Public Health Agency of Canada (PHAC)
2016–17 Departmental Results Report (DRR):
Supporting Information on Lower-Level Programs

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Supporting Information on Lower-Level Programs

Program 1.1: Public Health Infrastructure

Sub-Program 1.1.1: Public Health Workforce

Description

The Public Health Workforce Sub-Program contributes to the development and maintenance of a Canadian public health workforce which has the ability to respond to public health issues and requirements at any time. Working with federal, provincial and territorial partners and stakeholders, the Sub-Program provides training and support to public health professionals to develop and maintain their ability to carry out core functions and respond effectively and cooperatively to public health events. The Sub-Program takes a leadership role in developing; identifying core competencies; coordinating and delivering training; strengthening national response capacity for disease outbreaks and public health events/emergencies, and providing funding to strengthen and advance the use of research to improve public health policies and practices. The Sub-Program uses funding from the following transfer payment: Public Health Scholarship and Capacity Building Initiative.

Results achieved

Expected result	Performance indicators	Targets (Date)	Actual results		
			2016–17	2015–16	2014–15
Public health partners and stakeholders have the abilities necessary to execute their public health functions	Percentage of participants who say the training courses improved their public health knowledge and skills	90 (by Mar. 31, 2017)	94	N/A[a]	N/A[a]
	Percentage of post-secondary public health programs that use public health competencies in the design of their curriculum	75 (by Mar. 31, 2017)	88	N/A[a]	N/A[a]
	Percentage of field placement site organizations who report their capacity, including the ability to respond to public health events, increased	85 (by Mar. 31, 2017)	95	N/A[a]	N/A[a]

a. Actual results are not available given changes to the expected result and/or performance indicator methodology across the specified fiscal years.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
12,838,053	11,107,765	(1,730,288)

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
92	87	(5)

Sub-Program 1.1.2: Public Health Information and Networks

Description

The Public Health Information and Networks Sub-Program exists to enable public health partners to work collaboratively to address existing and emerging public health infrastructure issues and to ensure that public health professionals and partners have access to reliable, actionable public health data and information. It does this by facilitating coordination and collaboration among international, federal, provincial, and territorial partners. It establishes structures to facilitate access to accurate and reliable information, tools and models required by Canadian public health professionals and other stakeholders. With partners the Sub-Program provides leadership on the development of collaborative strategies, plans and responses to public health emergencies, emerging issues and those affecting the sharing of information for effective surveillance and action. The Sub-Program also invests in tools and processes to inform public health practice, providing evidence and applied knowledge, for effective decision-making. The Sub-Program uses funding from the following transfer payments: National Collaborating Centres for Public Health, and the International Health Grants Program.

Results achieved

Expected results	Performance indicators	Targets (Date)	Actual results		
			2016–17	2015–16	2014–15
Public health partners work collaboratively to address existing and emerging public health issues	Number of jurisdictions who sign the Multi-Lateral Information Sharing Agreement on infectious diseases and public health events	13 (by Mar. 31, 2017)	14	12	12

	Percent of Public Health Network Council and Steering Committee work plan items that are completed	85 (by Mar. 31, 2017)	61[1]	N/A[a]	N/A[a]
Canadians have access to reliable, actionable public health data and information	Percentage change in page views, averaged across all sections of the Chief Public Health Officer's Report on the State of Public Health in Canada	Establishing a baseline	N/A[b]	N/A[a]	N/A[a]

a. Actual results are not available given changes to the expected result and/or performance indicator methodology.

b. Data is unavailable for calculation of the percentage change; however, during 2016–17 there were 10,397 views (English = 8,998 views; French = 1,399 views). The percentage change will be reported in PHAC's 2017–18 DRR after a baseline is established.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
31,580,017	21,210,259	(10,369,758)

Actual spending was less than planned primarily due to the transfer of the assessed contribution to the Pan American Health Organization to Global Affairs Canada.

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
91	105	14

Sub-Program 1.1.3: Public Health Laboratory Systems

Description

The Public Health Laboratory Systems Sub-Program is a national resource providing Canada with a wide range of highly specialized scientific and laboratory expertise and access to state-of-the-art technologies. The Sub-Program informs public health professionals at all levels of government to enable evidence-based decision-making in the management of, and response to diseases and their risk factors. The Sub-Program conducts public health research, uses innovative approaches to advance laboratory science, performs reference laboratory

[1] This actual result is lower than the target because several work plan items were carried over to the following fiscal year due to either delays in receiving data needed to inform the development of the work plan item or changes in scope and/or the approach of the work plan item.

services, contributes to public health surveillance, provides outbreak response capacity and leads national public health laboratory coordination. The Sub-Program also addresses public health risk factors arising from human, animal and environmental interactions by conducting research, surveillance and population risk analysis. These combined efforts work to inform infectious disease-specific strategies and prevention initiatives. The knowledge generated and translated by the Sub-Program supports the development and implementation of national and international public health policies, guidelines, interventions, decisions and actions that contribute to the lifelong health of the population.

Results achieved

Expected results	Performance indicators	Targets (Date)	Actual results		
			2016–17	2015–16	2014–15
Canada has the laboratory capacity to address public health threats	Percent overall success rate in external proficiency exercises for accredited tests[2]	80 (by Mar. 31, 2017)	98	98	N/A[a]
	Percent of clients indicating overall satisfaction with laboratory reference services[3]	90 (by Mar. 31, 2017)	97	97	97

a. Actual results are not available given changes to the expected result and/or performance indicator methodology across the specified fiscal years.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
71,544,974	79,275,754	7,730,780

Actual spending was greater than planned primarily due to realignments of resources to fund scientific research.

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
540	551	11

[2] Data reported is off-set by one year to allow for results to be analyzed and reported by the assessing lab. In other words, those results reported in 2016–17 are for tests conducted during 2015–16.

[3] A satisfaction survey is conducted every three years; the last one was conducted in 2014.

Program 1.2: Health Promotion and Disease Prevention

Sub-Program 1.2.1: Infectious Disease Prevention and Control

Description

The Infectious Disease Prevention and Control Sub-Program is the national focal point for efforts to help prevent, mitigate and control the spread and impact of existing and emerging infectious diseases in Canada. The Sub-Program provides leadership for integrating activities related to surveillance, laboratory science, epidemiology, research, knowledge translation and exchange, intervention and prevention. Applying an evidence-based approach, the Sub-Program informs targeted prevention and control initiatives, such as immunization, for many infectious disease threats, including acute respiratory and vaccine preventable infections (e.g., influenza, measles), sexually transmitted and blood borne infections (e.g., Hepatitis B and C, HIV), hospital associated infections (e.g., C. difficile), and human diseases resulting from environmental exposures to food, water, animals and other vectors (e.g., Listeria , E. coli o157, West Nile virus). This Sub-Program reinforces efforts to protect the health and well-being of Canada's population and, efforts to reduce the economic burden of infectious disease by coordinating effective responses to public health risks, integrating action amongst partners and stakeholders, contributing to global efforts, and providing public health expert advice to guide individual health-related decision-making, and provides expert advice to federal, provincial and territorial partners and stakeholders. The knowledge generated and translated by the Sub-Program influences and enables the development and implementation of public health policies, guidelines, interventions and action—including those required to meet Canada's International Health Regulations (IHR) obligations—and helps to guide the population in their decisions regarding their personal health and that of their families.

Results achieved

Expected result	Performance indicator	Target (Date)	Actual results		
			2016–17	2015–16	2014–15
Actively engaged Canadians on infectious disease issues	Percent of information accessed via social media outreach mechanisms	0.6 (by Mar. 31, 2017)	1.6[a]	3.3	2.0

[a] The decrease in actual results for 2016–17 was attributable to:
i) The migration of PHAC webpages to Canada.ca, making this indicator no longer applicable as the majority of social media traffic from January 25–March 31, 2017 was not factored into the calculation;
ii) The omission of travel health-related content, previously a popular topic in social media, as PHAC ceased being the 'content owner' in September 2015; and
iii) Social media posts no longer being tagged with tracking codes since September 2016.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
49,818,191	51,148,435	1,330,244

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
333	337	5

Sub-Sub-Program 1.2.1.1: Immunization

Description

The Immunization Sub-Sub-Program seeks to protect Canada's population from the health risks associated with vaccine preventable diseases, thereby reducing the burden of infectious disease and making Canada's health care system more sustainable. The Sub-Sub-Program also allows Canada to meet its international obligations and commitments under the IHR. Working collaboratively with the provincial and territorial governments as well as with other stakeholders, intermediaries and researchers largely through the National Immunization Strategy, the Immunization Sub-Sub-Program plays a leadership role in activities that: secure a vaccine supply so that the Canadian population has timely access to safe, effective, economical and equitably distributed vaccines; support surveillance related to coverage and vaccine safety; enhance outbreak response; strengthen immunization research, innovation and development; and update goals for national vaccine preventable diseases and vaccination coverage rates. The Sub-Sub Program fosters, promotes and strategically manages surveillance, science and research to support evidenced-based public health decisions and actions by providing policy, process and knowledge leadership through: the collection and analysis of data; and the dissemination of timely, evidence-based guidance, decision-support tools, research and knowledge exchange and information products. Finally, the Sub-Sub Program supports the work of the National Advisory Committee on Immunization, which provides science-based expert advice on the use of existing and new vaccines for Canadian jurisdictions.

Results achieved

Expected results	Performance indicators	Targets (Date)	Actual results		
			2016–17	2015–16	2014–15
Program stakeholders have information and resources to prevent and control health risks, associated with vaccine preventable and respiratory infectious diseases and vaccine safety	Percent of total vaccines purchased for publicly funded immunization programs in Canada through the F/P/T Bulk Purchasing Program	N/A[a]	N/A[a]	N/A[a]	N/A[a]
Canadians and others living in Canada take positive action to protect themselves from the health risks associated with vaccine preventable and respiratory infectious diseases	Percent of 2-year old Canadian children who received at least one dose of measles-containing vaccine by their second birthday[4]	95 (by Mar. 31, 2017)	N/A[b]	89	N/A[b]
	Percent of adults aged 65+ having received pneumococcal vaccine[5]	80 (by Mar. 31, 2017)	42[c]	N/A[b]	37

a. This indicator cannot be reported on as information is not available.

b. Actual results are not available because this indicator is tracked on a biennial basis.

c. In 2016, vaccination coverage goals and disease reduction targets were updated by the National Goals and Targets Task Group and the new goal is 80% by 2025.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
7,999,631	11,446,607	3,446,976

Actual spending was higher than planned spending primarily due to funding received to improve vaccination coverage rates in Canada.

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
40	45	5

[4] This indicator uses data from the Childhood National Immunization Survey which is conducted every two years on uneven years (e.g., 2013, 2015, etc.).

[5] This indicator uses data from the Adult National Immunization Survey which is conducted every two years on even years (e.g., 2012, 2014, 2016, etc.).

Sub-Sub-Program 1.2.1.2: Infectious and Communicable Diseases

Description

The Infectious and Communicable Diseases Sub-Sub-Program supports the prevention and control of infectious diseases by monitoring emerging and re-emerging infectious diseases[6] which are identified by the Agency as leading causes of hospitalization and morbidity and mortality in Canada, and by developing strategic approaches to reduce the likelihood of infection. The Sub-Sub-Program assesses and models public health interventions, monitors and reports risk factors and trends associated with infectious diseases and works collaboratively with federal, provincial, territorial and international partners to develop national approaches to manage infectious disease threats including antimicrobial resistance, and helps prevent the transmission of these infections (such as healthcare-associated infections, sexually-transmitted infections, including HIV/AIDS, hepatitis B and C, tuberculosis, vaccine-preventable diseases, influenza, MERS-CoV and other respiratory infectious diseases). The Sub-Sub-Program also seeks to reduce the risk and incidence of infections and injuries associated with blood transfusions and organ transplantation by providing knowledge products to federal, provincial and territorial health care experts. This Sub-Sub-Program, informed by science, uses this knowledge to prepare for and prevent infectious disease outbreaks and generate guidelines, education materials, frameworks and reports to guide decision-making to support public health action. These activities inform national action plans and global responses to prevent and control infectious diseases, in accordance with the IHR. The Sub-Sub-Program uses funding from the following transfer payments: HIV and Hepatitis C Community Action Fund, and the Blood Safety Program.

Results achieved

Expected results	Performance indicators	Targets (Date)	Actual results		
			2016–17	2015–16	2014–15
New and updated guidance and tools on the prevention and control of infectious disease are available to health care providers to inform practice	Percent of emerging and re-emerging infectious disease guidance requiring an update that is updated and disseminated annually	75 (by Mar. 31, 2017)	75	75	71

[6] An emerging disease is one that has appeared in a population for the first time, or that may have existed previously but is rapidly increasing in incidence or geographic range. A re-emerging disease once was a major health problem globally or in a particular country, and then declined dramatically, but is again becoming a health problem for a significant proportion of the population.

Infectious disease surveillance information is available to support evidence based decision making	Timely publication of surveillance products: Percent of surveillance publications/ data products for key infectious diseases that were published within the established service standard or reporting cycle timelines	80 (by Mar. 31, 2017)	92	N/A[a]	N/A[a]

[a] Actual results are not available given changes to the expected result and/or performance indicator methodology across the specified fiscal years.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
28,882,590	25,200,418	(3,682,172)

Actual spending was less than planned primarily due to a transfer of funds to support the Canadian Immunization Research Network to improve vaccination coverage rates in Canada.

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
205	194	(11)

Sub-Sub-Program 1.2.1.3: Food-borne, Environmental and Zoonotic Infectious Diseases

Description

The Food-borne, Environmental and Zoonotic Infectious Diseases Sub-Sub-Program seeks to reduce the risk of food-borne, water-borne, environmental and zoonotic diseases in Canada which have the potential to adversely impact the health of Canada's population. By examining the interrelationship between the environment, animals and human health, the Sub-Sub-Program develops and disseminates measures to help address the risks associated with infectious disease threats such as Salmonella, E.coli O157, West Nile virus, Legionella, Listeria and, emerging antimicrobial resistance in the food chain (i.e., animals, food, and humans). The Sub-Sub-Program undertakes national surveillance of food-borne illness, zoonotic diseases and antimicrobial resistance in the food chain, conducts targeted research projects aimed at reducing infectious disease emergence, and manages Canada's national and international response to food- and water-borne disease outbreaks. It also addresses the risk associated with rising global population mobility through enhancing evidence-based information. The Sub-Sub-Program works with federal, provincial, territorial and regional

stakeholders as well as international public health organizations to help address emerging global food-borne, water-borne, environmental and zoonotic infectious diseases, in keeping with Canada's obligations under the IHR.

Results achieved

Expected results	Performance indicators	Targets	Actual results		
			2016–17	2015–16	2014–15
Knowledge uptake of food safety surveillance information	Percent of food safety surveillance information uptake by stakeholders	90 (by Mar. 31, 2017)	92	89	82
Multi-jurisdictional food-borne and zoonotic illness outbreaks are detected and responded to in a timely manner	Percent of significant multi-jurisdictional clusters that are assessed for further investigation within 24 hours of notification	90 (by Mar. 31, 2017)	91	90	93

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
12,935,970	14,501,411	1,565,441

Actual spending was higher than planned due to funding received to support Lyme disease and a reallocation to support the Climate Change Program.

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
88	98	10

Sub-Program 1.2.2: Conditions for Healthy Living

Description

The Conditions for Healthy Living Sub-Program supports improved health outcomes for Canada's population throughout life by enabling the development of healthy communities. Population-wide health promotion efforts that address health inequalities by responding to the needs of vulnerable and at-risk populations, including Indigenous populations, have been shown to improve health outcomes, especially where poor social, physical or economic living conditions exist. The Sub-Program contributes to early childhood development, sustains healthy living conditions into youth and adolescence, and builds individual and

community capacity to support healthy transitions into later life. In collaboration with provinces, territories, stakeholders, and organizations that assist individuals directly affected by a condition or disease, the Sub-Program advances initiatives to promote health and well-being. It also develops, tests, and implements evidence-based interventions that can help those facing challenging circumstances (e.g., family violence, poor mental health, communicable infections and social isolation). Finally, the Sub-Program provides evidence-based information for public health policies, practices and programs, and helps to build community public health capacity.

Results achieved

Expected results	Performance indicators	Targets (Date)	Actual results		
			2016–17	2015–16	2014–15
Programs, policies and practices to promote health and reduce health inequalities are informed by evidence	Percent of key stakeholders using evidence-based knowledge products	75 (by Mar. 31, 2018)	82[a]	80	N/A[b]
Communities have the capacity to respond to health inequalities of targeted populations	Percent of funded community organizations that leverage multi-sectoral collaborations (more than 3 types of partners) to support at risk populations	90 (by Mar. 31, 2018)	86[a]	86	89
	Percent of funded Hepatitis C and HIV/AIDS related community organizations that leverage formal partnerships arrangements to support at risk populations	95 (by Mar. 31, 2017)	94[a]	N/A[b]	N/A[b]
	Percent of funded community organizations that have leveraged funds from other sources	60 (by Mar. 31, 2018)	70[a]	70	68

a. Data is drawn from 2015 results, the most recent available.

b. Actual results are not available given changes to the expected result and/or performance indicator methodology across the specified fiscal years.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
191,412,984	185,475,383	(5,937,601)

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
326	280	(46)

Actual FTEs were less than planned primarily due to delays in staffing.

Sub-Sub-Program 1.2.2.1: Healthy Child Development

Description

The Healthy Child Development Sub-Sub-Program supports improvement of maternal and child health outcomes, and encourages positive health and development throughout the stages of infancy and childhood. Current research demonstrates that building resilience, developing empathy, exposing children to healthy eating practices and promoting breastfeeding can substantially compensate for adverse socio-economic conditions throughout their life. Through social science research, population health and community-based interventions, the Sub-Sub-Program works to promote positive physical, social and cognitive development, and reduce health inequalities in order to set a positive trajectory for sustained health throughout the life course. The Sub-Sub-Program engages key stakeholders to identify and address shared priorities related to healthy childhood and adolescent development, including fetal alcohol spectrum disorder, maternal and infant health, oral health, positive parenting practices and health status in Indigenous and Northern communities. It supports interventions to assist pregnant women, children, adolescents and families who face circumstances such as low socio-economic status, family violence, poor mental health and isolation. As well, it facilitates development and use of practice guidelines, frameworks for action, training, tools and supports which benefit the Canadian population, their families, other jurisdictions, national non-governmental organizations and public health practitioners. The Sub-Sub-Program provides funding through the following transfer payments: Canada Prenatal Nutrition Program (CPNP), Community Action Program for Children (CAPC), Aboriginal Head Start in Urban and Northern Communities (AHSUNC), Fetal Alcohol Spectrum Disorder (FASD) and Joint Consortium for School Health (JCSH).

Results achieved

Expected result	Performance indicators	Targets (Date)	Actual results		
			2016–17	2015–16	2014–15
Program participants experience improved health and well being	Percentage of Aboriginal children who are better prepared to start school as a result of being enrolled in the AHSUNC program	80 (by Mar. 31, 2018)	93[7]	N/A[a]	N/A[a]
	Percentage of parents and caregivers who state their children's health and well-being has improved as a result of program participation	90 (by Mar. 31, 2018)	90[8]	N/A[a]	N/A[a]
	Percentage of postnatal participants who breastfed their baby	90 (by Mar. 31, 2018)	89[9]	N/A[a]	N/A[a]

a. Actual results are not available given changes to the expected result and/or performance indicator methodology across the specified fiscal years.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
130,158,236	125,669,177	(4,489,059)

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
118	93	(25)

Actual FTEs were less than planned primarily due to delays in staffing.

[7] Data is drawn from a 2015 parent/caregiver survey, the most recent year of the survey.

[8] Ibid.

[9] Data is drawn from a 2015 participant survey, the most recent year of the survey.

Sub-Sub-Program 1.2.2.2: Healthy Communities

Description

The Healthy Communities Sub-Sub-Program aims to improve the community capacity to contribute to better health outcomes for Canada's population, including those who are vulnerable and at-risk. Evidence demonstrates that supportive social and physical community environments can have a positive impact on health status through the life course. Certain populations such as seniors, new Canadians, Indigenous Peoples or those living with a communicable or infectious disease, are more likely to experience health challenges that can be prevented or mitigated in a community context. By engaging federal departments, other levels of government and stakeholders, the Sub-Sub-Program implements shared priorities in disease prevention and health promotion initiatives. The Sub-Sub-Program develops, adapts and implements promising or innovative population health and community-based initiatives and interventions that equip communities to support the population, including those affected by a communicable disease, in living the healthiest, most productive lives possible. The Sub-Sub-Program facilitates the exchange and uptake of evidence-based information to inform decision making for policy and programs and improve public health outcomes within communities. The Sub-Sub-Program uses funding from the following transfer payments: Nutrition North Canada, Innovation Strategy, and programs for survivors of family violence.

Results achieved

Expected result	Performance indicator	Target (Date)	Actual results		
			2016–17	2015–16	2014–15
Organizations funded through community alliances has increased	Percent of organizations funded through community alliances	7 (by Mar. 31, 2018)	7	N/A[a]	N/A[a]

a. Actual results are not available given changes to the expected result and/or performance indicator methodology across the specified fiscal years.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
61,254,748	59,806,206	(1,448,542)

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
208	187	(21)

Actual FTEs were less than planned primarily due to delays in staffing.

Sub-Program 1.2.3: Chronic (non-communicable) Disease and Injury Prevention

Description

The Chronic (non-communicable) Disease and Injury Prevention Sub-Program works across sectors to design, deliver and expand innovative solutions for prevention in collaboration with the not-for-profit and private sectors to address complex public health problems. The Sub-Program emphasizes population health approaches that address common risk and protective factors for chronic diseases. The Sub-Program's premise is that no one sector alone can meaningfully address the causes of chronic disease and injury, and that the combined resources and expertise of a wide range of partners are required to identify and generate sustainable solutions to improve the health of the population. Also within this Sub-Program, work is undertaken to conduct public health research and surveillance, with an emphasis on tracking and understanding the common risk and protective factors for chronic diseases and injuries across the life course, and utilizing emerging sources of surveillance information and methods of collection where possible. The Sub-Program uses funding from the following transfer payments: Canadian Diabetes Strategy, Economic Action Plan 2015 Initiative – Brain Health, Healthy Living Fund, Concussions, Men's Health, Integrated Strategy for Healthy Living and Chronic Disease (Cancer, Cardiovascular Disease Program, Enhanced Surveillance for Chronic Disease, and Observatory of Best Practices), Canadian Breast Cancer Initiative, and the Federal Tobacco Control Strategy.

Results achieved

Expected results	Performance indicators	Targets (Date)	Actual results		
			2016–17	2015–16	2014–15
Healthy living promotion, chronic disease prevention, and injury prevention practices, programs, and policies for Canadians are informed by evidence	Percent of key stakeholders and partners using evidence	72 (by Mar. 31, 2017)	76[10]	76	76
	Percentage of returning users to the Chronic Disease Infobase Web Platform	25 (by Mar. 31, 2017)	21	N/A[a]	N/A[a]
Participating Canadians improve a behaviour in relation to common risk factors	Average daily number of minutes spent in moderate to vigorous physical activity (Ages 18+)	31 (by Mar. 31, 2017)	31	N/A[a]	N/A[a]

a. Actual results are not available given changes to the expected result and/or performance indicator methodology across the specified fiscal years.

[10] This survey is conducted every two years, reporting previous years' results.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
59,448,823	53,427,036	(6,021,788)

Actual spending was less than planned primarily due to delays in project for Grants and Contributions.

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
190	177	(13)

Program 1.3: Health Security

Sub-Program 1.3.1: Emergency Preparedness and Response

Description

The Emergency Preparedness and Response Sub-Program is the central coordinating point among federal, provincial, territorial and non-governmental public health partners. The Sub-Program is also responsible for strengthening the nation's capacity to help prevent, mitigate, prepare and respond to public health events/emergencies. In order to meet these goals, the Sub-Program's interventions include emergency preparedness, emergency planning, training and exercises, ongoing situational awareness and risk assessment, maintenance of a Health Portfolio Operations Centre, coordination of inter-jurisdictional mutual aid, deployment of surge capacity to provinces and territories, and deployment of Microbiological Emergency Response Teams and associated mobile laboratories. The Sub-Program seeks to protect all persons living in Canada and provides surge capacity to provinces and territories and fulfills Canada's international obligations for events, such as infectious disease outbreaks, pandemic influenza and bioterrorism. In addition, it coordinates response to natural or man-made disasters and preparedness for mass gatherings and high profile events. The Sub-Program enables the Agency to meet its obligations under the Emergency Management Act and IHR.

Results achieved

Expected result	Performance indicators	Targets (Date)	Actual results		
			2016–17	2015–16	2014–15
Canada has the capacity to prepare for and respond to public health events/emergencies	Percent of high impact and high likelihood public health risks that are mitigated by current Emergency Management plans and procedures	100 (by Mar. 31, 2017)	100	N/A[a]	N/A[a]
	Percent of inter-jurisdictional mutual aid/federal assistance requests coordinated for domestic and international response and resource sharing within negotiated timelines	100 (by Mar. 31, 2017)	100	100	100
	Percent of required Health Portfolio human resources ready to respond appropriately to events/emergencies on 24/7 basis	100 (by Mar. 31, 2017)	100	100	100

a. Actual results are not available given changes to the expected result and/or performance indicator methodology across the specified fiscal years.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
60,402,696	50,499,143	(9,903,553)

Actual spending was less than planned primarily due to funding re-profile for Ebola Preparedness and Response Initiatives to Protect Canadians at Home and Abroad.

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
169	173	4

Sub-Program 1.3.2: Border Health Security

Description

The Border Health Sub-Program helps protect Canadians from the introduction and spread of communicable disease across borders through administration and enforcement of the Quarantine Act and the Potable Water Regulations for Common Carriers under the Department of Health Act. The Sub-Program includes quarantine services for travellers, cargo and conveyances at Canadian ports of entry. It also includes a risk-based public health inspection program for passenger conveyances (including aircraft, trains, cruise ships and ferries) and ancillary services (such as flight kitchens and terminals). The Sub-Program provides ship sanitation inspections pursuant to the IHR. The Border Health Security Sub-Program promotes coordinated border health measures by creating linkages between key border departments and agencies, including the Canada Border Services Agency, Royal Canadian Mounted Police and the Canadian Food Inspection Agency.

Results achieved

Expected result	Performance indicators	Targets (Date)	Actual results		
			2016–17	2015–16	2014–15
Public Health risks associated with import and export of communicable diseases into and out of Canada are mitigated	Percentage of critical violations on conveyances and in facilities that are mitigated within prescribed timeframes	90 (by Mar. 31, 2017)	96	N/A[a]	N/A[a]

[a] Actual results are not available given changes to the expected result and/or performance indicator methodology across the specified fiscal years.

	Percent of designated Canadian points of entry that maintain the IHR core capacities	100 (by Mar. 31, 2017)	100	100	100

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
6,910,440	7,268,802	358,362

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
65	61	(4)

Sub-Program 1.3.3: Biosecurity

Description

The Biosecurity Sub-Program helps protect Canadians from threats to public health associated with the use of human and terrestrial animal pathogens and toxins. This Sub-Program has specific responsibility under the Human Pathogens and Toxins Act, the Human Pathogens and Toxins Regulations, and select sections of the Health of Animals Regulations to promote, monitor and enforce safe and secure biosafety practices and laboratory environments. Through the fostering of a foresight-based collaborative Canadian framework for pathogen oversight and accountability, the Sub-Program further contributes to public health security by assessing and addressing emerging risks and by mitigating risks posed by the malicious use of pathogens with the intent to harm. The Sub-Program employs a risk and performance-based approach for promoting compliance, ensuring compliance, and responding to non-compliances. The Sub-Program provides information, educational resources and technical assistance to assist regulated parties to achieve compliance. The Sub-Program authorizes the conduct of regulated activities through licensing and certification, monitors compliance with regulatory requirements through inspections and audits, and applies a graduated enforcement approach to correct non-compliance. The regulated activities for which licenses are issued are related to six distinct sectors: Academic, Hospital, Private Industry, Public Health, Environmental Health, and Veterinary/Animal Health. The Sub-Program also promotes coordinated pathogen oversight and capacity building between pathogen regulators and security partners domestically and internationally.

Results achieved

Expected result	Performance indicators	Targets (Date)	Actual results		
			2016–17	2015–16	2014–15
Safe and secure biosafety practices and laboratory environments	Percent of Human Pathogens and Toxins Act (HPTA) registered laboratories working with moderate risk pathogens and toxins compliant with requirements	90 (by Mar. 31, 2017)	100	100	100
	Percent of HPTA registered laboratories working or intending to work with high risk pathogens and toxins compliant with requirements	100 (by Mar. 31, 2017)	100	100	100
	Number of laboratory acquired infections[a]	0[b] (by Mar. 31, 2021)	5[c]	0	N/A

a. The notification of laboratory acquired infections is a new requirement that only became mandatory effective December 1, 2015. As this is a new requirement, it is anticipated that the number of laboratory acquired infections (LAIs) will go up during the early years of HPTA implementation.

b. A minimum of 5 consecutive years of data is needed to establish an accurate baseline. A baseline will be established following 2020–21 and a target will be set following the establishment of the baseline.

c. 5 LAIs were suspected or confirmed for the reporting period under the HPTA.

Budgetary financial resources (dollars)

2016–17 Planned spending	2016–17 Actual spending (authorities used)	2016–17 Difference (actual minus planned)
10,149,054	9,127,213	(1,021,841)

Human resources (full-time equivalents)

2016–17 Planned	2016–17 Actual	2016–17 Difference (actual minus planned)
81	79	(2)