Public Health Agency of Canada

2005-2006

Departmental Performance Report

Tony Clement
Minister of Health

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Overview

Message from Canada's Minister of Health

Since taking office in early 2006, Canada's new Government has shown its commitment to deliver on its priorities through concrete action. One key priority is the strengthening of our health care system – as Minister of Health, this is my paramount responsibility. I am personally committed to improving public health, and the Public Health Agency of Canada plays a critical role in this endeavour. In presenting to Parliament this 2005-2006 Departmental Performance Report for the Agency, this government acknowledges the vital importance of another of our priorities, strengthening government accountability and transparency, for earning and preserving the public trust.

As this report shows, the Public Health Agency of Canada's accomplishments have directly contributed to our vision of making Canadians among the healthiest people in the world.

In the realm of health and health care, this Government is focusing on several key areas. Strengthening the health care system and reducing patient wait times are directly impacted by the Agency's work to prevent disease and promote healthy living. Investments in promoting healthy living and preventing disease have the benefit of reducing strain on our health care system and increasing its sustainability for the future.

In addition to strategies on health promotion and chronic disease prevention and control, the Agency contributed to the strengthening of the public's health through a number of other initiatives. These included supporting the National Collaborating Centres for Public Health, and the Agency's role in creating the Pan-Canadian Public Health Network, which provides a mechanism for co-ordinated federal, provincial, and territorial action on public health. These initiatives contribute to keeping the public healthy, lessening the burden on the health care system, and ultimately reducing patient wait times.

During 2005-2006, the Agency significantly increased its emphasis on preparing for the potential of pandemic influenza and other public health emergencies. My own experience as a provincial Minister of Health during the 2003 SARS outbreak impressed on me the necessity of preparation and collaboration to be better able to respond to such emergencies. Learning from this and other experiences with infectious disease outbreaks around the world, the Agency has helped to expand Canada's capacity to track and respond to threats. This capacity will grow based on this government's Budget commitment of $1 billion to improve Canada's pandemic readiness.

In addition to protecting and promoting public health within Canada, the Agency contributed to this country's roles and responsibilities in the international community. The Agency delivered a helping hand to the United States as part of Canada's response to the devastation of hurricane Katrina. The Agency is also active in building linkages and encouraging collaboration between international partners for emergency preparedness and pandemic planning.

Canada's new government made a commitment to improve the health of all Canadians, and to strengthen our health care system to ensure its sustainability well into this country's future. This Report clearly demonstrates these commitments have been supported by real action by the Public Health Agency.

The Honourable Tony Clement
Minister of Health

Message from Canada's Chief Public Health Officer

It has now been two years since the Public Health Agency of Canada was created to strengthen the Government of Canada's ability to protect the health and safety of Canadians, and to provide a national focal point to lead efforts in the advancement of public health both nationally and internationally. I am pleased to be able to take part in this public accounting to Parliament of the Agency's work over 2005-2006.

This Departmental Performance Report shows that despite its youth the Agency has had a great many successes, and is continually striving towards helping Canadians become the world's healthiest people. Over the last year we celebrated our first anniversary and solidified our corporate structure. Throughout this time an emphasis on prudent financial responsibility guided all of our activities.

A few years ago, the outbreak of severe acute respiratory syndrome (SARS) launched an important discussion about the state of the public health system in Canada. This was one of several catalysts for the formation of the Agency, which counts among its chief functions monitoring and preparing for the emergence of infectious diseases. During 2005-2006, the Agency continued to refine preparedness plans in order to enhance its capacity to respond in case of a public health emergency, including pandemic influenza. We updated the Canadian Pandemic Influenza Plan in cooperation with the provinces, territories and other key stakeholders, and a contract was signed with a domestic supplier to increase vaccine production capacity. In the future, supported by 2006 Budget commitments, the Agency will continue to enhance its capacity to monitor and respond to public health emergencies, including pandemic influenza.

While enhancing our preparedness for emerging infectious diseases, the Agency also worked to strengthen its capacity to protect the public's health from risks such as obesity and low levels of physical activity, as well as chronic disease. Our disease prevention and healthy living strategies targeted these factors. Further, we established the Pan-Canadian Public Health Network, we continued to support the work of the National Collaborating Centres for Public Health, and we are supporting and contributing to the Canadian Strategy for Cancer Control.

Through these and other measures, the Agency has lived up to its mandate. It has anticipated and prepared for threats to public health, carried out surveillance and reported on diseases and preventable health risks, and used the best tools available to inform and advise Canadians on matters that will improve their health.

This, our second Departmental Performance Report, shows that the Agency, through its dedicated staff across the country, continued to forge public health linkages with our domestic and international partners and is meeting the

challenges and critical responsibilities we have been given by the Government of Canada. We are moving forward on fulfilling our vision of healthy Canadians and communities in a healthier world.

Dr. David Butler-Jones, M.D.
Chief Public Health Officer

Management Representation Statement

I submit for tabling in Parliament, the 2005-2006 Departmental Performance Report for the Public Health Agency of Canada.

This document has been prepared based on the reporting principles contained in the *Guide for the Preparation of Part III of the 2005-2006 Estimates: Reports on Plans and Priorities and Departmental Performance Reports*:

- It adheres to the specific reporting requirements outlined in the TBS guidance;
- It is based on the department's approved Program Activity Architecture structure as reflected in its MRRS;
- It presents consistent, comprehensive, balanced and reliable information;
- It provides a basis of accountability for the results achieved with the resources and authorities entrusted to it; and
- It reports finances based on approved numbers from the Estimates and the Public Accounts of Canada in the DPR

Dr. David Butler-Jones, M.D.
Chief Public Health Officer

How This Report is Structured

The 2005-2006 Departmental Performance Report of the Public Health Agency of Canada (the Agency) is structured as follows:

After the messages from the Minister and the Chief Public Health Officer, and a statement confirming the validity of the information in this document, Section I discusses performance information, and presents a summary of the Agency, highlighting its mission, vision, mandate, structure and geographic locations.

Section I continues with tables showing overall financial and human resources utilized during fiscal year 2005-2006, and presents a table summarizing progress against the priorities set out in the Agency's 2005-2006 Report on Plans and Priorities.

Section I concludes with an assessment of the Agency's performance in the context of the organization's operating environment – the key factors that have an impact on the way our programs are delivered. It concludes with an explanation of the progress against each commitment listed in the summary table.

Section II, Analysis by Strategic Outcome and Key Program, provides more detailed information on resources used, activities undertaken and progress made.

Section III, Supplementary Information, reports additional financial and other information as required by the Treasury Board Secretariat.

Section IV provides more organizational information, including the detailed organization chart and the new Program Activity Architecture being developed for use in 2007-2008.

Added throughout the report are links to the Agency's website and to websites of external partners and other organizations. Readers are encouraged to visit these sites for additional information about the work of the Agency and our partners.

How Performance Information is Gathered and Used at the Agency

The Agency gathers and uses both financial and non-financial information for operational and reporting purposes. Financial performance information is carefully monitored to ensure financial commitments are met and expenditures accounted for. Performance information is used for making operational decisions and for communicating with stakeholders. When appropriate, evaluations are used to generate and/or confirm performance information; they are also used to create or amend policies and/or procedures and to renew or change program designs.

Through the departmental performance reporting process senior managers are held accountable to report back on the commitments made by the Agency for the previous year.

The financial information at the heart of this report has been generated by the Finance and Administration Directorate, using the Agency's financial management systems. These numbers are verified internally, and may be validated from time to time through external reviews and audits.

The non-financial performance information used in this report was gathered from multiple internal sources including the senior managers responsible for carrying out the commitments set out in the 2005-2006 Report on Plans and Priorities. These managers report back on the actions taken and the results they have achieved, and the Planning and Performance Measurement team uses this information to develop this report.

Much of the information presented in this report deals with outputs, activities and early outcomes achieved. The Agency will continue to move towards increased measurement and use of medium- and longer-term outcomes for planning, managing and reporting.

Summary Information

The Agency's Reason for Existence

Canadians are among the healthiest people in the world. Two factors which contribute to Canadians' high quality of life are their access to a modern and sustainable publicly-funded *health care* system and the existence of a strong *public health* system. The actions of the public health community are often not as apparent as those in the conventional health care system, because public health targets the entire population working upstream to avoid potential problems and to deal with them as they occur. Public Health works to identify threats and risks to the health of Canadians at large, as opposed to health care, which focuses on individuals. While they are both part of the continuum of health, the emphasis in public health is the preventable. By helping keep Canadians healthy, the Agency, in partnership with the public health community, not only improves health and quality of life, but can also relieve some of the pressure on the health care system, helping to constrain costs and lessen patient wait times.

Public health involves a range of players and partners engaging in initiatives that promote health, prevent and control both infectious and chronic diseases, support public health research and surveillance activities and protect people from the consequences of health emergencies. In Canada, public health is a responsibility shared by the three levels of government, the private sector, the not-for-profit sector and health professionals such as family physicians. The Agency works closely with other federal departments and agencies, provinces and territories, and other stakeholders to keep Canadians healthy.

Events like the emergence of severe acute respiratory syndrome (SARS) in 2003, and the subsequent reports by public health experts, reinforced the need for

Canada to have a national point of focus for public health issues. In response, the Public Health Agency of Canada was established on September 24, 2004, and Dr. David Butler-Jones was appointed as the country's first Chief Public Health Officer. The creation of the Agency marked the beginning of a new approach to federal leadership and to collaboration with the provinces and territories in the Government's efforts to renew the public health system in Canada.

The role of the Public Health Agency of Canada can be summed up as follows:

- To take a lead role in the prevention of disease and injury and the promotion of health;
- To provide a clear focal point for federal leadership and accountability in managing public health emergencies;
- To serve as a central point for sharing Canada's expertise with the rest of the world and applying international research and development to Canada's public health programs; and
- To strengthen intergovernmental collaboration on public health and facilitate national approaches to public health policy and planning.

The Agency is mandated to work in collaboration with its partners to lead federal efforts and to mobilize pan-Canadian action in preventing disease and injury, and to promote and protect national and international public health by:

- Anticipating, preparing for, responding to and recovering from threats to public health;
- Carrying out surveillance of, monitoring, researching, investigating and reporting on diseases, injuries, other preventable health risks and their determinants, and the general state of public health in Canada and internationally;
- Using the best available evidence and tools to advise and support public health stakeholders nationally and internationally as they work to enhance the health of their communities;
- Providing public health information, advice and leadership to Canadians and stakeholders; and
- Building and sustaining a public health network with stakeholders.

The Agency participates in health surveillance – the ongoing, systematic use of routinely-collected health data to guide public health actions. Surveillance supports disease prevention, and enables public health professionals to manage outbreaks and threats. In collaboration with the Canadian Institute for Health Information and the Canadian Public Health Initiative and many other organizations, the Agency delivers surveillance programs including:

- Pandemic Influenza program
- HIV/AIDS Surveillance program
- National West Nile Virus Surveillance program
- Canadian Integrated Program for Antimicrobial Resistance Surveillance (CIPARS)
- Canadian Nosocomial Infection Surveillance Program (CNISP)
- National Enteric Surveillance Program (NESP)

Agency Contributions to Government of Canada Outcomes

The Agency's focus on public health allows it to contribute directly to a key Government of Canada Outcome:

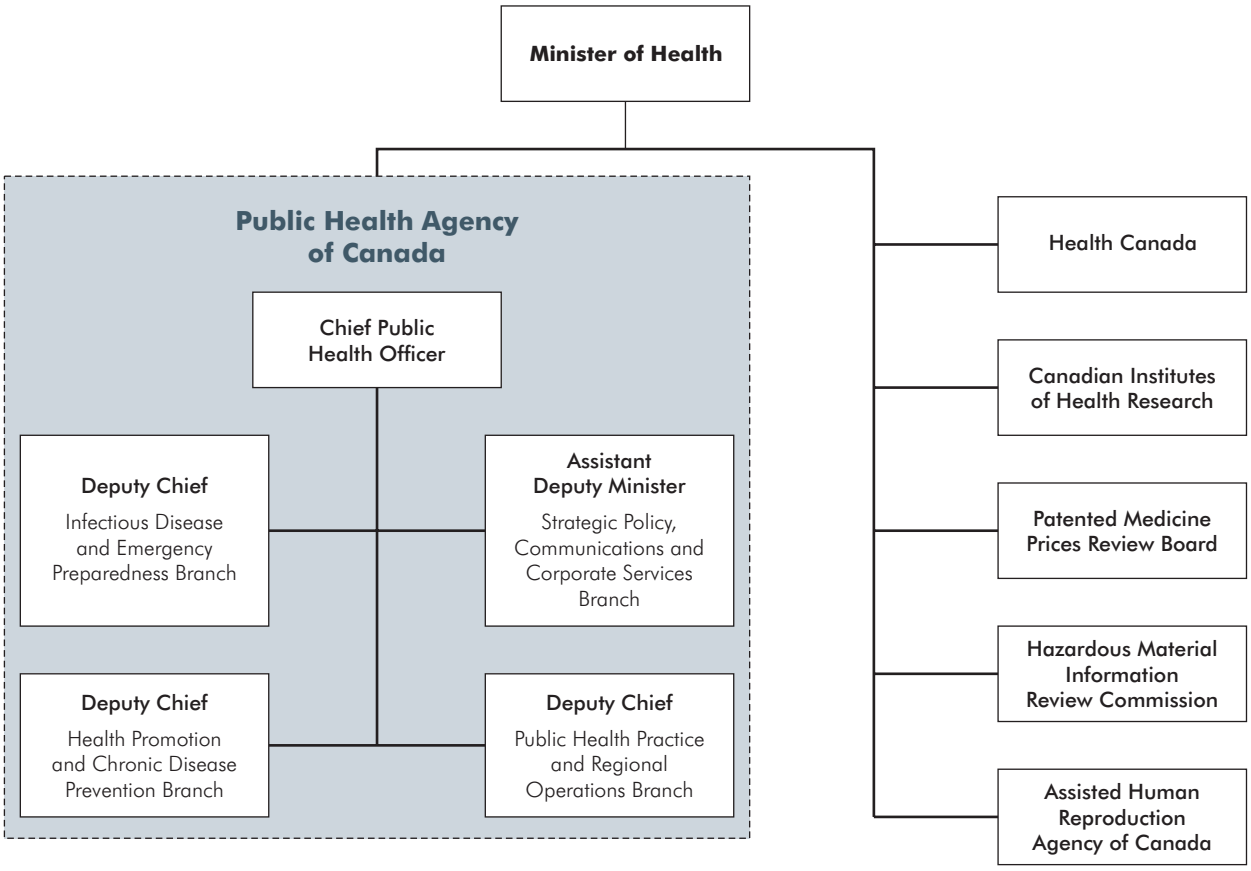
- **Healthy Canadians with access to quality health care.**
  The Agency's work also supports achievement of other Government of Canada outcomes, including:
  - **Safe and secure communities** – The Agency plays an important role in reducing the threat of infectious diseases and chemical and biological agents, and accordingly contributes to the safety of Canadian communities;

- **A safe and secure world through international cooperation** – The Agency is committed to strengthening global health security in collaboration with its international partners. To support Canada's participation in the Global Health Security Initiative, the Agency advances pandemic influenza preparedness, moves forward to prepare against chemical and biological threats, and leads the Global Health Security Action Group Laboratory Network. The Agency's efforts contribute to Canada's effective participation in the Security and Prosperity Partnership of North America;
- **An innovative and knowledge-based economy** – The Agency, in its own laboratories and working with partners, conducts and provides financial support for applied research on health technologies. For example, it facilitates the translation of research to develop and test newer, faster, and more productive technologies that can deliver safe and effective vaccine products to Canadians and thus advance broader socio-economic interests. This leading-edge work has the potential to generate 'spin off' economic development while it significantly boosts public confidence in Canada's ability to deal with emerging health threats.

(For more information about Government of Canada Outcomes see http://www.tbs-sct.gc.ca/report/govrev/05/cp-rc-sum02_e.asp#_Toc119739023)

The Agency at a Glance	
Type of Organization	Federal Agency, funded by Parliament
Mission	To promote and protect the health of Canadians through leadership, partnership, innovation and action in public health
Vision	Healthy Canadians and communities in a healthier world
Government of Canada Outcome Directly Supported	Healthy Canadians with access to quality health care
Strategic Outcome	Healthier Population by Promoting Health and Preventing Disease and Injury
Acts and Regulations Administered	*The Quarantine Act* *The Importation of Human Pathogen Regulations*
Key Activities	■ Health Promotion ■ Disease Prevention and Control ■ Emergency Preparedness and Response ■ Strengthening Public Health Capacity
Reporting to Parliament	The Agency reports to Parliament through the Minister of Health

The Agency's Structure



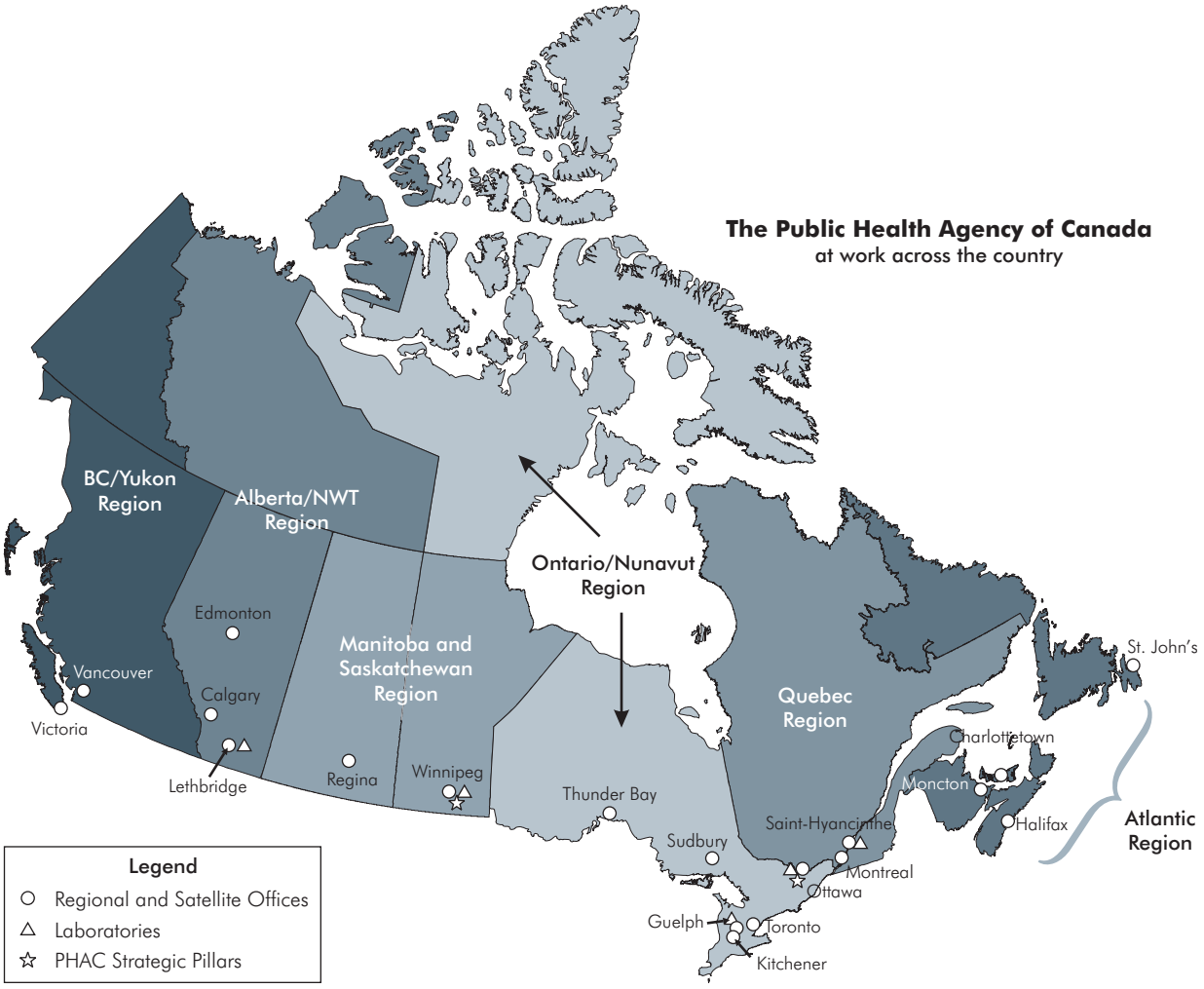
The Agency's Workforce

To ensure that it has the knowledge and skills required to develop and deliver the public health advice and tools that Canadians and public health professionals require, the Agency employs approximately 1,800 dedicated staff consisting of public health professionals, scientists, technicians, communicators, administrators, and policy analysts and planners. These employees work across Canada in a wide range of operational, scientific and technical, and administrative positions.

The Agency's largest concentration of employees is in the National Capital Region. The head office,in Winnipeg forms a 'second pillar' of administrative, operational and scientific expertise. In times of a national health emergency, Emergency Operations Centres in Ottawa and Winnipeg can be utlized to manage the crisis.

The Public Health Agency of Canada recognizes the need to have a strong presence throughout the country to connect with provincial governments, federal departments, academia, voluntary organizations and citizens. Outside of Winnipeg and the National Capital Region, the Agency's Canada-wide infrastructure consists of six Regions and a Northern Secretariat, with approximately 275 employees in 17 locations. The Agency's Regional Offices promote integrated action on public health throughout the country. Working in partnerships that cross sectors and jurisdictions, staff in these offices facilitate collaboration on national priorities, building on resources at the regional, provincial and district levels.

Map of Locations



This map indicates where the Agency has a significant presence.

Partners

Most public health activities, including those performed by the Agency, involve collaboration and partnership with the provinces and territories, other federal departments, health organizations, professional organizations, academia, the private and not-for-profit sectors and/or other stakeholders. This creates challenges for performance measurement, as positive health outcomes and trends invariably reflect the success of joint efforts by multiple partners.

The Agency works with many partners in the federal system, including the other members of Canada's Health Portfolio, and other federal departments and agencies whose work has an impact on public health. Key federal departments and agencies that the Agency works with include:

The Government of Canada's Health Portfolio

- Health Canada
- The Public Health Agency of Canada
- The Canadian Institutes of Health Research
- The Hazardous Materials Information Review Commission
- The Patented Medicine Prices Review Board
- The Assisted Human Reproduction Agency of Canada

For more information see:
www.hc-sc.gc.ca/ahc-asc/minist/health-sante/portfolio/index_e.html

Other Government of Canada Partners

- Agriculture Canada
- The Canada Border Services Agency
- The Canadian Food Inspection Agency
- Canadian Heritage – Sport Canada
- Environment Canada
- Infrastructure Canada
- Public Safety and Emergency Preparedness Canada
- Statistics Canada
- Transport Canada

The Agency's Total Financial Resources

Planned Spending ($M)	Total Authorities ($M)	Actual Spending ($M)
480.7*	497.0**	477.2***

* In the Agency's *Report on Plans and Priorities* for 2005-2006, planned spending was shown as $432.4 million, with a footnote explaining that additional budget commitments had been made and would be added. The $480.7 million includes those additional commitments.

** The agency began the year with authority to spend $432.4 million, and obtained additional authority through Governor General's Special Warrants. These warrants provided resources for Avian and Pandemic Influenza beyond what had initially been planned.

*** Variance between actual spending and total authorities reflects changes of plan for the acquisition of facilities for mock vaccine, procurement savings, pending policy approval, and spending controls put into place for the dissolution of Parliament and the subsequent election.

The Agency's Total Human Resources (Full Time Equivalents)

Planned	Actual	Difference
1,836	1,801	35

Summary of Performance Relative to Priorities

The following table outlines the financial resources planned and spent for each priority in the Agency's 2005-2006 *Report on Plans and Priorities* (available online at http://www.tbs-sct.gc.ca/est-pre/20052006/PHAC-ASPC/PHAC-ASPCr56_e.asp). It also provides a "report card" of progress on each commitment within each priority. A more detailed explanation of the performance is provided below the table (see, in particular, the Details of Performance section).

During 2005-2006 the Agency had a single strategic outcome and a single program activity as presented in the following table. An enhanced Program Activity Architecture, to take effect during fiscal year 2007-2008, is being developed to reflect the Agency's responsibilities, and to enable a more detailed reporting on accomplishments and resource use. Section IV presents the 'top layer' of the new Architecture.

Status on Performance				
Strategic Outcome: Healthier Population by Promoting Health and Preventing Disease and Injury **Program Activity:** Population and Public Health				
Priority	**Planned Spending**	**Actual Spending**	**Expected Results**	**Performance Status**
1. Develop and lead Canada's long-term strategic public health initiatives	$76.8 M	$79.3 M	1.1 Identify goals for improving the health status of Canadians	Successfully met
			1.2 Develop the Pan-Canadian Public Health Strategy	Partially met
			1.3 Establish the Pan-Canadian Public Health Network	Exceeded expectations
			1.4 Facilitate the establishment of, and provide ongoing support to, the National Collaborating Centres for Public Health	Successfully met
			1.5 Continue to enhance public health emergency preparedness and response	Successfully met
2. Develop, enhance and implement integrated and disease-specific strategies	$92.7 M	$102.1 M	2.1 Continue to develop integrated and disease-specific strategies for chronic disease and healthy living as well as to examine opportunities to integrate strategies for infectious diseases	Successfully met
			2.2 Continue to strive to assist Canadians in their efforts to maintain their health by leading healthy lifestyles	Successfully met
			2.3 Continue to promote healthy public policies at all levels of government	Successfully met

Status on Performance				
Strategic Outcome: Healthier Population by Promoting Health and Preventing Disease and Injury **Program Activity:** Population and Public Health				
Priority	**Planned Spending**	**Actual Spending**	**Expected Results**	**Performance Status**
3. Develop and enhance the capacity of the new Agency to meet its mandate	$52.5 M	$63.5M	3.1 Prepare enabling legislation which will set out the mandate of the Agency, roles and responsibilities of the CPHO, and the powers of the Minister	Successfully met
			3.2 Finalize the new organization structure, focussing efforts on achieving results, embracing program and policy innovation, showing leadership, partnering effectively and demonstrating commitment	Successfully met
			3.3 Forge relationships with the provinces and territories, colleagues, partners, stakeholders and other parties to demonstrate leadership, and develop and deploy the necessary levers and tools, and coordinate strategies and responses	Successfully met
			3.4 Actively promote excellence in science and continue to enhance and support evidence-based decision-making	Successfully met
			3.5 Strengthen the Agency's support of science and research activities, starting with the Public Health Framework for Science and Research	Successfully met
			3.6 Retain and recruit a workforce that has the knowledge and skills required to fulfill the Agency's mandate and objectives	Successfully met
			3.7 Develop the Winnipeg pillar	Successfully met
			3.8 Build upon the Agency's regional presence in health promotion and explore the establishment of stronger regional public health capacities that will allow it to connect to public health partners across the country	Successfully met
			3.9 Adopt a formal citizen engagement strategy that will better involve Canadians in decision-making	Partially met

Overall Departmental Performance

Strategic Context/Operating Environment

The rapidly expanding global economy, the convergence of people in large urban areas, the ease with which people and goods travel around the world, rapid advances in science and technology, and the changing nature of our environment are but some of the factors challenging Canada's public health system. Canada must be prepared to respond to public health threats that impact on the health of Canadians.

The Agency's 2005-2006 operating environment included the possibility that Canada's Parliament would not pass financial bills, and the election of a new government. Due to the fall of the government, financial operations were carried out under Governor General's Special Warrants during the year-end period.

External factors which influenced the Agency's activities during 2005-2006 included the emergence of infectious diseases, such as avian influenza and other potential pandemics, both nationally and internationally; natural disasters; social trends affecting the risk of diseases; and Canada's gradually aging population.

Infectious Disease Levels and Trends

The number of Canadians dying from or living with infectious diseases has been climbing since the 1980s. Worldwide, infectious diseases are the second leading cause of death and the leading killer of infants and children. The World Health Organization (WHO) estimates that in 1999, the most recent year for which statistics are available, approximately 17 million of the 56 million deaths that occurred worldwide were caused by infectious diseases. While the impact of this phenomenon is being felt most profoundly in developing countries, Canada has not been immune. The increase in the speed and volume of global travel places Canadians within 24 hours of almost any other place in the world – which is less than the incubation period for most communicable diseases transported by individuals or products. The threat of emerging and re-emerging infectious diseases and the potential for bioterrorism has made the ability to rapidly identify infectious agents and clusters of disease vitally-important.

Risks of Avian and Pandemic Influenza

There were two major infectious disease threats that Canada faced in 2005-2006. Each could have had a significant impact on our economic and social stability as well as on our collective and individual health and safety. The first was the potential for the highly contagious and deadly H5N1 (Asian) sub-type of avian influenza to spread to domestic birds in Canada. The second was the growing potential for the appearance of a new strain of this (or another) virus that has adapted to humans, resulting in human-to-human transmission and the possible setting off of a human influenza pandemic. According to WHO, the occurrence of the next pandemic influenza was – and is "a question of when, not if."

The H5N1 (Asian) avian influenza virus has demonstrated the ability to infect and cause fatal illness in humans. During the period from December 2003 to May 2006, 217 human cases, resulting in 123 deaths, have been laboratory-confirmed in 10 countries. While Canada has not experienced an outbreak of H5N1 (Asian), a 2004 outbreak of another strain of avian influenza resulted in the culling of approximately 17 million birds and the payment of $68 million in compensation to affected farmers.

Natural Disasters

In August 2005, Hurricane Katrina caused severe damage to the United States city of New Orleans, Louisiana and the surrounding Gulf Coast. This and other natural disasters vividly underscored the importance of emergency preparation and capacity building in order to enable the quick and effective responses necessary to minimize suffering and loss. Recent natural disasters provided many lessons and

highlighted the need for integrated and coordinated emergency management and effective emergency communications at all levels of governments, among federal departments and agencies, and with other stakeholders and individual citizens.

Risk Factors for Chronic Disease

Changes in Canadian society have resulted in shifts in nutrition patterns and in living and working conditions. These changes are key factors in the development of the leading chronic diseases in Canada. They have the potential to trigger significant increases in these diseases at substantial cost to the country's economy and society. Unhealthy eating, lack of physical activity and obesity continue to be critical public health issues that have a significant bearing on health outcomes for Canadians and the health care system.

Demographics

Changing demographics are an important factor in Canada. Decreasing birth rates and the upward trend in the proportion of seniors in the Canadian population contribute to projections that by 2016, seniors (65 years of age and older) will represent 16% of the country's population.

Details of Performance

The following section provides an explanation of the progress summarized in the 'report card' above. It identifies each commitment, indicates whether the Agency successfully met, partially met, or exceeded expectations, and then elaborates on what was planned and what was accomplished. All commitments were successfully met except two which were partially met and one where the Agency's performance exceeded expectations:

1. Develop and lead Canada's long-term strategic public health initiatives

1.1 Identify goals for improving the health status of Canadians – *Successfully met*

What was planned

In September 2004, First Ministers made a commitment to *"... set goals and targets for improving the health status of Canadians...."* As a result, one of the priorities identified in the Public Health Agency of Canada's 2005-2006 RPP was to identify such goals.

What was achieved

In 2005-2006, the Agency held a year-long consultation and validation process involving provinces, territories, public health experts, stakeholders and citizens to share their knowledge and vision for a healthy Canada. This process culminated in the drafting of goal statements which were validated by government and non-government partners, public health experts and stakeholders. Federal, provincial and territorial Ministers of Health approved the Health Goals for Canada on October 23, 2005. The Ministers also agreed that the Health Goals would inform each government in the development of its own initiatives. The Health Goals for Canada, which are broad, aspirational and directional in nature, represent a critical step in advancing cooperative work on healthy public policy and creating a foundation for new and ongoing intergovernmental and intersectoral efforts to improve the health of Canadians.

Health Goals for Canada

These goals are shared by all partners of the federal Health Portfolio, as well as all the provincial and territorial Ministers of Health who participated in the Health Goals process.

Overarching Goal

As a nation, we aspire to a Canada in which every person is as healthy as they can be – physically, mentally, emotionally, and spiritually.

Health Goals for Canada

Canada is a country where:

Basic Needs (Social and Physical Environments)

- Our children reach their full potential, growing up happy, healthy, confident and secure.
- The air we breathe, the water we drink, the food we eat, and the places we live, work and play are safe and healthy – now and for generations to come.

Belonging and Engagement

- Each and every person has dignity, a sense of belonging, and contributes to supportive families, friendships and diverse communities.
- We keep learning throughout our lives through formal and informal education, relationships with others, and the land.
- We participate in and influence the decisions that affect our personal and collective health and well-being.
- We work to make the world a healthy place for all people, through leadership, collaboration and knowledge.

Healthy Living

- Every person receives the support and information they need to make healthy choices.

A System for Health

- We work to prevent and are prepared to respond to threats to our health and safety through coordinated efforts across the country and around the world.
- A strong system for health and social well-being responds to disparities in health status and offers timely, appropriate care.

More information on the process and goals is available at:
http://www.healthycanadians.ca

1.2 Develop the Pan-Canadian Public Health Strategy – *Partially met*

What was planned

In conjunction with the Pan-Canadian Public Health Network Council, the Agency planned to collaborate on the development of a Pan-Canadian Public Health Strategy.

What was achieved

To date, the Public Health Network has focused its efforts on building an effective and efficient Network, and on delivering on the commitments and priorities identified by the Conference of Deputy Ministers of Health and the federal, provincial and territorial Ministers of Health, including those articulated in the Special Task Force report

entitled *Partners in Public Health*. These include federal, provincial and territorial collaboration on planning for and responding to pandemic influenza; work related to public health infrastructure and health promotion/healthy living; initiating the development of Memoranda of Understanding on the Provision of Mutual Aid during a Disaster or Public Health Emergency; and also initiating the development of a Public Health Information Sharing Agreement. The decision was made to postpone the development of a comprehensive Pan-Canadian Public Health Strategy until the Public Health Network was established and an agreement was in place to deal with emergencies. However, work done during 2005-2006 does address elements of a strategy; these will provide important groundwork for future initiatives to develop such a strategy.

1.3 Establish the Pan-Canadian Public Health Network – *Exceeded Expectations*

What was planned

In collaboration with the provinces, the territories, stakeholders, the Health Portfolio, and other partners, the Agency will establish the Pan-Canadian Public Health Network.

What was achieved

The Pan-Canadian Public Health Network (PHN) was publicly announced and launched by Federal, Provincial, and Territorial Ministers of Health on April 22, 2005. The PHN provides a focal point for intergovernmental collaboration, coordination, communications, joint policy development, and collective action on public health. It provides advice and regular reporting to Ministers and Deputy Ministers of Health. The Agency provided the federal co-chair of PHN's governing Council – the Chief Public Health Officer. The Council, which includes representation from all provinces and territories, also has a provincial co-chair. PHAC provides funding for the initiatives of the Network and provides secretariat, policy and technical support.

Development of the PHN has proceeded beyond what was planned. Key activities included recommending changes to the size and use of the National Antiviral Stockpile; and working towards interjurisdictional agreements on Public Health Information Sharing; and on Mutual Aid for Public Health Emergencies,

Six expert groups have been formed for sharing information and expertise, and to enable collaborative public health policy and technical development. The PHN expert groups focus on the following public health issues:

- Communicable Disease Control;
- Emergency Preparedness and Response;
- Canadian Public Health Laboratory;
- Surveillance and Information;
- Chronic Disease & Injury Prevention & Control; and
- Population Health Promotion.

PHAC's leadership and support for the PHN during 2005-2006 enabled Federal, Provincial, and Territorial jurisdictions to better prepare for public health emergencies and to continue to build public health capacity.

1.4 Facilitate the establishment of, and provide ongoing support to, the National Collaborating Centres for Public Health – *Successfully met*

What was planned

In 2005-2006, the Agency planned to facilitate the establishment of, and provide support to, a number of National Collaborating Centres (NCCs), each specializing in a different priority area of public health.

What was achieved

Five NCCs were established and provided with support. Four were managed by the Agency directly and one by provincial and territorial governments. The NCCs contributed to strengthening Canada's public health system by facilitating information sharing and collaboration between federal, provincial and territorial governments, academic institutions, international experts, non-government organizations, researchers and health professionals. (For more information see http://www.phac-aspc.gc.ca/php-psp/ncc_e.html)

1.5 Continue to enhance public health emergency preparedness and response – *Successfully met*

What was planned

The Agency planned to work with its many partners to improve preparedness for and responses to the broadest possible range of potential natural and human-caused public health emergencies. This work was to include the provision of preparedness training exercises, security for laboratories that handle dangerous human pathogens, and the maintenance of stockpiles of emergency supplies across the country. The Agency planned to continue providing health surveillance information to the international community through the Global Public Health Intelligence Network (GPHIN), as well as travel health information to the Canadian public. In addition, the maintenance and improvement of quarantine services at Canada's major international airports was also a priority, as was support for the passage of an improved *Quarantine Act*.

What was achieved

The Agency successfully completed many activities to build and strengthen Canada's emergency health and social service response capacity during 2005-2006. For example, it engaged in extensive planning and training activities with provincial and territorial governments and other partners. The National Emergency Stockpile System was improved and expanded into Newfoundland and Labrador. The GPHIN continued to be utilized internationally and to be recognized as the major source of global disease outbreak information. Dozens of travel advisories were disseminated to the Canadian public. The safety of the handling of dangerous human pathogens was improved through training exercises and laboratory certification. Of special significance was the work done to assist the Minister to bring Bill C-12, the revised *Quarantine Act,* before Parliament and to set the stage for its implementation.

2. Develop, enhance and implement integrated and disease-specific strategies

2.1 Continue to develop integrated and disease-specific strategies for chronic disease and healthy living as well as to examine opportunities to integrate strategies for infectious diseases – *Successfully met*

What was planned and achieved will be presented in two parts: a) Healthy Living and Chronic Disease, and b) Infectious Diseases.

2.1a Develop, enhance and implement integrated and disease-specific strategies for healthy living and chronic disease

What was planned

As the federal government's lead in health promotion and chronic disease prevention and control, the Agency aimed to promote the health of Canadians, reduce the impact of chronic disease in Canada and address the determinants of health. Its strategy was to focus on:

- Promoting health by addressing the conditions that lead to unhealthy

eating, physical inactivity and unhealthy weight;
- Preventing chronic diseases; and
- Supporting early detection and management of chronic diseases.

What was achieved
In 2005-2006, the Agency began implementation of the *Integrated Strategy on Healthy Living and Chronic Disease*. This Strategy uses broad measures aimed at the full spectrum of health and chronic disease as well as specific strategies to address diseases such as diabetes, cancer and cardiovascular disease.

The Agency also worked with multiple partners and stakeholders to reach agreement on and begin implementation of the Pan-Canadian Healthy Living Strategy through the Intersectoral Healthy Living Network.

2.1b Examine opportunities to integrate strategies for infectious diseases

What was planned
The Agency intended to provide an enhanced pan-Canadian capacity to conduct policy development, surveillance, investigation, research and program response for a number of infectious disease threats including food and water-borne diseases and community-acquired diseases such as sexually transmitted infections.

What was achieved
In the fall of 2005, an Agency-level working group was established to help coordinate and develop an approach to infectious disease management, prevention and control. The working group's recommendations were used to develop strategic directions for moving forward. Also during 2005-2006, work continued on developing and supporting a two-year provincial pilot project relating to the integration of prevention and response programs focused on sexually transmitted infections including human immunodeficiency virus (HIV), hepatitis C virus (HCV) and bloodborne pathogens.

2.2 Continue to strive to assist Canadians in their efforts to maintain their health for as long as possible by leading healthy lifestyles – *Successfully met*

What was planned
In collaboration with Health Canada and other government departments, the provinces and territories, national non-governmental organizations as well as other partners and stakeholders, the Agency planned to encourage Canadians to maintain and improve their health by being physically active and eating healthily, and adopting other personal health practices such as a tobacco-free lifestyle.

What was achieved
In 2005-2006, the Agency worked with other government departments, the provinces and territories, national non-governmental organizations and the private sector on the development and implementation of the Integrated Strategy on Healthy Living and Chronic Disease and the Pan-Canadian Healthy Living Strategy.

2.3 Continue to promote healthy public policies at all levels of government – *Successfully met*

What was planned
It was the intention of the Agency to collaborate with the provinces, the territories, stakeholders and international partners on chronic disease prevention and control in the areas of surveillance and risk assessment, and in the development of integrated policies and programs to enhance science capacity and intelligence to better inform public health policy development.

What was achieved
During 2005-2006, the Agency continued to promote healthy public policies through a

national consensus conference on goals and objectives for six vaccine preventable diseases which resulted in recommendations for diseases reduction and vaccine coverage. As well, as a direct result of Agency support and funding, almost all provinces and territories have implemented the four new vaccine programs (meningo, pneumo, varicella, acellular pertussis).

3. **Develop and enhance the capacity of the new Agency to meet its mandate**

3.1 **Prepare enabling legislation which will set out the mandate of the Agency, roles and responsibilities of the CPHO, and the powers of the Minister** – *Successfully met*

What was planned
The Agency planned that during 2005-2006, enabling legislation would be drafted, and that the Agency would assist the Minister in presenting the legislation for Parliament's consideration.

What was achieved
Enabling legislation was prepared and then introduced in the House of Commons as Bill C-75 on November 16, 2005. The legislation, however, died on the Order Paper when Parliament was dissolved. (The legislation was subsequently re-introduced in the House of Commons on April 24, 2006 as Bill C-5.)

3.2 **Finalize the new organization structure, focusing efforts on achieving results, embracing program and policy innovation, showing leadership, partnering effectively and demonstrating commitment** – *Successfully met*

What was planned
In its first full year of operation, it was the Agency's intention to finalize its new organizational structure and develop an approach to human resources and organizational development that will provide sufficient support to the organization and its program activities to ensure that the Agency's priorities are achieved and that Canadians will receive the benefits that they expect from their federal public health agency.

What was achieved
The Agency did establish its macro-organizational structure and staffed key positions during 2005-2006. The establishment of decision-making structures and processes within the organization has supported the Agency's ability to develop and deliver programming in health promotion, disease and injury prevention and emergency preparedness and response, with both domestic and international collaborative projects.

3.3 **Forge relationships with the provinces and territories, colleagues, partners, stakeholders and other parties** – *Successfully met*

What was planned
The Agency committed to continue the development of effective relationships with all its domestic and international partners and stakeholders, emphasizing areas of cooperation that facilitate the delivery of public health services to Canadians. Its intent in forging such relationships was to develop and to deploy the necessary levers and tools, and to coordinate strategies and responses.

What was achieved
The Agency did continue to maintain and further develop partnerships, collaborative relationships and networks with Health Portfolio departments and agencies, provincial and territorial governments and other important domestic and international organizations in order to develop policy, and undertake or facilitate research and programs related to public health.

3.4 Actively promote excellence in science and continue to enhance and support evidence-based decision-making – *Successfully met*

What was planned

It was the Agency's intention to actively promote excellence in science and to continue to enhance and support evidence-based decision making.

What was achieved

Throughout 2005-2006, the Agency continued to actively promote excellence in science and support evidence-based decision making. Examples of this include the development of research priorities for human papillomavirus (HPV) and influenza and the exploration of strategies for enhancing research capacity and coordination in Canada. As well, meetings to set research priorities on Influenza and HPV were held with researchers from across Canada, the United States, the United Kingdom and the vaccine industry. An internal knowledge translation working group was formed. A needs survey was conducted and analysis was begun.

3.5 Strengthen the Agency's support of science and research activities, starting with the Public Health Framework for Science and Research – *Successfully met*

What was planned

The Agency planned to launch the Public Health Framework for Science and Research as the first step in promoting excellence in science. Also the Agency committed to continue to enhance and support evidence-based decision making.

What was achieved

A strategic science plan was prepared to provide both a vision and a guide for science and technology activities within the Agency. It formed the basis for integrating the science and research requirements within the Agency, the Health Portfolio and across the Government. It also allows the Agency to align its general scientific strategies, priorities, resources, risk management activities, accountabilities and performance management to better reflect the Agency's overall priorities for sound management.

3.6 Retain and recruit a workforce that has the knowledge and skills required to fulfill its mandate by developing and delivering the right public health advice and tools to Canadians – *Successfully met*

What was planned

It was the Agency's plan to ensure that its staff has the necessary knowledge and skills required to develop and deliver the public health advice and tools that public health professionals and the public require to improve and maintain the health of Canadians. The Agency committed to adopting policies and practices to recruit and retain a workforce well suited to fulfilling the Agency's mandate and objectives.

What was achieved

The Agency took steps to retain current employees and to recruit suitable candidates for both new and vacant positions. For example, a draft recruitment strategy has been developed which envisions the implementation of the new federal public service policy on Learning, Training and Development. This initiative will not only continue to provide Agency employees with a means of upgrading their skills and knowledge, but will also allow for more developmental opportunities which are a key element for retention of personnel. The Agency's employees also benefit from its efforts to build public health capacity more generally across Canada, through their participation in the Skills Enhancement Program, which is designed to hone skills in the areas of epidemiology, surveillance and information management, and in the training

sessions, workshops and seminars organized under the Canadian Field Epidemiology Program. These actions provide a solid foundation for public health activities at the Agency that link to efforts at the local, national and international levels.

3.7 **An important part of the Agency's forward planning will be the development of its Winnipeg pillar** – *Successfully met*

What was planned

The Agency's predecessor, Health Canada's Population and Public Health Branch, was centred in Ottawa and had a significant regional network that included the National Microbiology Laboratory in Winnipeg. In its 2005-2006 *Report on Plans and Priorities*, the Agency affirmed that the development of its capacity in Winnipeg would be an important planning objective.

What was achieved

The Agency addressed this priority through study, and planning, by studying the feasibility of laboratory expansion, and by proactively addressing the issue of office accommodation for management and administrative staff.

To understand how to best develop an organization with major clusters of activity and expertise in Ottawa and Winnipeg as well as effective smaller nodes across Canada, the Agency commissioned a study to examine the organizational, financial and human issues. The consultants investigated and reported on the challenges and opportunities associated with guiding the Agency's geographically-optimized evolution.

The Agency initiated feasibility studies on potential expansion of the laboratory space in the Winnipeg area.

To ensure that there would be sufficient space to meet the need for office accommodation, a building in downtown Winnipeg has been leased that will act as the Agency's headquarters. It will house the Winnipeg offices of the Chief Public Health Officer; the Agency's Manitoba-Saskatchewan regional office; as well as some of the Agency's finance, human resources, communications, and administration staff. When the Headquarters opens it will enable valuable space at the National Microbiology Laboratory to be made available for potential research and scientific use.

3.8 **Build on the Agency's regional presence in health promotion and explore the establishment of stronger regional public health capacities that will allow it to connect to public health partners across the country** – *Successfully met*

What was planned

To better connect with health partners throughout Canada, the Agency planned to explore strengthening its regional capacity, building on the base of the Agency's regional presence in health promotion.

Also, the Agency planned to support its health promotion activities through community grant and contribution programs delivered both nationally and regionally as part of its efforts to address the broad determinants of health and the prevention of infectious and chronic diseases.

What was achieved

In addition to successfully delivering funding to community-based organizations for health promotion activities like the Community Action Program for Children, the Canadian Diabetes Strategy and the AIDS Community Action Program, the Agency's regional office staff maintained and expanded partnerships and networks with other federal departments, the provinces and territories, municipalities, health professional associations, university-based researchers, and for-profit and non-profit organizations, as the following examples illustrate:

- Providing financial and organizational support to an "Annual Public Health Days" program organized by a public health consortium in Québec. This event provides professional development opportunities for over 1,500 public health service providers and specialists each year.
- Contributing, through the Ontario regional office, to the development and implementation of the Francophone stream of the provincially funded June 2005 Ontario Health Promotion Summer School, sponsored by the University of Toronto's Centre for Health Promotion. This stream attracted a diverse group of public health nurses, health promoters and community health centre workers.
- The Vancouver Agreement is a tripartite urban development agreement that commits the three participating levels of government to a coordinated strategy to promote and support sustainable economic, social and community development in neighbourhoods like Vancouver's Downtown Eastside. The Agency's British Columbia regional office, in collaboration with Health Canada, played a strong role on the interdepartmental committee managing the federal participation in this agreement.

During 2005-2006, the Agency created and staffed the position of Director-General, Regions to define regional roles and develop plans and strategies to enhance regional capacity. The Agency also hired regional emergency preparedness and response coordinators.

3.9 Adopt a formal citizen engagement strategy that will better involve Canadians in decision making – *Partially met*

What was planned

The Agency intended to adopt a formal citizen engagement strategy.

What was achieved

The Agency determined that the adoption of a formal citizen engagement strategy on all matters was not an optimal use of its policy making and communications resources during 2005-2006. It focused its policy development resources on institution-building required for its second year of existence as a separate Agency. It directed its citizen engagement resources to specific areas where the public's need for information and a voice was particularly strong and critical to future success, such as the development of health goals.

Analysis by Strategic Outcome and Key Program

Analysis by Strategic Outcome

Strategic Outcome:
A Healthier Population by Promoting Health and Preventing Disease and Injury

Program Activity Name:
Population and Public Health

Financial Resources:

Planned Spending ($M)	Total Authorities ($M)	Actual Spending ($M)
480.7*	497.0**	477.2***

* In the Agency's Report on Plans and Priorities for 2005-06, planned spending was shown as $432.4 million, with a footnote explaining that additional budget commitments had been made and would be added. The $480.7 million includes those additional commitments.

** The agency began the year with authority to spend $432.4 million, and obtained additional authority through Governor General's Special Warrants. These warrants provided resources for Avian and Pandemic Influenza beyond what had initially been planned.

*** The actual spending is $19.8 million or 4.0% lower than total authorities mainly due to changes of plan for the acquisition of facilities for mock vaccine, procurement savings, pending policy approval, and spending controls put into place for the dissolution of Parliament and the subsequent election. Contributing to the lower spending were:

- A lapse of $16.4 million or 5.6% stemming from lower than expected operating expenditures for pandemic influenza preparedness, and for the integrated strategy on healthy living and chronic disease, and
- A lapse of $3.4 million or 1.9% that resulted from year end adjustments and lower than expected expenditures in various transfer payment programs.

Human Resources (Full Time Equivalents)

Planned	Actual	Difference
1,836	1,801	35

In collaboration with partners, the Agency leads federal efforts and mobilizes pan-Canadian actions to promote and protect national and international public health. These actions include anticipating, preparing for, responding to and recovering from threats to public health; monitoring, researching and reporting on diseases, injuries, other preventable health risks and their determinants, and the general state of public health in Canada and internationally. These activities are designed to support effective disease prevention and health promotion, and building and sustaining a public health network with stakeholders. The Agency uses the best available knowledge and evidence to inform and engage Canadian and international public health stakeholders on various aspects of public health activities and to provide public health information, advice and leadership.

This Program Activity supports all three Priorities in the 2005-2006 RPP.

Analysis by Key Program

Emergency Preparedness and Response

The role of the Agency's Centre for Emergency Preparedness and Response is to ensure that Canada is prepared to respond to the public health risks posed by all natural and human-caused disasters, such as infectious disease outbreaks, hurricanes, floods, earthquakes, and criminal or terrorist acts such as explosions and the release of toxins. Major preparedness challenges include planning to effectively deal with all possible hazards, providing training to all responders, coordinating among all levels of government, and holding sufficient emergency supplies across the country.

Emergency Preparedness Capacity

	Planned ($M)	Authorities ($M)	Actual ($M)
Emergency Preparedness Capacity	27.3	27.3	27.3

What was planned

It was the Agency's intention during 2005-2006 to continue to:

- Collaborate with provincial and territorial government emergency preparedness authorities to refine region-specific planning and act as a liaison with other federal government departments;
- Provide accurate and timely information on national and global public health events to Canadian and World Health Organization (WHO) officials through the Global Public Health Intelligence Network (GPHIN); and
- Support Canada's nationwide quarantine services to deal with the possible importation of dangerous infectious diseases.

In addition, the Agency planned to provide training in emergency preparedness to ensure that available professionals would be skilled in course design, and course delivery and to help partners to develop their own emergency training capacity. Finally, the Agency would help to coordinate public health security by providing essential resources to front-line health workers across the country.

What was achieved

The Agency engaged in extensive planning activities with provincial and territorial governments, other federal departments, and NGOs. For example, it worked with the provinces and territories to identify emerging priorities, establish work plans and coordinate federal-provincial/territorial emergency preparedness and response activities. The National Workshop on the Development of a National Health Incident Management System was hosted by the Agency in September 2005 in Winnipeg to identify key components and next steps in the development of such a system. This system would improve coordination across jurisdictions, help define roles and responsibilities and establish common federal-provincial/territorial protocols for responding to health emergencies in Canada. The Agency also hosted a pan-Territorial pandemic workshop designed to identify gaps in preparedness in the North.

SUCCESS STORY

Pan-territorial pandemic preparedness workshop

Three Agency Regional Offices (British Columbia-Yukon, Alberta/Northwest Territories and Manitoba/Saskatchewan) collaborated with Health Canada's Northern Secretariat to hold a one-day pan-territorial pandemic planning workshop in Yellowknife on March 30, 2006. The workshop was excellent representation from both the public health and emergency preparedness sides of the three territorial governments, including the three Territorial Health Officers. The workshop focused on sharing information on the status of pandemic planning in the Territories, analyzing strengths and gaps, and identifying opportunities for building capacity and collaborating on pan-territorial issues. The workshop report has been disseminated; it identifies a number of areas for further collaboration and planning which the Agency's Regional Offices are pursuing.

The Agency worked with Public Safety and Emergency Preparedness Canada (PSEPC) to build on the lessons learned during the 2004 and 2005 avian influenza outbreaks, to develop an interdepartmental protocol for early notification and liaison. The Agency co-hosted with PSEPC the National Forum on Emergency Preparedness and Response in November 2005 in the city of Québec. The National Forum brought together government and non-government stakeholders from across Canada to identify and discuss emerging issues related to the Canadian national health emergency management system, including the need to develop the preparedness capacity of the voluntary health sector for home or day care, for example, and to increase the focus on community resiliency i.e., the ability of communities to function during and after an emergency.

The Agency's Office of Emergency Preparedness, in collaboration with the Council of Health Emergency Management Directors, worked to develop a national health emergency management system, which aims at a more efficient interoperability of federal and provincial and territorial systems.

In addition to these planning activities, the Agency, either alone or collaboratively with partners and stakeholders, designed, developed and delivered a variety of training courses and programs. Some of these included:

- Multi-level Chemical, Biological, Radiological and Nuclear (CBRN) Training for First Responders;
- Emergency Health Services and Social Services Training; and
- Training and tools for laboratory personnel, field epidemiologists, emergency physicians and nurses, public health and health emergency management professionals. Numerous exercises were developed to ensure robust preparedness in all jurisdictions.

The Agency continued to maintain the Emergency Operations Centre system for the federal Health Portfolio, which provides the platform from which the Agency and Health Canada will respond to any public health emergency. An Emergency Response Plan for the Emergency Operations Centre for the Health Portfolio was put in place in 2005-2006.

The Agency continued to maintain and support quarantine services at six Canadian airports, by which approximately 94% of all international airline travellers arrive in Canada.

Other quarantine-related accomplishments of the past year include:

- Assistance to the Minister in piloting Bill C-12, the new *Quarantine Act* during the legislative process. This Act, which received Royal Assent on May 13, 2005, will come into force when new quarantine regulations have been drafted and approved;
- Development of Standard Operating Procedures to support the new Act;
- Development of on-line Training Program for Quarantine Officers, Environmental Health Officers and a customized training packages for the Royal Canadian Mounted Police and the Canadian Border Safety Agency; and

- Integration of Quarantine Service into preparedness and planning for Avian Influenza threat and Pandemic Planning initiatives to ensure robust capacity in dealing with these and other emerging infectious diseases.

Quarantine Act

The new *Quarantine Act* received Royal Assent on May 13, 2005. When it comes into effect, this legislation will assist in preventing the introduction and spread of communicable disease arriving in or departing from Canada. Administered at Canadian points of entry, the new quarantine legislation will offer enhanced protection to Canadians by providing the Government of Canada with new authorities and modern tools to respond rapidly and effectively to the changing threat and risk environment in global public health.

In 2005-06, the Agency participated in the development, conduct and evaluation of national and international exercises in which Agency and Health Canada were active participants, including the *TOPOFF* and the *Ardent Sentry* series of exercises. The agency was a major contributor to the design of *TOPOFF 3/TRIPLE PLAY* and a significant participant, with about 30 staff members participating in the 5-day exercise in April 2005.

Agency expertise was called upon to lead the development of pandemic influenza exercises conducted by other departments, including one (*CommandEx*) held by Health Canada and one (*Novel Threat*) held by Foreign Affairs Canada . The agency also participated in regional and provincial exercises, including *Prairie Fever I*, *Prairie Fever II*, *Atlantic Guard III* and a Manitoba avian influenza exercise. The Agency was active in the development of additional internal as well as joint federal, provincial, and territorial exercises.

SUCCESS STORY

Canada's first national pandemic influenza exercise

In November 2005 the agency hosted Canada's first national pandemic influenza exercise, as part of the National Forum on Emergency Preparedness and Response. It was a day of information gathering and sharing for participants from all provinces and territories representing different sectors of the health portfolio, the emergency management sector and various federal government departments.

The exercise addressed emergency planning and response management issues that will arise during the course of an influenza pandemic in a variety of areas, including surveillance, vaccination, antiviral medications, communications and emergency response. Participants in this exercise included those responsible for pandemic planning and response management, and specifically staff working in the areas of public health, public information, public safety, emergency management and health care, among others. This exercise emphasized management of public health response.

Exercise Atlantic Guard III

Exercise Atlantic Guard III was a four-day interdepartmental and intergovernmental command post exercise conducted in the Atlantic Region on November 1-4, 2005. As exercise participants, the Agency's Atlantic Region Office and Health Canada activated a Regional Emergency Coordination Centre in their offices at the Maritime Centre in Halifax NS, and provided liaison officers to joint federal-provincial emergency operations centres in Nova Scotia, New Brunswick and Prince Edward Island. The exercise involved simulated security, public health and maritime-related incidents, such as chemical, biological and radiological/nuclear (CBRN) and terrorism incidents, and other threats to public safety and health.

The Agency's Travel Medicine Program utilizes tools such as the Global Public Health Intelligence Network (GPHIN), which anticipates and tracks infectious diseases using software to monitoring large volumes of worldwide news related to infectious and chronic disease, natural disasters, environmental and agricultural concerns that might affect the health of Canadian travellers. The Travel Medicine Program enhances public health security by providing essential up-to-date information on international public health events to international Canadian travellers and front-line health care workers.

SUCCESS STORY

Global Public Health Intelligence Network (GPHIN)

GPHIN is a secure, Internet-based "early warning" system that gathers preliminary reports of public health events of significance in seven languages (English, French, Chinese (simplified & traditional), Russian, Arabic and Spanish) on a real-time, 24-hour/7-day basis. This unique system gathers and disseminates relevant information on disease outbreaks and other public health events by monitoring global media sources such as newswires and Web sites. GPHIN is the primary source of informal information about potential public health threats worldwide for the Public Health Agency of Canada, the Canadian Food Inspection Agency, foreign governments and international organizations such as WHO. Recently, GPHIN was acknowledged at a technology, entertainment and design award ceremony in the United States for its contribution to global public health surveillance.

Emergency Response Capacity

	Planned ($M)	Authorities ($M)	Actual ($M)
Emergency Response Capacity	11.9	11.9	11.9

What was planned

In order to respond to the anticipated needs of Canadians following a natural or human-caused disaster, during the 2005-2006, the Agency was to maintain its 24-hour/7-day response capability and the ability to deliver supplies from the National Emergency Stockpile System (NESS)anywhere in Canada within 24 hours. In addition, it planned to enhance its laboratory response operations to address biological weapons or agents, to coordinate provincial and territorial emergency health and social services through the Council of Health Emergency Management Directors and the Council of Emergency Social Services Directors and finally to staff, train and supply two Health Emergency Response Teams (HERTs) that would assist the provinces and territories to create surge capacity in the event of public health emergencies.

What was achieved

All stated plans were met, except for the establishment of the two Health Emergency Response Teams (HERT).

The Agency maintained its 24/7 response capability as well as ensuring that NESS could meet its 24-hour commitment. NESS also met a key distribution goal by acquiring a warehouse in Newfoundland and Labrador. By the end of FY 2005-2006, the system consisted of 9 federal warehouses and approximately 1,300 pre-positioned storage sites strategically located across Canada. The Agency continued to build an effective stockpile of critical supplies in order to respond to pandemic and other public health emergencies.

SUCCESS STORY

Hurricane Katrina

On Saturday, September 3, 2005, the Agency received a request for medical supplies from the United States Department of Health and Human Services to aid with Hurricane Katrina recovery efforts. The Agency activated the National Emergency Stockpile System's Ottawa depot to prepare supplies and handle logistics, including sourcing a chartered flight. The following day, supplies including medical supplies, cots, blankets and batteries were flown to Atlanta, Georgia, for use in the relief effort.

In collaboration with the provinces, Emergency Response Assistance Plan (ERAP) Teams are set up across the country, comprised of various professionals who would respond to transportation issues involving infectious substances affecting humans, Risk Group 4. They completed their annual training and their stocks replenishment, as coordinated through the Agency.

In addition, the Agency's newly renovated Containment Level 3 Lab became operational and serves as a biological threat response lab for the National Capital Region. In support of this effort the lab acquired a BIOLOG bacterial identification system that contains a dangerous pathogens database. As part of its mobile biological threat response capacity, the Agency participated in three field response deployments as part of Canada's Joint National Chemical, Biological, Radioactive and Nuclear Response Team and in the delivery of two Biological Basics training courses to the first responder community.

SUCCESS STORY

Emergency Response Assistance Plan (ERAP)

The Agency hosted a central "Train the Trainer" session that brought the national ERAP teams together with local and national first responders (police and fire), which opened lines of communication between the two communities. This was an innovate action towards public health, as 15 trained ERAP teams and officials from each province and territory, local first responders (i.e. HAZMAT) from across Canada, the Canadian Food Inspection Agency, Health Canada, and the RCMP gathered together on January 23-25, 2006 to focus on how best to prepare for and respond to national transportation emergencies.

During 2005-2006, the National Office of Health Emergency Response Teams (NOHERT) continued to address all aspects of planning for, and establishing, the teams of health professionals from outside the federal government who will comprise the HERT contribution to medical surge capacity. The NOHERT completed the specification of the composition of the HERT teams as well as the specifications for the standardized, air deployable encampments consisting of shelter, equipment/supplies and amenities to support medical response teams in the field. Procurement began for the first two of four modules.

The NOHERT was not successful in establishing two HERT teams as planned, in part due to the complexities of licensing, and to conditions in the market for the services of health professionals. However, in February 2006 the Agency created an Epidemiology Emergency Response Team (EERT) for deployment during times of great need. The creation of EERT augmented the surge capacity available to assist the provinces and territories to manage emergency situations.

Infectious Disease Prevention and Control

The number of Canadians dying from or living with infectious diseases has been climbing since the 1980s, largely because of HIV/AIDS. The steep increase in sexually transmitted infections (over 500% since 1997), concurrent trends of co-infection involving diseases such as hepatitis C and syphilis, the unpredictability of emerging pathogens and the animal origins of emerging and re-emerging infectious diseases are all contributing to current trends. Relatively new threats such as the spread of antimicrobial-resistant organisms and hospital-acquired infections are compounding the challenges surrounding modes of disease transmission, adding a significant risk to public health and severely limiting treatment options for a number of infectious diseases.

Canada's annual death rate from infectious diseases currently stands at 10.5 per 100,000, a figure which shows no sign of declining despite recent advancements in prevention, treatment and control. HIV/AIDS continues to be a national epidemic, as roughly 58,000 people currently live with HIV. About one quarter of infected individuals are unaware of their condition.

The dynamic evolution of disease pathogens creates formidable challenges for the prevention and control of infectious diseases. In addition, the potential for co-infection by multiple micro-organisms with common risk factors, behaviours and modes of transmission increases the need for comprehensive approaches across all infectious diseases. During 2005-2006 the Agency explored new and innovative ways of addressing these diseases through scientific advances and by exploring new collaborations and partnerships. Consistent infrastructure, surveillance systems and strengthened capacity were key to ensuring that timely and appropriate information was available to all of Canada's federal, provincial and territorial governments.

HIV/AIDS

	Planned ($M)	Authorities ($M)	Actual ($M)
HIV/AIDS	34.8	34.8	35.0*

** Variance between authorities and actual expenditure resulted from re-prioritizing among programs, within the overall authorized and budgeted limits.*

What was planned

The Federal Initiative to Address HIV/AIDS in Canada is a partnership among the Public Health Agency of Canada, Health Canada, the Canadian Institutes of Health Research, and Correctional Service Canada. The goals of the Initiative are to prevent new infections, slow the progression of the disease and improve quality of life, reduce the social and economic impact of HIV/AIDS and contribute to the global efforts against HIV.

In 2005-2006, the Agency's key activities were to:

- Strengthen knowledge of HIV/AIDS to better inform HIV prevention, care, treatment and support programs;
- Develop discrete approaches for those populations most vulnerable to HIV/AIDS;
- Increase public awareness of HIV/AIDS in order to reduce stigma and discrimination;
- Develop comprehensive HIV/AIDS programs and services that are integrated with those for other diseases such as hepatitis C and sexually transmitted infections;
- Broadly engage other federal departments to address factors that influence health, such as housing and poverty;
- Increase Canadian engagement in the global response to HIV/AIDS; and
- Improve the communication of outcomes from federal investments in HIV/AIDS.

What was achieved

The Agency undertook activities in program development, research and communications in its efforts to achieve its goals related to HIV/AIDS. The role of the Agency is to promote awareness among both at-risk groups and the general public, assist those providing services related to the disease and undertake research to advance our knowledge and understanding of HIV and AIDS in collaboration with its domestic and international partners.

In 2005-2006, the Agency funded the Canadian Public Health Association, a national organization, to engage in community based social marketing campaigns to increase awareness related to HIV/AIDS in order to influence public attitudes and behaviour regarding HIV/AIDS. The Agency also provided funding to a regional organization, AIDS Vancouver, to carry out a similar social marketing campaign. Among the outcomes from Phase 1of the AIDS Vancouver campaign, 76% of the participants indicated that the campaign message prompted them to think about the safety of the sex they had been having.

The Agency was also engaged in the production and dissemination of HIV/AIDS prevention, diagnosis, care, treatment and support publications and information across Canada. For example, in the reporting period, 30 treatment information workshops held throughout Canada benefited approximately 1500 frontline service providers and persons living with HIV/AIDS.

Under the lead of the Agency, an Assistant Deputy Ministers (ADM) committee was created to provide interdepartmental leadership, increased coordination and cooperation, and improved coherence of federal policies and programs to more effectively address HIV/AIDS and its underlying factors. The federal departments and agencies involved are Health Canada, the Canadian Institutes of Health Research, Citizenship and Immigration Canada, Foreign Affairs Canada, Human Resources and Social Development Canada, Indian and Northern Affairs Canada, Industry Canada, the Canadian International Development Agency, Canadian Heritage and Justice Canada. Following the creation of this committee, a concept paper was prepared to guide the development of a Government of Canada position statement on HIV/AIDS. Also, a work plan for interdepartmental activities for 2006-2007 was prepared.

The Agency studied HIV survivors to determine the long-term effects of improved social support networks in mitigating social isolation and discrimination and preventing the further spread of sexually transmitted infections.

In 2005-2006, the Agency developed and distributed the 2006 *Canadian Guidelines on Sexually Transmitted Infections* (STIs). Built on evidence-based expertise in screening, treatment and control of STIs, including HIV, the revised Guidelines are distributed to clinical practitioners throughout Canada.

Guidelines for the *Non-Reserve First Nations, Inuit and Métis Communities HIV/AIDS Project Fund* were revised by the Agency to promote awareness of HIV, hepatitis C and STIs and to support harm reduction activities.

The Agency provided its expertise to bilateral and multilateral projects that engaged Canadians in the global response to HIV/AIDS. It provided technical assistance in one project, funded by CIDA, to the government of Pakistan to improve that country's HIV/AIDS surveillance system. In a second, the Agency was consulted by the Canadian Public Health Association to provide technical support to build HIV surveillance capacity in Bulgaria.

SUCCESS STORY

Integrating regional HIV and Hepatitis C programs

The integration of regional components of the HIV/AIDS strategy (AIDS Community Action Program – ACAP) and the hepatitis C program was completed in 2005-2006. During the fiscal year, the teams responsible for these programs developed a common work plan and a common project framework. The team used a single consultative framework to work with 47 HIV/AIDS and hepatitis C projects. Advantages of this integrated such approach included having a comprehensive vision to address common problems. Duplication of tasks was avoided, and inconsistencies were reduced or eliminated. This, in turn, harmonized program documentation and reduced the administrative burden on sponsoring organizations. Integration helped sponsoring organizations, and facilitated the development of public health capacity within the community.

Throughout 2005-2006, the Agency continued to publicly communicate its progress on the achievement of outcomes through annual reports such as: *Canada's Report on HIV/AIDS* (the World AIDS Day Report) published on December 1, 2005 and a surveillance publication entitled: *HIV and AIDS in Canada* published in April 2005. The first report was published in both print and Web formats (http://www.phac-aspc.gc.ca/aids-sida/hiv_aids/report05/index.html).

Pandemic Influenza Preparedness

	Planned ($M)	Authorities ($M)	Actual ($M)
Pandemic Influenza Preparedness	7.0*	35.3	30.5**

* Variance between planned spending and total authorities is mainly due to in-year approval, in a Governor General's Special Warrant, for an investment to take immediate steps for avian and pandemic influenza preparedness.

** The variance between total authorities and actual expenditure resulted largely from procurement savings as well as cancellation of purchase orders when timing requirements could not be met.

What was planned

Recognizing that an influenza pandemic has the potential to be the largest public health infectious disease emergency in Canadian history, the Agency planned to take a leadership role in updating the Canadian Pandemic Influenza Plan, in collaboration with the provinces and territories, and in promoting implementation of the update by all levels of government. The Plan includes ensuring that there is an adequate domestic stock of influenza vaccines and ability to produce appropriate vaccines.

It was planned that the Agency would also continue to work with its global partners on disease surveillance of diseases that could signal the onset of a pandemic, and to ensure that the necessary global cooperation is in place prior to a pandemic.

What was achieved

The Agency took a leadership role in updating the Canadian Pandemic Influenza Plan. Working with Health Canada, Public Safety and Emergency Preparedness Canada, the provinces and territories and other key stakeholders, it developed updates to incorporate the new knowledge and expertise, including the updated pandemic phases defined by the World Health Organization (WHO) which reflect the level of international risk. Key annexes on communications, surveillance and public health measures were also added to the Plan.

To ensure that Canada has a substantial, domestically produced supply of vaccines should the need arise, the Agency signed a contract with a domestic manufacturer of major influenza vaccines to increase

that company's production capacity to 8 million doses per month. The contract stipulates that Canadian orders will be filled before the company sells to other countries. The Agency also participated with the provinces and territories in a review of guidelines for the use of pandemic influenza vaccine should supply shortages arise.

Through the Canadian Public Health Network, the Agency continued to enhance its pandemic preparedness by increasing the diversity and size of the National Antiviral Stockpile, through purchases of both oseltamivir and zanamivir.

During the March 9, 2006 Deputy Minister's meeting on pandemic planning, the Deputy Ministers agreed in principle that the National Antiviral Stockpile should be increased from 16 million to 55 million doses, and that those supplies should be used to treat persons who may require medical treatment in the event of an influenza pandemic.

The Agency, working with the voluntary sector, continued to support and co-lead the Canadian Immunization Committee, the Pandemic Influenza Committee, the National Advisory Committee on Immunization and their working groups to develop strategies and policies that serve to reduce or eliminate vaccine-preventable or infectious respiratory infectious diseases; to reduce the negative impact of emerging infectious diseases and to maintain the confidence of the Canadian public and professionals in the country's immunization programs.

The Agency continued to undertake studies towards the development of knowledge on a potential influenza pandemic in Canada. For instance, studies were conducted on the strain that caused the 1918 influenza pandemic by re-creating it under laboratory conditions. The 1918 "Spanish flu" is commonly used as reference in preparations for an upcoming influenza pandemic. Having confirmed that the 1918 virus can be recreated under laboratory conditions and that the resulting virus is lethal in primates, we can now develop a safe vaccine strain that would protect humans while learning more about how influenza viruses cause severe illness.

The Agency, in collaboration with the United States and the United Kingdom, designed and funded two research studies to evaluate the impact of universal versus targeted influenza immunization programs. Phase 1 of the Influenza Immunization Program Evaluation Study was initiated by the Agency in April 2005 and extended beyond that fiscal year (completion is expected during 2006). It consists of an evaluation of how Ontario's universal influenza immunization program compares with other influenza immunization programs that target populations at high risk of complications in Canada and/or other countries with comparable demographics, health care systems and influenza season patterns. The Agency continued to participate with the WHO in the development of an action plan for Canada to address pandemic vaccines issues. The Agency also worked on other pandemic prevention/mitigation strategies with WHO, and the Global Health Security Action Group. In addition, the Agency collaborated with Health Canada in its work under the Security and Prosperity Partnership which is to develop North American strategies to deal with both pandemic influenza and avian influenza.

Research activities related to pandemic influenza planning included the *Evaluation of Influenza Immunization Programs in Canada*, carried out in collaboration with the Canadian Institutes of Health Research (CIHR) and other partners, including the Canadian Immunization Committee.

Health Care/Hospital Acquired (Nosocomial) Infections

	Planned ($M)	Authorities ($M)	Actual ($M)
Health Care/Hospital Acquired (Nosocomial) Infections	3.9	3.9	4.0*

* Variance between authorities and actual expenditure resulted from re-prioritizing among programs, within the overall authorized and budgeted limits.

What was planned

Studies indicate that 5% to10% of all patients who enter a health facility develop a nosocomial (health care/hospital acquired) infection. As the provision of direct health care is almost exclusively all under provincial and territorial jurisdiction, the Agency's Nosocomial Infections Program works with the provinces and the territories to focus on the public health impact of infectious agents transmitted during the provision of health care.

The Agency intended to expand the scope of recommendations in its *Infection Control Guidelines*, which are designed to eliminate health care/hospital acquired infections.

It was the Agency's plan to expand over a three-year period starting in 2005-2006, the number of active surveillance projects and policy activities related to critical health care-acquired infections under the Canadian Nosocomial Infection Surveillance Program.

The Agency intended to conduct an in-depth analysis of infectious disease outbreaks in Canadian health care facilities and to develop contingency plans for emerging infectious agents in those facilities.

The Agency planned to use information from a prevention and control survey of all of the hospitals in Canada to refine the infection prevention and control recommendations related to a bacterium often involved in nosocomial infections, *C. difficile*. The Agency also planned to carry out studies in order to determine whether there is a way of differentiating severe cases of *C. difficile* from mild cases.

What was achieved

During 2005-2006, the Agency reviewed the *Infection Control Guidelines*, which now cover the entire spectrum of health care providers, such as acute care and long-term care institutions, office and outpatient care, and home care. The Guidelines can be found at: http://www.phac-aspc.gc.ca/dpg_e.html#infection .

The Agency-supported Canadian Nosocomial Infection Surveillance Program expanded the number of its active surveillance projects and policy activities related to critical health care-acquired infections during 2005-2006.

Work was completed during five months of a planned six-month *C. difficile* surveillance program within 35 acute-care hospitals in 8 provinces. In addition, active surveillance of *C. difficile* was expanded to include cardiac surgical site infections, and laboratory work and data analysis was undertaken on the *C. difficile* strains to determine whether there is a way of differentiating severe cases of *C. difficile* from mild cases.

Animal-to-Human (Zoonotic) Diseases

	Planned ($M)	Authorities ($M)	Actual ($M)
Animal to Human (Zoonotic) Diseases	19.5	19.5	20.3*

* Variance between authorities and actual resulted from re-prioritizing among programs, within the overall authorized and budgeted limits.

What was planned

The Agency planned to continue to provide the necessary infrastructure and scientific expertise to support basic surveillance, science, research, coordination and leadership involving specific animal-to-human diseases. This included continuing research on and surveillance of the West Nile virus (WNV) in collaboration with Canada's blood agencies, to minimize risks to the country's blood supply. This also included continuing research on the virulence and host adaptation of major enteric (gastrointestinal) pathogens. The Agency planned to work with stakeholders to develop a pan-Canadian surveillance program for monitoring trends in antimicrobial resistance in selected enteric pathogens and indicator bacteria isolated from humans, animals and food sources.

What was achieved

The Agency provided diagnostic reference services for viruses such as WNV and continued surveillance for rarely occurring diseases such as Rocky Mountain fever. It also enhanced surveillance activities that provided new findings related to diseases like Lyme disease and completed studies on antivirals which identified 2 antiviral compounds with a wide range of activity against arboviruses, a class of viruses spread by blood sucking insects.

The Agency collaborated with provincial and territorial partners to maintain a national surveillance system for WNV, developed and updated guidelines, participated in national and international projects on disease epidemiology and therapeutic approaches, and educated the public on protection from the virus.

The Agency developed a model on mosquito's specific habitat preferences that makes predictions of when and where WNV might pose a threat to human populations based on, for example, climate data. It also collaborated with the University of Montréal and other partners on WNV and Lyme disease modelling, focusing on the effects of climate change in southern Quebec.

The Agency, in partnership with the University of Montréal, obtained Canada Foundation for Innovation funding for the creation of a high-performance mathematical disease-modelling tool, providing the infrastructure necessary to analyse current and emerging infectious disease problems threatening Canada.

In addition, the Agency conducted vaccine studies that further assess the efficacy of vaccines containing genes of Marburg, Ebola and Lassa fever viruses.

Agency researchers used comparative genomics techniques for the detection of emerging foodborne pathogens as work continued on the public health significance of virulence factors, genomics and gene expression.

In April 2005, the Agency's Canadian Integrated Outbreak Surveillance Centre launched its Travel and the Zoonotic Alert modules, this providing a national infrastructure for rapid dissemination of information about potential infectious disease outbreaks.

C-EnterNet, a multi-partner initiative facilitated by the Agency, initiated a pilot study in the Waterloo, Ontario, region. Through comprehensive sentinel site surveillance implemented through local public health units, C-EnterNet supported activities designed to reduce the burden of enteric (intestinal) disease.

The Agency expanded its Canadian Integrated Program for Antimicrobial Resistance Surveillance (CIPARS) to include additional pathogens, and to encompass agricultural commodities such as on-farm milk-fed veal and on-farm beef, and retail food commodities such as turkeys and ready-to-eat foods.

The Agency participated in the International Network for Integrated Surveillance for Antimicrobial Resistance in Enteric Bacteria, a committee of international agencies with interested in surveillance for antimicrobial resistance in agri-food products. This network was set up as a result of the WHO meeting on antimicrobial resistance held in Winnipeg on September 16, 2005.

Other Activities Associated with Infectious Disease Prevention and Control

Throughout 2005-2006, the Hepatitis C Prevention, Support and Research Program's regional and national staff continued to work with community-based organizations such as the Canadian Public Health Association to provide prevention programs, material and training to at-risk communities and those who provide services to them.

The Agency worked with stakeholders to develop bloodborne pathogen surveillance systems such as the national Transfusion Transmitted Injuries Surveillance System. This system monitors adverse events and errors related to transfusion in order to evaluate bloodborne pathogen transmission in different targeted groups (e.g. blood and bone marrow recipient groups) across the country.

The Agency developed a pilot surveillance system for cells, tissues and organs (CTOSS), to monitor the transmission of infectious disease associated with transplantation in partnership with Health Canada.

International collaborative efforts were enhanced through the Public Health Agency of Canada's participation in the International Circumpolar Surveillance Initiative. The Agency has been part of the initiative since 1999 and has contributed funding to the Centers for Disease Control and Prevention in the United States. Data collected contributed to the understanding of the epidemiology of invasive bacterial diseases among northern populations, thus fostering the formulation of prevention and control strategies for these populations.

Health Promotion and Chronic Disease Prevention and Control

Health is determined by a number of factors, including conditions in society, and personal health practices. More and more Canadians have one or more risk factors, like unhealthy eating and physical inactivity, that often lead to the major chronic diseases: heart disease and stroke, cancer, diabetes and respiratory disease.

Unfortunately, the burden of preventable death and disease has been growing, reducing the quality of life, increasing wait times for health care, and challenging the sustainability of the health care system.

Studies have also shown the following risks and challenges:

- Two thirds of death and disability could be avoided. Up to 80% of Canadians have at least one health behaviour they could change to improve their health.
- Chronic disease and injury account for more than 75% of deaths and 87% of disabilities each year.[1] The associated economic burden to Canada is estimated at $70 billion per year or about 62% of direct health care costs.[2]
- Two in five Canadian males and one in three Canadian females face a cancer diagnosis in their lifetimes.[3]
- The levels of obesity and overweight found are much higher than those of previous studies based on self-reported data. When overweight and obesity are considered together, 65% of men and 53% of women have excess weight. Most troubling is that the most dramatic increases are among children and adolescents. As an individual's body mass index increases, so does the likelihood of reporting high blood pressure, diabetes and heart disease.

[1] Public Health Agency of Canada using 2003 Vital Statistics data from Statistics Canada, 2006.
[2] Health Canada (2002), Economic Burden of Illness, 1998.
[3] Canadian Cancer Statistics, 2006.

To address the growing burden of chronic disease in Canada, the Government announced an investment of $300 million over five years to build an Integrated Strategy on Healthy Living and Chronic Disease.

The Strategy is designed to promote the health of Canadians, reduce the impact of chronic disease in Canada, and address the determinants of health. Based on collaboration, the Strategy, which includes disease-specific initiatives, focuses on three pillars:

- Promoting health by addressing the conditions that lead to unhealthy eating, physical inactivity and unhealthy weight;
- Preventing chronic diseases; and
- Supporting early detection and management of chronic diseases.

SUCCESS STORY

SummerActive/WinterActive

The Agency, in partnership with Health Canada and Canadian Heritage, collaborated with the provinces and territories to develop "SummerActive" and "WinterActive", a set of community mobilization initiatives designed to help Canadians improve their health by encouraging and supporting regular physical activity, healthy eating and a tobacco-free lifestyle, and by participating in sport activities. http://www.summeractive.org

Integrated Healthy Living Strategy

	Planned ($M)	Authorities ($M)	Actual ($M)
Integrated Healthy Living Strategy	17.3*	8.0**	4.6***

* The initial plan reflected budget commitments but lacked policy approval and spending authority.

** The Agency requested a lower amount through Governor General's Special Warrants than was initially planned, in light of evolving operational conditions and pending policy approval.

*** Actual spending was lower than authorities, due primarily to pending policy approval.

What was planned

In 2005-2006, the Agency planned to promote physical activity, healthy eating and healthy weights through the Pan-Canadian Healthy Living Strategy (http://www.phac-aspc.gc.ca/hl-vs-strat/index.html) by means of the following activities:

- Mobilizing action and engaging partners across jurisdictions, the health system and other sectors;
- Consolidating promotion and prevention efforts where people work, live learn and play by working through the determinants of health, targeting common risk factors for multiple diseases and injury, and;
- Developing a research and surveillance agenda and communications/health information strategy.

The Intersectoral Healthy Living Network would make an important contribution to this process.

Through the National Clearinghouse on Family Violence and the Family Violence Initiative, the Agency planned to collect, develop and disseminate information on family violence across the country and abroad.

What was achieved

In 2005-2006, the Agency reached an agreement with participating provinces and territories on the Pan-Canadian Healthy Living Strategy. (Although Quebec shares the general goals of this Canada-wide strategy, it was not involved in its development and does not subscribe to it). Under part of this agreement, governments set targets to increase by 20%, by the year 2015, the proportion of Canadians

who participate in physical activity, eat healthily and have a healthy weight.

Through the coordinating committee of the Intersectoral Healthy Living Network, various other partners and stakeholders participated in the development of the Pan-Canadian Healthy Living Strategy, including non-governmental organizations, Aboriginal organizations and the private sector. Implementation activities also began during the year; they included the development of an approach to research and surveillance and a communications strategy.

SUCCESS STORY

Northern Food Security Partnership/ Bayline Regional Roundtable (BRRT)

The Bayline Regional Roundtable (BRRT) is a partnership established to secure better year-round access to safe food in northern Manitoba. The Bayline region consists of small towns located along a rail line connecting The Pas to Churchill. Many of these communities are without year-round roads and are accessible only by train or plane. The lack of supplies such as fertilizer, rakes and rototillers in many remote communities limits them to small-scale food production. As part of BRRT's Northern Food Security Partnership Initiative, funded by the Agency and the Manitoba government, the Rototiller Project assists by securing resources from the private sector and individuals (e.g., free seeds and fertilizer from Canadian Tire, transportation from VIA Rail and Perimeter Air, and advice from volunteers) to support the initiative.

In addition, the Agency completed the development of the Integrated Strategy on Healthy Living and Chronic Disease and began its implementation. Activities on the Healthy Living components included the development of a detailed implementation plan and an approach to evaluation. The Agency also collaborated with provincial and territorial governments to establish the Joint Consortium for School Health, a forum which is to act as a catalyst in strengthening cooperation among ministries, departments, agencies and others, and in building the capacity of the health and education sectors to work together. The Consortium will develop programs, policies and practices that improve the health of young people and address specific issues and risk factors such as physical activity, healthy eating and their relationship to healthy weights.

Also, the 2005-2006 Physical Activity Contribution Program awarded contributions of $3.5 million to 23 projects that support the voluntary sector in increasing access to convenient, safe, affordable and attractive opportunities to integrate physical activity and healthy eating into daily life.

SUCCESS STORY

Healthy Lunches to Go Tour

As obesity rates continue to increase in Canada, to promote healthier living, the Canadian Health Network, working with significant support from the Agency, leveraged the popularity of the content area on healthy eating to pilot a highly successful social marketing project: the *Healthy Lunches to Go Tour*. This project provides Canadians with a tool that advises them on how to pack healthier lunches and motivates them to do so. The Tour engaged more than 14,000 visitors during 2005-2006, and over 84% of participants indicated that the information was helpful in their quest to make healthier lunches. http://www.canadian-health-network.ca

Integrated Strategies for Chronic Disease

	Planned ($M)	Authorities ($M)	Actual ($M)
Integrated Strategies for Chronic Disease	6.5	10.7*	11.1**

* The authorities reflect funding requested through Governor General's Special Warrants.

** Variance between authorities and actual resulted from re-prioritizing among programs, within the overall authorized and budgeted limits.

What was planned

The Agency intended to continue developing integrated strategies addressing chronic disease and healthy living in collaboration with Health Portfolio partners, the provinces and territories and other Canadian and international public health partners.

What was achieved

In 2005-2006, the federal, provincial and territorial Ministers of Health launched the Pan-Canadian Public Health Network. The Network facilitates coordinated governmental responses on public health matters; supports the day-to-day business of public health, and facilitates access to mutual aid between governments during emergencies. The Agency took a lead role in supporting the establishment of the Public Health Network, by creating a federal, provincial and territorial secretariat to support and manage the Network. The Agency provided funding for the initiatives and supported the expert groups and the Network's Council. The Agency, along with the provinces and territories, established the Surveillance Information Expert Group as part of the Public Health Network to identify and develop areas of shared expertise and common experience. In establishing the Public Health Network, the Health Ministers created a mechanism to support a new, more collaborative approach in the area of public health. This will be particularly critical during public health emergencies, but will also assist Canada in establishing a coordinated vehicle to address serious public health issues, such as obesity and non-communicable disease.

In addition, to enhance surveillance of arthritis and other rheumatic conditions, the Agency developed and approved new arthritis indicators (such as sleep quality, blood pressure, access to healthcare, and level of public awareness) to support the measurement of progress toward public health goals and targets. Stakeholders involved in this process included the Canadian Institute for Health Information (CIHI), the Canadian Arthritis Network and the Canadian Rheumatology Association.

As well, the Agency provided leadership for the revitalization of the Canadian Task Force on Preventive Health Care (http://www.ctfphc.org). The Task Force worked to improve the quality of health care by publishing clinically-based preventive intervention evidence used by practitioners on chronic diseases (such as diabetes) and new epidemics (such as obesity). The creation of a new infrastructure for the Task Force will lead to increased capacity of health professionals and the community, and, ultimately, healthier public policy. International models were explored to ensure that a sustainable structure would be established. A national interdisciplinary Advisory Committee was also established to work with the Agency and the Task Force to provide strategic advice on policy and practice issues.

Chronic Disease-Specific Strategies

	Planned ($M)	Authorities ($M)	Actual ($M)
Chronic Disease-Specific Strategies	10.7	16.0*	15.4**

* The authorities reflect funding requested through Governor General's Special Warrants.

** Variance between authorities and actual resulted from re-prioritizing among programs, within the overall authorized and budgeted limits.

What was planned

The Agency planned to continue to work closely with cardiovascular disease (CVD) partners to build on the Canadian Heart Health Initiative (CHHI), the Cardiovascular Action Plan, and targeted hypertension initiatives.

In addition, the Agency would continue to implement the Canadian Strategy for Cancer Control (CSCC) in several strategic areas: research; support, psychosocial and palliative care; primary prevention; standards; guidelines; human resource planning; and surveillance.

It was also the Agency's intention to evaluate the results of its contributions to the Canadian Breast Cancer Initiative (CBCI), whose purpose is to reduce breast cancer incidence and mortality and improve the quality of life of those affected by breast cancer.

The Agency planned to address the control and management of diabetes for populations at risk and for those living with the disease.

What was achieved

Key partners, internal and external to the Health Portfolio, engaged in the planning for a new CVD strategy. This represented an initial transition step from the Canadian Heart Health Initiative (CHHI), building on the lessons learned from that initiative. In addition, the Surveillance Advisory Committee for Cardiovascular Disease (CVD) was established to provide ongoing expert advice from academia, health professional organizations, consumer-based and volunteer non-governmental organizations (NGOs), Statistics Canada, the Canadian Institute for Health Information, and provincial and territorial governments.

Hypertension is a risk factor for cardiovascular disease. Of particular concern is that symptoms can be absent, even in cases of high blood pressure. This poses a challenge for early diagnosis and long-term control. In 2005-2006, the Agency established the Canadian Hypertension Monitoring System, in collaboration with Statistics Canada, academia, the Canadian Hypertension Society and the Canadian Hypertension Education Program. This system includes an analysis of national population-based health surveys designed to examine the prevalence of hypertension and its treatment; to monitor physicians' prescription practices related to anti-hypertensive medication and to analyze mortality and hospitalization data for related conditions, including strokes and congestive heart failure.

Patient wait time reduction is a priority for Canadians, particularly for those living with cancer. To stimulate new research and help decision makers and policy makers take action and set priorities, the Agency published the annual *Canadian Cancer Statistics* in collaboration with the Canadian Cancer Society, the National Cancer Institute of Canada, Statistics Canada, provincial and territorial government cancer registries and researchers, and university and agency-based researchers (http://www.phac-aspc.gc.ca/ccdpc-cpcmc/cancer/pub_e.html). The Agency also increased its knowledge of cancer staging through development of training materials and sharing of best practices among provincial cancer registries.

SUCCESS STORY

International Cancer Control Congress

With support from the Canadian Strategy for Cancer Control and the World Health Organization, the Agency co-hosted the first International Cancer Control Congress, which brought together experts from 65 countries. The Congress participants shared strategies, experiences, tactics and best practices on the implementation of population-based cancer control was increased. Through such dialogue, the community gained an increased global understanding of the science underlying cancer control. As well, the Congress identified which population-based programs are effective, what key elements lead to maximum impact at the population level, what collaborative partnerships are needed, and how to build an international community of practice. (http://www.meet-ics.com/cancercontrol).

Breast cancer is the most frequently diagnosed cancer in Canadian women. One in 9 women in Canada will develop breast cancer in her lifetime, and one in 27 will die from it. The Canadian Breast Cancer Initiative (CBCI), launched in 1993, supports breast cancer research, care and treatment, professional education, programs for early detection, and access to information http://www.phac-aspc.gc.ca/ccdpc-cpcmc/bc-cds/cbci_main_e.html. Through the CBCI, the Agency provided $4 million and expertise to support stakeholder cancer control projects. In 2005-2006, the Agency synthesized evaluation summaries of the breast cancer projects (e.g. *Cancer Education and Scr eening Project* (Manitoba), and the *Development and Implementation of a 5 Year Breast Cancer Strategic Plan in British Columbia and the Yukon*) and reported the following achievements:

- Increased collaboration, networking, information exchange, and partnership. This facilitated the initiation of new projects, and reduced duplication and overlap. These were found to be among the strengths of these projects, both for those directly involved as well as for the communities they served;
- Increased leadership and involvement shown by survivors, and a stronger sense of participant ownership;
- Expanded peer support and community contact networks across the country, including stronger links with Aboriginal and women living in rural/remote areas;
- The development of information and educational materials; interactive websites, and teleconferencing networks; and
- Increased community capacity building for breast cancer program coordination, development, and delivery.

With help from the CBCI, new and valuable information about the needs of women with breast cancer and how to support them continues to be integrated into the projects, thereby ensuring services and support to communities that otherwise might not provide adequate breast cancer assistance. Also through the CBCI, the Agency invested $3 million to support the Canadian Breast Cancer Research Alliance (CBCRA - http://www.breast.cancer.ca). As the primary funder of breast cancer research in Canada, the CBCRA maintains an alliance of partners to focus resources on all aspects of the disease, including prevention, early detection, treatment, fundamental laboratory investigations, quality of life and health services.

Diabetes is a complex national and international health problem, one that cannot be addressed effectively by any single agency or sector of society. For this reason, the Canadian Diabetes Strategy (CDS) was launched in 1999. It represents Canada's first-ever attempt to deal with diabetes comprehensively and collaboratively. The CDS sought to increase public awareness about diabetes, prevent diabetes where feasible, and help Canadians better manage the disease and its complications.

In 2005-2006, the Agency prepared and analyzed a comprehensive evaluation report spanning the first five years of the CDS (1999-2004). The report indicated that networks and alliances were enhanced, that provinces and territories began developing chronic disease strategies, and that non-governmental organizations became engaged participants. The Strategy might become even more effective if lessons learned are disseminated and acted upon so as to reduce the time needed to achieve concrete and observable progress.

While it is difficult at this stage to state how deep an impact the CDS will have on Canadian morbidity rates and diabetes incident rates, evaluation results indicate a likelihood of real and long-term impact on attitudes and behaviours toward healthy eating and physical activity. This may, in turn, contribute to a reduction in risk factors such as obesity and sedentary lifestyles which often lead to diabetes and other chronic diseases. Evaluation results have also begun to inform decisions about funding allocations for an enhanced CDS and improvements to Agency programming and community-based contribution projects. Thus the Agency began to engage stakeholders in a new approach focused on target populations who are at higher risk of developing diabetes, especially those who are overweight, are obese or have pre-diabetes. Other target populations include individuals over age 40; persons who have high blood pressure and high levels of cholesterol or other fats in the blood; those with a family history of diabetes; or members of certain high-risk ethnic populations.

In 2005-2006, the Agency released two documents entitled *Building a national diabetes strategy: synthesis of research and collaborations (Volume 1)* (http://www.phac-aspc.gc.ca/ccdpc-cpcmc/diabetes-diabete/english/pdf/BuildingaNationalDiabetesStr-eng.pd)f and *Building a national diabetes strategy: A strategic framework (Volume 2)* (http://www.phac-aspc.gc.ca/ccdpc-cpcmc/diabetes-diabete/english/pdf/NDS-Strategic_Framework-Eng.pdf). Prepared by the Coordinating Committee for the National Diabetes Strategy (comprised of the Agency, Health Canada, the Diabetes Council of Canada, national Aboriginal organizations, and the provinces and territories), these documents provide a basis to move forward on action areas for addressing diabetes.

SUCCESS STORY

National Diabetes Surveillance System (NDSS)

Managed by the Agency, the National Diabetes Surveillance System (NDSS) collects and disseminates critical information by facilitating and coordinating the surveillance of diabetes in each province and territory and among Aboriginal communities, through the use of multiple databases. The resulting rich source of data can be used not only for surveillance but also for examining many policy and research questions in developing effective, long-term diabetes prevention, care and control strategies. Perhaps most importantly, the NDSS has been the catalyst for exciting partnerships with various jurisdictions across Canada and internationally to achieve the shared goal of reducing the burden of diabetes. For instance, in 2005-2006, the Agency supported the implementation of agreements previously struck among British Columbia's Ministry of Health, the British Columbia Chiefs Health Committee, and Health Canada to increase the sharing of health information on the First Nations.

Other Activities Associated with Health Promotion

Childhood and Adolescence
In recognition of the fact that some children and families are at higher risk for poor health outcomes, the Agency continued to implement three community-based programs with multiple partners at all levels:

- the Community Action Program for Children (http://www.phac-aspc.gc.ca/dca-dea/programs-mes/capc_main_e.html) provides funding for community groups to deliver healthy promotion programs for at-risk children who are up to 6 years old; it is estimated that it serves over 65,000 participants in over 3,000 communities across the country in a typical month;
- the Canada Prenatal Nutrition Program (http://www.phac-aspc.gc.ca/dca-dea/programs-mes/cpnp_main_e.html), funds community agencies to increase access to heath services and supports for pregnant at-risk women, it reaches about 50,000 women per year, including 60% of the population living in poverty, 37% of pregnant Aboriginal women, and 40% of new teenage mothers (live births) in Canada; and
- Aboriginal Head Start in Urban and Northern Communities (http://www.phac-aspc.gc.ca/dca-dea/programs-mes/ahs_main_e.html) which funds local Aboriginal organizations to provide health promotion programs for off-reserve children up to age 6, and reaches 4,500 First Nations, Inuit and Métis children in 130 Canadian communities.

Under a one-year program extension for 2005-2006, the Agency's *Centres of Excellence for Children's Well-Being* continued to promote knowledge development and exchange through multiple partnerships whose objective is the healthy development of children and youth. Examples of these activities include the Centre of Excellence for Early Childhood Development release of its internationally acclaimed *Early Childhood Development Encyclopedia*. In addition, the Centre of Excellence for Children and Adolescents with Special Needs developed an on-line service and information directory for parents of children with special needs in the Atlantic provinces.

The Agency's *Nobody's Perfect Parenting Program*, is a national parenting education program available throughout Canada to parents of children from birth to age five. During 2005-2006, the Agency assisted with the implementation of this program in Japan, the Dominican Republic and Argentina.

SUCCESS STORY

Fetal Alcohol Spectrum Disorder

Over the last fiscal year, the Agency's Ontario and Nunavut Region has been raising awareness of Fetal Alcohol Spectrum Disorder (FASD) across Ontario. With the Ontario ministries of Education, Children and Youth, Corrections and Justice and the provincial Attorney General's Office, it has created the FASD Intergovernmental Action Network of Ontario (FIANO).

In addition to FIANO, the Agency provided funding support to the FASD Stakeholders for Ontario, a group of experts from across the province. This group has worked collaboratively to address FASD, and has created five working groups - Urban Aboriginal, Prevention, Intervention and Support, Diagnosis and Disability, and Justice - to deliver on their priorities.

Canadian Health Network

The Canadian Health Network (http://www.canadian-health-network.ca) is responding effectively to Canadians' growing need for reliable on-line health information. Surveys indicate that 95% of CHN users are either satisfied or very satisfied with the information they found on the site. As well, 92% of first-time users of the site become return users.

Over the past year, the number of subscribers to the biweekly CHN newsletter, *HealthLink*, has tripled to reach over 30,000 health information consumers. The CHN has developed a strong following with this information vehicle and the Agency has been a key tool for advancing its objective of providing Canadians with health information.

The CHN is successfully reaching a diverse range of Canadians. For example 39% of visits come from health professionals who in turn connect the Network to a broad audience. The CHN partners with 19 non-profit organizations representing health expertise from across the country to deliver credible, quality-assured health information to Canadian consumers through their own networks.

Family Violence

The Agency was responsible for leading and coordinating the Family Violence Initiative and for managing the National Clearinghouse on Family Violence on behalf of 14 federal departments, Crown corporations and agencies (http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence). The Initiative promotes public awareness of the risk factors of family violence and the need for public involvement; strengthens the criminal justice, housing and health systems' response to family violence; and supports data collection, research and evaluation efforts.

Aging and Seniors

In 2005-2006, the Agency undertook work in relation to seniors and emergency preparedness and response. In addition, the Agency released a report entitled *The State of Seniors Falls in Canada* to support and promote research, policy and programs that help prevent falls and fall-related injuries.

Other Activities Associated with Chronic Disease Prevention and Control

The Agency made significant contributions to the design and development of key national health surveys including:

- the *Canadian Health Measures Survey*, which will provide critical baseline data for monitoring changes in chronic disease markers and key risk factors related to these conditions; and
- the *Canadian Community Health Survey (CCHS)*, a fundamental surveillance tool for the national, provincial and regional level surveillance tool. (http://www.statcan.ca/english/sdds/5049.htm).

The Agency also worked closely with Health Canada and Statistics Canada to manage the release of the CCHS Cycle 2.2 (Wave 1), which described obesity results based on measured heights and weights for the first time in 25 years. Results from the 2004 Survey indicated that 23.1% of Canadians aged 18 or older, an estimated 5.5 million adults, were obese. This is much higher than estimates compiled from self-reported data collected in 2003, which reported an obesity rate of 15.2%, as well as the 13.8% rate reported in the Canada Health Survey in 1978-1979. (http://www.hc-sc.gc.ca/fn-an/surveill/nutrition/commun/cchs_focus-volet_escc_e.html). Results from the CCHS will continue to inform the work of the Agency and others to assist Canadians in maintaining their health.

Public Health Tools and Practice

One of the most crucial factors in the containment of public health threats is the ability to collect, analyze and disseminate specific information within the larger picture. As well, the skill level of public health professionals, their numbers, their distribution across Canada of public health professionals and their ability to move between jurisdictions are significant in the management of health threats. It is also imperative that front line public health professionals be equipped with the tools and associated skills to contribute to enhancing Canada's public health capacity.

The potential impact of disease outbreaks on Canadians is such that effective public health services must be delivered. This is a national undertaking to enhance the existing public health infrastructure in Canada which relies on a multitude of partners working with federal, provincial and territorial governments. In order to be successful in this endeavour, a common understanding of, a common strategy and concerted action to build public health infrastructure capacity needs to be established. Issues related to such an understanding and a strategy are discussed in the report *Improving Public Health System Infrastructure in Canada* (March 2005), prepared by the Strengthening Public Health System Infrastructure Task Group of the Advisory Committee on Population Health and Health Security. Effective federal, provincial and territorial collaborative mechanisms are fundamental to facilitating that discourse and achieving Canada's public health goals.

Public Health Tools and Applications Development

	Planned ($M)	Authorities ($M)	Actual ($M)
Public Health Tools and Applications Development	5.3	5.3	3.5*

* A pan-Canadian Public Health Communicable Disease Surveillance and Management System is being developed by the Canada Infoway Inc. which will gradually replace the integrated Public Health Information System (iPHIS) system. Further iPHIS development work was stopped, which led to a variance in spending.

What was planned

The Agency planned to strengthen public health capacity through the development, provision and enhancement of tools and applications that can support front-line public health professionals and improve their long-term capabilities for informed decision making in the provision of services to Canadians. This would facilitate the effective, efficient and sustained delivery of public health services that protect Canadians from disease and raises their understanding of health and its maintenance.

More specifically, the Agency planned to further improve the integrated Public Health Information System (iPHIS), in association with the provinces and territories, and to develop outbreak and quarantine management capabilities. iPHIS is a unique Web-based software suite consisting of customized health information management modules for the use of front-line public health professionals. It enables the recording, storage, access and management of patient-specific health information, e.g., treatments and outcomes. In the event of a disease outbreak, this capacity would be especially important, since it would facilitate timely information sharing, response coordination and effective action.

In addition, the Agency planned to promote the Public Health Map Generator (PHMG), an online geographic information systems (GIS) tool provided under its GIS program. The PHMG is capable of addressing the current need for a cost-effective solution to create, simply and quickly, maps that facilitate analysis and decision making.

What was achieved

As the usage of iPHIS continued in several Canadian provinces and territories, the Agency provided related maintenance and support services by enhancing to the system, to ensure the pandemic readiness of the provinces and territories and to facilitate the collection of national public health data. The Agency also continued consultations with the iPHIS Program Advisory Groups, firstly to ensure that user needs are addressed and secondly, to ensure that these needs are being reflected in the Canada Health Infoway's Electronic Public Health System (EPHS).

The current users of iPHIS expect the Agency to continue to maintain and enhance this system until the Infoway's EPHS is adopted and the capacity for support of the EPHS is created within the provinces and territories.

The Agency launched the Public Health Map Generator (PHMG) at the Canadian Public Health Association's annual conference in September 2005. The Agency also offered two provincial workshops on the use of GIS for public health practice, one in the Ontario and Nunavut Region and the other in Newfoundland and Labrador. Participants included Medical Officers of Health and other health practitioners. Currently, 75 public health organizations use the PHMG.

The Agency strengthened its partnership with GeoConnections, a national partnership program developed to enhance and expand the Canadian Geospatial Data Infrastructure (CGDI) in order to reinforce the foundation for public health GIS.

The Agency increased its GIS data holdings with respect to pandemic influenza preparedness, including information such as the location of border crossings and emergency centres. These data sets will increase the ability of front-line public health practitioners to pinpoint the location of emergency centres within minutes.

In addition, the Agency undertook GIS research work in Nova Scotia with respect to the availability of breast cancer screening clinics for women and raised the opportunity of redesigning the screening program and thus providing access to a wider population.

Building Public Health Human Resource Capacity

	Planned ($M)	Authorities ($M)	Actual ($M)
Building Public Health Human Resource Capacity	5.8	5.8	4.9*

* Variance between actual spending and authorities reflects spending controls put into place for the dissolution of Parliament and the subsequent election. To comply with these restrictions, program work including developmental work for additional training modules was scaled back from what had initially been planned and authorized.

What was planned

In 2005-2006, The Agency planned to enhance the public health human resource capacity in Canada by delivering online training programs and sponsoring training programs in epidemiology, surveillance and information management.

More specifically, the Agency planned to continue its Canadian Field Epidemiology Program (CFEP) and to deliver on its commitments to double the admission of trainees by 2007-2008. This CFEP aims to increase the number of public health professionals in Canada that are trained to investigate health emergencies, health threats, outbreak management and other public health issues by providing specialized training in the practice of applied epidemiology. This training is not provided by either academic or workplace settings. Field Epidemiologists trained in the 30 years of the program's operation have investigated more than 250 outbreaks and other public health issues.

Learning from SARS: Renewal of Public Health in Canada (the 2003 Naylor Report) and subsequent federal, provincial and territorial reports pointed to significant gaps in health sector human resources in Canada and the urgent need to address these gaps. To continue to address these gaps, in 2005-2006, the Agency planned to build on the success of its Skills Enhancement Program and to offer additional training modules to public health practitioners.

The Skills Enhancement Program complements the CFEP by providing high-quality and easily accessible learning opportunities to the public health workforce across Canada. It is delivered through collaborative efforts of the Agency and its provincial and territorial partners, professional associations, academic institutions, and provides a means of recognition by universities, professional associations and public health authorities of the enhanced knowledge acquired.

What was achieved

By working with partners at all levels of government, the Agency moved a step closer to delivering on its commitment to double the intake of public health professionals into the CFEP by 2007-2008. A cohort of five Field Epidemiologists are currently enrolled for the 2004-2006 period (the CFEP is a two-year program). This number increased to eight Field Epidemiologists and one Community Medicine Resident affiliate in the 2005-2007 cohort and will increase to ten in 2006-2008 cohort.

The Agency expanded its Skill Enhancement for Public Health Programs which build a solid foundation for public health practice by providing continuing education for public health professionals across Canada. The "Epidemiology of Chronic Diseases" module was launched in September 2005 and the "Outbreak Investigation and Management" module was launched in January 2006. Approximately 1,300 practitioners took the Skills Enhancement modules during 2005-2006.

In addition, the Agency started to put together plans for implementing the strategies discussed and identified under the Public Health Human Resource Task Group (PHHR-TG) of the Advisory Committee on Health Delivery and Human Resources (ACHDHR) and the Advisory Committee on Population Health and Health Security (ACPHHS), especially those identified in the pan-Canadian Framework for Public Health Human Resource Planning.

Other Activities Associated with Public Health Tools and Practice

The Agency demonstrated leadership by working to create the Public Health Law and Ethics Program. The purpose of this program is to develop strategies and tools to improve the coherence and cohesiveness of Canada's public health legislative architecture and to facilitate ethical decision-making in the field of public health. The Agency, working with international and domestic stakeholders, undertook preliminary work for the holding of the first-ever Canadian Conference on the Public's Health and the Law in November 2006.

The Agency also furthered its commitments to adhere to the International Health Regulations of the World Health Organization by continuing its approach of designing complementary, coherent and consistent policy supported by pan-Canadian legislation.

The Agency also continued to work to develop meaningful tools and strategies and to coordinate approaches in the area of surveillance and information, notably through the establishment of the Surveillance and Information Expert Group (SIEG), with shared expertise and common experience its federal, provincial and territorial partners.

Other Programs and Services

	Planned ($M)	Authorities ($M)	Actual ($M)
Other programs and services	330.7*	318.5**	308.7***

* Planned spending includes planned program spending announced in the 2005 Budget.

** Authorities did not initially include planned spending announced in the 2005 Budget. For reasons including the restriction in spending imposed to the Agency during the election campaign, the Agency requested less than the planned level of funding for the programs and services listed below.

*** Variance between actual spending and total authorities reflects changes of plan for the acquisition of facilities for mock vaccine, procurement savings, and spending controls put into place for the dissolution of Parliament and the subsequent election.

Other Agency programs and services are listed below, including links to the web sites which provide details.

- **Laboratory Security**
  http://www.phac-aspc.gc.ca/ols-bsl/index.html
- **Childhood and Adolescence**
  http://www.phac-aspc.gc.ca/dca-dea
- **Aging and Seniors**
  http://www.phac-aspc.gc.ca/seniors-aines/index_pages/whatsnew_e.htm
- **Canadian Health Network**
  http://www.canadian-health-network.ca
- **Health Surveillance and Epidemiology**
  http://www.phac-aspc.gc.ca/hsed-dsse/index.html
- **Chronic Disease Surveillance**
  http://www.phac-aspc.gc.ca/ccdpc-cpcmc/surveil_e.html
- **Countrywide Integrated Non-communicable Disease Intervention (CINDI)**
  http://www.phac-aspc.gc.ca/ccdpc-cpcmc/cindi/index_e.html
- **World Health Organization Collaborating Centre on Non-Communicable Disease Policy**
  http://www.phac-aspc.gc.ca/ccdpc-cpcmc/international_e.html
- **Hepatitis C**
  http://www.phac-aspc.gc.ca/hepc/hepatitis_c/index.html
- **Blood Safety Surveillance**
  http://www.phac-aspc.gc.ca/hcai-iamss/index.html
- **Immunization and Respiratory Infections**
  http://www.phac-aspc.gc.ca/dird-dimr/index.html

Supplementary Information

Table 1: Comparison of Planned to Actual Spending (including FTEs)

This table offers a comparison of the Main Estimates, planned spending, total authorities, and actual spending for fiscal year 2005-2006 as well as actual spending for 2004-2005 for the Public Health Agency of Canada and its predecessor. Before the Agency was created on September 24, 2004, this business line included the Population and Public Health Branch as well as part of other branches of Health Canada.

(in millions of dollars)

		2005–06			
	2004-05 Actual	Main Estimates	Planned Spending	Total Authorities	Total Actuals
Population and Public Health	586.7	423.1	480.7*	497.0**	477.2***
Total	**586.7**	**423.1**	**480.7**	**497.0**	**477.2**
Less: Non-respendable revenue	0.0	0.0	0.0	0.0	0.2
Plus: Cost of services received without charge	11.4	0.0	16.8	16.8	17.6
Total Departmental Spending	598.1	423.1	497.5	513.8	494.6
Full-time Equivalents	1,666	1,836	1,836	N/A	1,801

* In the Agency's Report on Plans and Priorities for 2005-2006, planned spending was shown as $432.4 million, with a footnote explaining that additional budget commitments had been made and would be added. The $480.7 million includes those additional commitments.

** The agency began the year with authority to spend $432.4 million, and obtained additional authority through Governor General's Special Warrants. These warrants provided resources for Avian and Pandemic Influenza beyond what had initially been planned.

*** Variance between actual spending and total authorities reflects changes of plan for the acquisition of facilities for mock vaccine, procurement savings, pending policy approval, and spending controls put into place for the dissolution of Parliament and the subsequent election.

The $163.6 million decrease from the actual for 2004-2005 to the Main Estimates for 2005-2006 is mainly due to the items paid in 2004-2005 but not required in 2005-2006 as follows:

- A conditional grant of $100 million to the Canada Health Infoway Inc. as a one-time allocation to invest in the development and implementation of pan-Canadian Health Surveillance System (see table 7); and
- $50.1 million transferred to Provinces and Territories to improve access to health care and treatment services for persons infected with hepatitis C through the blood system.

The $57.6 million increase from Main Estimates to Planned Spending is mainly due to additional resources announced in Budget 2005 in relation to various initiatives such as Pandemic Influenza Preparedness; Integrated Strategy on Healthy Living and Chronic Disease, Hepatitis C Prevention, Support and Research program.

The $16.3 million increase from the planned spending and the total authorities reflect additional resources received for Avian and Pandemic Influenza.

The $19.8 million or 4.0% difference between the total authorities and the total actuals is due to:

- A lapse of $16.4 million in operating expenditures due to lower than expected requirements for pandemic influenza preparedness, and for the integrated strategy on healthy living and chronic disease. It also reflects delays resulting from the election and subsequent change of Government, and
- A lapse of $3.4 million due to year end adjustments and lower than expected expenditures in various transfer payment programs.

Table 2: Resources by Program Activity

This table reflects how resources are used within the Public Health Agency of Canada.

(in millions of dollars)

Program Activity	2005–06 Budgetary				
	Operating	Grants and Contributions	Total: Gross Budgetary Expenditures	Less: Respendable Revenue	Total: Net Budgetary Expenditures
Population and Public Health					
Main Estimates	259.2	164.0	423.2	(0.1)	423.1
Planned Spending	290.0	190.8	480.8	(0.1)	480.7
Total Authorities	317.0	180.1	497.1	(0.1)	497.0
Actual Spending	300.7	176.6	477.3	(0.1)	477.2

Table 3: Voted and Statutory Items

This table explains the way Parliament votes resources to the Public Health Agency of Canada and basically replicates the summary table listed in Part II of the Main Estimates. Resources are presented in Parliament in this format. Parliament approves the voted funding and the statutory information is provided for information purposes.

(in millions of dollars)

		2005–06			
Vote or Statutory Item	Truncated Vote or Statutory Wording	Main Estimates	Planned Spending	Total Authorities	Total Actuals
30	Operating expenditures	234.7	263.4	293.8	277.6
35	Grants and contributions	164.0	190.8	180.1	176.6
(S)	Contributions to employee benefit plans	24.4	26.5	23.1	23.0
(S)	Spending of proceeds from the disposal of surplus Crown assets (actual is $12,367)	0.0	0.0	0.0	0.0
	Total	**423.1**	**480.7**	**497.0**	**477.2**

Please refer to table 1 for explanation of major variances.

Table 4: Services Received Without Charge

(in millions of dollars)

	2005–2006
Accommodation provided by Public Works and Government Services Canada	7.0
Contributions covering employers' share of employees' insurance premiums and expenditures paid by Treasury Board of Canada Secretariat (excluding revolving funds). Employer's contribution to employees' insured benefits plans and associated expenditures paid by TBS	10.6
Salary and associated expenditures of legal services provided by the Department of Justice Canada*	0.0*
Total 2005–2006 Services received without charge	**17.6**

*Health Canada reported $3.5 M which includes the $0.1 M for PHAC. PHAC is reporting $0.0 in order to avoid double counting.

Table 5: Sources of Respendable and Non-respendable Revenue

Respendable Revenue

(in millions of dollars)

		2005-2006			
	Actual 2004-05	Main Estimates	Planned Revenue	Total Authorities	Actual
Population and Public Health					
Sale to federal and provincial/territorial departments and agencies, airports and other federally regulated organizations of first aid kits to be used in disaster and emergency situations	0.1	0.1	0.1	0.1	0.1
Spending of proceeds from the disposal of surplus Crown assets	0.0	0.0	0.0	0.0	0.0
Total Respendable Revenue	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**

Non-respendable Revenue

(in millions of dollars)

		2005-2006			
	Actual 2004-05	Main Estimates	Planned Revenue	Total Authorities	Actual
Population and Public Health					
Sale of first aid kits/net vote revenue surplus; retention of royalties					0.1
Interest on Accounts Receivable ($11,890)					0.0
Sundries – credit cards rebate					0.1
Total Non-respendable Revenue					**0.2**

Table 6: Details on Transfer Payment Programs (TPPs)

The following is a summary of the transfer payment programs for the Public Health Agency that are in excess of $5 million. All the transfer payments shown below are voted programs.

1. Contributions to persons and agencies to support health promotion projects in the areas of community health, resource development, training and skill development, and research.
2. Community Action Program for Children (CAPC) and Canada Prenatal Nutrition Program (CPNP)
3. Contributions towards the Federal Initiative to Address HIV/AIDS in Canada
4. Aboriginal Head Start in Urban and Northern Communities; Early Childhood Development
5. Grant to the Terry Fox Foundation for cancer research

Supplementary information on Transfer Payment Programs can be found at http://www.tbs-sct.gc.ca/est-pre/estime.asp.

Table 7: Foundations (Conditional Grants)

The Agency provided a one-time conditional grant to the following organization:

- Canada Health Infoway Inc.

Further information on this Conditional Grant can be found at: http://www.tbs-sct.gc.ca/est-pre/estime.asp.

Table 8: Horizontal Initiatives

The Public Health Agency of Canada is the federal lead for the Federal Initiative to Address HIV/AIDS in Canada.

Supplementary information on this horizontal initiative can be found at: http://www.tbs-sct.gc.ca/est-pre/estime.asp.

Table 9: Financial Statements

Statement of Management Responsibility

PUBLIC HEALTH AGENCY OF CANADA

Responsibility for the integrity and objectivity of the accompanying financial statements for the year ended March 31, 2006 and all information contained in these statements rests with the agency's management. These financial statements have been prepared by management in accordance with Treasury Board accounting policies which are consistent with Canadian generally accepted accounting principles for the public sector.

Management is responsible for the integrity and objectivity of the information in these financial statements. Some of the information in the financial statements is based on management's best estimates and judgment and gives due consideration to materiality. To fulfil its accounting and reporting responsibilities, management maintains a set of accounts that provides a centralized record of the agency's financial transactions. Financial information submitted to the Public Accounts of Canada and included in the agency's Departmental Performance Report is consistent with these financial statements.

Management maintains a system of financial management and internal control designed to provide reasonable assurance that financial information is reliable, that assets are safeguarded and that transactions are in accordance with the *Financial Administration Act*, are executed in accordance with prescribed regulations, within Parliamentary authorities, and are properly recorded to maintain accountability of Government funds. Management also seeks to ensure the objectivity and integrity of data in its financial statements by careful selection, training and development of qualified staff, by organizational arrangements that provide appropriate divisions of responsibility, and by communication programs aimed at ensuring that regulations, policies, standards and managerial authorities are understood throughout the agency.

The financial statements of the agency have not been audited.

David Butler-Jones
Chief Public Health Officer
Ottawa, Canada

Date

Luc Ladouceur
Director General and Senior Financial Officer
Finance Planning and Administration Directorate
Ottawa, Canada

Date

Statement of Operations (unaudited)

PUBLIC HEALTH AGENCY OF CANADA

For the year ended March 31 (in dollars)	**2006**	2005 (Note 9)
Expenses		
Transfer payments	**175,244,575**	320,344,911
Salaries and employee benefits	**170,341,797**	144,229,239
Professional and special services	**55,138,587**	49,271,661
Utilities, material and supplies	**41,351,299**	56,019,819
Travel and relocation	**15,793,168**	9,486,474
Accommodation	**11,961,621**	4,559,902
Amortization of tangible capital assets	**6,263,550**	5,688,781
Purchased repair and maintenance	**6,019,930**	2,785,335
Communication	**4,748,297**	2,863,709
Information	**4,599,372**	4,421,571
Rentals	**1,307,661**	1,499,851
Other	**1,180,989**	(12,663,876)
	493,950,846	**588,507,377**
Revenues		
Voluntary compliance undertakings	**268,114**	**539,642**
Net cost of operations	**493,682,732**	**587,967,735**

The accompanying notes form an integral part of the financial statements

Statement of Financial Position (unaudited)

PUBLIC HEALTH AGENCY OF CANADA

At March 31 (in dollars)	**2006**	2005 (Note 9)
Assets		
Financial assets		
Accounts receivable and advances (Note 4)	**5,884,928**	832,561
Total financial assets	**5,884,928**	832,561
Non-financial assets		
Tangible capital assets (Note 5)	**65,742,171**	65,330,942
Total non-financial assets	**65,742,171**	65,330,942
TOTAL	**71,627,099**	**66,163,503**
Liabilities and Equity of Canada		
Liabilities		
Accounts payable and accrued liabilities	**79,975,372**	48,041,000
Vacation pay and compensatory leave	**7,387,369**	6,624,350
Employee severance benefits (Note 6)	**24,109,715**	19,735,445
Other liabilities	**2,402,497**	2,005,472
	113,874,953	76,406,267
Equity of Canada	**(42,247,854)**	(10,242,764)
TOTAL	**71,627,099**	**66,163,503**

Contractual Obligations (Note 7)

The accompanying notes form an integral part of the financial statements

Statement of Equity (unaudited)

PUBLIC HEALTH AGENCY OF CANADA

For the year ended at March 31 (in dollars)	**2006**	2005 (Note 9)
Equity of Canada, beginning of year	**(10,242,764)**	(329,312,292)
Net cost of operations	**(493,682,732)**	(587,967,735)
Current year appropriations used (Note 3)	**477,166,397**	586,658,946
Revenue not available for spending (Note 3)	**(193,247)**	(64,805)
Change in net position in the Consolidated Revenue Fund (Note 3)	**(32,895,508)**	309,043,122
Services provided without charge by other government departments (Note 8)	**17,600,000**	11,400,000
Equity of Canada, end of year	**(42,247,854)**	**(10,242,764)**

The accompanying notes form an integral part of the financial statements

Statement of Cash Flow (unaudited)

PUBLIC HEALTH AGENCY OF CANADA

For the year ended March 31 (in dollars)	**2006**	2005 (Note 9)
Operating activities		
Net cost of operations	**493,682,732**	587,967,735
Non-cash items:		
Amortization of tangible capital assets (Note 5)	**(6,263,550)**	(5,688,781)
Services provided without charge by other government departments (Note 8)	**(17,600,000)**	(11,400,000)
Variations in Statement of Financial Position:		
Variation in accounts receivable and advances	**5,052,368**	(1,123,017)
Variation in accounts payable	**(31,934,372)**	322,157,095
Variation in vacation pay and compensatory leave	**(763,019)**	(522,099)
Variation in employee severance benefits	**(4,374,271)**	(1,968,847)
Variation in other liabilities	**(397,025)**	955,750
	437,402,864	**890,377,836**
Capital investment activities		
Acquisitions of tangible capital assets (Note 5)	**6,674,778**	**5,259,427**
Financing activities		
Net cash provided by Government of Canada	**(444,077,642)**	**(895,637,263)**

The accompanying notes form an integral part of the financial statements

Notes to the Financial Statements (unaudited)

PUBLIC HEALTH AGENCY OF CANADA

1. Authority and Objectives

The Public Health Agency of Canada (PHAC) was created as a new agency by orders in council on September 24, 2004 in response to growing concerns about the capacity of Canada's public health system to anticipate and respond effectively to public health threats. Its creation is the result of wide consultation with the provinces, territories, stakeholders and Canadians. It also follows recommendations from leading public health experts - including Dr. David Naylor's report, Learning from SARS: Renewal of Public Health in Canada, as well as other Canadian and international reports - for clear federal leadership on issues concerning public health and improved collaboration within and between jurisdictions. Bill C-5, the Public Health Agency of Canada Act, would provide a statutory foundation for the new agency and was introduced in the House of Commons on April 24, 2006. The Bill has passed all stages before the House of Commons, and, received 1st reading before the Senate on June 20th, 2006 just days prior to its adjournment. The Senate is expected to resume consideration of the Bill upon its return this Fall.

The agency is mandated to work in collaboration with its partners, to lead federal efforts and to mobilize pan-Canadian action in preventing disease and injury, and to promote and protect national and international public health through the following:

- Anticipating, preparing for, responding to and recovering from threats to public health;
- Carrying out surveillance of, monitoring, researching, investigating and reporting on diseases, injuries, other preventable health risks and their determinants, and the general state of public health in Canada and internationally;
- Using the best available evidence and tools to advise and support public health stakeholders nationally and internationally as they work to enhance the health of their communities;
- Providing public health information, advice and leadership to Canadians and stakeholders; and
- Building and sustaining a public health network with stakeholders.

2. Summary of significant accounting policies

The financial statements have been prepared in accordance with Treasury Board accounting policies which are consistent with Canadian generally accepted accounting principles for the public sector.

Significant accounting policies are as follows:

(a) Parliamentary appropriations

The agency is financed by the Government of Canada through Parliamentary appropriations. Appropriations provided to the agency do not parallel financial reporting according to Canadian generally accepted accounting principles since appropriations are primarily based on cash flow requirements. Consequently, items recognized in the statement of operations and the statement of financial position are not necessarily the same as those provided through appropriations from Parliament. Note 3 provides a high-level reconciliation between the two bases of reporting.

(b) Net Cash Provided by Government

The agency operates within the Consolidated Revenue Fund (CRF), which is administered by the Receiver General for Canada. All cash received by the agency is deposited to the CRF and all cash disbursements made by the agency are paid from the CRF. The net cash provided by Government is the difference between all cash receipts and all cash disbursements including transactions between departments of the federal government.

2. Summary of significant accounting policies (continued)

(c) Change in net position in the Consolidated Revenue Fund

The change in net position in the Consolidated Revenue Fund is the difference between the net cash provided by Government and appropriations used in a year, excluding the amount of non respendable revenue recorded by the agency. It results from timing differences between when a transaction affects appropriations and when it is processed through the CRF.

(d) Revenues

Revenues are accounted for in the period in which the underlying transaction or event occurred that gave rise to the revenues.

(e) Expenses

Expenses are recorded on an accrual basis:

- Grants are recognized in the year in which the conditions for payment are met. In the case of grants which do not form part of an existing program, the expense is recognized when the Government announces a decision to make a non-recurring transfer, provided the enabling legislation or authorization for payment receives parliamentary approval prior to the completion of the financial statements.
- Contributions are recognized in the year in which the recipient has met the eligibility criteria or fulfilled the terms of a contractual transfer agreement.
- Vacation pay and compensatory leave are expensed as the benefits accrue to employees under their respective terms of employment.
- Services provided without charge by other government departments for accommodation, the employer's contribution to the health and dental insurance plans and legal services are recorded as operating expenses at their estimated cost.

(f) Employee future benefits

i) Pension benefits: Eligible employees participate in the Public Service Pension Plan, a multiemployer plan administered by the Government of Canada. The agency's contributions to the Plan are charged to expenses in the year incurred and represent the total obligation to the Plan by the agency. Current legislation does not require the agency to make contributions for any actuarial deficiencies of the Plan.

ii) Severance benefits: Employees are entitled to severance benefits under labour contracts or conditions of employment. These benefits are accrued as employees render the services necessary to earn them. The obligation relating to the benefits earned by employees is calculated using information derived from the results of the actuarially determined liability for employee severance benefits for the Government as a whole.

(g) Accounts receivable

Accounts receivable are stated at amounts expected to be ultimately realized. They are mainly comprised of amounts to be recovered from other government departments and the recovery is considered certain. As a result, no provision has been recorded as an offset against these amounts.

(h) Contingent liabilities

Contingent liabilities are potential liabilities which may become actual liabilities when one or more future events occur or fail to occur. To the extent that the future event is likely to occur or fail to occur, and a reasonable estimate of the loss can be made, an estimated liability is accrued and an expense recorded. If the likelihood is not determinable or an amount cannot be reasonably estimated, the contingency is disclosed in the notes to the financial statements.

2. Summary of significant accounting policies (continued)

(i) Tangible Capital Assets

All tangible capital assets having an initial cost of $10,000 or more are recorded at their acquisition cost. The agency does not capitalize intangibles, works of art and historical treasures that have cultural, aesthetic or historical value, assets located on Indian Reserves and museum collections.

Amortization of tangible capital assets is done on a straight-line basis over the estimated useful life of the asset as follows:

Asset Class	Amortization Period
Buildings	25 years
Works and infrastructure	25 years
Machinery and equipment	8-12 years
Computer equipment	3-5 years
Computer software	3 years
Other Equipment	10-12 years
Motor Vehicles	4-7 years
Other Vehicles	10 years

(j) Measurement uncertainty

The preparation of these financial statements in accordance with Treasury Board accounting policies which are consistent with Canadian generally accepted accounting principles for the public sector requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenues and expenses reported in the financial statements. At the time of preparation of these statements, management believes the estimates and assumptions to be reasonable. The most significant items where estimates are used are the liability for employee severance benefits and the useful life of tangible capital assets. Actual results could significantly differ from those estimated. Management's estimates are reviewed periodically and, as adjustments become necessary, they are recorded in the financial statements in the year they become known.

3. Parliamentary Appropriations

The agency receives most of its funding through annual Parliamentary appropriations. Items recognized in the statement of operations and the statement of financial position in one year may be funded through Parliamentary appropriations in prior, current or future years. Accordingly, the agency has different net cost of operations for the year on a government funding basis than on an accrual accounting basis. The differences are reconciled in the following tables:

(a) Reconciliation of net cost of operations to current year appropriations used:

(in dollars)	**2006**	2005
Net cost of operations	**493,682,732**	587,967,735
Adjustments for items affecting net cost of operations but not affecting appropriations:		
Add (Less):		
Services provided without charge by other government departments	**(17,600,000)**	(11,400,000)
Amortization of tangible capital assets	**(6,263,550)**	(5,688,781)
Allowance for severance benefits	**(4,374,270)**	(1,968,847)
Refund/Reversal of previous years expenses	**6,413,953**	12,985,429
Justice Canada legal fees	**(808,786)**	(447,796)
Vacation pay and compensatory leave	**(763,019)**	(522,099)
Revenues not available for spending	**193,247**	64,805
Proceeds from disposals of crown assets	**12,367**	907
Other non appropriated amounts	**(475)**	408,166
	(23,190,533)	(6,568,216)
Adjustments for items not affecting net cost of operations but affecting appropriations:		
Add (Less):		
Advances cleared to expenses	**(580)**	0
Acquisitions of tangible capital assets	**6,674,778**	5,259,427
	6,674,198	5,259,427
Current year appropriations used	**477,166,397**	586,658,946

3. Parliamentary Appropriations (continued)

(b) Appropriations provided and used:

(in dollars)	2006	2005
Operating expenditures - Vote 30 (2005 Vote 1)	**234,719,000**	262,170,365
Governor General's Special Warrants	**59,164,660**	0
Grants and contributions - Vote 35 (2005 Vote 5)	**164,009,000**	223,173,676
Governor General's Special Warrants	**645,000**	0
Transfer from Treasury Board - Vote 5	**15,415,000**	0
Total Voted Parliamentary Appropriations	**473,952,660**	485,344,041
Lapsed appropriations:	**(19,842,270)**	(18,556,844)
Total Voted Parliamentary Appropriations Used	**454,110,390**	466,787,197
Contributions to employee benefit plans	**23,043,639**	19,861,740
Spending of proceeds from the disposal of surplus Crown assets	**12,367**	8,689
Canada Health Infoway Inc	**0**	100,000,000
Collection Agency Fees	**0**	1,320
Current year appropriations used	**477,166,397**	586,658,946

(c) Reconciliation of net cash provided by Government to current year appropriations used:

(in dollars)	2006	2005
Net cash provided by Government	**444,077,642**	895,637,263
Revenue not available for spending	**193,247**	64,805
Refund/Reversal of previous years expenses	**6,413,953**	12,985,429
Justice Canada legal fees	**(808,786)**	(447,796)
Variation in accounts receivable and advances	**(5,052,947)**	1,123,018
Variation in accounts payables	**31,934,371**	(322,157,095)
Proceeds from disposals of Crown assets	**12,367**	907
Other adjustments	**396,550**	(547,585)
Change in net position in the Consolidated Revenue Fund	**32,895,508**	(309,043,122)
Current year appropriations used	**477,166,397**	586,658,946

4. Accounts receivable and advances

(in dollars)	2006	2005
Receivables from other Federal Government departments and agencies	**4,724,495**	29,479
Receivables from external parties	**1,142,623**	789,554
Employee advances	**17,810**	13,528
	5,884,928	832,561

5. Tangible capital assets

Cost

(in dollars)	Opening Balance	Acquisitions	Disposals and write-offs	Closing balance
Land	604,137	0	0	**604,137**
Buildings	71,670,200	11,039	0	**71,681,239**
Works and Infrastructure	508,611	55,814	0	**564,425**
Machinery and Equipment	30,238,622	5,487,041	0	**35,725,663**
Computer Equipment	2,677,102	280,351	0	**2,957,453**
Computer Software	781,392	114,715	0	**896,107**
Other Equipment	1,116,521	632,858	0	**1,749,379**
Motor Vehicles	36,230	92,960	0	**129,190**
Other Vehicles	84,253	0	0	**84,253**
	107,717,068	6,674,778	0	**114,391,846**

Accumulated Amortization

(in dollars)	Opening Balance	Amortization	Disposals and write-offs	Closing balance
Buildings	22,929,018	2,866,029	0	**25,795,047**
Works and Infrastructure	3,390	21,089	0	**24,479**
Machinery and Equipment	17,722,922	2,589,174	0	**20,312,096**
Computer Equipment	1,060,890	463,722	0	**1,524,612**
Computer Software	390,456	180,624	0	**571,080**
Other Equipment	168,349	127,900	0	**296,249**
Motor Vehicles	28,681	13,178	0	**41,859**
Other Vehicles	82,419	1,834	0	**84,253**
	42,386,125	6,263,550	0	**48,649,675**

Net tangible capital assets

(in dollars)	Opening Balance	Closing Balance
Land	604,137	**604,137**
Buildings	48,741,182	**45,886,192**
Works and Infrastructure	505,221	**539,946**
Machinery and Equipment	12,515,700	**15,413,567**
Computer Equipment	1,616,212	**1,432,841**
Computer Software	390,936	**325,027**
Other Equipment	948,172	**1,453,130**
Motor Vehicles	7,549	**87,331**
Other Vehicles	1,834	**0**
	65,330,942	**65,742,171**

Amortization expense for the year ended March 31, 2006 is $6,263,550 (2005 - $5,688,781).

6. Employee benefits

(a) Pension benefits

The agency's employees participate in the Public Service Pension Plan, which is sponsored and administered by the Government of Canada. Pension benefits accrue up to a maximum period of 35 years at a rate of 2 percent per year of pensionable service, times the average of the best five consecutive years of earnings. The benefits are integrated with Canada/Québec Pension Plans benefits and they are indexed to inflation.

Both the employees and the agency contribute to the cost of the Plan. The expense presented below represents approximately 2.6 times the contributions by employees.

(in dollars)	**2006**	2005
Expense for the year	**17,052,293**	12,412,741

The agency's responsibility with regard to the Plan is limited to its contributions. Actuarial surpluses or deficiencies are recognized in the financial statements of the Government of Canada, as the Plan's sponsor.

(b) Severance benefits

The agency provides severance benefits to its employees based on eligibility, years of service and final salary. These severance benefits are not pre-funded. Benefits will be paid from future appropriations. Information about the severance benefits, measured as at March 31, is as follows:

(in dollars)	**2006**	2005
Accrued benefit obligation, beginning of year	**19,735,444**	17,766,598
Expense for the year	**5,268,011**	2,465,548
Benefits paid during the year	**(893,740)**	(496,701)
Accrued benefit obligation, end of year	**24,109,715**	19,735,445

7. Contractual Obligations

The nature of the agency's activity results in multi-year contracts and obligations whereby the agency will be committed to make some future payments when the services/goods are received. Contractual obligations that can be reasonably estimated are as follows:

(in dollars)	**2007**	**2008**	**2009**	**2010**	**2010**	**2011 and thereafter**	**Total**
Transfer payments	**0**	**0**	**0**	**0**	**45,900,000**	**45,900,000**	**91,800,000**

8. Related party transactions

The agency is related as a result of common ownership to all Government of Canada departments, agencies, and Crown corporations. The agency enters into transactions with these entities in the normal course of business and on normal trade terms. Also, during the year, the agency received services which were obtained without charge from other Government departments as presented in part (a).

(a) Services provided without charge

During the year the agency received without charge from other departments. These services without charge have been recognized in the agency's Statement of Operations as follows:

(in dollars)	**2006**	2005
Accommodation	**7,000,000**	2,300,000
Employer's contribution to the health and dental insurance plans	**10,600,000**	9,000,000
Legal services	**0**	100,000
	17,600,000	11,400,000

The Government has structured some of its administrative activities for efficiency and cost-effectiveness purposes so that one department performs these on behalf of all without charge. The costs of these services, which include payroll and cheque issuance services provided by Public Works and Government Services Canada, are not included as an expense in the agency's Statement of Operations.

(b) Payables and receivables outstanding at year-end with related parties:

(in dollars)	**2006**	2005
Accounts receivable with other government departments and agencies	**4,724,495**	29,479
Accounts payable to other government departments and agencies	**5,484,462**	1,468,828

9. Comparative information

The control and supervision of the Population and Public Health Branch of Health Canada was transferred to the Public Health Agency of Canada (PHAC) by Order in Council pursuant to the Public Service Rearrangement and Transfer of Duties Act, effective 24 September 2004. The 2004-05 amounts cover the financial transactions relating to the activities now performed by PHAC.

Table 10: Response to Parliamentary Committees, and Audits and Evaluations for Fiscal Year 2005–2006

Response to the Auditor General including to the Commissioner of the Environment and Sustainable Development (CESD)

The April 2005 report of the Auditor General, in Chapter 2 – National Security in Canada, contained the following recommendations and Agency responses related to the Public Health Agency of Canada:

- 2.126 **Recommendation.** The Public Health Agency of Canada should co-ordinate the management of its National Emergency Stockpile System (NESS) with other federal agencies and include the NESS in the National Emergency Response System.

  Public Health Agency of Canada's response. PHAC is working closely with Public Safety and Emergency Preparedness Canada on a number of fronts, including input into the development of the National Emergency Response System (NERS) and a National Health Emergency Management System. Part of that process will include ensuring that the NESS is closely linked to the emergency response activities outlined in the NERS.

- 2.127 **Recommendation.** Based on risk assessments and casualty scenarios, the Public Health Agency of Canada should update the contents of the national emergency stockpile as soon as possible. It should also secure arrangements for the transportation and distribution of supplies during emergencies.

  Public Health Agency of Canada's response. PHAC is currently undertaking a strategic review of the NESS that includes a review of the contents of the stockpile. The strategic review, to be completed in 2006, will include risk assessments (initial risk assessment completed November 2004) and casualty scenarios. Emergency transportation of NESS supplies is being addressed through the National Emergency Transportation System (NETS).

PHAC's Regional Emergency Response Co-ordinators will soon be developing NESS provincial and territorial emergency transportation plans in collaboration with each jurisdiction.

Response to Parliamentary Committees

Two recommendations of the **Report of the Standing Committee on Public Accounts, National Security in Canada, 2005**, refer to the Public Health Agency of Canada:

- RECOMMENDATION 11 – That Health Canada should immediately resolve the legal issues that are blocking the creation of emergency response medical and smallpox teams and report on its progress in its annual departmental performance report.
- RECOMMENDATION 12 – That the Public Health Agency of Canada purchase items for the national emergency stockpile based on risk assessments and casualty scenarios and report on its progress in its annual departmental performance report. It should also improve its ability to transport and distribute supplies during emergencies and report on its progress in its annual departmental performance report.

Re: legal issues blocking creation of emergency response medical and smallpox teams:

The creation of emergency response medical and smallpox teams are affected by a number of legal issues which require careful consideration by the government as a whole. For example, there is no provision in legislation that allows for members of such teams to be designated as federal employees, nor are there legislative provisions that would provide them with legal protections such as **indemnification**. The Public Health Agency of Canada is working closely with the Treasury Board Secretariat and the Public Services Human Resources Management Agency of Canada to address the federal legal issues as quickly as possible.

During 2005-2006 the Agency continued to address interjurisdictional legal issues through the Pan Canadian Public Health Network, which is supporting the development of memoranda of understanding on the provision of mutual aid during disasters and public health emergencies.

The Agency continues to address all aspects of planning for, and establishing, the teams of health professionals from outside the federal government who will comprise the Health Emergency Response Teams (HERT) contribution to medical surge capacity. During 2005-2006 the Agency completed the specification of the composition of the HERT teams as well as the specifications for the standardized, air deployable encampments consisting of shelter, equipment/supplies and amenities to support medical response teams in the field. Procurement began for the first two of four modules.

The establishment of HERT teams has been affected by the complexities of licensing, as well as by conditions in the market for the services of health professionals. In February 2006 the Agency created an Epidemiology Emergency Response Team (EERT) for deployment during times of great need. The creation of EERT augmented the surge capacity available to assist the provinces and territories to manage emergency situations.

Re: purchasing items for the national emergency stockpile based on risk assessments and casualty scenarios:

The Agency's National Emergency Stockpile System working group, in collaboration with the Integrated Threat Assessment Committee, Public Safety and Emergency Preparedness Canada and the provinces and territories, developed a risk and threat analysis document in the fall of 2005. This document is being used as a framework to design and plan a modern day stockpile based on threat and casualty scenarios for natural and human caused disasters, and as a guide for procurement.

Re: improving ability to transport and distribute supplies during emergencies

- PHAC is addressing this requirement as a member of the National Emergency Transportation Strategy (NETS) committee. This committee is in the process of negotiating contracts with transportation companies to access emergency transportation services for the federal government when existing contingency arrangements can't meet the requirements.
- The Agency is also addressing this through the National Emergency Stockpile System strategic review transportation sub-committee, which identified the need for the NESS group to work formally and collaborate with NETS to develop an integrated federal-provincial strategic transportation plan. The strategic review transportation sub-committee completed its deliberations, and expects its report and recommendations will be included in the strategic review final report scheduled for completion in fall 2006. Steps taken to implement these recommendations should further improve the ability to transport and distribute needed supplies during emergencies.

External Audits (Note: These refer to other external audits conducted by the Public Service Commission of Canada or the Office of the Commissioner of Official Languages.)

No external audits of the Agency were conducted by the Public Service Commission of Canada or the Office of the Commissioner of Official Languages during 2005-2006.

Internal Audits or Evaluations
Evaluations Completed
Evaluation of the Aboriginal Head Start Urban and Northern Communities Program
Evaluation of the Canadian Diabetes Strategy
Evaluation of the Canadian Health Network
Evaluation of the Centres of Excellence for Children's Well-Being

Table 11: Sustainable Development Strategy

The *Auditor General Act* was amended in 1995 to require federal departments and agencies to table Sustainable Development Strategies (SDS) in Parliament every three years. As a federal agency under Schedule I of the *Financial Administration Act*, PHAC is required to prepare a Sustainable Development Strategy (SDS) within two years of its creation, to table it in Parliament during 2006-07, to update it every three years, and to report annually to Parliament through its Departmental Performance Report.

During 2005-06, in preparation for development of its first SDS, PHAC identified an SD Champion, established a PHAC-based Office of Sustainable Development, developed a work plan, created a department-wide SD working group, and engaged external technical expertise to assist in the creation of the SDS.

Table 12: Procurement and Contracting

Department Points to Address	Organization's Input
1. Role played by procurement and contracting in delivering programs	Procurement and contracting are integral to program delivery and support at the Public Health Agency of Canada (the Agency). They are essential in terms of providing goods and services to the department by contracting for services and procuring goods, particularly in the scientific and research disciplines. Collaboration, sharing of expertise and related information as well as providing operational support are key to ongoing policy and program delivery.
2. Overview of how the department manages its contracting function	The Materiel Management Directorate of Health Canada provides procurement and contracting services as part of the Memorandum of Understanding between Health Canada and the Agency for the provision of shared corporate services to the Agency. Senior contract specialists from Health Canada have been co-located within the Agency to promote procurement planning and develop procurement strategies with the cooperation of program managers. As of July 1st 2005, the Agency used the Health Canada Contract Requisition and Reporting System (CRRS) as the official system of record for contracts and departmental callups valued at $10,000 or more. PHAC also uses the same model as Health Canada for its Contract and Requisition Control Committee (CRCC) which reviews and approves most agreements including all service contracts and call-ups of more than $10,000.
3. Progress and new initiatives enabling effective and efficient procurement practices	Effective July 1, 2005, the Contract Requisition and Reporting System (CRRS) was implemented as a contract tracking, workflow and approval system. It provides improved capacity to report on contract activity, respond to Access to Information (ATI) and ministerial enquiries and incorporates a review and approval workflow for long form contracts and call-ups against standing offers. This system continues to be expanded and will eventually capture other types of agreements along with enhanced reporting capabilities. The Agency continued to strengthen its Contract and Requisition Control Committee (CRCC) function through continuous improvement of its review and documentation processes. Health Canada procurement resources were deployed to the Agency to develop procurement strategies for program managers and liaise with all parties regarding the processing and administration of contracts.

Table 13: Service Improvement

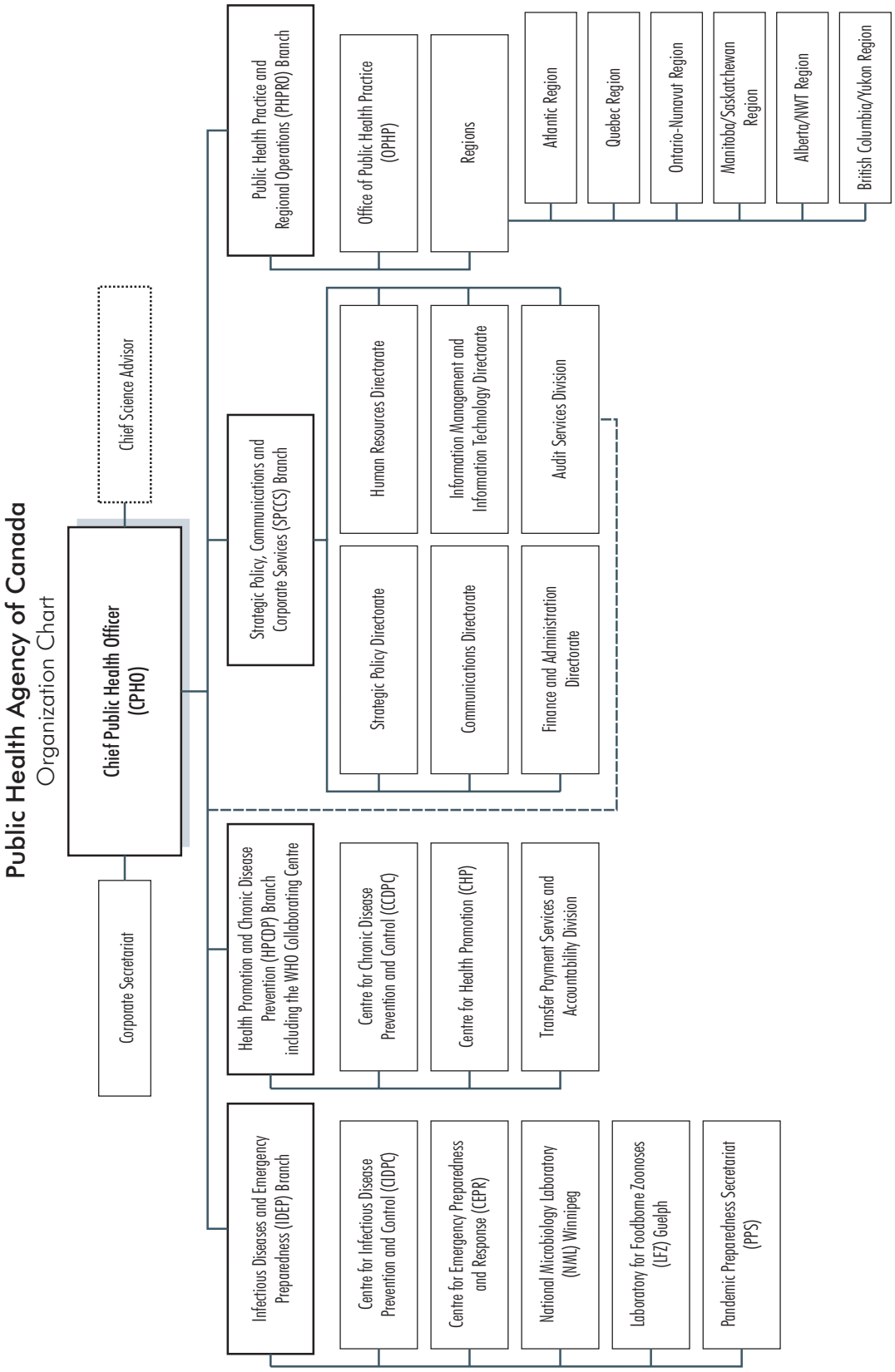
The Agency does not provide services to individual Canadians. However, it interacts with organizations that apply for Grants and Contributions. From time to time the Agency measures their satisfaction with the processes and procedures used to solicit, receive, review, select, and notify organizations seeking funding. The Agency also tracks the satisfaction of recipients with the processes used to dispense funds and to learn about how the funds are utilized, and about the resulting benefits to Canadians.

Work undertaken during 2005-06 included making significant progress on a study of satisfaction of organizations that had successfully completed projects supported by the Agency's Population Health Fund. The study began with a file review of 213 projects which had been completed between October 2002 and September 2005. Then telephone interviews were undertaken with 80 selected projects, which included all 34 National projects, plus a random sample of 46 of the 179 regional projects.

When this report was released in May 2006 it showed that 99% of responders felt the application guidelines were either very clear (70%) or reasonably clear (29%). Support received during the application process was rated as excellent (64%) or good (27%) by most respondents. 4.5% rated the support during this phase as fair, and an additional 4.5% rated it as poor. Implementation support was again mostly reported as excellent (64%) or good (23%), while 8% rated it as fair and 6% rated it as poor. The Agency regularly reviews its processes and procedures to ensure that the best possible balance is maintained between service to recipients and accountability to parliament and Canadians.

Other Items of Interest

Organizational Chart



Information on proposed new PAA

During 2005-2006 the Agency had a single strategic outcome and a single program activity. An enhanced Program Activity Architecture, to take effect during fiscal year 2007-2008, is being developed to reflect the Agency's responsibilities, and to enable a more detailed reporting on accomplishments and resource use. The following material presents the new Strategic Outcome and Program Activities; additional layers of the activity architecture will be developed by fall 2006.

CROSSWALK		
	CURRENT	AMENDED
Strategic Outcome	Healthier Population by promoting health and preventing disease and injury	Healthier Canadians and a stronger public health capacity
Program Activity(ies)	Population and Public Health	Health Promotion Disease Prevention and Control Emergency Preparedness and Response Strengthen Public Health Capacity Program Management and Support

Management, Resources and Results Structure				
SOs and PAs changes affecting 2007-08 Estimates, future year Estimates, and Public Accounts Displays as well as Reference Levels for 2008-09 and for future years				
Ministry	Department	Changed Strategic Outcomes	Changed Program Activities	Changed Program Descriptions
Health Canada	Public Health Agency of Canada	Healthier Canadians and a stronger public health capacity	Health promotion	In collaboration with partners, the Public Health Agency of Canada supports effective actions to promote healthy living and address the key determinants of health and major risk factors for chronic disease, by contributing to knowledge development, fostering collaboration, and improving information exchange among sectors and across jurisdictions.
			Disease prevention and control	In collaboration with its partners, the Agency leads federal efforts and mobilizes domestic efforts to protect national and international public health. These include: ■ monitoring, researching and reporting on diseases, injuries, health risks and the general state of public health in Canada and internationally; and ■ supporting development of knowledge; intersectoral and international collaboration; and developing policies and programs and prevent, control and reduce the impact of disease and injury

Ministry	Department	Changed Strategic Outcomes	Changed Program Activities	Changed Program Descriptions
			Emergency Preparedness and Response	The Public Health Agency of Canada provides a national focal point for anticipating, preparing for, responding to and facilitating recovery from threats to public health, and/or the public health complications of natural disasters or human caused emergencies. The Agency applies the legislative and regulatory provisions of The *Quarantine Act*. It collaborates with international partners to identify emerging disease outbreaks around the globe. Providing leadership in identifying and addressing emerging threats to the health and safety of Canadians through surveillance, risk analysis and risk management activities, the Agency partners with Health Canada, other federal departments, the provinces and territories, international organizations and the voluntary sector to identify, develop and implement preparedness priorities. The Public Health Agency of Canada manages and supports the development of health-related emergency response plans for natural and human caused disasters including the National Influenza Response Plan. The Agency is actively engaged in developing and sponsoring training in emergency preparedness, and coordinates counter-terrorism preparations to respond to accidents or suspected terrorist activities involving hazardous substances. The Agency is a leader on biosafety related issues. It stands ready to provide emergency health and social services, and manages the National Emergency Stockpile System with holdings ranging from trauma kits to complete 200 bed emergency hospitals.
			Strengthen Public Health Capacity	Working with national and international partners, the Agency develops and provides tools, applications, practices, programs and understandings that support and develop the capabilities of front-line public health practitioners across Canada. The Agency facilitates and sustains networks with provinces, territories, and other partners and stakeholders to achieve public health objectives. The Agency's work improves public health practice, increases cross-jurisdictional human resources capacity, contributes to effective knowledge and information systems, and supports a public health law and policy system that evolves in response to changes in public needs and expectations.