Public Health
Agency of Canada

Agence de la santé
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Public Health Agency of Canada

2010–11

Departmental Performance Report

The Honourable Leona Aglukkaq, P.C., M.P.
Minister of Health

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Minister's Message

As Canada's Minister of Health, I am pleased to present the Public Health Agency of Canada's (PHAC) Departmental Performance Report for fiscal year 2010–11. The Agency's work demonstrates the Government of Canada's strong commitment to protecting and improving the health and safety of all Canadians.

The report highlights progress on important public health initiatives that contribute to the prevention of disease and injury and help promote health and wellness. For example, the Agency spearheaded a strategy to engage youth and stakeholders in discussion and action on healthy weights, beginning with "Our Health Our Future," an innovative Internet engagement approach. Undertaken on behalf of the Public Health Network Council and in collaboration with provincial and territorial governments, this engagement approach formed the foundation for ongoing work in 2011–12 to combat the short- and longer-term health effects of obesity among Canadian children and youth. This supports and aligns with the *Declaration on Prevention and Promotion*, and *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework on Action for Healthy Weights*, which was adopted by federal, provincial and territorial ministers of Health and/or Health Promotion/Healthy Living, and endorsed by ministers responsible for Sport, Physical Activity and Recreation. In the past year PHAC also continued collaborative efforts related to mental health, diabetes, heart disease, and multiple sclerosis (MS). A notable example was a two-million-dollar contribution to the Canadian Institute for Health Information for the development of the Canadian MS Monitoring System to deliver a better understanding of MS disease patterns and the use of treatments across Canada.

As part of its ongoing response to lessons learned from the H1N1 influenza pandemic, the Agency continued to take steps to further strengthen our readiness to respond to urgent public health issues. A new long-term pandemic vaccine contract awarded in March 2011 provides provincial and territorial governments with a broader range of vaccine products. Additionally, a pandemic vaccine contract has been put in place as a backup source for use in the event that Canada's primary supply is disrupted. These contracts support a secure supply of vaccine for Canadians in the event of an influenza pandemic.

On behalf of the Government of Canada, PHAC coordinates the Canadian HIV Vaccine Initiative, funded by the Government of Canada and the Bill & Melinda Gates Foundation. The renewed collaboration brings together leading researchers from the public and private sectors and the international community to develop an HIV vaccine. To address high rates of tuberculosis (TB) in Northern Canada, PHAC supported the pilot Taima TB Research Project to enhance existing preventative activities and inform future northern efforts to diagnose and treat latent TB infections.

The Agency also maintains the National Emergency Stockpile System, which supported the Government's response to the Japan earthquake and several requests for surge supplies and pharmaceuticals from provinces. The Agency also fulfilled its public health role during the G8/G20 summits in Ontario by deploying Microbiological Emergency Response Teams and mobile laboratories to aid in the onsite maintenance of biosafety and biosecurity.

Through this broad scope of important activities and working closely with provinces, territories, public health professionals and scientists, PHAC continues to be a global leader in disease and injury prevention, anticipating and responding to urgent health and safety events, and helping to increase the knowledge and skills of public health practitioners across Canada.

The Honourable Leona Aglukkaq, P.C., M.P.
Minister of Health

Message from the Chief Public Health Officer

This performance report describes the breadth of work undertaken at the Public Health Agency of Canada (PHAC) to support the health of Canadians. Our employees, working with others, apply their expertise to the pursuit of reducing health inequalities, identifying and preventing disease and injury, and building the capacity of public health practitioners across Canada.

Our accomplishments speak to the PHAC's leadership in working with provinces, territories, public health practitioners and international public health agencies. These partnerships drive real progress in public health. For example, Canada's 2010 Foodborne Illness Outbreak Response Protocol (FIORP) sets out the key guiding principles and operating procedures for the identification of and response to food-borne illness affecting more than one province or territory. It includes the PHAC, provinces and territories, as well as Health Canada and the Canadian Food Inspection Agency. FIORP enables an effective, timely and coordinated response to food-borne illness across Canada, regardless of where it occurs.

Collaboration is also essential to promoting the health, well-being and quality of life of Canadians. PHAC provided funding to support the development and launch of revised physical activity guidelines by the Canadian Society for Exercise Physiology in January 2011 and partnered with the Canadian Institutes of Health Research to fund knowledge syntheses informing future physical activity guideline development. To help keep children and youth safe during activities, the Agency developed the Active and Safe initiative to address sport- and recreation-related injuries. In partnership with the World Health Organization, PHAC played a leading role in creating friendlier, healthier communities for seniors through the Age-Friendly Communities Initiative involving 400 communities in seven provinces across Canada.

Evidence and science are the foundation of the Agency's decision-making, policies and programs. The science undertaken at our world-class laboratories supports the prevention and response to large-scale outbreaks, whether they originate here in Canada or in other countries. In 2010–11, our scientists continued to conduct leading-edge research to identify and combat new and emerging viruses and bacteria. At the Laboratory for Foodborne Zoonoses, scientists developed a methodology to distinguish between different strains of bacteria for faster identification of the source of food-borne illness. Scientists at the National Microbiology Laboratory performed whole genome sequencing of the cholera strains in the 2010 outbreak in Haiti to help determine their origins. To ensure compliance with the *Human Pathogens and Toxins Act,* the Agency reached out to laboratory researchers and workers who handle, store or use human pathogens and toxins, to help build capacity to respond to the new requirements to handle these potentially risky materials in a safe and secure way.

Building public health capacity remains an important Agency focus. Last year, training was provided to over 3,000 public health practitioners both within and external to PHAC through the *Skills Online* program. An online pilot epidemiology course aimed at northern and Aboriginal learners provided effective, culturally appropriate training while overcoming obstacles of geographic distance. This pilot increased the capacity of northern and Aboriginal public health practitioners working in their communities. Within our own walls, we continued to build a healthy, vibrant and productive workplace, led by public service renewal efforts and ongoing commitment to our values of respect for democracy, integrity, stewardship and excellence.

This report demonstrates PHAC's ongoing commitment to improving the health of Canadians, in partnership with the provinces and territories, public health stakeholders and organizations. I am very pleased to be a part of this collective public health effort in Canada.

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

Section I – Organizational Overview

Raison d'être

Public health involves the organized efforts of society to keep people healthy and to prevent injury, illness and premature death. It includes programs, services and policies that protect and promote the health of all Canadians. In Canada, public health is a responsibility that is shared by the three levels of government in collaboration with the private sector, non-government organizations, health professionals and the public.

In September 2004, the Public Health Agency of Canada (the Agency) was created within the federal Health Portfolio to deliver on the Government of Canada's commitment to increase its focus on public health in order to help protect and improve the health and safety of all Canadians and to contribute to strengthening the health care system.

Responsibilities

The Agency has the responsibility to:

- contribute to the prevention of disease and injury, and to the promotion of health;
- enhance the quality and quantity of surveillance data and expand the knowledge of disease and injury in Canada;
- provide federal leadership and accountability in managing public health emergencies;
- serve as a central point for sharing Canada's expertise with the rest of the world and for applying international research and development to Canada's public health programs; and
- strengthen intergovernmental collaboration on public health and facilitate national approaches to public health policy and planning.

Strategic Outcome and Program Activity Architecture (PAA)

In order to pursue its mandate effectively, the Agency aims to achieve a strategic outcome of the promotion of health, reduced health inequalities, and the prevention and mitigation of disease and injury, supported by its Program Activity Architecture depicted in the following figure.

Strategic Outcome: Canada is able to promote health, reduce health inequalities, and prevent and mitigate disease and injury

1.1 Science and Technology for Public Health	**1.2 Surveillance and Population Health Assessment**	**1.3 Public Health Preparedness and Capacity**	**1.4 Health Promotion**	**1.5 Disease and Injury Prevention and Mitigation**	**1.6 Regulatory Enforcement and Emergency Response**	**2.1 Internal Services**
	1.2.1 Public Health Surveillance	1.3.1 Public Health Capacity	1.4.1 Healthy Communities	1.5.1 Chronic Disease Prevention and Mitigation	1.6.1 Regulatory Enforcement	2.1.1 Governance and Management Support
	1.2.2 Population Health Assessment	1.3.2 Preparedness	1.4.2 Emerging Priorities and Innovation in Health Promotion	1.5.2 Injury Prevention and Mitigation	1.6.2 Emergency Operations	2.1.2 Resource Management Services
		1.3.3 Public Health Networks	1.4.3 Childhood and Adolescence Programs	1.5.3 Infectious Disease Prevention and Control	1.6.3 Emergency Stockpile	2.1.3 Asset Management Services
			1.4.4 Aging and Seniors			

Organizational Priorities

Performance Status Legend

Performance Status	Definition
Exceeded	More than 100 per cent of the expected level of performance for the priority identified in the corresponding Report on Plans and Priorities (RPP) was achieved during the fiscal year
Met all	100 per cent of the expected level of performance for the priority identified in the corresponding RPP was achieved during the fiscal year
Mostly met	80 to 99 per cent of the expected level of performance for the priority identified in the corresponding RPP was achieved during the fiscal year
Somewhat met	60 to 79 per cent of the expected level of performance for the priority identified in the corresponding RPP was achieved during the fiscal year
Not met	Less than 60 per cent of the expected level of performance for the priority identified in the corresponding RPP was achieved during the fiscal year

Organizational Priority	Status
I. Managing Public Health Risks to Canadians	**Type:** Ongoing **Program Activities:** 1.1, 1.2, 1.3, 1.5, 1.6
Strengthening the Agency's ability to anticipate and respond to both real and potential public health risks will help prevent and mitigate disease.	
a) Integrate expertise and information acquired through the management of the federal response to the H1N1 flu pandemic.	**Met all** The Agency has taken steps to address recommendations from Lessons Learned Review: Public Health Agency of Canada and Health Canada Response to the 2009 H1N1 Pandemic and the Senate Report on *Canada's Response to the 2009 H1N1 Influenza Pandemic*, particularly in the area of leadership and coordination. In accordance with its Management Response Action Plan, the Agency has secured new vaccine contracts to ensure rapid access to a Canadian produced pandemic vaccine.
b) Enhance preparedness to respond to emerging infectious diseases and other public health events (including the development and implementation of a mass-gathering plan).	**Met all** The Agency enhanced preparedness by initiating a review of the Canadian Pandemic Influenza Plan and the National Emergency Stockpile System, including improvements to the 24 hour/7 days a week capacity of the Emergency Operations Centre. With respect to mass gatherings, the Agency contributed to the successful management of public health risks at the G8/G20 Summits. As planned, the Agency deployed its Microbiological Emergency Response Team to assist in maintaining biological security at the Summits. The Agency also participated in the development of standard operating procedures and pre-summit exercises which facilitated information sharing with public health partners.
c) Strengthen surveillance strategies.	**Met all** The Agency enhanced a large number of disease- and population-specific surveillance systems across all disease types. The Agency also built capacity in scenario-based assessments of complex public health issues.

<table>
<tr><th>Organizational Priority</th><th>Status</th></tr>
<tr><td rowspan="2">II. Promoting the Health of Vulnerable Canadians</td><td>Type: Ongoing</td></tr>
<tr><td>Program Activities: 1.2, 1.3, 1.4, 1.5</td></tr>
<tr><td colspan="2">Improving the health of disadvantaged and vulnerable Canadians by means of more strategic and focused policies and interventions will help reduce health inequalities.</td></tr>
<tr><td>a) Strengthen initiatives to advance the health and well-being of children and youth.</td><td>Met all
The Agency demonstrated the continuing need for early intervention to advance the health and well-being of children and youth, and developed mechanisms for on-line engagement and outreach to children and youth. For example, this year the Fetal Alcohol Spectrum Disorder National Strategic Fund provided funding for projects contributing to the evidence base on the prevalence and impact of the disorder in Canada.</td></tr>
<tr><td>b) Engage other sectors and government departments to influence and develop healthy public policies and related investments.</td><td>Met all
Canadians of all ages and backgrounds benefit from employing healthy living strategies. Building on established momentum, the Agency:
• increased the capacity of northern and Aboriginal public health practitioners working in their communities;
• engaged other sectors and government departments in a dialogue on obesity to contribute to healthy public policy; and
• supported the development of revised physical activity guidelines.</td></tr>
<tr><td>c) Support the design, implementation and assessment of innovative policies and interventions. This includes the systematic knowledge sharing for broader benefits to Canadians.</td><td>Met all
Increased surveillance activities at the Agency enhanced knowledge and understanding of chronic and infectious diseases and contributed to closing knowledge gaps in areas such as neurological diseases and antimicrobial resistance for the broader benefit of Canadians.

Some of the innovative policies and interventions supported by the Agency include the Age-Friendly Community Initiative for seniors and “Equipping Canadians – Mental Health Throughout Life”.</td></tr>
<tr><td>d) Strengthen evidence base to develop policies and interventions.</td><td>Met all
The Agency supported the design, implementation and assessment of innovative policies and interventions, particularly in the area of mental health and the reduction of health inequalities.</td></tr>
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<table>
<tr><th>Organizational Priority</th><th>Status</th></tr>
<tr><td rowspan="2">III. Public Health Capacity</td><td>Type: Ongoing</td></tr>
<tr><td>Program Activities: 1.2, 1.3, 1.5, 1.6</td></tr>
<tr><td colspan="2">Enhancing pan-Canadian and Agency capacity will build a stronger public health system and, in turn, promote health, reduce health inequalities, and prevent and mitigate disease and injury.</td></tr>
<tr><td>a) Strengthen public health field service and response capacity.</td><td>Met all
The Agency is in process of operationalizing the federal, provincial, and territorial agreement on mutual aid, including mechanisms to coordinate and support the inter-jurisdicational sharing of health professional resources when aid is requested. Additional strengthening of public health field services and response capacity was achieved by:
• launching and operating the Field Service Training Institute;
• increasing registration in the Skills Online learning modules; and</td></tr>
</table>

	• piloting Aboriginal Public Health EPI-1, designed to effectively reach geographically distributed learners.
b) Strengthen regulatory approach to public health (e.g., develop regulations in support of the *Human Pathogens and Toxins Act*).	**Met all** The Agency strengthened the regulatory approach to public health by enhancing quarantine services, ensuring International Health Regulations compliance, and engaging in extensive collaboration with stakeholders as a first step in the development of the regulatory framework for the implementation of the *Human Pathogens and Toxins Act*. Early successes include the registration of approximately 1,000 organizations handling human pathogens and toxins.
c) Enhance initiatives related to food safety, including Listeriosis.	**Met all** The Agency enhanced initiatives related to food safety by addressing, in cooperation with Health Canada and the Canadian Food Inspection Agency, the recommendations of the Agency's *Lessons Learned Review of the 2008 Listeriosis Outbreak* as well as the *Report of the Independent Investigator into the 2008 Listeriosis Outbreak* which includes the development of the Public Health Reserve framework in preparation for training and exercise events.

Organizational Priority	Status
IV. Improving Knowledge Dissemination and Use of Best Practices in Public Health	**Type:** Ongoing **Program Activities:** 1.2, 1.3, 1.4, 1.5, 1.6
Improved use of effective practices in public health based on the development of a more robust foundation of knowledge will promote health, reduce health inequalities, and prevent and mitigate disease and injury.	
a) Develop a strategy for enhancing the dissemination of knowledge products on the Agency's Web site.	**Somewhat met** The Agency has improved Web-based dissemination of knowledge products by developing query and analysis tools for publically available data that allows users to customize tables and charts to their needs and utilizing the Canadian Best Practices Portal to generate and disseminate evidence-based knowledge at the local, provincial/ territorial, national and international levels. Work is continuing to develop a broader strategy to enhance dissemination of knowledge products on the Agency's Web site.
b) Strengthen mechanisms to translate evidence to practice-based guidelines and tools through the Canadian Task Force on Preventive Health Care and collaboration with other organizations focused on moving evidence into action.	**Met all** The Agency continues to support the Canadian Task Force on Preventive Health Care to lead the development of clinical practice guidelines for primary and preventive care. The Task Force completed a synthesis and full evidence review report and prepared guidelines and auxiliary journal articles on breast cancer screening. In addition, new Task Force-led working groups on diabetes, depression, cervical cancer, obesity in children and adults, and hypertension were established to engage stakeholders in the review and development of the guidelines and associated knowledge translation tools.

Organizational Priority	Status
V. Achieving Business Excellence	**Type:** Previously committed to **Program Activity:** 2.1
Strengthening the management and administrative infrastructure will enable the Agency to better serve the public health interests and needs of Canadians.	
a) Provide strategic and policy support for the Agency's operational goals and for Ministerial priorities, with an emphasis on science-based decision-making.	**Mostly met** The Agency is currently developing a Science and Research Strategic Plan to align science and research activities with Agency's operational goals and Ministerial priorities. This plan will help ensure that in addition to maintaining the level of excellence when conducting science, the Agency is conducting the right science to provide strategic and policy support.
b) Develop tools for a stable, forward-looking management infrastructure (e.g., Investment Plan).	**Somewhat met** The Agency stabilized its program activity architecture and continues to review and improve its accompanying performance measurement framework. The Agency has drafted its first Investment Plan, including an investment list for internal consultation, prioritization, and validation. This Investment Plan is expected to be completed in 2011–12. The Agency also developed a Risk Management Policy and its first corporate risk profile identifying key Agency risks, drivers, treatment strategies, and controls. The Agency will carry forward its plans to work on risk management tools and communicate across the Agency risk management requirements contained in the Integrated Risk Management Standard.

Organizational Priority	Status
VI. People Management	**Type:** New **Program Activity:** 2.1
Influencing the development of a people-oriented workplace culture that values workforce excellence, leadership and employee engagement, supports the needs of the Agency's programs and results in the realization of the strategic outcome.	
a) Conduct a review of service delivery and strategic human resource management in support of Agency priorities and mandate, and implement within the three-year planning horizon.	**Somewhat met** In 2009–10, the Agency conducted a review of service delivery and strategic human resources (HR). An HR Service Delivery model has since been developed and is in the process of being implemented. The work plan for the integrated, revised, HR suite of policies is under development, and HR dashboards are scheduled to be completed in 2011-12.
b) Establish a Human Resource Management Framework (HRMF) over the three-year planning horizon to support Public Service Renewal and the Chief Public Health Officer.	**Met all** The Agency has developed a People Management Framework (formerly the HRMF) and made good progress in year one of this three-year plan including the: • initiation of talent management discussions at the executive level and succession planning tools for key positions; • preparation of migration to PeopleSoft to replace outdated HR information system; • establishment of a staffing monitoring framework; and

Organizational Priority	Status
	• development of resourcing and recruitment priorities.
c) Adopt a holistic approach to workplace well-being through a series of initiatives aimed at increasing employee engagement, motivation and wellness.	**Met all** The Agency developed, implemented and monitored progress of its Workplace Well-being Action Plan. Key activities included: • preparing and delivering a presentation for senior management on the key priority areas and related activities; • delivering training to over 215 employees across Canada on anti-harassment and respect in the workplace; and • launching a "wiki" on workplace well-being which has been visited over 2,700 times.

Risk Analysis

The Public Health Agency of Canada faces a range of challenges as it strives to achieve its Strategic Outcome and deliver on its priorities. These challenges emanate from a changing policy environment, shaped by: continuing economic uncertainty; demographic change; an expanding global food supply chain with food now sourced from many different countries; and increasing rates of international migration, commerce and travel. Working within this environment, there is an increasing appreciation of the need to continue to enhance coordination and collaboration, both externally, among federal, provincial, territorial, regional and local health authorities, and internally, within the Agency and the Health Portfolio, to enable the effective management of the prevention and mitigation of chronic and infectious diseases, including the response to food-borne and infectious disease outbreaks. Within this changing policy environment, PHAC has continued to respond to shifting priorities and to address risks in order to deliver results to Canadians.

Managing and Responding to Infectious Disease

Increased international migration, commerce and travel increase the likelihood of infectious disease outbreaks in Canada and globally. The speed of transmission of such diseases is also increasing, because of the daily movement of millions of people due to international travel, as highlighted during the H1N1 outbreak. During this fiscal year, the Agency has continuously worked on a number of fronts to prepare for such risks. In particular, the Agency continues to work with Health Canada and other partners to identify and integrate the lessons learned and evaluation recommendations from the *Lessons Learned Review: Public Health Agency of Canada and Health Canada Response to the 2009 H1N1 Pandemic* and the Senate Report on *Canada's Response to the 2009 H1N1 Influenza Pandemic*. The Agency has also taken the first steps to conduct a comprehensive review and revision of the Canadian Pandemic Influenza Plan (CPIP) in collaboration with provinces and territories to facilitate an evergreen document that evolves with new evidence and experience. Furthermore, to ensure readiness to respond to pandemics, a new long-term pandemic vaccine contract awarded in March 2011 provides provincial and territorial governments with a broader range of vaccine products. A pandemic vaccine contract has been put in place as a backup source for use in the event that Canada's primary supply is disrupted. These contracts support a secure supply of vaccine for Canadians in the event of an influenza pandemic. PHAC has also updated its analysis of the national antiviral stockpile size and composition and is currently working on a long-term sustainability strategy.

The management of and response to public health risks depends on the ability of the Agency and its partners to conduct rigorous baseline public health surveillance during emergencies such as the H1N1 outbreak. With this in mind, the Agency has increased its efforts to enhance its surveillance capacity, which includes taking important steps to develop an integrated, "systems" approach to surveillance in Canada, a key priority among federal, provincial and territorial (F/P/T) public health stakeholders. The Agency has also collaborated with Health Canada to make significant advancements in emergency management by developing the Health Portfolio Emergency Response Plan, which is aligned with Canada's Federal Emergency Response Plan.

As well, the Agency led the Pilot Infectious Disease Impact and Response Systems program designed to strengthen Canada's public health infrastructure and address health risks associated with water-borne and vector-borne infectious diseases resulting from climate change. The Agency also recognizes the infectious disease risks inherent in mass gatherings. With this in mind, a mass gathering plan was drafted and provided for operational contingencies in the event of a pandemic during Vancouver 2010 Olympics and the G8/G20 meetings.

Responding to Food-borne Illnesses

The 2008 Listeriosis outbreak made it clear that the way food comes to the tables of Canadians in the 21st century raises an increased risk of food-borne illnesses. To respond to this risk, the Agency has collaborated with Health Canada and the Canadian Food Inspection Agency to implement measures to address the recommendations made in the *Report of the Independent Investigator into the 2008 Listeriosis Outbreak*. The implementation of these recommendations will allow the Government of Canada to become more effective in its response to such illnesses, especially when they span more than one jurisdiction. The Agency has also strengthened the national surveillance of Listeriosis by adding *Listeria monocytogenes* to the National Enteric Surveillance Program, which conducts weekly surveillance on other enteric pathogens.

Responding to this risk requires an intergovernmental and interdepartmental approach. To that end, and following extensive consultations, F/P/T Deputy Ministers of Health and Agriculture, the F/P/T Food Safety Committee and the Council of Chief Medical Officers of Health endorsed a modernized Foodborne Illness Outbreak Response Protocol (FIORP) in June 2010. Furthermore, the Agency also collaborated with Health Canada and the Canadian Food Inspection Agency to develop a Food-borne Illness Emergency Response Plan (FIERP) for food-borne illness outbreaks requiring a response beyond the scope of the FIORP (2010). The FIERP uses a common incident command structure and lays out the principles for Health Portfolio management of a food-borne illness emergency.

Demographic Change

The Agency recognizes that Canada's population is aging and that this creates new demands on the health care system where there is a serious risk of rising costs. The need to address this issue is one of the reasons why the Chief Public Health Officer decided to focus on the senior population in his *Annual Report on the State of Public Health in Canada, 2010: Growing Older – Adding Life to Years*. The Agency is working to address this risk through a range of concrete initiatives. For example, the Agency has played a leading role in creating friendly environments for seniors through an Age-Friendly Communities Initiative. As well, the Agency and Health Canada have developed the Eat Well and Be Active Educational Toolkit to support health and education intermediaries to teach children and adults, including seniors, about healthy lifestyle choices. Finally, the Agency collaborates with the public health community to monitor trends and risk factors for chronic diseases that are more prevalent in older adults and to support prevention efforts.

Corporate Risk

PHAC continues to improve its approach to risk management through the implementation of its Integrated Risk Management Standard. Key accomplishments for 2010–11 include: the approval of the Agency Risk Management Policy (key to establishing risk management expectations and responsibilities); approval of a new Corporate Risk Profile that identifies risks, risk drivers, risk controls, and risk treatment strategies; and risk management training for staff. The Agency will carry forward its plans to work on risk management tools (such as common criteria for risk impact, probability, controls and tolerance) and to better communicate the risk management requirements contained in the Integrated Risk Management Standard (such as a risk management Intranet site for Agency staff); areas that the Agency did not advance as far as it would have liked.

Summary of Performance

2010–11 Financial Resources ($ M)

Planned Spending	Total Authorities	Actual Spending
664.8	711.9*	618.1**

2010–11 Human Resources (Full-Time Equivalents - FTEs)

Planned	Actual	Difference
2,590	2,606	(16)***

*Total Authorities are higher than Planned Spending by $47.1M mainly due to inclusion of additional authorities for: a special project related to pandemic vaccine availability; the Operating Budget Carry Forward; and the renewal of funding for Aboriginal Head Start in Urban and Northern Communities.

**Actual Spending in 2010–11 was $93.8M lower than Total Authorities primarily due to: postponement of the special project related to pandemic vaccine availability while alternatives are being explored and the short-term postponement of activities under the renewed Canadian HIV Vaccine Initiative; deferment of funding to subsequent fiscal years for the construction of the JC Wilt Laboratory; and modest underspending of budgets for operations and contributions.

***The variance between Planned and Actual FTE Utilization is 16 FTEs, which is mainly due to hiring of skilled professionals for selected program areas.

Summary of Performance Tables

Strategic Outcome: Canada is able to promote health, reduce health inequalities, and prevent and mitigate disease and injury		
Performance Indicators	**Targets**	**2010–11 Performance**
Health-adjusted life expectancy (HALE) at birth	Maintain or exceed Canada's 2001 HALE at birth as reported by Statistics Canada.[1] Overall - 69.6 Women - 70.8 Men - 68.3	As of 2001, Statistics Canada reports overall HALE at birth in Canada at 69.6 years. Women have a HALE of 70.8 years and men have a HALE of 68.3 years at birth.[2]
The difference, in years, in HALE at birth between the top-third and the bottom-third income groups in Canada	Maintain or reduce the difference in years. Women - 3.2 Men - 4.7	Canadian men and women in the highest income group have a HALE of 70.5 and 72.3 years as of 2001, respectively. Comparison of HALE across income groups shows that, at birth, women in the highest income group have a HALE that is 3.2 years higher than women in the lowest group. Similarly, men in the highest group have a HALE that is 4.7 years higher than men in the lowest income group.[3]

[1] Statistics Canada. CANSIM Table 102-0121 and Catalogue no. 82-221-X.

[2] Statistics Canada. CANSIM Table 102-0121 and Catalogue no. 82-221-X.

[3] Statistics Canada. 37b-HLT: health adjusted life expectancy (HALE) by income. In: Comparable health indicators—Canada, provinces and territories. Ottawa: Statistics Canada; 2001. Catalogue 82-401-XIE. Available from: http://www.statcan.gc.ca/pub/82-401-x/2002000/4064312-eng.htm#2.

How long Canadians live in good health is determined by factors including: personal and family lifestyle risk factors; environmental and genetic factors; technological advances; social determinants; availability and quality of health care; and public health practices and initiatives at the federal, provincial/territorial, and local levels of government. The Agency works with governmental and non-governmental stakeholders to contribute to these public health initiatives. The results of these combined factors and efforts can best be assessed by looking at summary measures of population health.

Health Adjusted Life Expectancy (HALE) is a composite, summary measure of population health. It is more comprehensive than the better-known *Life Expectancy* measure, as HALE combines length of life and health-related quality of life into a single indicator. HALE is defined as "the number of years in full health that an individual can expect to live given the current morbidity and mortality conditions."[4]

PHAC contributes to increasing HALE in Canada through all the Agency's programs. Undertaken in collaboration with F/P/T health partners, these programs provide federal leadership and support in promoting health, reducing health disparities, enhancing public health capacity, preventing and mitigating injuries and chronic and infectious diseases, providing relevant research support, monitoring health and disease situations and trends, and reducing the risk and consequences of public health emergencies.

($ M)

Program Activity	2009–10 Actual Spending	2010–11[5]				Alignment to Government of Canada Outcomes
		Main Estimates	Planned Spending	Total Authorities	Actual Spending	
Science and Technology for Public Health	74.5	85.0	85.0	97.2	81.6	Healthy Canadians
Surveillance and Population Health Assessment	66.1	57.4	58.3	78.0	76.0	Healthy Canadians
Public Health Preparedness and Capacity	329.0	121.1	104.1	106.2	60.7	Healthy Canadians
Health Promotion	177.0	178.7	178.8	183.4	177.4	Healthy Canadians
Disease and Injury Prevention and Mitigation	132.8	114.9	115.7	102.6	86.3	Healthy Canadians
Regulatory Enforcement and Emergency Response	53.3	28.3	29.5	25.0	23.2	A Safe and Secure Canada
Total	**832.7**	**585.4**	**571.4**	**592.4**	**505.2**	

Program Activity	2009–10 Actual Spending	2010–11			
		Main Estimates	Planned Spending	Total Authorities	Actual Spending
Internal Services	**111.5**	**92.6**	**93.4**	**119.5**	**112.9**

[4] Statistics Canada. Available from: http://www40.statcan.gc.ca/l01/cst01/hlth67-eng.htm [Accessed Aug 16, 2011.]

[5] Commencing in the 2009–10 Estimates cycle, the resources for Program Activity: Internal Services are displayed separately from other program activities; they are no longer distributed among the remaining program activities, as was the case in previous Main Estimates. This has affected the comparability of spending and FTE information by Program Activity between fiscal years.

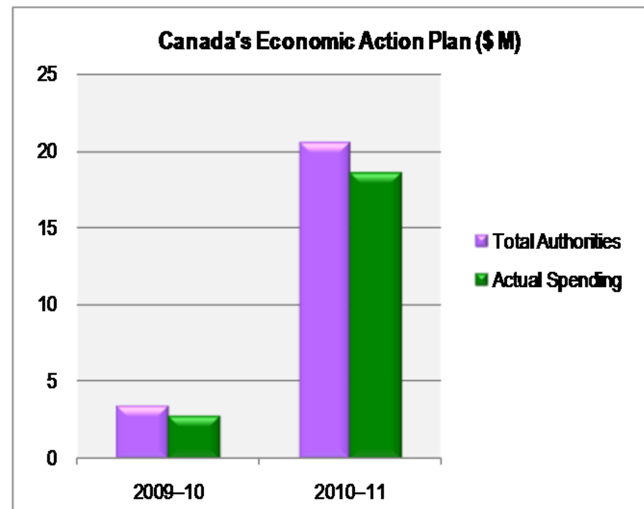
Expenditure Profile

Canada's Economic Action Plan

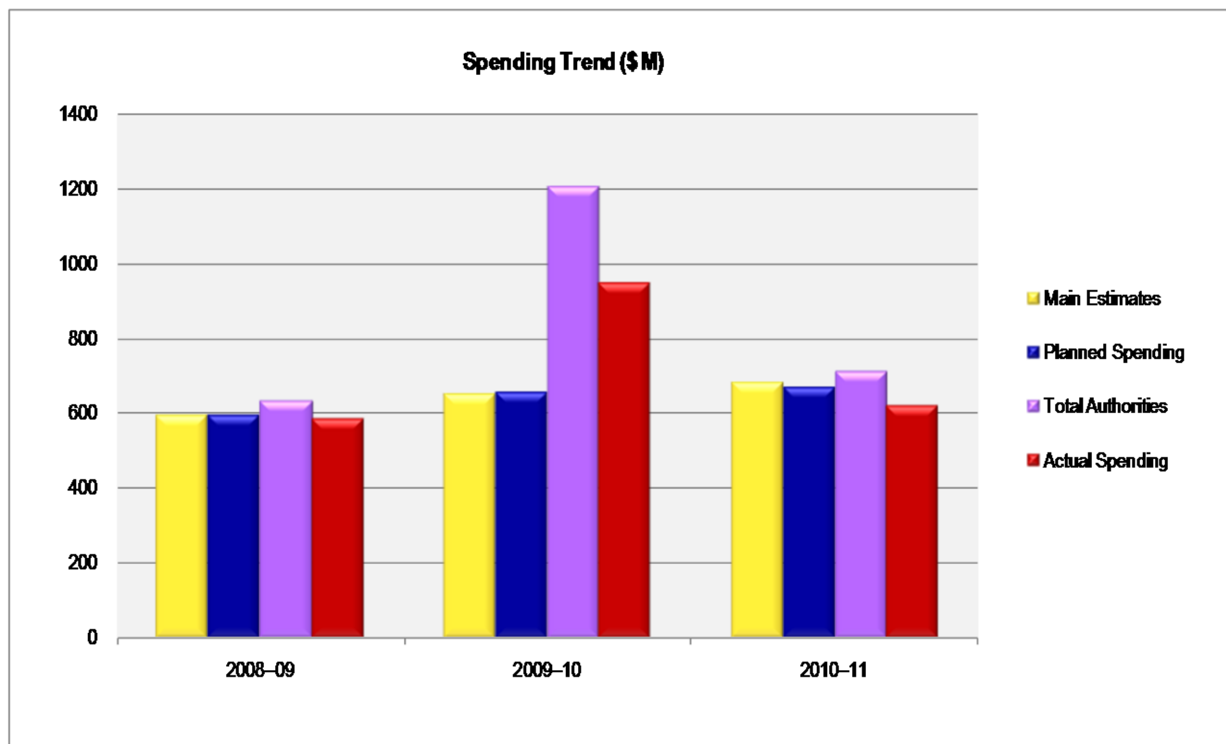
To support the effective and efficient movement of specimens and goods within the Canadian Science Centre for Human and Animal Health (CSCHAH), an expansion of the CSCHAH was approved by Treasury Board in April 2009 as part of Canada's Economic Action Plan. Forecast spending for the project was $20.6M in 2010–11.

Actual spending was $18.7M in 2010–11 resulting in a surplus of $1.9M. Savings of $1.5M were due to the construction management approach contract which allowed for redesign during the project to create efficiencies.

The project has reached substantial completion and is expected to be finished in October 2011. Forecast spending is $0.4M for 2011–12.



Departmental Spending Trend



Estimates by Vote

For information on our organizational Votes and/or statutory expenditures, please see the 2010–11 Public Accounts of Canada (Volume II) publication. An electronic version of the Public Accounts is available on the Public Works and Government Services Canada Website.[6]

[6] See Public Accounts of Canada 2010, http://www.tpsgc-pwgsc.gc.ca/recgen/txt/72-eng.html.

Section II – Analysis of Program Activities by Strategic Outcome

Strategic Outcome

The Agency's Strategic Outcome is Canada is able to promote health, reduce health inequalities, and prevent and mitigate disease and injury. The following section describes the seven program activities through which the Agency works to achieve the Strategic Outcome, and identifies the expected results, performance indicators and targets for each activity. This section also explains how the Agency achieved the expected results and presents the financial and human resources dedicated to each program activity.

Program Activity: Science and Technology for Public Health

This program deals with the development and application of leading edge national public health science and innovative tools, providing specialized diagnostic laboratory testing and reference services, and mobilizing Canadian scientific capacity and networks to enable Canada to improve public health and better respond to emerging health risks. The program's primary clients are public health professionals working in federal, provincial, territorial, municipal/ local and non-governmental organizations (NGOs).

Financial Resources ($ M) 2010–11		
Planned Spending	Total Authorities	Actual Spending
85.0	97.2*	81.6**

Human Resources (Full-Time Equivalents/FTEs) 2010–11		
Planned	Actual	Difference
311	351.7	(40.7)***

*The variance of $12.2M between Planned Spending and Total Authorities is mainly due to $10.5M of internal reallocations from other program activities.

**Actual Spending was $15.6M lower than Total Authorities primarily due to the deferment of funding to subsequent fiscal years for the construction of the JC Wilt Laboratory as well as lower than budgeted costs of the CSCHAH capital project.

***The variance between Planned and Actual FTE Utilization is mainly due to internal realignment of activities as the organization adjusted to the new Program Activity Architecture.

Program Activity Expected Results:

- Public health decisions and interventions by public health officials are supported by research and timely and reliable reference service testing.

Performance Indicator(s)	Target	Performance Status
Percentage of accredited reference service tests within turnaround time (TAT)	80%	Exceeded Where turnaround time information is available, 97.16% of accredited reference testing at the Agency was performed within stated turnaround times for 2010–11. The Agency is expanding the scope of its laboratory information management systems which will provide improved tracking of turnaround times going forward.

…continued from previous page Percentage of reference service testing performed under acceptable accreditation standards	100%	Somewhat met 63% of the Agency's programs providing reference services have one or more International Organization for Standardization (ISO) accredited tests. Plans are in place for the Agency to increase the percentage of programs with one or more ISO accredited tests. Once a program begins operating within the ISO quality system, it is expected to maintain laboratory practices consistent with ISO requirements for all accredited and non-accredited tests.
Research Publications Impact Factors	Target was established at: 1500	Exceeded In 2010, there were 1,639 citations to PHAC research papers published in the three-year period of 2008–2010.[7]
Reference Services External Reviews	Target was determined to be: 100% of reference service programs subject to external review achieving a ranking of "acceptable" or better	Mostly met Five Agency laboratory programs—the National Laboratory for HIV Reference Services, Field Studies, Rabies & Rickettsia, Bloodborne Pathogens & Hepatitis, and Enteric & Enteroviruses—were reviewed by a panel of internal and external public health professionals. In their qualitative assessment, the external review committee found the activities of the reference programs under review to be satisfactory and in some cases exemplary. Future iterations of the external review process will use a formalized ranking scale consistent with the target. The most recent survey indicated more than 90% of respondents were satisfied or very satisfied with the reference services provided by the Agency's Laboratory for Foodborne Zoonoses.

Performance Summary and Analysis of Program Activity

The Agency's National Microbiology Laboratory (NML) and Laboratory for Foodborne Zoonoses (LFZ) conduct reference services, research, and surveillance activities to support provincial public health efforts to control infectious diseases within Canada.

PHAC Facts…
A methodology to distinguish between strains of *Campylobacter*—Comparative Genomic Fingerprinting—was developed by Agency scientists. This new methodology is applicable to other strains of bacteria that have been difficult to tell apart such as *Listeria monocytogenes*. This technique will improve the ability to identify sources of food-borne illness.

Conducting over 60,000 diagnostic tests annually on a variety of viral, bacteria, and other microbiological pathogens as well as over 16,800 tests that provided scientific information on *Salmonella*, *E.coli* and antimicrobial resistance at the human-animal-environment interface, the Agency continues to deliver timely information on new and emerging public health threats. For example, understanding the unique characteristics of *Salmonella*, *E. coli*, *Campylobacter* spp., and *Listeria,* and why they are harmful to human health translates into more rapid and accurate identification of the exact bacteria type associated with outbreaks of illness in Canada. In response to the outbreak of cholera in Haiti in 2010, the Agency utilized its advanced bioinformatics computational tools and experience to perform whole genome sequencing on the Haitian cholera strains. These techniques—previously used in response to pandemic H1N1 and the 2008 Listeriosis outbreak—assisted in the investigation of the cholera outbreak, increased the global understanding of the strains responsible for the Haitian outbreak, and will lead to improved downstream research on those strains in the future.

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[7] Using a three-year period for publications creates a rolling average which smoothes year-over-year fluctuations in the amount of research published and provides sufficient time for publications to be cited.

Additional Agency research has:

- yielded positive early results in the search for vaccines for Ebola and Simian Immunodeficiency Virus (SIV);
- developed new H1N1 monoclonal antibodies for diagnostic and therapeutic use and, to date, sequenced 237 pandemic H1N1 genomes;
- provided information on relevant food/animal/environment sources of food-borne illness via examination of non-human samples of bacteria;
- enabled PHAC and its collaborators to identify food-related public health risks in a timely manner and act upon the evidence to the benefit of Canadians and global citizens; and
- provided novel public health knowledge related to biological variability across the Canadian population in terms of predisposition to and risk of infectious and chronic diseases.

PHAC Facts…
Antimicrobial resistance (AMR) is a growing threat to public health in Canada and globally. In 2010, Agency researchers, in collaboration with national and international partners, helped identify two emerging antimicrobial-resistant organisms, *Klebsiella pneumoniae* carbapenemase and New Delhi metallo-beta-lactamase.

The Agency's science and technology programs also play a vital laboratory-based role in surveillance networks, including FluWatch, PulseNet, the National Enterics Surveillance Program, the Creutzfeldt-Jakob Disease Surveillance System, International Circumpolar Surveillance, the Canadian Nosocomial Infections Surveillance Program and surveillance programs associated with the National Immunization Strategy.

Lessons Learned

The Audit of Laboratory Management (June 2010) found that the level of excellence of the science and research continues to meet the ISO accreditation requirements and the needs of clients and stakeholders. However, to ensure the best use of Agency resources going forward, the audit also found that the Agency could: improve senior corporate oversight of the science and research activities of the labs; provide increased strategic direction at the Branch level; and more clearly define authorities, accountabilities, roles, and responsibilities for Agency laboratories and Centres. In response, the Agency is currently developing a Science and Research Strategic Plan to align science and research activities with Agency priorities.

Operationally, it is critical for the LFZ to accurately monitor turnaround times in the reference laboratories (which provide services to provinces, territories and public health professionals). The Agency will prioritize the implementation of a new laboratory information system to provide improved tracking of turnaround times.

Program Activity: Surveillance and Population Health Assessment

This program facilitates ongoing, systematic analysis, use and sharing of routinely collected data with and among provinces, territories, local health authorities, and other federal departments and agencies so that they can be in a better position to safeguard the health of Canadians. This program is necessary because of the continuous risk to the health of Canadians from emerging infectious and chronic diseases as well as other population health risk factors that are present in the population. The program is geared towards working with federal departments and agencies, other levels of government, health professionals, and hospitals and laboratories across the country to facilitate the development of surveillance systems and sharing of information.

Financial Resources ($ M) 2010–11		
Planned Spending	Total Authorities	Actual Spending
58.3	78.0*	76.0

Human Resources (Full-Time Equivalents/FTEs) 2010–11		
Planned	Actual	Difference
347	384.4	(37.4)**

*The $19.7M net increase between Planned Spending and Total Authorities is mainly due to $18.5M of internal reallocations from other program activities to best reflect the new Program Activity Architecture. Actual Spending on Surveillance and Population Health Assessment remains comparable with previous years.

**The variance between Planned and Actual FTE Utilization is mainly due to internal realignment of activities as the organization adjusted to the new Program Activity Architecture.

Program Activity Expected Result:

- Federal, provincial, territorial and local jurisdictions have the comprehensive, consistent and timely national picture of chronic and infectious diseases, risk factors, and determinants of health required to manage infectious and chronic diseases and risk factors to health.

Performance Indicator(s)	Target	Performance Status
Percentage of key stakeholders indicating that Canada's surveillance and population health assessment provide the information required to manage infectious and chronic diseases	Determine baseline by March 31, 2011	Somewhat met The Agency's 2010–11 Surveillance Governance Review confirmed that the existing governance structure is working, and the key stakeholders involved in the review indicated that the Agency's surveillance activities have greatly improved. It also concluded, however, that the Agency should improve coherence in its surveillance activities. The World Health Organization's May 2011 report on the *Implementation of the International Health Regulations (2005)* has indicated that Canada has the necessary formal and informal contact processes in place to efficiently support global early-detection and risk-assessment functions. Some mechanisms and processes to promote alignment among federal and provincial and territorial surveillance roles and responsibilities are in place and others are being set up. For example, the recently created Public Health Infrastructure Steering Committee of the Public Health Network (PHN) has acknowledged the surveillance infrastructure gaps (such as information sharing agreements). This group agreed to the formation of an F/P/T Task Group to develop the framework necessary for an integrated, federated system for public health surveillance in Canada. A new governance structure to support the transition of the PHN and develop the necessary strategy for a

…continued from previous page		national surveillance system was implemented on April 1, 2011. The results of an online survey regarding the Chief Public Health Officer's *Report on the State of Public Health in Canada, 2010: Growing Older – Adding Life to Years*, indicated that readers found the content to be "very useful".

Performance Summary and Analysis of Program Activity

The Agency is making consistent progress on improvements to the coordination of its surveillance systems and programs to ensure relevant and timely public health data and information are available to health care professionals and decision makers. This target population uses surveillance and population health assessment information to rapidly identify public health events and take coordinated action to minimize the health, social and economic impact on Canadians.

Implementation of the goals and objectives of the PHAC Surveillance Strategic Plan and the recommendations of the *2008 May Report of the Auditor General* related to surveillance of infectious disease are underway. Actions to strengthen infectious disease surveillance have focused on the development of the Federal/Provincial/Territorial (F/P/T) Multilateral Information Sharing Agreement (MLISA), and foundational activities necessary to support this work. This has included clarifying business processes for infectious disease surveillance and urgent public health events, identifying options for improved coordination of notifiable disease surveillance, implementing Phase II of the Data Quality Framework across all surveillance systems for a national picture of health trends, and developing data standards and a PHAC Surveillance Data Management Framework. Partnerships with key federal actors (i.e., Statistics Canada, Canadian Institute for Health Information) were strengthened in order to build sound quality assurance practices in the sourcing, acquisition and maintenance of health data.

> **PHAC Facts…**
> C-EnterNet information concluded that public pools are a prime transmission zone for the parasitic pathogen, *Cryptosporidium*, as opposed to drinking water. This information resulted in the development of guidelines for pool disinfection. Many public health units in Ontario have implemented this guidance over the summer 2011 swimming season.

Improved coordination of surveillance was achieved through clarified roles, responsibilities and reporting timelines for national tuberculosis data collection. Such improvements will translate into heightened quality of reports such as Tuberculosis in Canada: 2009 pre-release.

Related efforts to strengthen public health surveillance in Canada include: standard operating procedures for routine surveillance on sexually transmitted infections (including gonorrhea, chlamydia and infectious syphilis) and hepatitis C virus; new methods of surveillance for the risk of Lyme disease and other emerging tick-borne diseases; a joint Agency and Canadian Food Inspection Agency assessment of current surveillance priorities for zoonoses; a national user guide and reporting form for the Canadian Adverse Events Following Immunization Surveillance System; and the early stages of implementation for the PHAC Data Quality Framework Assessment Tool across all surveillance systems.

The Agency also supports disease- and population-specific surveillance systems in order to better understand the contributing factors to disease transmission. With respect to infectious disease, some examples include: I-track (focusing on people who inject drugs), M-track (focusing on gay, bisexual and other men who have sex with men), E-track (focusing on persons originating from HIV endemic countries), and plans to develop A-track (focusing on Aboriginal peoples) in the Regina area. In addition, a second sentinel site for integrated enteric pathogen surveillance was established; this was a follow-up to evaluation recommendations for the C-EnterNet Program. With respect to chronic disease, the examples include the Cancer in Young People surveillance system and expanding the Canadian Chronic Disease Surveillance System to include hypertension and mental illness. Surveillance of healthcare associated infections was also expanded through the addition of a Prince Edward Island site to the Canadian Nosocomial Infection Surveillance Program. All provinces are now represented in the program.

> **PHAC Facts…**
> PHAC provided enhanced epidemiology and surveillance support to the Saskatchewan Ministry of Health in a collaborative investigation of the underlying factors contributing to the rise of reported HIV infections in Saskatchewan. Funding was provided to support community-based solutions and responses to the increase of new HIV infections and to develop an evaluation framework for Saskatchewan's new HIV/AIDS Strategy. Concurrent enhanced HIV surveillance studies are being conducted to provide further information to guide the response to HIV in Saskatchewan.

The Agency continues to produce timely and accurate information on disease risk factors and determinants of health. A short list of the numerous publications and reports includes:

- Self-reported Influenza Vaccination, Illness and Absenteeism Among Canadian Healthcare Workers during the 2009 H1N1 Influenza Pandemic
- *Report from the Canadian Chronic Disease Surveillance System: Hypertension in Canada, 2010*
- Canadian Integrated Program for Antimicrobial Resistance Surveillance Quarterly *Salmonella* Reports
- *Life with Arthritis in Canada: A personal and public healthcare challenge*

PHAC Facts…
The Chronic Disease Risk Factor Atlas was released in June 2010. It provides information on major chronic disease risk factors with national trends over time, age-specific prevalence estimates, and maps of the prevalence of risk factors in health regions across the country .Understanding these risks is crucial, because approximately four out of five Canadians have at least one modifiable risk factor for chronic disease.

Contributing to the timeliness and accessibility of data, the Agency has also enhanced Web-based query and analysis tools for publically available Web-based data that allow users to customize tables and charts. For example, in November 2010, PHAC launched an innovative, interactive database to enable users to access surveillance information and customize it to meet their needs. These "Data Cubes" were developed in part at PHAC and are designed primarily for public health professionals and epidemiologists to obtain the information they need on health indicators.

PHAC Facts…
PHAC has developed a Privacy Management Framework including a Policy on the Collection, Use and Dissemination of Public Health Data, and has deployed a web-based tool for Privacy Impact Assessment within the Agency.

Taking surveillance data and information to the next logical step, the Agency is building capacity in scenario-based assessments of complex public health issues. These scenarios are detailed analyses which include economic investigations to support public health policy development. Knowledge translation and dissemination activities were completed for the H1N1 scenarios and the *Children and Physical Activity Scenarios Project: Evidence-based Visions of the Future.*

PHAC has also established an internal working group on Population Health Indicators and continues to be a key partner in the national and international development of key health indicators such as the Health Adjusted Life Expectancy and Disability Adjusted Life Years. PHAC has pursued development of an on-line tool that will allow key stakeholders to access and manipulate Economic Burden of Illness in Canada data to support their respective analytical needs with a pilot slated for 2011–12.

In 2010–11, the Agency conducted 21 economic and cost-of-illness consultations. These analyses looked at both the direct costs (hospitals, physicians and drugs) and indirect costs (lost production due to disability and death). The findings contributed to the recently released *Obesity in Canada: A joint report from the Public Health Agency of Canada and the Canadian Institute for Health Information.*

PHAC Facts…
The Canadian Integrated Program for Antimicrobial Resistance Surveillance group worked with the CODEX Alimentarius Commission ad hoc Intergovernmental Task Force on Antimicrobial Resistance. The Task Force produced guidance on methodology and processes for risk assessment and its application to the antimicrobials used in human and veterinary medicine, with subsequent consideration of risk management options. This international collaboration is a key initiative in the control of antimicrobial resistance in the food-chain.

As required by the *Public Health Agency of Canada Act*, the Chief Public Health Officer's *Report on the State of Public Health In Canada, 2010: Growing Older - Adding Life to Years* was submitted to the Minister of Health and was subsequently tabled in Parliament on October 27, 2010. The 2010 CPHO Report focused on the health and well-being of Canada's seniors aged 65 years and over. The report highlighted the fact that Canada's seniors are living longer lives and that many are experiencing good overall health. It included the following areas of seniors' health and well-being: physical and mental health; economic and social well-being; access to care and services; and abuse and neglect. Survey results indicate that readers found the content to be very useful, with strong support for the theme of seniors' health. Content was reported by readers to inform or influence professional work, as well as personal interests and opinions. Respondents also report having used (or intending to use) the report: to support research papers, articles and presentations; as a reference document for general knowledge about public health or seniors' health; to cite statistical data for presentations, policy discussions or approaches to policy/programming; and for personal or professional discussions with colleagues.

Lessons Learned

The 2010–11 PHAC Surveillance Governance review suggested that a dedicated resource is required for the role of the Senior Surveillance Advisor in order to provide the necessary vision and leadership, bring coherence to PHAC's surveillance activities, and provide a strong national public health surveillance presence. The Agency is currently working towards the second 5-year Surveillance Strategic Plan. This plan will highlight a comprehensive and coherent approach to surveillance and potentially have a dedicated role for the Senior Surveillance Advisor in the new governance structure. A draft work plan for the implementation of the 2012–2017 PHAC Surveillance Strategic Plan is under development.

Coupled with this internal review, the need for a national coordinated approach was confirmed in the *Lessons Learned Review: Public Health Agency of Canada and Health Canada Response to the 2009 H1N1 Pandemic*. While individual disease surveillance systems may be functioning reasonably well, there is increasing recognition that in order to provide effective public health responses, an efficient national network of prioritized public health surveillance systems is critical. This was acknowledged as a key priority for action among F/P/T public health stakeholders. Getting the fundamental principles right and commonly understood between stakeholders as well as developing a shared understanding of the purposes, roles, and mechanisms of surveillance is essential to achieving this desired goal.

The review also noted that existing networks, systems and tools have successfully facilitated the prompt exchange of science, surveillance and research information. However, the review identified needed improvements in surveillance and recommended an integrated surveillance system for immunization which includes managing inventories, tracking vaccine uptake, monitoring adverse events and the finalization of agreements on sharing surveillance information across jurisdictions. One step in addressing these recommendations is the signing of a five-year funding contract with the Immunization Monitoring Program ACTive (IMPACT), a paediatric hospital-based, national active surveillance network administered by the Canadian Paediatric Society. This program monitors adverse events following immunization, vaccine failures, and selected infectious diseases in children that are, or are soon to be, vaccine preventable. Additional responses included retention of the active hospital-based surveillance system to monitor the intensity of influenza cases and reports on related deaths and a comprehensive analysis of the cost effectiveness of antiviral stockpiles.

Program Activity: Public Health Preparedness and Capacity

This program increases Canada's public health preparedness and capacity by: providing tools, training and practices that enhance the capabilities of organizations and people who have a role in Canada's public health; increasing public health human resource capacity; developing and maintaining Canada's ability to prepare for public health emergencies; and by establishing/maintaining networks both within and outside Canada. The program is necessary as public health skills, tools and networks are required for Canada to be able to keep Canadians healthy.

Financial Resources ($ M) 2010–11		
Planned Spending	Total Authorities	Actual Spending
104.1	106.2*	60.7**

Human Resources (Full-Time Equivalents) 2010–11		
Planned	Actual	Difference
412	345.8	66.2***

*Total Authorities were higher than Planned Spending by $2.1M mainly due to the inclusion of additional authority for a special project related to pandemic vaccine availability, offset by $18.8M for internal reallocations to other program activities.

**Actual spending was lower than Authorities by $45.5M mainly due to postponement of the special project related to pandemic vaccine availability while alternatives are being explored.

***The variance between Planned and Actual FTE Utilization is mainly due to internal realignment of activities as the organization adjusted to the new Program Activity Architecture.

Program Activity Expected Results:

- Canada has the capacity for public health interventions including emergency response

Performance Indicator(s)	Target	Performance Status
Percentage of capacity gaps bridged by stakeholders (i.e., federal, provincial, territorial and local jurisdictions)	75% by June 15, 2011 and 100% by June 15, 2012	Met all The revised International Health Regulations (IHR) adopted by the World Health Assembly in May 2005 require all IHR States Parties to assess the ability of their national structures and resources to meet minimum national core capacities for surveillance and response, and to develop a plan of action to ensure that these capacities will be present and functioning throughout their regions by 2012. Reflecting capacity at the federal, provincial, territorial and local levels, an annual WHO IHR capacity assessment tool is used to assess national public health intervention capacity beyond those required for the IHR. This tool will be used to calculate progress towards the percentage target. The Public Health Agency of Canada has the mandate to implement the IHR on behalf of the Government of Canada and its provincial and territorial (P/T) partners.

Performance Summary and Analysis of Program Activity

One fundamental component of public health is the awareness and communication of roles and responsibilities. With the purpose of strengthening preparedness, the Agency has collaborated with its partners to enhance plans and processes.

Most notably, the Health Portfolio has made significant advancements in emergency management by developing and approving the Health Portfolio Emergency Response Plan (HP ERP) to provide direction for responding to and managing emergencies within the Health Portfolio's mandate and area of expertise. Structured as an "all hazards" plan, the HP ERP defines the scope, framework and roles and responsibilities within which the Public Health Agency of Canada and Health Canada operate to fulfill their responsibilities under the *Emergency Management Act* and ensure an appropriate response to the complete range of emergencies that could affect the health and well-being of Canadians (including pandemic influenza).

> **PHAC Facts...**
>
> Pursuant to the direction of the Deputy Ministers of Health following the 2009 H1N1 pandemic, a body of work was developed through the Emergency Preparedness and Response Expert Group to ensure pandemic influenza preparedness and response activities during the pandemic period are well integrated and managed into the new proposed Public Health Network governance structure.

The HP ERP supports the Government of Canada's core plan for coordinating response to emergencies where federal support is required, Public Safety Canada's Federal Emergency Response Plan (FERP). The FERP is the cornerstone document which defines the processes that the federal government will use during emergencies and clarifies the decision-making structures in the event of an emergency. Approved in 2010–11, the Public Health and Essential Human Services Emergency Support Function #5 is an annex to the FERP and outlines how the Health Portfolio coordinates the provision of emergency health and social services resources, and augments local health care capacity to affected province(s) and/or territory(ies), when requested. The improved coordination of plans and partnerships will assist in clearly defining roles and responsibilities across the HP and preventing duplication of effort.

Further to enhanced planning and preparedness at the Agency, numerous improvements to pandemic planning were realized in 2010–11. First, utilizing the best available evidence from the H1N1 pandemic, the Agency has developed new recommendations related to national antiviral stockpile size and composition. Second, foundational work to inform a comprehensive review and revision of the Canadian Pandemic Influenza Plan was undertaken in collaboration with provinces and territories, with revisions to the main body of the Plan scheduled for 2011–12. Third, the Canadian domestic pandemic vaccine contract was renewed, with a further contract established for a backup supplier for pandemic vaccine. Work is underway to develop a strategy for the long term sustainability of antiviral stockpiles going forward. Last, the *Lessons Learned Review: Public Health Agency of Canada and Health Canada Response to the 2009 H1N1 Pandemic* and the Senate Report on Canada's Response to H1N1 were released, with an H1N1 Management Response Action Plan developed to address the evaluation recommendations contained in the reports.

Information sharing agreements and protocols is another component of emergency preparedness and capacity. Providing financial and secretariat support to the Pan-Canadian Public Health Network (PHN) enabled the Agency to develop a better understanding of Canadian current recovery capacity and practices. This facilitated the identification of efficient and effective collaborative approaches, as well as enhancing the Agency's collective pan-Canadian capacity to respond to events affecting public health. In addition, the Agency leveraged the increased momentum, in the provinces and territories, and engaged in Canada-United States pan-border public health discussions.

Moreover, the funding and secretariat support extended to the full range of groups within the PHN including PHN Council, Expert Groups, Issue Groups and Task Groups. For example, Agency support of the memorandum of understanding (MOU) on national aid and MOU on information sharing during a public health emergency includes processes and templates for information sharing during an emergency. The Agency also provided input into the PHN review process to ensure pandemic influenza preparedness and response activities during the pandemic period are well integrated and managed into a newly proposed PHN governance structure.

> **PHAC Facts...**
>
> PHAC provided technical and policy support to the PHN and worked in collaboration with provinces and territories to advance key public health priorities for Canada in 2010–2011, including promoting healthy weights for children and youth, and pandemic preparedness and response.

A second fundamental component of public health is enhancing the capacity of organizations and people with a role in Canada's public health systems by providing tools and training to increase public health human resource capacity. To further this objective, the Agency brought First Nations, Inuit and Métis learners to an online study group to provide feedback on content and delivery modifications to improve the learning module. Primary benefits for the learners included enhanced awareness, knowledge and understanding of public health concepts, history and terminology, with a major outcome noted in increased job confidence. Other benefits included addressing the issue of distance learning, supporting learners with ethnic origins in an oral learning tradition, and increased motivation amongst colleagues to seek educational opportunities. The learning for public health conducted in the Aboriginal Public Health EPI-1 pilot validated the use of on-line study methodology for remote communities. The *First Nations, Inuit and Métis Pilot of "Basic Epidemiological Concepts (EPI-1) Evaluation Report"* was released in June 2010.

> **PHAC Facts…**
>
> The Canadian Public Health Service is a program designed to build Canada's public health workforce and capacity by placing qualified public health officers in jurisdictions across Canada in order to respond to both routine and emerging public health needs. This would include added support in the event of an outbreak of pandemic influenza. By the end of 2010–11, 23 public health officers were hired and placed in public health sites across Canada.

Additionally, the Skills Online catalogue of learning modules was revised to include the Public Health Core Competencies, June 2010. Information from stakeholder workshops underpinned this revision by developing tools to support the use of Core Competencies for Public Health in Canada: Release 1.0 and providing the foundation for jurisdiction-specific programs. Capacity issues constrained certain activities however, and the development of new modules did not proceed as planned.

The first Field Service Training Institute (FSTI) was held in May 2010 with 23 training modules developed and 135 participants. The planning and organization for the 2011 FSTI was completed in this fiscal year with the selection of food-borne illness as a focus. This preparatory work included Train the Trainer facilitator training and development of course content.

> **PHAC Facts…**
>
> The number of health practitioners registering in the Agency's Skills Online course modules increased to 3661 in 2010–11 from 2494 in 2009–10.

PHAC continues to support the pan-Canadian evaluation of Panorama in order to support a next generation case management system for sharing of information during outbreaks. PHAC initiated the Outbreak Management Project in 2010–11 to define, document and validate PHAC and provincial/territorial food-borne outbreak business requirements.

PHAC continued to provide maintenance and support for the Integrated Public Health Information System (iPHIS) which is currently deployed across Canada.

Lessons Learned

The Health Portfolio Emergency Operations Centre (HP EOC) was activated during the Nuclear Emergency in Japan in March 2011 to monitor radiation-related health risks to Canadians both abroad and at home. As the first HP EOC activation in response to a radiological or nuclear event, it was deemed a success. The activation integrated human resources from across government into the HP EOC (such as subject matter experts with regular HP EOC staff) to enable a coordinated response. This successful integration of the Health Portfolio with other federal departments and regional, provincial and territorial partners provides a solid foundation for future responses to CBRNE (chemical, biological, radiological, nuclear, and explosive) events.

To ensure all hazards response capacity including pandemic influenza preparedness and response, the Agency provided inputs to the PHN review process. In the process a need was identified for a continued F/P/T Health Emergency Management Network to advance the key activities and deliverables of the PHN and the Centre for Emergency Preparedness and Response.

The registration for Skills Online learning regularly closes off registration at capacity and maintains a wait list of an additional 40 percent of capacity; conservative estimates suggest that demand would support an increase of 70 percent per year above the three thousand learners in 2010–11. The training constraint is a lack of resources to provide trainers (for both online and face to face learning) in remote locations. This excess demand will not be addressed at the current time, however the Agency is exploring increased utilization of online courses such as the Aboriginal Public Health EPI-1 pilot. The feedback on a follow-up report from the students noted that they found that the improved accessibility was a significant benefit to reaching geographically distributed learners—they embraced online learning. This strategy to provide increased learning opportunities is a focus of existing resources.

Current project activities and the insights gained from participating in pan-Canadian development, maintenance and governance of case management system such as iPHIS and Panorama governance have led to the conclusion that it is highly improbable that a sole electronic system can be used for the collection and analysis of public health data. Since it has been recognized that PHAC and its P/T partners will always be using multiple electronic systems for such purposes, the Agency is moving forward on this issue by providing leadership and support in the areas of data standards, interoperability, privacy/security, and the development of formal agreements on information sharing. This will facilitate the seamless and standardized collection and transmission of public health data, particularly during emergency and outbreak situations. A new Public Health Infrastructure Steering Committee has been established (April 2011) within the Public Health Network to initiate and oversee projects to address areas such as pan-Canadian data standards and data sharing agreements.

Program Activity: Health Promotion

This program provides leadership and support in promoting health and reducing health disparities among Canadians. It supports Canadians in making healthy choices throughout all life stages through initiatives focused on, for example, child development, families, lifestyles, and aging. It also facilitates the conditions that support these choices by working with and through others to address factors and determinants that influence health, such as health literacy, food security, social support networks and the built environment.

Financial Resources ($ M) 2010–11		
Planned Spending	Total Authorities	Actual Spending
178.8	183.4*	177.4**

Human Resources (Full-time Equivalents) 2010–11		
Planned	Actual	Difference
417	392.6	24.4***

*The increase of $4.6M in Total Authorities in 2010–11 is due to the renewal of the Aboriginal Head Start Initiative in Urban and Northern Communities.

**Actual Spending was $6.0 M lower than Total Authorities mainly due to modest underspending of budgets for operations and contributions.

***The variance between Planned and Actual FTE Utilization is mainly due to internal realignment of activities as the organization adjusted to the new Program Activity Architecture.

Program Activity Expected Result:

- Canadians are supported in making choices that promote healthy human development

Performance Indicator(s)	Target	Performance Status
Number of external cross-government and cross-sectoral collaborations to address public health needs and common determinants of health and wellbeing	Baseline established at: 108 +/- 20%	Met all The Agency led 117 cross-sectoral collaborations involving P/T governments, other federal departments, universities, health and social service agencies and non-governmental organizations, the private sector and international organizations (including the Canadian Reference Group on the Social Determinants of Health, Public Health Network and the ministers of Sport, Physical Activity, and Recreation (SPAR), the PHAC Innovation Strategy and the European Union-Canada Collaboration on physical activity for children and youth).
Number of health promotion programs, activities and initiatives supporting Canadians in making healthy choices	Baseline established at: 1,275 +/- 15%	Met all PHAC participated in 1,295 health promotion programs, activities and initiatives to generate and disseminate knowledge products, design and test innovative approaches to priority public health issues, and deliver programming and strategic initiatives.

Performance Summary and Analysis of Program Activity

The Agency provided funding and support for vulnerable children and families through the Canada Prenatal Nutrition Program (CPNP), the Community Action Program for Children (CAPC) and the Aboriginal Head Start in Urban and Northern Communities (AHSUNC). CPNP/CAPC projects completed during the review period focused on Agency priorities such as mental health, healthy weights, injury prevention, child health and the environment. After 15 years, the AHSUNC program has demonstrated that locally controlled and designed early intervention strategies can improve the health of Aboriginal children by supporting their physical, personal and social development. In 2010–11, 4,800 Aboriginal children participated in the program at 129 sites across Canada. On the eve of National Child Day 2010, the Government of Canada announced a five-year extension (2010 to 2015) to

support strategic, time-limited AHSUNC projects focusing on capacity building, training initiatives, parent resources, and culturally appropriate early childhood development services and assessment tools.

The Agency's Fetal Alcohol Spectrum Disorder (FASD) activities aim to mitigate the impact of alcohol exposure in pregnancy by building awareness among key stakeholders, delivering policies and programs that reduce the number of alcohol-affected births and improve the outcomes of individuals already affected. This year, the FASD National Strategic Fund provided funding for projects contributing to the evidence base on the prevalence and impact of FASD in Canada such as the Canadian Association of Paediatric Health Centre's *National Screening Tool Kit for Children and Youth Identified and Potentially Affected by Fetal Alcohol Spectrum Disorder*.

PHAC Facts…
The *Alcohol Use and Pregnancy Consensus Clinical Guidelines*, funded by PHAC and published by the Society of Obstetricians and Gynaecologists of Canada, are the world's first national guidelines for alcohol and pregnancy and set out consistent, evidence-based recommendations for health physicians to use when discussing alcohol with women of child-bearing age.

This spring, Canada's Ministers of Health launched Our Health Our Future: A National Dialogue on Healthy Weights – Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action on Healthy Weights, which was adopted by Ministers of Health and/or Health Promotion/Healthy Living in September 2010 and endorsed by Ministers responsible for Sport, Physical Activity and Recreation in February 2011. Through the Framework, Ministers agreed to make childhood obesity a collective priority, to champion this issue, and to coordinate joint and/or complementary actions within many areas of Canadian society to help create the conditions for healthy weights so that children have the healthiest possible start in life. The Framework is the first action resulting from the Declaration on Prevention and Promotion, also endorsed by Ministers, which recognizes that promoting health and preventing chronic disease, disability and injury is a shared responsibility and helps all Canadians live longer, healthier lives.

In addition, one of the key priorities of the Agency's Innovation Strategy focuses on the promotion of healthy weights, prevention of overweight and obesity, and attainment and maintenance of healthy weights with an emphasis on actions that will contribute to the reduction of inequalities. Under the umbrella of Achieving Healthier Weights in Canada's Communities, 37 initiatives have been funded across the country targeting individual, family and environmental factors with a particular emphasis on higher risk or disadvantaged populations/communities. The "Managing Obesity Across the Life-Cycle: An Intervention Approach" solicitation resulted in the funding of five initiatives to develop obesity management tools for health practitioners working with children, youth, and families in managing their obesity.

Physical activity plays an important role in the health, well-being and quality of life of Canadians, and helps to prevent chronic diseases like cancer, Type 2 diabetes and heart disease. In addition to providing funding to support the revised physical activity guidelines launched by the Canadian Society for Exercise Physiology in January 2011, PHAC partnered with the Canadian Institutes of Health Research and funded knowledge syntheses to inform future physical activity guideline development. The Agency supported the Canadian Fitness and Lifestyle Research Institute for data collection and surveillance activities to monitor physical activity levels of children and youth against targets set by F/P/T ministers of Sport, Physical Activity and Recreation. In partnership with its provincial counterparts, the Agency initiated a process to modernize the F/P/T Coordinated Sport and Physical Activity Monitoring Program. PHAC also partnered with the F/P/T Physical Activity and Recreation Committee to identify case studies that show promise in increasing capacity among Aboriginal leaders to increase physical activity for Aboriginal youth.

There is growing understanding of the public health challenges posed by many aspects of our built environment[8] and the need to ensure communities are designed to promote healthy living. The Agency has played a leading role in creating friendly environments for seniors through an Age-Friendly Communities Initiative engaging 400 communities and seven provinces; releasing *Age-Friendly Communication: Facts, Tips and Ideas* and *On the Road to Age-Friendly Communities*, and developing an implementation and evaluation guide for distribution in 2011 to assist communities in establishing the age-friendly communities model consistently across Canada.

The Agency continued its collaborative efforts with the Mental Health Commission of Canada on the development of a Mental Health Strategy for Canada. PHAC also completed a third stage in the development of a Canadian Mental Health Impact Assessment tool, to be completed in 2012–13, which emphasizes issues of inequality as they affect the mental health status of

[8] The built environment can be broadly defined as environments that have been created or modified by people. These environments include: neighbourhood designs; schools; homes; workplaces; recreation areas; location of stores; and the location and design of roads; sidewalks, bike lanes and footpaths. The built environment is a key determining factor in the promotion of physical activity and the prevention of obesity.

vulnerable populations. In addition, through "Equipping Canadians – Mental Health throughout Life", the Agency's Innovation Strategy continued its focus on mental health promotion and the reduction of inequalities in mental health. Nine multi-year projects focusing on children, youth, and families were initiated for a four-year period (2010–11 to 2014–15) in multiple geographic sites and settings across the country. The projects support a range of interventions to address the needs of diverse populations at higher risk (e.g., Aboriginal, immigrant, low income groups and Northern populations) and to build protective factors and skills (e.g., coping skills, self-esteem) at various stages of early life development.

Lessons Learned

Early, consistent, and meaningful collaboration with other government departments, provinces and territories, university-based researchers, health and social service professionals, non-governmental organizations (NGOs), the private sector and youth continue to advance ongoing efforts to strengthen a common vision with stakeholders of a Canadian society that foster healthy, safe, and productive Canadians.

In response to the Audit of Health Promotion Programs 2009, the Agency has fully or significantly implemented the audit recommendations and ensured that structures and process are operating as intended in all required areas of the organization. Program and funding priorities are well aligned, with greater rigour and tools in place for project monitoring, evaluation, and reporting through confirmed operating principles and standard operating procedures. Outstanding action plans and communications mechanisms are expected to be fully implemented by the end of 2011–12 as planned.

Evaluations of the Children's Programs found a continuing need for programs targeting at risk populations. In response to *The National Evaluation of Aboriginal Head Start In Urban and Northern Communities (2003-2005)*, December 2006, the Agency began national implementation of the Brigance Head Start screen to collect holistic school readiness information that would enable comparison over time. The Evaluation of the Canada Prenatal Nutrition Program 2004-2009, recommended that the Program continue to monitor threats to maternal, infant, and child health to inform implementation and enable the program to adapt and respond to emerging health priorities. The Evaluation of the Community Action Program for Children: 2004-2009 recommended further study to identify the most effective delivery models for early intervention with children growing up under conditions that lead to higher rates of poor health, developmental difficulties, social, cognitive and behavioural problems.

Program Activity: Disease and Injury Prevention and Mitigation

This program develops and implements strategies, undertakes prevention initiatives, and supports stakeholders to prevent and mitigate chronic disease, injury, and prevent and control infectious disease. The work leads federal efforts and serves collaboratively to mobilize domestic efforts. The program is necessary given the current and potential impact of injury and chronic and infectious disease on the health of Canadians and the sustainability of the Canadian health care system.

Financial Resources ($ M) 2010–11		
Planned Spending	Total Authorities	Actual Spending
115.7	102.6*	86.3**

Human Resources (Full-Time Equivalents) 2010–11		
Planned	Actual	Difference
414	341.8	72.2***

*The $13.1M net decrease between Planned Spending and Total Authorities is mainly due to transfers of $11.1M to other programs and a permanent transfer of $3.0M to the Canadian Institutes of Health Research to continue to fund targeted breast cancer research.

**Actual Spending was $16.3M lower than Total Authorities mainly due to the short-term postponement of activities under the renewed Canadian HIV Vaccine Initiative and modest underspending of budgets for operations and contributions.

***The variance between Planned and Actual FTE Utilization is mainly due to internal realignment of activities as the organization adjusted to the new Program Activity Architecture.

Program Activity Expected Result(s):

- Diseases and injury are prevented and mitigated

Performance Indicator(s)	Target	Performance Status
Rate of age-standardized new diagnoses of major diseases during a one-year period (i.e., incidence)	Baselines were established at: HIV reported rate of 8.6 per 100,000 persons aged ≥15 yrs (rate in 2009 for newly diagnosed HIV cases)	Mostly met Baselines are under development for healthcare-acquired infections and additional community-acquired infections. HIV diagnosis rates for other high-income countries are typically calculated per total population, whereas Canada's rates are per the adult population (>15 years), so a direct comparison cannot be made. In 2009, the HIV diagnosis rate in the USA for 2009 was 17.4 per 100,000 population; 10.7 per 100,000 population in the UK; 7.6 per 100,000 population in France; 3.5 per 100,000 population in Germany; and 1.3 per 100,000 in Australia.
	Acute hepatitis B reported incidence: 0.69 per 100,000 population (2009) Acute hepatitis C reported incidence: 1.88 per 100,000 (2009)	As compared to other countries, Canada has relatively low overall rates of reported hepatitis B and C. However, these rates are considerably higher among certain sub-populations in Canada, such as Aboriginal populations.

…continued from previous page	TB reported rate of 4.7 per 100, 000 population	The reported incidence rate of TB in Canada (4.7 per 100,000) is one of the lowest in the world. In 2009, the reported rates of TB were 12.0 per 100,000 population in the UK; 6.4 per 100,000 in Australia; and 4.1 cases per 100,000 in the United States. However, a disproportionally high rate is noted among Canadian-born Aboriginal populations, and foreign-born populations.
	Diabetes: 6.1 per 1,000 population Cancer: 4 per 1,000 population Hypertension: 25.8 per 1,000 population Asthma: 5.3 per 1,000 population COPD: 8.2 per 1,000 population	PHAC established age-standardized incidence baselines for diabetes, cancer, hypertension, asthma and chronic obstructive pulmonary disorder (COPD). Rate of age standardized new diagnoses for major diseases: • Diabetes: Source – Canadian Chronic Disease Surveillance System, 2006/07) • Cancer: Source – Statistics Canada, 2007 • Hypertension Source– Canadian Chronic Disease Surveillance System, 2006/07 • Asthma: Source – Pilot data from Canadian Chronic Disease Surveillance System, 2007/08 (excluding Quebec) • Chronic Obstructive Pulmonary Disorder: Source– Pilot data from Canadian Chronic Disease Surveillance System, 2007/08 (excluding Quebec)

Performance Summary and Analysis of Program Activity

As a follow-up to the Interim Evaluation of the National Immunization Strategy, PHAC has collaborated with and engaged provinces, territories, Health Canada, other federal government departments and industry through the Canadian Immunization Committee, the National Advisory Committee on Immunization and via the Committees' working and task groups to examine and strengthen the National Immunization Strategy. PHAC participated in the planning and steering committee for the 2010 Canadian Immunization Conference. The conference focused on emerging issues in immunization, vaccine safety, and communication techniques, strategies and tools to address immunization issues.

To increase stakeholder knowledge and capacity regarding the prevention and control of infectious diseases in communities and settings where health care is provided, the Agency published Guidance: Infection Prevention and Control Measures for Healthcare Workers in Acute Care and Long-term Care Settings for Seasonal Influenza (2010), Infection Prevention and Control Measures for Healthcare Workers in All Healthcare Settings - Carbapenem-resistant Gram-negative Bacilli (2010) and Essential Resources for Infection Control Guidelines (July 2010).

In response to the *Report of the Independent Investigator into the 2008 Listeriosis Outbreak*, PHAC collaborated with Health Canada and the Canadian Food Inspection Agency to develop a Food-borne Illness Emergency Response Plan (FIERP) for food-borne illness outbreaks requiring a response beyond the scope of the FIORP (2010). The Plan uses a common incident command structure. The Agency also strengthened the national surveillance of listeriosis by adding *Listeria monocytogenes* to the National Enteric Surveillance Program (NESP). The Agency now collects timely case-based information on listeriosis cases to strengthen detection and provision of public health responses for sporadic cases and outbreaks of invasive human listeriosis.

> **PHAC Facts…**
> Following extensive consultation with federal, provincial and territorial (F/P/T) partners, Canada's Food-borne Illness Outbreak Response Protocol (FIORP) 2010 was endorsed by the F/P/T Deputy Ministers of Health and Agriculture as well as the F/P/T Food Safety Committee and the Council of Chief Medical Officers of Health (June 2010). To validate the FIORP and communicate the roles and responsibilities of F/P/T partners during a multi-jurisdictional food-borne illness outbreak, PHAC delivered on its commitment to exercise the FIORP in each province and territory through a series of bilateral training exercises. Between January and April 2011, thirteen bilateral exercises were delivered across Canada to some 600 local, territorial, provincial, and federal public health officials, in conjunction with laboratory and food safety stakeholders.

Pathogens arising at the human-animal-environment interface are a continuing focus for research, risk assessment and intervention, particularly those affecting from the food chain. The evaluation of the Pilot Infectious Disease Impact and Response

Systems program demonstrated how it has strengthened Canada's public health infrastructure and addressed health risks associated with water-borne and vector-borne infectious diseases resulting from climate change. In addition, Agency researchers developed the first user-friendly and easily accessible dose-response database module for rapid assessment of the impacts of food contamination events and powerful decision-making tools (such as a multi-criteria decision analysis tool) for field application to enable the Agency to better manage public health threats. The Agency has also been recognized internationally for its use of space technology to help assess the impact of agricultural and environmental systems on the health of vulnerable populations and address public health issues in any geographical area world-wide.

During the review period, the Agency continued to support the Canadian Task Force on Preventive Health Care in the development of clinical practice guidelines for primary and preventive care. The Task Force completed a synthesis and full evidence review report and prepared guidelines and auxiliary journal articles on Breast Cancer Screening that were submitted in February 2011 for publication in the *Canadian Medical Association Journal* (publication anticipated in fall 2011). In addition, new Task Force-led working groups on diabetes, depression, cervical cancer, obesity in children and adults, and hypertension were established to engage stakeholders in the review and development of the guidelines and associated knowledge translation tools.

PHAC Facts...
Canada's Ministers of Health and Health Promotion/ Healthy Living endorsed Creating a Healthier Canada: Making Prevention a Priority in September 2010. This Declaration recognized the increasing burden of disease, disability and injury in Canada and outlined a shared vision for health promotion and disease and injury prevention as a priority in Canada. This collaboration helped to enhance Canada's ability to prevent and manage diseases and injuries.

The Canadian Best Practices Portal generates and disseminates evidence-based knowledge at the local, P/T, national and international levels. The Portal presents 350 best practices related to chronic disease prevention and health promotion with more than 75 resources related to evidence-based planning. Visits to the Portal increased by more than 11,000 over the previous year, up from 42,560 visitors in 2009–10. New topics broaden the scope of the interventions and enhance its effectiveness in areas such as chronic disease prevention amongst vulnerable populations, injury prevention, seniors' mental health promotion, psychosocial and physical activity.

The Agency, in collaboration with the Neurological Health Charities Canada continued efforts in support of the four-year National Population Study on Neurological Conditions, awarding funding to 10 neurological research projects that will improve knowledge on the prevalence, risk factors, use of health services, economic cost and impact of 13 neurological conditions. The Agency also worked with Statistics Canada to add questions about neurological conditions to the Canadian Community Health Survey, and to develop of a survey on the prevalence of neurological conditions in long-term residential care facilities. In addition, the Agency signed a $2M contribution agreement with the Canadian Institute for Health Information for development of a multiple sclerosis monitoring system.

The Agency's support for the Canadian Hypertension Education Program enables the development of interactive educational tools to assist health professionals and people living with hypertension and diabetes in the prevention and the reduction of hypertension. Recently published data from the Canadian Health Measures Survey demonstrates significant increases in awareness and treatment of hypertension in Canada since the initiation of the Program.

As its contribution to the Food and Consumer Safety Action Plan related to injury prevention and control, the Agency enhanced the Canadian Longitudinal Survey on Aging with questions on cause, severity and place of occurrence of injuries, and initiated a process to establish an agreement linking emergency room data with trauma hospital admissions in relation to consumer product injury.

The Agency continues to lead the Federal Initiative to Address HIV/AIDS in Canada and the Canadian HIV Vaccine Initiative. These initiatives demonstrate leadership towards federal and multi-sectoral approaches to the prevention and control of HIV/AIDS, advancing the basic science of HIV vaccine discovery and social research in Canada and low- and middle-income countries, and contributing to the global response. (Further details are available in Section III Supplementary Information Tables.)

Lessons Learned

Lessons Learned: Public Health Agency of Canada's Response to the 2008 Listeriosis Outbreak identified solutions for improving PHAC's response to outbreaks and ensuring Canadians are provided with the highest levels of food safety protection

now and in the future. This Lessons Learned Report aligns with the *Report of the Independent Investigator into the 2008 Listeriosis Outbreak* and both have been used to improve PHAC's capacity in emergency preparedness and response.

In February 2010, the Agency initiated Phase 1 of the National Lung Health Framework. Projects addressing baseline needs assessments for public awareness initiatives among high-risk populations and the identification of successful models for asthma awareness programs for school-aged children were completed at the end of July 2010. Solicitation for Phase 2 projects began April 2010, however, some stakeholders were not aware of opportunities for funding in this phase. In response, the Agency will build a more proactive outreach program involving a wider range of stakeholders to promote greater regional representation and innovative partnerships.

The *Evaluation of the Canadian HIV Vaccine Initiative* on August 2010 examined the progress of the Canadian HIV Vaccine Initiative (CHVI) and determined if changes were required to the design, delivery, and direction of the activities. All the recommendations in the evaluation have been addressed in the renewal of the CHVI, as announced in July 2010 by the Government and the Bill & Melinda Gates Foundation. The new direction of the CHVI is well aligned with Canada's strengths—discovery research, expertise in regulatory issues, and clinical trial capacity building—while addressing the recommendations in the Evaluation and with the *2010 Scientific Strategic Plan of the Global HIV Vaccine Enterprise*. The Initiative will address the broader spectrum of the development of an HIV vaccine with the goal of accelerating the development of a safe, effective, affordable and globally accessible HIV vaccine.

The *AIDS Community Action Program Evaluation Summary Report 2007-09*, March 2010, concluded that the AIDS Community Action Program (ACAP) funded projects are successful in reaching out to and engaging many of the Federal Initiative to Address HIV/AIDS's key populations. The evaluation recommends that ACAP be repositioned within the broader context of sexually transmitted and blood-borne diseases, with an integrated funding approach to address HIV/AIDS, hepatitis C and health determinants that also affect other sexually transmitted infections. The evaluation also recommends that ACAP projects be better positioned to strengthen reach to at-risk populations, most notably Aboriginal people and people from countries where HIV is endemic.

The National Immunization Strategy Interim Evaluation (2003–2007) published in July 2008 determined that the National Immunization Strategy (NIS) continues to be relevant at both federal and P/T levels, as the design and implementation of the NIS were considered effective overall. In particular, progress was made on a number of key areas including: enhancing partnerships and collaboration; improving timely access to immunization programs; improving vaccine coverage; reducing vaccine-preventable diseases; ensuring coordinated approaches; and enhancing vaccine affordability. Opportunities for improvements were also identified in the following areas: public health research (programmatic research and evaluation relating to immunization); coordination between the Canadian Immunization Committee and the National Advisory Committee on Immunization; attention to special populations (mobile populations, immigrants, Aboriginal peoples); and sustainable funding models. Based on the interim evaluation findings, efforts continue to be made to review the NIS in order to determine how to improve the effectiveness and efficiency of immunization policies and programs in Canada, build on past successes, adapt to emerging trends, and remain a world leader in immunization.

The Evaluation of the Capacity-Building Component of the Canadian Breast Cancer Initiative, May 2008, recommended that the voices of those directly affected by breast cancer be strengthened in initiatives and that there be access to information and support for those who need it. PHAC continues to fund and consult with breast cancer networks. The results of a satisfaction survey provided to breast cancer networks in February 2010 led to changes in funding applications such as extending application submission periods and providing user-friendly proposal templates to applicants. In addition, face-to-face visits have been carried out by program consultants with Canadian Breast Cancer Initiative funded recipients across Canada to provide improved support for financial and activity reporting.

Program Activity: Regulatory Enforcement and Emergency Response

This program deals with: providing regulatory enforcement; managing the Health Portfolio Emergency Operations Centre, the National Emergency Stockpile System (NESS) and the Health Emergency Response Teams (HERT); and responding to national and international public health emergencies including natural disasters, serious outbreaks of infectious disease such as pandemic influenza, or emergencies that result from human activities.

Financial Resources ($ M) 2010–11		
Planned Spending	Total Authorities	Actual Spending
29.5	25.0*	23.2**

Human Resources (Full-Time Equivalents) 2010–11		
Planned	Actual	Difference
178.0	148.7	29.3***

*The $4.5M net decrease between Planned Spending and Total Authorities is mainly due to transfers of $5.1M to other programs.

**Actual Spending was lower than Total Authorities mainly due to favorable contract negotiations for various services and deferrals of pharmaceutical purchases.

***The variance between Planned and Actual FTE Utilization is mainly due to internal realignment of activities as the organization adjusted to the new Program Activity Architecture.

Program Activity Expected Result(s):

- Canada responds to public health emergencies in a timely manner

Performance Indicator(s)	Target	Performance Status
Respond to an emergency situation within 24 hours	100%	Met all The Health Portfolio Emergency Operations Centre (HP EOC) facilitated communication between internal and external stakeholders, responding to requests for assistance within two hours of receipt of information. The HP EOC was active for a total of 83 days in response to four events. The Watch Office Program provided situational awareness and early warning to Portfolio partners in the event of public health emergencies. The HP EOC has supported several planned and unplanned activations over 2010–11.

Performance Summary and Analysis of Program Activity

This program activity hosts three complementary elements of preventing and mitigating disease and injury. With respect to emergency response, it develops and implements the governance and management systems and maintains the physical infrastructure required. It also works to prevent public health emergencies by implementing World Health Organization's (WHO) International Health Regulations and domestic legislative and regulatory frameworks governing quarantine services and pathogens and toxins. Across the three elements, the Agency has improved its leadership, coordination and stakeholder engagement.

On the leadership front, the Health Portfolio Emergency Operations Centre was recognized by the WHO as the Canadian focal point of the Global Outbreak Alert and Response Network and established processes for international deployment of PHAC expertise for health events such as the cholera outbreak in Haiti. Further, a thorough analysis and revision of Health Portfolio Emergency Operations Standard Operating Procedures (SOP) were undertaken with completion expected in 2011–12. As part of this process, Quarantine Services completed six of the seven recommendations in a Quarantine H1N1 after action report (the seventh is an ongoing undertaking), and a communications protocol and training plan addressed gaps in leadership and coordination during public health emergencies.

PHAC Facts...

The Agency's H1N1 experience and implementation of the International Health Regulations underscores the vital role played by Quarantine Services, particularly in relation to Border Health Measures.

Following consultation with Agency's F/P/T partners, the concept of a national reserve of health care professionals to help meet outbreak response needs is no longer being developed. A new approach to operationalize the F/P/T agreement on mutual aid is being developed and tested. This approach includes mechanisms to coordinate and support the inter-jurisdictional sharing of health professional resources when F/P/T mutual aid is requested.

In response to the *Report of the Independent Investigator into the 2008 Listeriosis Outbreak*, the Agency undertook to explore the feasibility of a Public Health Reserve of applied public health experts to address food-borne outbreaks. An inventory of knowledge and skill sets required to detect and respond to food-borne illness events was created and validated, and a gap analysis was completed. This informed the scope of the Public Health Reserve pilot and the training strategy. In consultation with internal and external public health experts, the Public Health Reserve framework was developed, and will be tested and assessed in the next fiscal year through various training and exercise events. The 2011 Field Services Training Institute is planned as a key event to train potential reservists.

In addition, the Agency established a secretariat office to coordinate its surge capacity and ensure the assignment of the pre-qualified individuals needed to effectively manage and respond to multi-jurisdictional outbreaks.

The Agency also played a lead role in mitigating the risks to public health during the G8/G20 summits in Ontario. Its Microbiological Emergency Response Teams (MERT) and mobile laboratories (containment level 3 laboratory-truck and containment level 2 laboratory-trailer) were deployed to aid in the onsite maintenance of biosafety and biosecurity. And in recognition that infectious diseases can be transmitted around the globe in a matter of hours, the MERT was also deployed to the Democratic Republic of Congo to respond to an outbreak of the highly pathogenic agent Ebola.

Physical infrastructure maintained by the Agency, such as the National Emergency Stockpile System (NESS), continued to support timely response to infectious disease emergencies and bioterrorism incidents. For example, the NESS supported the Government's response to the Japan earthquake and responded to several requests for surge supplies and pharmaceuticals from provinces. In response to the 2010 Audit of Emergency Preparedness and Response, a review to modernize the NESS is underway to ensure alignment with PHAC's current health emergency response role and address operational issues.

PHAC Facts…

Governments are placing a much greater emphasis on organizational readiness, event management, and business continuity as a result of past emergencies and events such as the August 2003 blackout, the H1N1 pandemic in 2009, the Vancouver Winter Olympic Games in 2010, and the G8/G20 summits in Toronto. To enhance public health preparedness and capacity, PHAC has maintained a Business Continuity Planning (BCP) program that addresses an "all hazards" approach to response and internal recovery capability. Tested through its 72 ongoing Business Continuity Plans and 24 Table Top Exercises, the BCP program is designed to enhance the internal capacity of the Agency so that it has the ability to maintain critical services to fulfill its mandate to Canadians.

A major focus of the Agency with respect to preventing public health emergencies is the *Human Pathogens and Toxins Act* (2009) Implementation Project Plan. A five-year project plan to develop the supporting policy and regulatory framework, it includes updated bio-safety standards and guidelines; a licensing program; a suite of regulations; and compliance and enforcement policy and tools. This supporting framework—building upon the legislative framework implemented in 1990 as well as the *Human Pathogens Importation Regulations* (1994)—will provide increased protection against the risks to Canadians posed by human pathogens and toxins through domestic controls and standardized operational practices, laboratory handling procedures and biocontainment requirements.

In response to stakeholder concerns regarding inadequate opportunities for consultation during legislative review of the *Human Pathogens and Toxins Act* (HPTA), the Agency committed to extensive consultations to inform the development of a strengthened national biosafety program and supporting regulations. Pre-consultations with the provinces and territories, the Canadian Public Health Laboratory Network, and 16 key national associations led to the development of a multi-year Consultation Plan (2011–14). This Plan will ensure meaningful and inclusive engagement opportunities for interested and affected parties at various stages of the policy and regulatory framework development process, and meet Agency obligations under the federal *Cabinet Directive on Streamlining Regulation.*

While the Agency works to implement the HPTA, it continues to ensure the safety and security of imported human pathogens and toxins under the *Human Pathogen Importation Regulations* (HPIR). And to further assist Canadian laboratories and regulated parties meet compliance requirements under the HPTA and the HPIR, the Agency updated and enhanced technical documents that describe the hazardous properties of a human pathogen and recommendations for work involving these agents in a laboratory setting.

To reduce the regulatory burden on researchers, PHAC and the Canadian Food Inspection Agency have initiated the harmonization and integration of Canadian biosafety standards and guidelines. This initiative will harmonize current national biosafety requirements found in the following existing standards and guidelines: *Laboratory Biosafety Guidelines 3rd Edition, 2004* ; *Containment Standards for Veterinary Facilities 1st Edition, 1996*; and the *Containment Standards for Laboratories, Animal Facilities and Post Mortem Rooms Handling Prion Disease Agents, 2005* .

PHAC Facts...

The *Human Pathogens and Toxins Act* implementation has already achieved some early successes. Early registration of approximately 1,000 organizations handling human pathogens and toxins has already identified laboratories requiring improvements to their laboratory systems and biosafety practices. In response, the Agency provided laboratory-specific guidance on safe pathogen handling procedures. Cross-Canada consultations and outreach have increased understanding by Canadian laboratories and key national organizations of their obligations in relation to the safe and secure use and, containment of human pathogens and toxins. For example, there has been a 24% increase this year in the number of Compliance Letters issued by the Agency, suggesting that laboratories are increasingly self-assessing their compliance with the Public Health Agency of Canada's Laboratory Biosafety Guidelines.

The Agency is proceeding toward full compliance with the WHO International Health Regulations (IHR) by June 2012. For the purpose of improving the 24 hour/7 days a week capacity of the Emergency Operations Centre, the Agency implemented a Watch Office Program and Situational Awareness Platform, in collaboration with the Global Public Health Intelligence Network. This program provides intelligence monitoring and early warning to meet the requirements of Portfolio partners in the event of public health emergencies. Products from this platform are the Public Health Daily Intelligence Report and the All-Hazards Daily Brief for PHAC. After receipt of confirmation from the WHO IHR compliance for its Quarantine Program, the Agency continued to improve screening measures at major points of entry.

Lessons Learned

NESS mini-clinics meet the ongoing needs of provinces and territories and those of major events such as the G8/G20. And, based on the success of the Hospital Training and Exercise Program implemented for G8/G20, the Agency reviewed the content of its Training and Exercise Series Pilot to make this available to more hospitals in Ontario and other provinces. This exercise also highlighted the need for formal mechanisms for sharing of health professional resources. These mechanisms, as discussed above, are under development.

The Evaluation of the National Emergency Stockpile System was completed in 2010–11 and provided recommendations on focusing the domestic role of NESS, examining the disposition of supplies, providing support for integrated emergency response, and including NESS in any future considerations of PHAC's international role. The evaluation report clearly supported the relevance of NESS and the importance of a federally managed stockpile of public health supplies for the health and safety of Canadians.

During pre-consultations, HPTA stakeholders encouraged the Agency to consider a range of ongoing engagement activities and to position its consultations within a broader strategy for sustained stakeholder relations and legislative and regulatory compliance promotion. The resulting comprehensive stakeholder engagement strategy is supported by a robust infrastructure, including a new stakeholder database and Web presence, a generic consultation account, and a new HPTA information booth for key events and conferences.

Program Activity: Internal Services

Internal services support the Agency's strategic outcome and all Program Activities. Internal services are groups of related activities and resources that are administered to support the needs of programs and the corporate obligations of an organization. These groups are Management and Oversight Services, Communications Services, Legal Services, Human Resources Management Services, Financial Management Services, Information Management Services, Information Technology Services, Real Property Services, Materiel Services, Acquisition Services, and Travel and Other Administrative Services. Internal services include only those activities and resources that apply across the Agency and not those provided specifically to a program.

Financial Resources ($ M) 2010–11		
Planned Spending	Total Authorities	Actual Spending
93.4	119.5*	112.8**

Human Resources (Full-Time Equivalents) 2010–11		
Planned	Actual	Difference
511	641.5	(130.5)***

*The net increase of $26.1M in Total Authorities is mainly due to an allocation from the Operating Budget Carry Forward and transfers from other programs.

**Actual Spending was lower than Total Authorities due to modest underspending of operating budgets.

***The variance between Planned and Actual FTE Utilization is mainly due to internal realignment of activities as the organization adjusted to the new Program Activity Architecture.

Program Activity Expected Results:

- The communications, service operations and programs of the Agency comply with applicable laws, regulations, policies and/or plans and meet the diverse needs of the public
- Strategic allocation and prudent use of resources among programs, processes and services
- Information technology and management that supports government priorities and program and service delivery
- Assets are acquired and managed in a sustainable and financially responsible manner, throughout their lifecycle, to support the cost-effective and efficient delivery of government programs and services

Performance Indicator(s)	Target	Performance Status
Compliance with the statutory time requirements of the *Access to Information Act and Privacy Act*	"A" rating (95% and above)	Mostly met PHAC achieved a compliance rate of 86.9%. Of the 176 responses provided to applicants last year, 153 were within the legislated time lines.
Compliance with the Government of Canada Communications Policy	100%	Met all PHAC's communication activities conducted this year are compliant with the Government of Canada Communications Policy.
Compliance with the Government of Canada *Official Languages Act*	100%	Mostly met Over 96% of PHAC Executives meet the language requirements of their positions. Human Resources is actively supporting the remaining Executives in their efforts to achieve required language levels within designated time frames. Of the 13 open Official Languages complaints, two have been closed, six have been sent to the Commissioner of Official Languages for closure and five remain active. In addition, awareness activities sensitize employees, managers and senior management to their official languages (OL) rights and obligations.

<table>
<tr><td>Compliance with the Government of Canada Employment Equity Act</td><td>Aboriginal People – 3.3%
Persons with Disabilities – 4.3%
Visible Minorities – exceeds 12.9%
Women – 61.8%</td><td>Mostly met

PHAC met or exceeded target for three of the four designated groups, but did not meet the target for visible minority representation.

PHAC Representation - April 10, 2010
Women: WFA: 61.9% PHAC: 69.6% (+7.7)
Aboriginal: WFA: 3.2% PHAC: 3.2%
VM: WFA: 13.2% PHAC: 12.9% (-0.3)
PWD: WFA: 4.3% PHAC: 4.4% (+0.1)

*Workforce Availability (WFA)</td></tr>
<tr><td>% growth of critical shortage occupational groups[9]

*This indicator will be modified for 2011–12 to PHAC Shortage Group list.</td><td>PE: 29
MD: 46
EC: 612
EG: 261
SE: 59</td><td>Mostly met

In 2010–11 the Agency's analysis of unproductive staffing processes over previous years identified shortage groups. The Agency established a Shortage Group list for endorsement by senior management, which will provide managers with greater flexibility when hiring employees to specific groups/levels using non-advertised processes.

<table>
<tr><th></th><th>April 2009</th><th>April 2011</th><th>% growth April 2011</th></tr>
<tr><td>PE</td><td>29</td><td>38</td><td>31%</td></tr>
<tr><td>MD</td><td>43</td><td>37</td><td>-14%</td></tr>
<tr><td>EC</td><td>577</td><td>714</td><td>24%</td></tr>
<tr><td>EG</td><td>217</td><td>219</td><td>1%</td></tr>
<tr><td>SE</td><td>58</td><td>54</td><td>-7%</td></tr>
</table></td></tr>
<tr><td>% Year-end Agency variance of planned vs. actual expenditures</td><td>5% variance or less</td><td>Mostly met

Operating: 5.0%
Overall (including capital, grants and contributions): 7.0%</td></tr>
<tr><td>Compliance with the Government of Canada Common Look and Feel (CLF) 2.0</td><td>100%</td><td>Somewhat met

PHAC CLF 2.0 compliance rate remains at 70%.</td></tr>
<tr><td>% of major capital assets with completed asset condition reports</td><td>100%</td><td>Not met

The Agency's First Annual Major Capital Asset Condition Report launched in January 2010. Due to year-end timing and resource restraints, condition reports were only received for 56% of the Agency's Major Capital Assets.</td></tr>
</table>

Performance Summary and Analysis of Program Activity

Originally planned to be completed in 2010–11, the Agency's strategic relations framework is now scheduled to be completed in 2011–12 (human resources were re-allocated towards other priorities during the period). The focus of this framework will be to guide the Agency to work effectively with stakeholders to advance policy development.

PHAC's People Management Framework guides people management activities across the Agency and is framed by three strategic pillars: workforce and workplace, strategic direction, and service delivery. Good progress has been made on this three-year plan on the following initiatives:

[9] The RPP 2010-11 commitment is to "increase or maintain workforce availability estimates based on April 1, 2009 baseline numbers." The percentage growth targets are still under development.

- alignment of performance management processes and the launch of an automated Professional Development Plan/Personal Learning Plan tool;
- initiation of talent management discussions at the executive level and succession planning tools for key positions;
- development of resourcing and recruitment priorities;
- preparation of migration of PeopleSoft to replace PHAC's outdated Human Resource (HR) information system; and
- implementation of a re-aligned organizational structure for HR service delivery.

Some people management initiatives experienced delays in 2010–11 such as the implementation of the HR Services Delivery model and the development of the branch-level dashboards due to data quality issues. Fewer than anticipated people management policies and directives were developed. Progress of note in 2010–11 in these areas includes the establishment and endorsement of a Staffing Monitoring Framework and Program for the Agency. This will provide a roadmap for the Agency as it continues to build its staffing program and is also a key piece to maintaining staffing delegation. The data clean-up exercise is underway and is expected to be completed in August 2011. This will allow the generation of branch-level dashboards with key HR performance indicators. The HR Service delivery area has been re-structured and key positions staffed.

The Agency's Workplace Well-being Co-Champions were identified and an Action Plan was approved by PHAC's Executive Committee for implementation in three areas: harassment and discrimination in the workplace; ongoing dialogue between employees and management; and work-life balance and improved employee dedication and engagement.

In February 2010, the Agency's Values and Ethics Framework and Action Plan was approved. Since the approval much has been accomplished. For example, a PHAC Values and Ethics Working Group has been established, training sessions from the Health Canada Ethics and Ombudsman Services were delivered to over 1200 PHAC employees in 2010–2011, a consultation on the draft TBS Code of Values and Ethics for the Public Sector was held in December 2010, and a draft PHAC Values and Ethics Code was developed and approved by senior management. This draft code will be used for consultation purposes and a final version is expected to be sent for senior management approval in 2011–12. The Agency also struck its Conflict of Interest (COI) Committee in November 2010 which is chaired by an ADM level executive and comprised of DG level executives and an outside expert on the matter. The role of the Committee is to provide policy guidance to senior management and employees to mitigate risks associated with COI at PHAC.

The Agency's revised 2011–12 Performance Management Framework (PMF) was approved by Treasury Board Secretariat on June 29, 2010. PHAC has decided to stabilize the 2010–11 PAA and continues to improve the PMF to ensure that the Agency's expected results, performance indicators and targets are specific, measurable, relevant and attainable in a timely manner.

The Risk Management Policy and a new Corporate Risk Profile that identifies risks, risk drivers, risk controls, and risk treatment strategies was developed and approved. The Agency hoped to roll out common tools to assess risk with corresponding training, but in testing the tools, it was determined that the tools required more refinement before wide-spread use in the Agency. The Agency had also hoped to communicate risk management requirements more extensively to staff. That did not occur and a Communications Strategy is being developed to address the situation. It is expected to be implemented in 2011–12.

> **PHAC Facts...**
> In 2010–11, the Agency delivered the first risk management training for staff as a risk management training workshop delivered to over 40 persons.

In 2010–11, the Agency shifted from a de-centralized to a centralized model for the evaluation function and restructured the governance of the function with the head of evaluation reporting directly to the deputy head-level. With the centralization of the evaluation function, the Agency-specific policy suite on evaluation will no longer be required. As per the Five-Year Evaluation Plan, eight evaluations were completed on schedule, in addition to two evaluations that were completed before their planned date of 2011–12.

The Project Management Framework was developed and includes policy and procedure manuals to help improve the project management capacity at PHAC. The overall objective of this Framework is to standardize Agency-wide processes and comply with the Treasury Board Policy on the Management of Projects.

> **PHAC Facts...**
> The Agency developed its first Annual Procurement Plan; Capital Asset Accounting Standard and training procedures for protecting PHAC assets; Guide to the Disposal of Surplus Material; and published annual Fleet Management Reports.

As part of the Materiel Management Framework, Life Cycle Asset Management training sessions were offered to employees in the Agency's National Capital Region and Laboratory for Foodborne Zoonoses. The training sessions included sections on potential considerations for the planning and acquisition stages, such as: maintenance; cost and ease of eventual disposal; environmental impacts; the importance of proper bar coding; and overall inventory management. Significant attention was given to the disposal side of asset management, with reviews of the various options and tools at the Agency's disposal.

Lessons Learned

PHAC will continue to use innovative approaches and mechanisms to collect employees' perspectives in the development of PHAC's Science and Research Strategic Plan. For instance, PHAC used a "Choicebook" or online crowd-sourcing tool that enabled employees to provide their input and views online regarding guiding principles and in prioritizing activities relating to the Plan.

In order to ensure that 100% of major capital assets have completed asset condition reports, the annual Major Capital Assets Condition report process will be integrated into the Capital Asset Inventory process, which is launched in the spring. The Second Annual Major Capital Asset Condition report is due August 26, 2011, with a firm target of 100%.

The Agency developed a sex and gender based analysis (SGBA) tool for policies, programs and plans. Through the application of this tool to all eligible policy proposals and plans completed in 2010–2011 (only 54 percent of proposals included SGBA in the previous year), PHAC staff increased understanding of the unique needs of men and women. Acknowledging the direct relationship between sex and gender and health inequalities, the Agency is further integrating SGBA across the full spectrum of Agency activities. A five-year SGBA Action Plan is under development to improve the quality and consistency of current SGBA practice and to increase its application to: research design and peer review; data collection, analysis and reporting; and the administration of grants and contributions.

The Agency recognizes that improved planning and standardized processes are critical to the successful implementation of a new Service Delivery model. Although the implementation of the HR Service Delivery Model experienced delays, corrective actions under development include various tools such as checklists, automated project tracking mechanisms and the development of a Client Service Strategy.

In order to support the objectives of the People Management Framework, resourcing and recruiting priorities were developed. Efforts are now underway to communicate these to all employees through the Recruitment Champion. The Agency understands that increased consultation with managers and employees is necessary to ensure that Agency-wide people management initiatives align with and support the business needs. To this end, the Agency's Human Resources Directorate will work more horizontally with the program areas through working groups and consultations. For instance, employees will have the chance to provide input into the development of PHAC's Values and Ethics Code through various means such as dialogue sessions and messaging from the Values and Ethics Champion.

Embedded in the Values and Ethics Code for the Public Service are the Conflict of Interest Measures. A great deal of effort has been dedicated to raising managers' awareness on the measures of the Code and associated risks. We will continue our outreach and communications, thereby strengthening employees' ability to identify and deal with potential conflict of interest situations.

Canada's Economic Action Plan

To support the effective and efficient movement of specimens and goods within the Canadian Science Centre for Human and Animal Health (CSCHAH), an expansion of the CSCHAH was approved by Treasury Board in April 2009 as part of Canada's Economic Action Plan. Forecast spending for the project was $20.6M in 2010–11.

Actual spending was $18.7M in 2010–11 resulting in a surplus of $1.9M. Savings of $1.5M were due to the construction management approach contract which allowed for redesign during the project to create efficiencies.

The project has reached substantial completion and is expected to be finished in October 2011. Forecast spending is $0.4M for 2011–12.

A performance management framework for the Agency's Economic Action Plan project was established in the 2010–11 Report on Plans and Priorities. It is highlighted by the three expected results and performance indicators below.

Expected Results	Performance Indicators	Performance Summary
Increased pathogen diagnosing capacity	# of specimens processed by period of time	Construction of the new CSCHAH specimen shipping and receiving bay continued in 2010–11. As a result, no specimens were processed through this new bay.
Faster response to health emergency situations	Response time of diagnostic once sample is received	Construction of the new CSCHAH specimen shipping and receiving bay continued in 2010–11. As a result, no specimens were processed through this new bay.
Job Creation	# of jobs created	In 2010–11, approximately eighty (80) short-term full-time positions have been directly created for the duration of this project, including: three positions within PHAC and Public Works and Government Services Canada; five temporary positions for the design consultant; and 72 for the construction management contract. Indirectly, additional jobs were maintained for local suppliers through the purchase of construction materials, equipment rentals and equipment purchases.

Section III – Supplementary Information

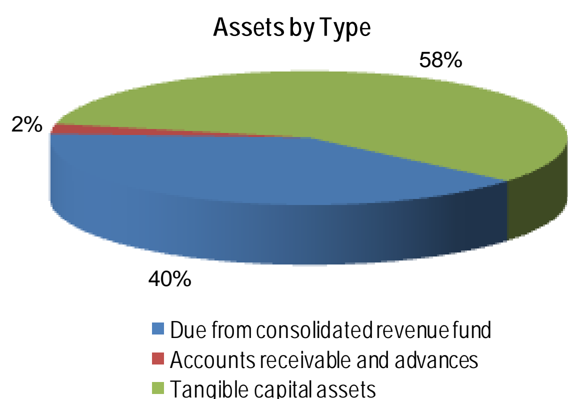
Financial Highlights

Condensed Statement of Financial Position for the year ended March 31	% Change	2009–10 ($ M)	2010–11 ($ M)
Total Assets	(35.3%)	268.8	174.0
Total Liabilities	(46.8%)	(243.4)	(129.6)
Equity of Canada	74.8%	(25.4)	(44.4)
		268.8	**174.0**

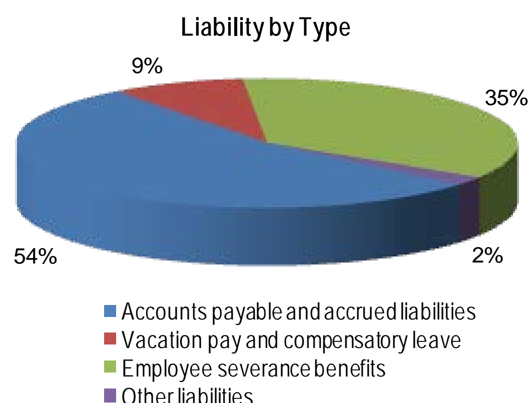
Condensed Statement of Financial Operations for the year ended March 31	% Change	2009–10 ($ M)	2010–11 Forecast ($ M)	2010–11 ($ M)
Total Expenses	(35.4%)	950.2	651.0	613.8
Total Revenues	(33.3%)	0.3	0.3	0.2
Net Cost of Operations	**(35.4%)**	**949.9**	**650.7**	**613.6**

Financial Statements

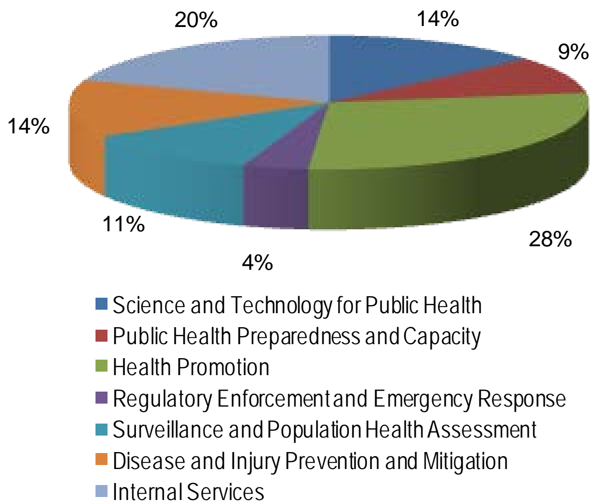
The Agency's 2010–11 Financial Statements are available online.

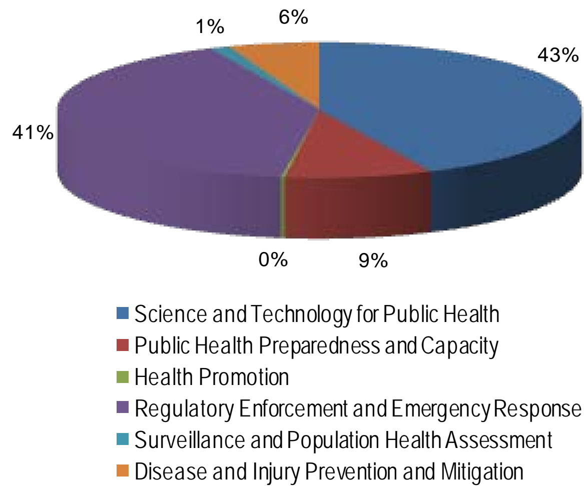


Total assets were $174 million, a decrease of 35.3% ($94.8M) in comparison to the previous year's total of $268.8M. Due from consolidated revenue fund represented $69.2M (40%); Accounts receivable and advances represented $4.2M (2%) and Tangible capital assets represented $100.5M (58%) of total assets.



Total liabilities were $129.6M, a decrease of 46.8% ($113.8M) in comparison to the previous year's total of $243.4 million. Accounts Payable and Accrued Liabilities represented $69.5M (54%); Vacation Pay and Compensatory Leave represented $11.2M (9%); Employee Severance Benefits represented $46.0M (35%) and Other Liabilities represented $2.8M (2%) of total liabilities.





Total expenses for the Agency were $613.8M. The Agency spent $84..4M (14%) on Science and Technology for Public Health; $54.8M (9%) on Public Health Preparedness and Capacity; $175.6M (28%) on Health Promotion; $25.0M (4%) on Regulatory Enforcement and Emergency Response; $68.8M (11%) on Surveillance and Population Health Assessment; $84.9M (14%) on Disease and Injury Prevention and Mitigation and $120.5M (20%) on Internal Services.

The Agency receives most of its funding through annual Parliamentary appropriations although some revenue is generated from program activities. All cash received by the Agency is deposited to the Consolidated Revenue Fund (CRF) and all cash disbursements made by the Agency are paid from the CRF. The Agency's total revenue was $183.1 thousand of which $40.2 thousand is respendable.

List of Supplementary Information Tables

The following tables are located on the Treasury Board Secretariat Web site.

- Details on Transfer Payment Programs (TPPs)
- Green Procurement
- Horizontal Initiatives
- Internal Audits and Evaluations
- Sources of Respendable and Non-Respendable Revenue

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