Windsor	67,119	100,507	97,640	80,267	142,502 **Note: 5 year average= 97,607**	4+ lanes
Truck shipments to and from Toronto and Hamilton	181,567	191,839	186,954	332,986	139,044 **Note: 5 year average= 206,514**	4+ lanes

Note 1: Statistics Canada. Table 23-10-0142-01 Origin and destination of transported commodities, Canadian Freight Analysis Framework (see Appendix A). Shipments represent the aggregate number of shipments transported.

Algoma PUBLIC HEALTH
Santé publique Algoma
www.algomapublichealth.com

Briefing Note

To: The Board of Health

From: Hilary Gordon, Manager Community Wellness & School Health

Written by: Dr. Lyall Pacey, Resident Physician

Date: 9/23/2026

Re: Improvement to Safety on Algoma Highways

☒ **For Information** ☒ **For Discussion** ☒ **For a Decision**

PURPOSE

This briefing recommends supporting the letter from Northeastern Public Health (NEPH) urging improvements to Northern Ontario's highway safety through investment in improved maintenance and safety infrastructure.

KEY MESSAGES

- Algoma's communities rely on the Northern Ontario highways for their transportation, economy, education, and healthcare systems to function. Continued improvements in safety practices and design will allow day-to-day use while minimizing risk of injury.
- The boards of the Thunder Bay District Health Unit (TBDHU) and NEPH have submitted letters to the Premier and Prime Minister, highlighting strategies for improving highways in Northern Ontario.
- Progress toward some of NEPH's recommendations is underway, and there are opportunities for continued improvement in the areas of highway safety, collaborating with Northern communities to optimize infrastructure for safety, and to identify high-risk collision zones to maintain emergency response, health-care access, and access to essential goods and services.

RECOMMENDED ACTIONS

That the Board of Health send a letter of endorsement for NEPH's letter to the Premier of Ontario and Prime Minister of Canada, to support continued and further actions to improve the safety of Northern Ontario highways.

BACKGROUND

- Whether the routine of supplying a pharmacy in Wawa, an ambulance responding to an emergency in Serpent River, or APH delivering a dose of rabies vaccine to Blind River, the pieces of Algoma's health system depend on highways.
- Algoma residents rely heavily on highways for daily travel to work and school, as well as to access essential services and amenities, including grocery stores and healthcare. Algoma's health unit consists of 21 municipalities, 2 large unorganized areas, and multiple Indigenous communities. Our

population is older than the average in Ontario, and has a higher rate of chronic and life-limiting diseases across all ages.[1]

- The major highways in Algoma – Highways 17, 101, 129, and 556 – support an average of 4,773 vehicles per day, with approximately 1.8 million kilometers traveled by these vehicles.[2] Between 2018 and 2022, the provincial highway in Algoma had an average of 314 collisions per year, resulting in 19 deaths and 342 injuries. 47% of roadway deaths in Algoma happen on highways, even though only 21% of roadway collisions happen on highways.[3]
- Expanding and improving the safety of Northern Ontario's highways are consistent with the Prime Minister's five nation-building criteria, as laid out by the Federation of Northern Ontario Municipalities in July 2025.[4] Regarding public health, the criteria point to:
    - Emergency and Climate Resilience – the movement of emergency services or evacuation in the face of threats (e.g., wildfires) depend on safe highways, as well as safe alternative routes.
    - Economic Resilience and Supply Chain Reliability – the health sector and the economic stability that supports our residents need a reliable transportation network.
    - Improved Safety for Remote Access – Algoma's numerous municipalities, including Indigenous communities, deserve safe access to goods and services.[4]

EVIDENCE/ANALYSIS

- The provincial government has taken significant strides to rehabilitating the Northern highways in recent years. In Algoma, progress that reduces collisions includes funding for widening portions of Highway #17, twinning highways, adding more alternating passing lanes, rest stops, and enforcement.[5]
- The NEPH letter and resolution calls on both the provincial and federal governments to prioritize three major areas:[7]
    - Phased implementation of the 2+1 highway system – Algoma finds itself in Phase 2 as proposed by Federation of Northern Ontario Municipalities (FONOM), which would occur after trials near Nipissing.[4,6]
    - Collaboration with Northern communities to ensure planning incorporates health, safety, and equity considerations – Algoma's largest populations are along Highway 17, but many smaller communities rely on local highways, which may have different safety and access considerations than the larger provincial highways.
    - Designate zones with higher risk of collisions for safety upgrades, with priority attention to sections that would cut off emergency response, health care, and essential resources.

OPHS STANDARDS[8]

Substance Use and Injury Prevention: The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses risk and protective factors to reduce the burden of preventable injuries and substance use in the health unit population.

Healthy Environments: The board of health shall identify risk factors and priority health needs in the built and natural environments.

Population Health Assessment: The board of health shall interpret and use surveillance data to communicate information on risks to relevant audiences.

Health Equity: The board of health shall lead, support, and participate with other stakeholders in health equity analysis, policy development, and advancing healthy public policies that decrease health inequities.

STRATEGIC DIRECTIONS

Our Approach: Focusing on Upstream Pathways

- *Build capacity to strengthen community action, create supportive environments and promote local healthy public policy with community partners*
- *Work at the systems level to better support people facing inequities*

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July 16, 2026

The Honourable Sylvia Jones
Deputy Premier and Minister of Health
Government of Ontario
sylvia.jones@ontario.ca

Dear Minister Jones,

Re: Healthy Smiles Ontario Schedule of Dental Services and Fees

On behalf of the Board of Health for Lakelands Public Health (LPH), I am writing to support the concerns raised by the Board of Health for Algoma Public Health in its May 21, 2026 correspondence, and to urge the Ministry of Health to review and update the Healthy Smiles Ontario (HSO) Schedule of Dental Services and Fees.

Since the introduction of the Healthy Smiles Ontario (HSO) program, public health professionals and stakeholders, including the Ontario Dental Association (ODA), have raised concerns that HSO reimbursement rates remain at approximately 40% of the ODA Suggested Fee Guide. This has led to limited provider participation, resulting in barriers to accessing dental care for vulnerable children and youth.

Dental caries (tooth decay) remains the most common preventable chronic childhood disease in Canada. Untreated dental disease causes pain, infection, difficulty with eating and sleeping, as well as learning disruptions. Thus, timely access to oral health care for children and youth is essential for overall well-being.

HSO plays a vital role in oral health equity by funding preventive and dental treatment services for eligible children and youth. Ontario public health units bridge the gap to this support by offering oral health screening, referrals, program promotion, and navigation services. This collaboration aids in connecting children and their families with crucial access to dental care. Since the introduction of the Canadian Dental Care Plan (CDCP) it has been observed by members of the Ontario Association of Public Health Dentistry that an increasing number of dental providers in Ontario are refusing to accept children on HSO unless their family is also enrolled in the federal program, which offers a higher reimbursement rate than HSO. This presents a significant challenge to individuals and families who do not qualify, cannot afford to pay the co-payment, and/or cannot pay the balance bill associated with the CDCP.

Haliburton
Box 570
191 Highland Street, Unit 301
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Lindsay
108 Angeline Street South
Lindsay, ON K9V 3L5

Peterborough
Jackson Square
185 King Street, Box 301
Peterborough, ON K9J 2R8

Port Hope
200 Rose Glen Road
Port Hope, ON L1A 3V6

Local findings collected by LPH support these concerns. According to a recent phone survey, only 8 out of 44 dental providers in Northumberland County, the City of Kawartha Lakes, and Haliburton County reported accepting families covered solely by HSO. Feedback from clients and dental offices also indicates that some providers who accept HSO limit the number of HSO clients they will see, further restricting timely access to care. Staff have heard similar concerns in Peterborough and Peterborough County; however, no comparable survey was conducted, because HSO clients can access care through the LPH Community Dental Care Clinic.

The Board of Health for LPH urges the Ministry of Health to review and update the HSO Schedule of Dental Services and Fees. Reimbursement rates that better reflect the cost of dental treatment would strengthen provider participation and improve timely access to dental services for children and youth who rely on HSO.

Thank you for your consideration of this important matter. We appreciate the Ministry's continued commitment to improving oral health and reducing health inequities for Ontario residents and would welcome the opportunity to contribute local perspectives to any future review of the HSO program.

Sincerely,

Original signed by

Deputy Mayor Ron Black
Chair, Board of Health

/ag

Encl.: Algoma Correspondence, May 2026

cc: Dr. Kieran Moore, Ontario Chief Medical Officer of Health
Dr. David A. Brown, Chair, Board of Directors and President, Ontario Dental Association
Local MPPs
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)Sincerely,

From: allhealthunits **On Behalf Of** alPHa communications
Sent: Monday, July 27, 2026 3:49 PM
To: allhealthunits
Cc: Board
Subject: [allhealthunits] alPHa - BOH Section - Governance Continuity & Fiduciary Obligations During Municipal Election Transition

ATTENTION ALL:
Boards of Health Section Members
Dear Boards of Health Section Members,

As the 2026 municipal election approaches, Boards of Health will experience a period between the expiry of current municipal appointments and the appointment of new municipal representatives. During this transition, some Boards of Health may be temporarily unable to achieve quorum, creating governance challenges while statutory and operational responsibilities continue.

To support planning for this transition, legal counsel has prepared the following resource:

- **Governance Continuity & Fiduciary Obligations During Municipal Election Transition** – a briefing note outlining the legislative framework, governance considerations, and practical planning measures for Boards of Health with **Appendix – Sample Resolution** – a model resolution that Boards of Health may wish to adapt, in consultation with legal counsel, to support continuity of operations should quorum be temporarily unavailable following the municipal election.

These documents are intended to provide governance guidance only and do not constitute legal advice. As governance structures, by-laws, delegation frameworks, and municipal agreements vary across Ontario, each Board of Health should obtain independent legal advice before adopting or implementing a **Continuity of Operations** framework or resolution.

We encourage Boards of Health to review these materials well in advance of the municipal election and to consider whether additional planning is appropriate based on their local governance arrangements.

Take Care,

Loretta

Loretta Ryan, CAE, RPP
Chief Executive Officer
Association of Local Public Health Agencies (alPHa)
PO Box 73510, RPO Wychwood
Toronto, ON M6C 4A7
Tel: 416-595-0006 x 222

www.alphaweb.org

From: allhealthunits on behalf of alPHa communications
To: allhealthunits
Cc: board
Subject: [allhealthunits] alPHa Letter - Provincial Funding for Local Public Health Agencies
Date: Thursday, August 20, 2026 2:56:46 PM
Attachments: image001.jpg

PLEASE ROUTE TO:

All Board of Health Members
All Members of Regional Health & Social Service Committees
All Senior Public Health Managers

Hello,
Following this week's announcement regarding the extension of the 1 per cent annual increase in provincial base funding for local public health units, alPHa has sent a letter to Minister Jones thanking her for the provincial government's continued commitment to local public health and the greater certainty this provides as boards of health plan and allocate resources for the coming year. The letter acknowledges the province's continued commitment to local public health, while outlining our concerns that a 1 per cent increase is not sufficient to address the ongoing pressures facing boards of health. We will continue to work with the province to ensure local public health has sufficient, predictable, and sustainable funding to deliver the programs and services required to protect the health of our communities.
Take Care,
Loretta

Loretta Ryan, CAE, RPP
Chief Executive Officer
Association of Local Public Health Agencies (alPHa)
PO Box 73510, RPO Wychwood
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Tel: 416-595-0006 x 222

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From: allhealthunits on behalf of alPHa communications
To: allhealthunits
Cc: Board
Subject: [allhealthunits] alPHa - 2026 Ontario Municipal Elections Resources
Date: Tuesday, September 8, 2026 12:55:01 PM
Attachments: image001.jpg

PLEASE ROUTE TO:

All Board of Health Members
All Members of Regional Health & Social Service Committees
All Senior Public Health Managers

Dear alPHa Members,
With the return to school, and the 2026 municipal election campaign in full swing, alPHa would like to highlight a number of resources that may be useful to members during the election period. Whether you are engaging with municipal candidates, participating in local conversations about public health, or looking for accessible resources to share, the following are available for your use:

Public Health Matters

Aimed at decision-makers, the ***Public Health Matters*** infographic series is a particularly useful resource during the municipal election campaign. The series provides concise and accessible information that helps to explain the role of local public health and its contribution to healthy communities and a strong Ontario. Together, the five infographics provide a broad picture of local public health, from explaining its role and demonstrating its impact, to making the case for investment and highlighting its contribution to healthy communities and a strong economy. The infographics can be shared individually, or as a collection, and are useful when communicating with municipal candidates and others during the campaign. The infographics, and associated videos, are available in English and French.

Public Health Matters Infographic	**Focus**
#1 A Public Health Primer	Explains what local public health is and the role it plays in protecting and promoting health.
#2 Fall Vaccine Success	Demonstrates the impact of prevention and immunization in protecting communities.
#3 A Business Case for Local	Makes the case for investment in local public

Public Health	health.
#4 Keeping Ontarians Healthy and Safe	Highlights how local public health protects and promotes the health and safety of communities.
#5 A Strong Economy Supported by Healthy Communities	Illustrates the connection between healthy communities and a strong economy.

Resolutions and Correspondence

The **alPHa Resolutions** and **Correspondence** provide a valuable source of information about the priorities, issues, and positions that have shaped alPHa's work on behalf of Ontario's local public health agencies. For Members preparing for conversations with municipal candidates, these resources offer a wealth of background information on issues that matter to local public health and the communities we serve. These can help provide context on current public health priorities, identify relevant past work, and provide additional information when questions arise during the campaign. The collection includes the **alPHa submission to the 2026 Ontario Budget consultation**, along with correspondence and Resolutions addressing a wide range of public health priorities. The Resolutions can also be searched by year and/or topic, making it easy to find information on specific issues. Members are encouraged to explore these resources as a source of background,
context, and supporting information throughout the municipal election period.

Information Break Newsletter

Information Break is alPHa's members' portal and an important source of information on issues, developments and activities affecting local public health in Ontario. The **newsletter archive** provides access to previous issues of *Information Break*, offering a useful record of alPHa updates, public health developments, government announcements, resources and other information shared with members over time. During the municipal election period, the archive can be a valuable starting
point for members looking for additional background or context on issues that may arise in conversations with candidates, municipal leaders and community partners. It is also a convenient way to revisit information and resources that may have been shared previously but are particularly relevant to current discussions. Members are encouraged to use the archive when preparing for conversations and looking for additional information to share throughout the campaign.

Use These Resources During the Municipal Election Period!

The municipal election campaign provides an important opportunity to help candidates and communities better understand the role, value and breadth of local public health and the contribution it makes to healthy, safe and vibrant communities across Ontario.

We encourage members to make use of these resources throughout the campaign and to share these with municipal candidates, community partners and others who may benefit from a better understanding of local public health. Thank you for your continued work to strengthen local public health across Ontario!

Take Care,

Loretta

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September 17, 2026

The Honourable Doug Ford
Premier of Ontario
premier@ontario.ca

The Honourable Sylvia Jones
Deputy Premier and Minister of Health
Government of Ontario
sylvia.jones@ontario.ca

Dear Premier Ford and Minister Jones:

Re: Endorsement of Bill 121, Save a Life Act (Naloxone Kit Registration and Public Access), 2026

On behalf of the Lakelands Public Health (LPH) Board of Health, we are writing to formally communicate our endorsement of Bill 121, Save a Life Act, being proposed by Dr. Robyn Lennox, MPP Hamilton Centre.

Naloxone is a medication that can temporarily reverse the effects of an opioid poisoning or overdose, providing critical time for emergency medical services to arrive. It is safe and easy to administer and does not have any effect on a person who is not experiencing an opioid drug poisoning. The Save a Life Act proposes to make naloxone equally accessible and available to save lives as Automated External Defibrillators (AEDs). The Act would locate naloxone in community centres and other designated public spaces where AEDs are currently housed.

Evidence shows that the availability of naloxone is a significant contributor to the recent decline in mortality from opioid overdose in Canada. Further, provinces with higher distribution experienced substantial mortality declines, while those with lower distribution experienced less changes. Ontario has experienced a 15% decline in opioid poisoning deaths since naloxone became publicly available in 2016.

Naloxone is currently available to eligible individuals free of charge through health units, community-based organizations and participating pharmacies. An online tool is available to help Ontarians locate where they can get a naloxone kit in their community. However, changes to the Ontario Naloxone Program for Pharmacies (ONPP) have resulted in fewer pharmacies staying in the program. Further, insurance requirements present a barrier to agencies becoming community distribution partners resulting in fewer locations where naloxone could

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185 King Street, Box 301
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200 Rose Glen Road
Port Hope, ON L1A 3V6

be available. Access is also limited by office hours, lack of transportation, and only partial coverage by outreach. As an illustration, fewer nasal and intramuscular naloxone kits were distributed through Lakelands Public Health partners and offices in Q1 of 2026 (952) than in Q1 of 2025 (1,355), reflecting funding constraints and staffing challenges among major distribution partners, and the closure of the Peterborough Consumption and Treatment Services (CTS) site.

The need for naloxone remains significant across the region, particularly among populations experiencing barriers to healthcare access, including people who use drugs, individuals living in rural communities, and those experiencing homelessness. However, the access to naloxone in many Lakelands communities remains limited. Expanding public access to naloxone by making kits available in locations where AEDs are already installed would help address current service gaps and improve timely access to this life-saving medication during an emergency when seconds count. As other overdose response mechanisms are dismantled, naloxone remains one of the most effective tools to deal with the toxic drug crisis in real-time in communities.

Sincerely,

Original signed by

Deputy Mayor Ron Black
Chair, Board of Health

/ag

cc: Dr. Robin Lennox, MPP, Hamilton Centre
Local MPPs
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)