The Case for a Global Health Strategy for Canada

John Kirton, James Orbinski and Jenilee Guebert
Global Health Diplomacy Program,
Munk Centre for International Studies
University of Toronto

Submitted on March 31, 2010

Prepared for
the Strategic Policy Branch in the International Affairs Directorate of
Health Canada

The Case for a Global Health Strategy for Canada

John Kirton, James Orbinski and Jenilee Guebert[1]
Global Health Diplomacy Program,
Munk Centre for International Studies,
University of Toronto
March 31, 2010

Prepared for
the Strategic Policy Branch in the International Affairs Directorate of
Health Canada

Abstract

Health is increasingly recognized as a global as well as a domestic issue. This study thus examines the case for developing a Canadian global health strategy. It highlights the major strands of global health strategies already in place in Canada, the primary Canadian players in the field and the motivation for past actions. It examines the impact of global health trends on Canadians, and indicates where Canada has led and where it will be importantly involved in the future. It assesses whether there is a resulting need for an overall global health strategy for Canada, and specifies the benefits, costs, risks and risk-mitigation measures that could arise in developing such a strategy. It suggests how a Canadian global health strategy might be designed and what it might contain.

Canada could derive many benefits from a global health strategy. There are also costs and risks that could arise. However, a properly prepared, designed and executed global health strategy would lead to better health both within and outside Canada. A global health strategy would help to improve the effectiveness and efficiency of the various actors and activities operating in global health. It would provide a clear focus for Canada's global health goals, would mobilize and concentrate scarce human and monetary resources, and would provide a plan for how to reach Canada's global health objectives. Without a strategy, Canada risks falling behind those consequential countries that already have or are likely to develop a strategy and it will be more difficult for Canada to compete and partner effectively with leaders in the field.

[1] The authors gratefully acknowledge the research assistance of Caroline Bracht, Robin Lennox, Julia Kulik and Sophie Langlois.

About the Authors

John Kirton

John Kirton is co-director of the Global Health Diplomacy Program, director of the G8 Research Group and co-director of the G20 Research Group based at the Munk Centre for International Studies at Trinity College, and a professor of political science at the University of Toronto. He has advised the World Health Organization and the Canadian and Russian governments, and has written widely on global health governance and G7/8 and G20 summitry. His most recent books include *Innovation in Global Health Governance: Critical Cases* (co-edited with Andrew F. Cooper, Ashgate, 2009), *Governing Global Health: Challenge, Response, Innovation* (co-edited with Andrew F. Cooper, Ashgate, 2007) and *Canadian Foreign Policy in a Changing World* (Thomson Nelson, 2007). He is co-author of, among other articles, "Making G8 Leaders Deliver: An Analysis of Compliance and Health Commitments, 1996–2006," *Bulletin of the World Health Organization* (March 2007). Kirton is also co-editor of three book series published by Ashgate Publishing and the editor of Ashgate's five-volume *Library of Essays in Global Governance,* including a volume on global health published in 2009.

James Orbinski

James Orbinski is co-director of the Global Health Diplomacy Program at the Munk Centre for International Studies at Trinity College, and a professor of both medicine and political science at the University of Toronto. He also practises clinical medicine at St. Michael's Hospital. As president of Médecins Sans Frontières (MSF) from 1998 to 2001, he launched its Access to Essential Medicines Campaign and accepted the Nobel Peace Prize awarded to MSF. He led MSF missions in Zaire and Rwanda and served as medical coordinator in Afghanistan and Somalia. He co-chaired MSF's Neglected Diseases Working Group, which led to the Drugs for Neglected Diseases Initiative. He is co-founder of Dignitas International and has served on the boards of the Global Alliance for TB Drug Development, the Stephen Lewis Foundation and Canadian Doctors for Medicare. He is a founding member of the editorial boards of *Open Medicine* and *Conflict and Health*. Orbinski is a member of the Climate Change and Health Council and the World Economic Forum's Global Agenda Council on Health Care Systems and Cooperation. He is the author of the award-winning *An Imperfect Offering: Humanitarianism in the 21st Century* (Doubleday, 2008) and was the subject of the 2007 documentary *Triage: Dr. James Orbinski's Humanitarian Dilemma*.

Jenilee Guebert

Jenilee Guebert is the director of research for the Global Health Diplomacy Program as well as for the G8 Research Group and the G20 Research Group, based at the Munk Centre for International Studies in Trinity College at the University of Toronto. Her work embraces global health governance, the climate change–health connection, environment's lessons for global health governance, G8 health diplomacy and compliance, and Canadian and NAFTA responses to the H1N1 outbreak. Recent works include "Looking to the Environment for Lessons for Global Health Diplomacy," "Canada's G8 Leadership on Global Health," "Bringing Health into the Climate Change Regime," and "Moving Forward on Global Health Diplomacy: Implementing G8 and APEC Commitments." She has had previous experience working for the Calgary Health Region, Statistics Canada and Elections Ontario. She has been a member of the field teams of the G8 and G20 Research Groups on site at several G8 and G20 summits and has been involved in a number of workshops and conferences focused on global health and Canada's year as G8 host in 2010.

Table of Contents

Executive Summary 6
Introduction 8
Canadian Principles for Global Health 10
Global Health Strategies and Canada 11
- Current Health Strategies in Canada 11
- Major Players in Global Health in Canada 12
- Motivation for Canadian Action on Global Health 12
- The Need for a Strategy Now 13
- Benefits, Costs and Risks of a Strategy 15
- Potential Areas for Action and Initiative 18

Components of a Canadian Global Health Strategy 20
- Canadian Priorities 20
- Global Demands 20
- Canada's Comparative Advantage 21
- Canada's Partners 22

References 26
Appendix A: Canada's Global Health Contributions 34
Appendix B: Global Health Actors in Canada 36
Appendix C: Canada's Role in Regional and International Health-Related Organizations 37
Appendix D: Canadians Affected by Diseases 38
Appendix E: Canadian Public Opinion on Health Issues 39
Appendix F: Benefits, Costs and Risks of a Global Health Strategy for Canada 41
Appendix G: Canada's Free Trade Agreements 43
Appendix H: Effects of Climate Change on Human Health Identified by the Intergovernmental Panel on Climate Change 44
Appendix I: Comparison of National Global Health Strategies 45
Appendix J: Steps for Creating a Canadian Global Health Strategy 48
Appendix K: Research Methodology 49

Executive Summary

Health is increasingly a global issue. National health challenges often have global sources and their solutions thus require global responses. Canada and its citizens are vulnerable to health challenges from abroad. And Canadians are committed to achieving better health outcomes at home and abroad for all.

For decades Canada has played an active role in global health. It has developed several health strategies to address a variety of health challenges. It has worked with governments, non-governmental organizations, businesses and academics to improve health outcomes. Canada has participated in numerous global forums to craft global health initiatives and commitments. And Canada has committed significant resources to improve the health and safety of Canadians and citizens abroad.

In the current climate Canada needs a global health strategy. There is an *increasing number of health threats* as well as *greater mobility* of individuals and health workers. *Resources are limited* and need to be used in the most effective and efficient manner possible. *Research* on global health challenges, trends and approaches has proliferated in recent decades and it is now understood that coordinated, global approaches are necessary for the effective governance of health. Canada is *hosting three international summits* in 2010 where it will have an opportunity to lead on global health. There has been a push for stronger *accountability* in the international system to ensure that countries, including Canada, are keeping their global health commitments. *Other countries* have already developed global health strategies, which have proven useful for mobilizing resources, setting clear priorities and improving internal collaboration, coordination, efficiency and effectiveness. And while governments have continued to focus attention and resources on global health challenges, the number of people inflicted with disease has continued to increase and thus an adequate global health response is still required.

Many benefits would arise from developing a Canadian global health strategy. It would lead to *improved health* in Canada and globally. It would provide Canadian global health actors with a *better understanding* of the health activities currently underway. It would provide *greater transparency* regarding Canada's global health priorities and objectives. It would help Canada *focus* on which activities should be enhanced, eliminated or reformed in resource-constrained times. It would support *collaboration, coordination and cooperation* among the many departments, agencies and other actors that deal with health in Canada, fostering a more coherent and cost-effective approach. It would strengthen national *security* and *international partnerships*. It would *mobilize more resources* by giving Canadian and international actors clear, compelling priorities to support on a broad scale. It would ensure that Canada could *respond effectively to the unexpected health crises* that will inevitably arise. It would offer an opportunity for Canadians and others to cultivate a global heath regime that supports Canada's

interests and values. It would advance Canada's *foreign policy* and *international economic development goals*.

Several costs also could arise from a Canadian global health strategy. It will take *time and resources* to develop a global heath strategy. It could generate *conflicts* over whether there should be a strategy, what it should contain, who should be involved and who should lead. It could *divert attention* away from problems that also require attention. It could require a *modification of mandates or operating procedures* for certain actors. It could *complicate relationships* between different levels of government, departments or other actors.

Risks could also arise if the strategy is not developed properly. If the strategy is too *inflexible*, *general*, *under-ambitious* or *over-ambitious,* it could be ineffective. *Satisficing*, *log rolling* and *accountability demands* could all have potential negative affects as well. However, several measures could mitigate these costs and risks.

Canada's global health strategy could focus on the health-related Millennium Development Goals (MDGs), the global health issues that have already had a significant impact on Canadians at home, the international issues or institutions where Canada plays a significant role, the global health commitments that Canada has already made but not yet met, niche areas where Canada has medical and research expertise, neglected topics where Canada could carve out a leadership role, or health issues that are critical in countries where Canada has a key foreign policy or development interest. Any one or combination of these factors could form the core of a Canadian global health strategy.

Available evidence suggests that Canada should develop a global health strategy and that the strategy should be commenced as soon as possible.

Introduction

There is an increasing range of health issues that transcend national boundaries and require action on the global forces that determine the health of people. The broad political, social and economic implications of health issues have brought more diplomats into the health arena and more public health experts into the world of diplomacy. Simple classifications of policy and politics — domestic and foreign, hard and soft, or high and low — no longer apply.

— Ilona Kickbusch, Gaudenz Silberschmidt and Paulo Buss

Since the 2000 G8 Okinawa Summit, there has been a significant shift in global heath. The number of actors in the field has grown exponentially (Orbinski 2007). International health commitments have expanded in number and ambition (Guebert 2009; Sridhar 2009). Financial pledges to global health have risen substantially (see Appendix A; Fallon and Gayle 2010). Global health has increasingly been a priority for international development and a key component of foreign policy, security, trade and the environment.

At the same time, countries recognize that challenges to public health and safety at home often have global sources and that their solutions thus require global responses. The recent outbreaks of severe acute respiratory syndrome (SARS) and the H5N1 and H1N1 influenza viruses have dramatically shown Canadians and others how countries and societies are now integrally interdependent (Sridhar 2009; Fidler 2004). Canada and its citizens are vulnerable at home to diseases, pathogens, toxic contaminants and the effects of climate change that cross borders via the atmosphere, humans, animals, wildlife and imported food. Food safety in Canada depends partially on the regulatory structures of other countries (as in the case of melamine in Chinese baby food exports, the emergence and spread of bovine spongiform encephalopathy [BSE], and the use or non-use of bovine growth hormone in beef). The effects of climate change in Canada are largely due to human activities outside Canada. The 2.5 million Canadians who live abroad, the 50 million Canadians who travel abroad and the 250,000 citizens who migrate to Canada every year are vulnerable to abundant health risks beyond Canada's borders, some of which they bring with them when they return (Cannon 2010; Canada, Department of Citizenship and Immigration 2009).

Canada's role in global health has grown. Pathogens and health "problems without passports" have diminished the ability of governments to protect their people by erecting defences at their borders. This is especially the case for Canada, which has one of the longest land borders and the longest coastline in the world. Health issues must thus be dealt with at their source, anywhere in the world, before disease can erupt, spread and intrude into Canadians' homes. At the same time, Canada remains committed to improving the health of all people, particularly the poorest and most vulnerable, in the world outside.

Various actors involved in global health within and outside Canada have cooperated on past projects. But Canada has no overarching global health strategy to guide a more comprehensive, collaborative and coordinated approach. Such coordinated responses for global and domestic action have become critical to solving many "national" health problems (Switzerland, Federal Department of Home Affairs and Federal Department of Foreign Affairs [FDHA/FDFA] 2006). Thus an inclusive, coherent global health strategy is critical to governing health. Several consequential countries and communities close to Canada have already developed their own global health strategies, among them the United Kingdom, the European Union and Switzerland. Other significant countries including the United States are working toward one (Ali and Narayan 2009; Fallon and Gayle 2010). Now is the time for Canada to identify the benefits, costs and risks of such a strategy to determine whether and why Canada should develop one of its own.

Canadian Principles for Global Health

The case for developing a Canadian global health strategy is supported by the consistency and coherence of the basic health-related principles that have been highlighted by Canadian governments led by both major political parties in their defining doctrines of national and international policy since 1945.[2]

- The first, fundamental principle, appearing since 1949, is a high-quality national healthcare program, equally benefiting all Canadians regardless of economic status.
- The second principle, first appearing in 1957, is the agricultural–health pathway, which has been a development priority that includes food, agriculture, famine relief (as in Ethiopia in 1984) and, by 2010, nutrition for children's and maternal health abroad as well as a domestic priority involving food safety.
- The third principle, arising first in 1967, is the link between the environment and health, and the resulting need for a multi-stakeholder partnership among government, academics and the private sector; by 2002 climate change appeared as the key environmental element affecting health.
- The fourth principle, emerging in 1970 in the wake of the Nigerian civil war, is the international–domestic link, affirming that Canadians' health cannot be protected if infection is rampant in other parts of the world.
- The fifth principle, starting in 1989, is the need for a focus on a wide range of health-related issues: HIV/AIDS, drug abuse and aging-associated illnesses, with breast cancer and tobacco-related illnesses added in 1997, AIDS-affected children in 1999, SARS, avian influenza and AIDS in Africa in 2004, H1N1 influenza in 2009, and children's and maternal health in 2010.
- The sixth principle, foreshadowed in 1957, is the high priority afforded to the institutions of the United Nations and instruments of Canadian official development assistance (ODA), with a recent focus on the Millennium Development Goals (MDGs), a possible G20 summit on health, access to affordable medicines, the creation of the Public Health Agency of Canada (PHAC) in 2004 and the prominent place of children's and maternal health on the agenda of the Canadian-hosted G8 summit in 2010.

There is thus a cumulatively clear, consistent, coherent, comprehensive set of core principles on which a Canadian global health strategy can now be built.

[2] The analysis of Canadian principles relevant to global health was based on a systematic review of health-related passages in the Speeches from the Throne and major foreign policy statements issued by the Government of Canada since 1947.

Global Health Strategies and Canada

Current Health Strategies in Canada

The Canadian government has long led in advancing important global health initiatives. When the World Health Organization (WHO) was established, Dr. Brock Chisholm — a former Canadian deputy minister of health — was appointed as the first head. During the framing of the WHO constitution, a Canadian delegate aptly argued for broad and inclusive membership in the organization, stating:

> We cannot afford to have gaps in the fence against disease; and any country, no matter what its political attitudes or affiliations are, can be a serious detriment to the effectiveness of the World Health Organization if it is left outside. It is important that health should be regarded as a world-wide question, quite independent of political attitudes in any country in the world (Sharp 1947).

Canada has subsequently developed specific strategies to address individual health challenges. They cover a wide range of demographic groups including youth, aboriginal people and women; diseases including diabetes and cancer; mental health; the determinants of health including food; and animal safety (Health Canada 1999; PHAC 2005, 2007, 2008a; Mental Health Commission of Canada undated-a, undated-b; Government of Canada 2008b). These strategies have largely been internally oriented, but have been influenced by or have contained an inherent international dimension. Canadian stakeholders have suggested that Canada should develop additional health strategies. These include a global health strategy for indigenous peoples and a Canadian global health strategy (Smylie 2004; Singer 2009).

Canada currently invests approximately $550 million annually on global health initiatives (Singer 2009). Federal, provincial and territorial departments and agencies have devoted substantial resources to developing and implementing strategies to tackle specific global health challenges. These include G8 health action plans and pandemic plans — particularly since the SARS outbreak in 2003, the H5N1 scare in the mid 2000s and the recent H1N1 pandemic (Canada, Department of Finance 2006; PHAC 2010a, 2010b; G8 2003). Several research institutes in Canada, many strongly supported by Canadian government resources, have developed collaborative national and international partnerships on health initiatives as well (Canadian Institutes of Health Research [CIHR] 2002; Health Research Council of New Zealand 2009; CIHR 2008; Ray, Daar, Singer and Thorsteinsdóttir 2009).

Canada has taken a leadership role in hosting meetings on global health. It hosted the first meeting of the Global Health Security Initiative (GHSI) in November 2001 (GHSI 2001). In October 2005, Canada convened an international

meeting to collaborate and coordinate pandemic influenza preparedness (DFAIT 2009). Canada is also one of five independent industrialized countries often called on to chair or mediate delicate global health negotiations (Silberschmidt 2009).

A Canadian global health strategy could thus strengthen, improve and foster comprehension, communication and coherence among this rich array of component sectoral strategies and partnerships. It could avoid unnecessary duplication and mobilize actors to work together for maximum impact in meeting Canada's global and national health goals.

Major Players in Global Health in Canada

Within Canada, many actors play a key role in global health (see Appendix B). At the international and regional levels, Canada has a role in many intergovernmental institutions involved in global health (see Appendix C). Given the number and diversity of these institutions, there are benefits in having Canadian participation in each flow from a single global health strategy at home.

Within civil society and the private sector, there are many academic, research, business and non-governmental organizations (NGOs) — nationally oriented, transnational in nature or linked internationally — that are dedicated to global health. For example, Canadian civil society organizations such as the Canadian Public Health Association (CPHA) worked with the WHO and many international governmental and non-governmental partners to establish the 1986 Ottawa Charter for Heath Promotion. This seminal international charter focused on enabling people to increase control over their health and on building healthy public policy across all domains of government beyond the health sector. Led by Canadian civil society through the 1990s and now into the 21st century, this charter has resulted in the globally successful Healthy Cities project that looks at environmental aspects of sustainable urban development as a determinant of health (Kickbusch 1989). In 2005, an offshoot of this process produced the domestically successful BC Healthy Communities Project, an initiative to build capacity for healthy thriving and resilient communities in Ontario, New Brunswick and Quebec (see <www.bchealthycommunities.ca>).

Motivation for Canadian Action on Global Health

Canadians have been motivated to act on global health as a result of the direct impact of global health challenges, such as pandemic disease, food safety and security, and climate change on health at home and abroad as well as by the international and domestic application of the core values that Canadians share. Many Canadians suffer from infectious and chronic diseases, many of which have spread from other countries (see Appendix D). Canadians want to maintain and improve their health and, at the same time, the health of others around the world (see Appendix E; International Development Research Centre [IDRC] 2008).

Beyond self-interest and altruism, Canadians increasingly recognize the interdependence of the health of people at home and the health of people abroad.

Protecting the health and safety of Canadians has been a deep and durable priority of the Canadian government for decades. Canada spends 10.1% of its gross domestic product (GDP) on health — one of the highest in the world (Organisation for Economic Co-operation and Development [OECD] 2009b). The government has long pursued a foreign policy that reflects Canadians' values of democracy, peace and equity and its distinctive national values of antimilitarism, environmentalism, openness, multiculturalism, globalism and international institutionalism (Singer 2010; Kirton 2007). This pursuit has led to supporting actions and initiatives on global health, such as the Global Polio Eradication Initiative (GPEI) since 1985, the MDGs since 2000, the Global Fund to Fight AIDS, Tuberculosis and Malaria since 2002, the Framework Convention on Tobacco Control (FCTC) since 2003 and the International Health Regulations (IHR), which Canada was involved in negotiating and revising since 2004 and which entered into force in 2007. Numerous bilateral initiatives have been taken as well (see Appendix A).

Increasingly, the government has recognized that Canada's interests are connected with the rest of the world (Government of Canada 2010). Thus actions on global health not only promote Canadians' values and a broad range of Canadian interests, but are also necessary to directly protect Canadians' own health.

The Need for a Strategy Now

Now is the time for Canada to develop its own global health strategy. Countries cannot govern health adequately on their own (United Kingdom, HM Government 2008; Cooper, Kirton and Schrecker 2007). Infectious diseases do not respect borders and therefore collaboration to deal with health threats at their distant source is necessary for a successful response. Development strategies are integral to advancing democracy and human rights, to creating a more prosperous, democratic and equitable world, to stopping and preventing terrorism, to building a stable global economy, to stopping and preventing conflicts, and to preventing and containing global pandemics (Clinton 2010).

All states, including Canada, have become increasing vulnerable to global health threats (Fischer 2009). This vulnerability became clear after the anthrax attacks in the United States immediately following the attacks of September 11, 2001, and the cases of SARS, H5N1 and H1N1 (Bennett 2009; Chan 2009a, 2009b; Global Health Security Initiative 2009). Canada is also vulnerable to the looming health impacts of climate change, such as increasing incidence of malaria (Berrang-Ford et al. 2009).

Demand for attention to global health and international health standards has been increasing due to the increased mobility of individuals and health workers

(through migration and travel), rising costs, increasing scientific knowledge and the growing technical complexity of health challenges and capacity to respond to those challenges (FDHA/FDFA 2006). By placing more emphasis on health abroad, Canada can help to limit diseases from spreading to its territory. More collaboration and regulation on food and product safety challenges such as BSE and avian influenza will help limit the negative health, trade and economic impacts that can result. For example, it is estimated that $1.5 billion was lost in economic revenue in Ontario alone as a result of SARS (Price-Smith 2009). Better collaboration and cooperation could prevent or at least limit similar impacts in the future. Both the awareness of global health challenges and global health research have increased and much more is known about the interconnectedness and interdependence of health challenges (Kirton 2009). There is thus more evidence to support the development of a global health strategy now.

In 2010, Canada has a unique opportunity to play a leadership role on global health as it will host the G8 summit in Muskoka and the G20 summit in Toronto in June and the North American Leaders' Summit in September. The Prime Minister has already declared that children's and maternal health is a top priority for the G8 Muskoka Summit. A strategy could support the initiatives that have already been put forward at Muskoka and other international meetings.

A strategy could also help keep Canada and others accountable to their past and future health commitments, including the MDGs, which remain far from being reached. As the Prime Minister said at the World Economic Forum in January 2010, "Accountability … is the prerequisite for progress" (Harper 2010b). A global health strategy could help Canada reach the MDGs by their 2015 deadline (HM Government 2008). It could also assist in ensuring accountability on Canada's commitments made in a broad array of international forums in recent years.

Other countries have recently recognized the benefits of developing a global health strategy. The growing number includes some of Canada's closest international partners. Switzerland, now one of Canada's free trade partners, was the first to adopt a global health strategy, doing so in October 2006 (Sridhar 2009; FDHA/FDFA 2006). The United Kingdom and European Union adopted strategies in 2007 and 2008 respectively (Commission of the European Communities 2007; HM Government 2008). The United States, China and Brazil are currently considering similar policies (Kickbusch and Erk 2009; Ali and Narayan 2009; Fallon and Gayle 2010). Norway, which allocates the highest percentage of GDP to ODA and has taken the lead in pushing countries to reach MDGs 4 and 5, is considered one of the most active countries in global health (Silberschmidt 2009). To be competitive with its peers and to partner effectively with them, Canada needs its own global health strategy.

Moreover, Canada should develop a global health strategy because the world simply will not wait. Population growth, climate–health impacts and the spread of infectious disease will not improve unless drastic measures are taken to prevent

and stop them. The health, economy, security and stability of many at home and abroad will suffer greatly without action.

Why Now?

1. Vulnerability to global health threats has increased.
2. Individuals and health workers are more mobile.
3. Better, more effective use of scarce resources is needed in today's time of restraint.
4. More is known about the interdependencies, intersections and impacts of health.
5. Canada will host three major summits in 2010 at which global health could be a focal point.
6. Increased accountability for compliance on health commitments is needed.
7. More countries are developing global health strategies.
8. The world will not wait.

A global health strategy would help ensure the health and safety of Canadians. It would strengthen progress and plans for future actions. It would help outline Canada's short-, medium- and long-term global health goals and ensure that the individual health-related commitments Canada makes in international forums and at home are consistent and coherent parts of an overall approach. It would help render consistent and synergistic provincial, national and international plans. It would provide a mechanism for better coordination. It would clearly set out Canada's global health priorities so that all the actors involved have a clear understanding of Canada's objectives. It would enable Canada to take a more proactive role on global health (as opposed to a reactionary and defensive one). It would provide more effective and efficient responses that are increasingly needed to save and enhance human lives and to reduce the soaring social and economic costs both in Canada and abroad (Kates, Fischer and Lief 2009).

Benefits, Costs and Risks of a Strategy

There are benefits, costs and risks that could come from developing a Canadian global health strategy (see also Appendix F).

Benefits

Canada could derive many benefits from the process of developing a Canadian global health strategy as well as from the strategy itself. A global health strategy would lead to better health in Canada and abroad (World Vision International 2009; HM Government 2008). It would provide the various Canadian actors involved in global health with a clearer understanding of what their relevant colleagues are currently doing. It would provide greater transparency and a clear framework of what Canada's global health priorities are, how Canada plans to meet them and what each actor's role should be. This framework would also help to focus research efforts. It would provide guidelines for collaboration, coordination

and cooperation particularly among actors from non-health areas and those with traditional health backgrounds. It would improve internal cooperation and provide shared objectives and better clarity for all Canadian actors in the field of global health and the Canadian public as a whole (FDHA/FDFA 2005). It could help to build stronger partnerships with key international actors. It would help ensure that Canada is using its scarce resources to best effect. It would catalyze others, including philanthropists, to contribute more resources to defined, identified and compelling priorities. It would help improve preparation and response for unexpected health crises that will inevitably arise. It would promote Canadian interests and values (see Appendix E). And it would help to ensure that Canada meets it foreign policy and international development goals.

Benefits

1. Improved health in Canada and globally.
2. Clearer understanding of current and relevant global health activities.
3. Greater transparency.
4. Clear framework of Canada's global health priorities.
5. Guidelines for collaboration, coordination and cooperation.
6. Strengthened international partnerships.
7. More effective and innovative application of resources.
8. Better response to unexpected health crises.
9. Promotion of Canadian interests and values.
10. Support for Canadian foreign policy and international development goals.

Costs

A global health strategy will bring some costs to Canada. It will take time and resources to develop. There will be potentially conflict-generating conversations about whether such a strategy is necessary, how it should be done, who should lead, what the role of each actor is and what the common priority goals should be.[3] The process of developing the strategy could divert attention from other individual and immediate problems. It may require some actors to change their missions, expertise and even authorizing legislation to play their full intended part as an integral component of the larger whole. It might also require that an analysis of current commitments and component strategies be conducted, which would be time consuming and would delay progress. Canada's complex federal system also adds complications.

[3] Because there is a diverse array of actors involved in global health in Canada, conflicting or competing objectives may arise. For example, actors in trade may have different views and objectives from those in development, complicating the treatment of issues such as access to affordable medicines (Silberschmidt 2009). Similarly, environmental actors and health actors may have different views on the use of dichlorodiphenyltrichloroethane (DDT) to fight malaria. These varying views will be challenging to overcome.

Costs

1. Time and resources.
2. Conflict-generating conversations.
3. Diverted attention from individual and immediate problems.
4. Possible changes for actors' missions, expertise and authorizing legislation.
5. Time-consuming analysis of current commitments and component strategies.
6. Complications from federal-provincial relations.

Risks

As with any new development, there are potential risks to developing a global health strategy. Inflexibility in policy and resource investment could result from developing a fixed comprehensive approach. This in turn would make it more difficult for Canada to shift its priorities after putting a public global health strategy in place. An emerging crisis that requires immediate attention might be ignored or dealt with inappropriately or inadequately as a result. At the other end of the scale, there is the danger of setting objectives that are too general in scope or provide insufficient guidance. Such generality may contribute to confusion due to multiple interpretations. Under-ambition could result from a consensus that rests at the lowest common denominator or defines global health too narrowly. Over-ambition may result from defining global health too broadly. A poorly designed global health strategy could alienate key actors that should be involved in the process, causing further division and inconsistency. There is also a chance of overcrowding, with too many actors diluting the usefulness of such an exercise or making it unmanageable. Satisficing could result as actors may meet merely the minimum requirements to comply with their obligations, preventing more ambitious commitments from being achieved. Log rolling — exchanging favours to mutual benefit — could cause incoherence and synthetic, forced synergies. There is also the risk that existing commitments could be disregarded. The specification of goals in a global health strategy could imply that they trump older, but still important, commitments.

Risks

1. Inflexibility.
2. Generality.
3. Under-ambition.
4. Over-ambition.
5. Alienation.
6. Overcrowding
7. Satisficing.
8. Log rolling.
9. Diverted or neglected attention to existing commitments.

Cost and Risk Mitigation Measures

Measures can be taken to mitigate the costs and risks involved in a global health strategy.

First, a list of all the possible costs and risks should be identified. This will ensure that measures are taken to prevent or reduce them.

Second, the global health strategy should be properly thought through. An exercise undertaken in haste is more likely to produce unintended risks and costs.

Third, all the relevant actors should be included in developing a global health strategy. A comprehensive and consultative approach will help guarantee a sense of inclusiveness and a coherent, synergistic and successful strategy. Any competing, inconsistent on irrelevant proposals can be tackled at an early stage.

Fourth, goals and limitations should be clearly identified at the outset. The articulation of why a global health strategy is desirable and what it aims to achieve is critical to creating a coherent and useful strategy.

Fifth, it is important to identify who will supply the resources necessary to developing the global health strategy.

Sixth, the global health strategy needs to be properly balanced. It needs to be sufficiently flexible to adapt to emerging crises, yet be bound in such a way that it is clear, concise and constraining in what it hopes to achieve.

Seventh, it must respect existing commitments and support their implementation. Doing so will uphold the integrity of the actors involved in developing the global health strategy and keep them accountable for their past promises.

Potential Areas for Action and Initiative

Canada's global health strategy could focus on several subjects, in particular the following:

- The health-related MDGs that deal with children's and maternal health, which the Prime Minister has already set as one of Canada's priorities for the G8 Muskoka Summit (Harper 2009, 2010a; Government of Canada 2010).
- Global health issues that have already significantly affected Canadians at home, such as West Nile virus, SARS, BSE and H1N1 (see Appendix D; Maioni 2008; Bennett 2009; Price-Smith 2009; Chan 2009a, 2009b; PHAC 2009d, 2010b).
- Those international issues or institutions where Canada has played a significant role in the past, such as the Global Fund, polio, the International AIDS Vaccine Initiative (IAVI), tuberculosis, the GAVI Alliance, the International Partnership for Microbicides, infant and child health, maternal health, micronutrient deficiencies and the strengthening of health systems (see Appendix A; Government of Canada 2008a; Kirton and Guebert 2010a; Singer 2009; Cannon 2010).

- Other health commitments already made on the global stage but not yet met, such as pledges made at the G8 summit (Guebert 2009).
- Any niche where Canada has medical and research expertise, such as diabetes or global health research (Phillips 2001; CNW Group 2009a; Singer 2009).
- The identification of a neglected topic where Canada could carve out a leadership role, such as global health diplomacy, neglected tropical diseases, food security, gender equality, the definition of global public health goods or innovation (Singer 2009).
- Health issues that are critical in countries where Canada has a key foreign policy and development interest, notably Afghanistan, Haiti, the Dominican Republic, India, El Salvador, Guatemala, Honduras and Nicaragua (see Appendices A and G).

Components of a Canadian Global Health Strategy

Canadian Priorities

A Canadian global health strategy will reduce pandemic risk and improve the health and safety of Canadians at home and abroad. It will help ensure that Canadians are protected from security threats such as bioterrorism. It will foster innovation in global health. It will help Canada plan and protect its citizens against the negative health-related effects of climate change, unsafe food and products, and migration (Berrang-Ford et al. 2009; Kirton and Guebert 2010b).

A global health strategy will also express Canadians' interests and values abroad. Canadians believe that health care is one of the most important domains that politicians should address. In repeated public opinion surveys, Canadians have identified health care as the most important (or one of the most important) issues for politicians to deliberate on. Canadians approve of them doing so abroad as well as at home (see Appendix E; Bildook 2008; Public Works and Government Services Canada 2008; Robbins SCE Research 2010; Association of Faculties of Medicine of Canada et al. 2010).

As an integral part of protecting Canadians' health and promoting their interests and values, a global health strategy will help meet Canadians' international responsibilities in the many communities that they share with others. These responsibilities start geographically with the North American and Arctic communities and extend to the Americas, the Atlantic and Asia Pacific regions, Africa through the Commonwealth and Francophonie, and the global community as a whole.

Canada has also committed to solving global health challenges in a variety of international forums over the past decades. Many of these commitments still need to be fulfilled. In addition to the MDGs and commitments made at G8 summits, promises made at Asia Pacific Economic Cooperation (APEC) summits and at Commonwealth and la Francophonie heads of government meetings, Canada has bilateral commitments with countries including Afghanistan, Haiti and Sudan (CIDA 2009a). Canada could use a global health strategy to help meet these objectives in a reasonable and responsible way.

Global Demands

Many actors have devoted time and resources to developing and using global health strategies because many health challenges are increasing, are often inherently global and therefore require global coordination in response (FDHA/FDFA 2006; HM Government 2008; Commission of the European Communities 2007; Sridhar 2009).

There has also been an increasing recognition that non-health influences actors from abroad — especially those that are inherently and fully global — can severely

affect human health (Sridhar 2009; HM Government 2008; Kirton and Guebert 2010b). Non-health influence begin with climate change, food and agriculture, trade and migration. The Intergovernmental Panel on Climate Change (IPCC) has identified numerous connections between climate change and health (see Appendix H; IPCC 2007a, 2007b). A 2007 survey showed that 82% of Canadians were concerned with "climate change and its impact on health" (Canadian Medical Association 2007).

The food and agriculture–health connection was highlighted by recent experiences with BSE, H5N1 and H1N1 (Government of Canada 2008b).

The Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) at the World Trade Organization (WTO) forged a necessary collaboration between trade and health, while Canada's growing array of bilateral free trade agreements intensify the trade-health connection as well (DFAIT 2010a; see Appendix G).

The migration of health workers remains a challenge for countries of origin, many of which are already suffering from major deficiencies in health workers (WHO 2007). Canada is home to more than 15,000 scientific and health-related professionals from developing countries (Singer 2010). There is also the possibility that current and prospective Canadians and other citizens who enter or immigrate to Canada can bring illness contracted abroad that may spread (Kirton and Guebert 2010b).

The levels and trends in some major communicable diseases such as HIV/AIDS, and non-communicable diseases such as diabetes, obesity, cancer and tobacco-related illnesses have risen and are predicted to continue to rise (see Appendix D; WHO 2006, 2009).

The public has increasingly demanded that governments justify their spending, particularly in recent times when resources have become limited (Clinton 2010). Global health strategies provide a tool for governments to communicate why it is important to spend money on global health initiatives and to clearly indicate where funding is allocated.

Canada's Comparative Advantage

Canada can contribute to global health and improve its impact on the health of Canadians and others through international leadership, accepting global responsibilities and expanding its international influence. Canada has a strong and capable community of health professionals, facilities, research, development, innovation and training to mobilize in a coordinated way (Singer 2009). Canada's academic institutions, private sector innovators, civil society actors and organizations, and research bodies, led by the CIHR and IDRC, can all contribute to a strong Canadian global health strategy (Singer 2010; Canadians for Health Research 2008).

Canada can contribute financially to global health through public sector, private sector, civil society and other non-governmental disbursements, including

to those global initiatives where Canada has already made a leading contribution (see Appendix A; CIDA 2009a).

Canada can lead on global health issues in key international institutions, starting with the hosting of the G8, G20 and North American Leaders' Summit in 2010. Canada has already made health a priority of the G8 Muskoka Summit in June. The stated topic of children's and maternal health could also be discussed with the G20, which deals with the health-related issues of finance, trade, food security and development (Silberschmidt 2009; Kirton and Guebert 2010a). At the North American Leaders' Summit in September, a continued discussion of pandemic preparedness and planning and best practices would be useful (Kirton and Guebert 2010c, 2010d).

Canada could build on its global health leadership by seeking to appoint respected officials to the executive boards and senior staffs of health-related international organizations of consequence, including the WHO, Pan American Health Organization (PAHO) and the OECD. It could encourage any new international health organizations that arise to locate their secretariats in Canada. It could make sure that Canadian representatives at health-related meetings of consequence includes high-level officials. It can draw on the Canadian experience of those who are already in positions of power, and those such as WHO director Margaret Chan, who obtained her medical degree from the University of Western Ontario.

Canada could also lead in creating a platform to explore and support innovation as it applies to global health. This would mean recognizing that innovation includes seeking success through experimentation while accepting that risk is a necessary component of innovation, because tolerance for failure is a learning stage in developing genuinely effective new global health initiatives and strategies. Such a process would draw from domestic and international civil society actors, the private sector, academia, philanthropic entities, and governmental and intergovernmental bodies to explore and experiment with the factors, actors and enablers that can lead to resilient and healthy individuals and communities domestically and globally.

Canada could also consider identifying specific responsibilities and assuming leadership in neighbouring and strategic regions, including the Arctic, the North American community, Haiti and Afghanistan. Within these areas, it should focus on the most vulnerable first.

Canada's Partners

With regard to a partnership strategy, several lessons can be learned from the evidence and cases of what others have done (see Appendix I).

First, it is important to establish why a strategy would be useful and beneficial in Canada. This report and the companion one written by Ronald Labonté and Michelle Gagnon (2010), as well as others exploring a Canadian global health

strategy, should be shared with the various Canadian global health actors. Their comments and questions should be taken into consideration and explored further where necessary.

Second, Canada should determine the factors driving it to consider a national global health strategy. Two main aims drove the UK to develop its global health strategy: "to use health as an agent for good in foreign policy" and to ensure more transparency and clarity on the impact of foreign and domestic policies on global health (Sridhar 2009). Switzerland, which hosts the WHO in Geneva, recognized that internationally coordinated responses were required in health; these two factors drove it to develop a global health strategy (Sridhar 2009). Others have suggested that the search for effective ways to use scarce resources was a key driver. New research and evidence that highlighted the effectiveness and benefits of more integrated and focused global health approaches also had an impact. A clear understanding of the reasons behind Canada's desire for a strategy will help to frame the context and narrative of the overall policy.

Third, the main aims of the global health strategy must be identified. The UK's "stability first" strategy targeted five actions: enhance global health security to improve economic and political stability; create stronger, fairer and safer systems to deliver health; make international organizations including the WHO and the EU more effective; engage in stronger, freer and fairer trade for better health; and strengthen the way the UK develops and uses evidence to improve policy and practice (HM Government 2008). The EU identified three main objectives: fostering good health in an aging Europe, protecting citizens from health threats and supporting dynamic health systems and new technologies (Commission of the European Communities 2007). The five main priorities of the Swiss government's global health strategy are to protect national health interests from global health threats, including influenza pandemics, consumer health threats and non-communicable disease; harmonize national and international health policies; improve the effectiveness of international collaboration in the area of health; improve the global health situation; and safeguard Switzerland's role as host country to international organizations and major companies working in health (FDHA/FDFA 2006). Canada can look to all these areas and objectives to see which should be adopted in a Canadian global health strategy. Certain ones, such a strengthening health systems, protecting citizens from global health threats and harmonizing national and international health policies, stand out as worthy candidates. Canada's global health strategy should consider aims that are best suited to Canadian values and interests.

Fourth, the resources necessary for developing and executing the global health strategy must be determined. As with the EU and Switzerland, Canada need not necessarily find new resources at the outset. Funds could be drawn from existing individual global health initiatives. The global health strategy would therefore be reinforce the goals already targeted (Sridhar 2009). However, allocating new resources, as the UK did, would signal that Canada is serious about implementing

its strategy and committed to seeing it through. It could also help catalyze or mobilize funding from other sources.

Fifth, a global health strategy should identify one-year, five-year and 10- to 15-year initiatives. The strategy should be reviewed after each period with reports published publicly, including recommendations for future actions and changes. There should be a balance of specified and flexible initiatives, so that clear goals can be set. At the same time there should be room to adjust to any crises that might arise, such as the 2010 earthquakes in Haiti and Chile or a future influenza pandemic. A five-year approach as an initial base would be a suitable timeline, following the example of the UK, the EU and Switzerland. Starting in 2010/11, it would also fit within the MDG timeframe. It could also include shorter plans and longer plans, as in the U.S. strategy (Fallon and Gayle 2010).

Sixth, the strategy should build on Canada's strengths in the academic, civil society, business and government sectors. It should also identify areas where Canada can improve and close critical gaps. It should specify what departments and agencies should be responsible for each initiative. It should also focus on merging non-health actors, such as those in trade, agriculture and the environment, and match them with those with relevant technical capacity, understanding and expertise in health.

Seventh, Canada should consider collaborating with other key actors, including those countries that have developed or are developing health strategies. It should continue to collaborate with long-standing partners starting with the WHO as the lead intergovernmental organization, and also with the UK, the U.S. and the EU. Canada should also encourage other countries to develop their own global health strategies, as part of a broad, globally coordinated approach.

Eighth, following the UK, Canada should consider appointing an independent, third-party body or office to review the success and effectiveness of a Canadian global health strategy. This same independent body should produce the progress reports and provide constructive advice on the next steps to ensure the strategy is implemented effectively.

Ninth, Canada should ensure that it remains open and transparent about conflicting interests that exist between departments and agencies, such as trade and development or environment and health. It should make it clear that it is ready to resolve discrepancies, or at least reduce differences, by clarifying roles and highlighting synergies. With the Canadian government already focused on accountability, this approach would strengthen its commitment to transparency.

Tenth, as with Switzerland's strategy and its federal sensibilities, the Canadian government should use its global health strategy to improve the integration and synergies among provincial, national and international health policies. It should clearly specify which actor or actors should lead and which should play a supporting role on each initiative for better clarity, cooperation, coordination and cost effectiveness.

Specific steps for delivering a strategy following these guidelines are identified in Appendix J.

A more systematic survey should be undertaken to explore the potential impact of a Canadian global health strategy. Cross-Canada consultations should be undertaken with academics, NGOs, politicians, bureaucrats and members of the business and industry communities. New public opinion polls should be conducted. Interdepartmental workshops should be convened. International stakeholders, particularly those from consequential countries that have already developed global health strategies, should be included in these processes.

References

Ali, Mohammed K. and K.M. Venkat Narayan (2009). "The United States and Global Health: Inseparable and Synergistic? The Institute of Medicine's Report on Global Health." *Global Health Action* 2. <www.globalhealthaction.net/index.php/gha/article/viewArticle/2035/2488> (March 2010).

Association of Faculties of Medicine of Canada, BIOTECanada, Canada's Research-Based Pharmaceutical Companies, Canadian Healthcare Association, Canada's Medical Technology Companies and Research Canada (2010). "Canada Speaks! 2010: Canadians Go for Gold in Health and Medical Research." January. <www.csbmcb.ca/Downloads/18-ResearchCanada-pollEng.pdf> (March 2010).

Bennett, Carolyn (2009). "Lessons from SARS: Past Practice, Future Innovation." In Andrew F. Cooper and John J. Kirton, eds., *Innovation in Global Health Governance: Critical Cases*. Farnham: Ashgate.

Berrang-Ford, L., J.D. Maclean, Theresa Gyorkos, J.D. Ford and N.H. Ogden (2009). "Climate Change and Malaria in Canada: A Systems Approach." *Interdisciplinary Perspective on Infectious Disease* (2009). <www.hindawi.com/journals/ipid/2009/385487.html> (March 2010).

Bildook, Kelly (2008). "Media, Public Opinion and Health Care in Canada: How the Media Affect 'The Way Things Are'." *Canadian Journal of Political Science* 41(2): 355–374.

Canada. Citizenship and Immigration Canada (2009). "Facts and Figures 2008 — Immigration Overview: Permanent and Temporary Residents." <www.cic.gc.ca/english/resources/statistics/facts2008/permanent/index.asp> (March 2010).

Canada. Department of Finance (2006). "The Budget Plan 2006: Focusing on Priorities." May 2. <www.collectionscanada.gc.ca/webarchives/20061129173143/www.fin.gc.ca/budget06/pdf/bp2006e.pdf> (March 2010).

Canada. Department of Foreign Affairs and International Trade (2010a). "Negotiations and Agreements." <www.international.gc.ca/trade-agreements-accords-commerciaux/agr-acc/index.aspx> (March 2010).

Canada. Department of Foreign Affairs and International Trade (2010b). "Trade and Intellectual Property: WTO Trade-Related Aspects of Intellectual Property Rights." <www.international.gc.ca/trade-agreements-accords-commerciaux/fo/trips_agree.aspx?menu_id=2&menu=R> (March 2010).

Canadian Institutes of Health Research (2002). "A First-Time Collaborative Effort in Canada Will Address Global Health Through Research: Joint Press Release." January 11. <www.cihr-irsc.gc.ca/e/8077.html> (March 2010).

Canadian Institutes of Health Research (2008). "Japan-Canada Joint Health Research Program." <www.cihr-irsc.gc.ca/e/35595.html> (March 2010).

Canadian International Development Agency (2009a). "Canada Moves on Another Element of Its Aid Effectiveness Agenda. News release, February 23.

<www.acdi-cida.gc.ca/acdi-cida/ACDI-CIDA.nsf/eng/NAT-223132931-PPH> (March 2010).
Canadian International Development Agency (2009b). "Catalytic Initiative to Save a Million Lives." <www.acdi-cida.gc.ca/acdi-cida/acdi-cida.nsf/eng/NAD-1249841-JLG> (March 2010).
Canadian International Development Agency (2009c). "Countries of Focus." <www.acdi-cida.gc.ca/acdi-cida/ACDI-CIDA.nsf/eng/JUD-51895926-JEP> (March 2010).
Canadian International Development Agency (2010). "Project Browser." Database. <www.acdi-cida.gc.ca> (March 2010).
Canadian Medical Association (2007). "Health of One-in-Four Canadians Hurt by the Environment." August 17. <www.cma.ca/multimedia/cma/Content_images/Inside_cma/Annual_Meeting/2007/GC_page/Report_Card_Release_e.pdf> (March 2010).
Canadians for Health Research (2008). "Public Health Researcher Extraordinaire: Meet Dr. Frank Plummer." *Future Health*. <www.chrcrm.org/main/modules/pageworks/index.php?page=018&id=1253> (March 2010).
Cannon, Lawrence (2010). "Address by Minister Cannon to the Economic Club of Canada Concerning the G8 Foreign Ministers Meeting." Toronto, March 22. <www.international.gc.ca/media/aff/speeches-discours/2010/2010-11.aspx> (March 2010).
Chan, Margaret (2009a). "Influenza A (H1N1)." Statement, April 29. <www.who.int/mediacentre/news/statements/2009/h1n1_20090429/en> (March 2010).
Chan, Margaret (2009b). "Influenza A (H1N1): Lessons Learned and Preparedness." July 2, Cancún. <www.who.int/dg/speeches/2009/influenza_h1n1_lessons_20090702/en> (March 2010).
Clinton, Hillary (2010). "Development in the 21st Century." Prepared text of speech delivered to the Center for Global Development, Washington DC, January 6. *Foreign Policy*. <www.foreignpolicy.com/articles/2010/01/06/hillary_clinton_on_development_in_the_21st_century> (March 2010).
CNW Group (2009a). "JDRF launches Clinical Trial Network Centre at University of Waterloo." Press release, March 8. <www.newswire.ca/en/releases/archive/March2010/08/c7713.html> (March 2010).
CNW Group (2009b). "On Eve of Medical Association's Annual Meeting: New Poll Shows Overwhelming Support for Public Health Care; CMA President Out of Touch with Most Canadians." August. <www.nanosresearch.com/news/in_the_news/CNW August 12 2009.pdf> (March 2010).
Commission of the European Communities (2007). "Together for Health: A Strategic Approach for the EU 2008–2013." White Paper. <ec.europa.eu/health/ph_overview/strategy/health_strategy_en.htm> (March 2010).
Community and Hospital Infection Control Association – Canada (2009). "Information about West Nile Virus." <www.chica.org/links_wnv.html> (March 2010).

Community and Hospital Infection Control Association – Canada (2010a). "Influenza, Avian Influenza and Pandemic Influenza." <www.chica.org/links_flu.html> (March 2010).
Community and Hospital Infection Control Association – Canada (2010b). "Pandemic (H1N1) 2009 Virus." <www.chica.org/links_swineflu.html> (March 2010).
Cooper, Andrew F., John J. Kirton and Ted Schrecker (2007). "Governing Global Health in the Twenty-First Century." In Andrew F. Cooper, John J. Kirton and Ted Schrecker, eds., *Governing Global Health: Challenge, Response, Innovation*. Aldershot: Ashgate.
Fallon, William J. and Helene D. Gayle (2010). *A Healthier, Safer and More Prosperous World.* Report of the CSIS Commission on Smart Global Health. <csis.org/files/publication/100318_Fallon_SmartGlobalHealth.pdf> (March 2010).
Fidler, David (2004). *SARS, Governance and the Globalization of Disease.* London: Palgrave Macmillan.
Fischer, Julie E. (2009). "Global Health Security: A Long-Term Perspective." Henry L. Stimson Center. <www.stimson.org/Presidential_Inbox_2009/JFischer_Final.pdf> (March 2010).
G8 (2003). "Health — A G8 Action Plan." Evian, June 2. <www.g8.utoronto.ca/summit/2003evian/health_en.html> (March 2010).
GAVI Alliance (2010). "Donor Contributions and Commitments." <www.gavialliance.org/support/donors/index.php> (March 2010).
Global Fund to Fight AIDS, Tuberculosis and Malaria (2010). "Pledges and Contributions." <www.theglobalfund.org/documents/pledges_contributions.xls> (March 2010).
Global Health Security Initiative (2009). "Special Ministerial Meeting on Pandemic (H1N1) 2009. September 11. <www.ghsi.ca/english/statementbrussels2009.asp> (December 2009).
Global Polio Eradication Initiative (2010). "Historical Contributions Since 1985." <www.polioeradication.org/content/general/HistContributionWeb28.January.2010.pdf> (March 2010).
Government of Canada (2008a). "Canada's Investments in Global Health." <camr-rcam.hc-sc.gc.ca/doc/invest-contrib/index-eng.php> (March 2010).
Government of Canada (2008b). "National Animal Health Strategy." <www.healthyanimals.ca/english/index_e.shtml> (March 2010).
Government of Canada (2010). "A Stronger Canada. A Stronger Economy. Now and for the Future." Speech from the Throne, March 3. <www.sft-ddt.gc.ca/grfx/docs/sft-ddt-2010_e.pdf> (March 2010).
Guebert, Jenilee (2009). "G8 Commitments on Health." G8 Research Group. <www.g8.utoronto.ca/evaluations/g8-commitments-health-to-2009.html> (March 2010).

Harper, Stephen (2009). "The 2010 Muskoka Summit." In John Kirton and Madeline Koch, eds., *The G8 2009: From La Maddalena to L'Aquila*. London: Newsdesk Media. <www.g8.utoronto.ca/newsdesk/harper-2009.html> (March 2010).
Harper, Stephen (2010a). Canada's G8 Priorities. January 26. Ottawa: Office of the Prime Minister of Canada.
Harper, Stephen (2010b). "Statement by the Prime Minister of Canada." Address to the World Economic Forum, Davos, 28 January. <www.pm.gc.ca/eng/media.asp?id=3096> (March 2010).
Health Canada (1999). "Women's Health Strategy." <www.hc-sc.gc.ca/ahc-asc/pubs/strateg-women-femmes/strateg-eng.php> (March 2010).
Health Canada (2009). "Canadian Tobacco Use Monitoring Survey." <www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/_ctums-esutc_prevalence/prevalence-eng.php#wave1_09> (March 2010).
Health Research Council of New Zealand (2009). "Indigenous Health Research." <www.hrc.govt.nz/root/pages_maori_health/Indigenous_health_research.html> (March 2010).
Intergovernmental Panel on Climate Change (2007a). "Climate Change 2007: Synthesis Report." <www.ipcc.ch/pdf/assessment-report/ar4/syr/ar4_syr.pdf> (March 2010).
Intergovernmental Panel on Climate Change (2007b). "Working Group II Report: Impacts, Adaptation and Vulnerability." <www.ipcc.ch/ipccreports/ar4-wg2.htm> (March 2010).
International Development Research Council (2008). "Global Health Research Initiative." <www.idrc.ca/en/ev-114548-201-1-DO_TOPIC.html> (March 2010).
Ipsos Reid (2006). "Majority (54%) Feel P.M. Was Wrong Not to Attend Recent International AIDS Conference." September. <www.ipsos-na.com/news-polls/pressrelease.aspx?id=3176> (March 2009).
Ipsos Reid (2007). "2007 Report Card on the Health Care System in Canada: Health of One in Four Canadians Hurt by the Environment." August. <www.ipsos-na.com/news-polls/pressrelease.aspx?id=3604> (March 2009).
Ipsos Reid (2008). "Not a Great First Impression: Only One in Three (34%) Canadians Claim to Know Anything about Dion's 'Green Shift' Plan." July. <www.ipsos-na.com/news-polls/pressrelease.aspx?id=4000> (March 2010).
Ipsos Reid (2009). "Most (85%) Want Canada to Be Known as a Global Leader in Finding Solutions to Poverty and Protecting the World's Children." November. <www.ipsos-na.com/news-polls/pressrelease.aspx?id=4611> (March 2010).
Kates, Jen, Julie Fischer and Eric Lief (2009). "The U.S. Government's Global Health Policy Architecture: Structure, Programs and Funding." April. Henry J. Kaiser Family Foundation. <www.stimson.org/globalhealth/pdf/GlobalHealth_KFF.pdf> (March 2010).

Kickbusch, Ilona (1989). "Healthy Cities: A Working Project and a Growing Movement." *Health Promotion*. 4(2): 77–82.
Kickbusch, Ilona and Christian Erk (2009). "Global Health Diplomacy: The New Recognition of Health in Foreign Policy." In Andrew Clapham and Mary Robinson, eds., *Realizing the Right to Health*. Zurich: Rüffer and Rub.
Kickbusch, Ilona, Gaudenz Silberschmidt and Paulo Buss (2007). "Global Health Diplomacy: The Need for New Perspectives, Strategic Approaches and Skills in Global Health." *Bulletin of the World Health Organization* 85(3): 230–232. <www.who.int/bulletin/volumes/85/3/06-039222/en/> (March 2010).
Kirton, John (2007). *Canadian Foreign Policy in A Changing World*. Toronto: Thomson-Nelson.
Kirton, John, ed. (2009). *Global Health*. Farnham: Ashgate.
Kirton, John and Jenilee Guebert (2010a). "Canada's G8 Global Health Diplomacy: Lessons for 2010." *Canadian Foreign Policy* 15(3). In press.
Kirton, John and Jenilee Guebert (2010b). "The Climate Change-Health Connection: Compounding Challenges for Scholars and Practitioners." Paper presented at the International Studies Association convention, New Orleans, February 17. <www.g8.utoronto.ca/scholar/kirton-guebert-isa-100217.pdf> (March 2010).
Kirton, John and Jenilee Guebert (2010c forthcoming). "North American Health Governance: Shocks, Summitry and Society Support." *Norteamerica*. In press.
Kirton, John and Jenilee Guebert (2010d). "Soft Law Regulation Coordination and Convergence in North America." In Monica Gattinger and Geoffrey Hale, eds., *Borders and Bridges: Canada's Policy Relations in North America*. Toronto: Oxford University Press.
Maioni, Antonia (2008). "The Media and Public Opinion about Health Care." Health Innovation Forum. <www.healthinnovationforum.org/2008/may/01/media-public-opinion> (March 2010).
Mental Health Commission of Canada (undated-a). "Evergreen: Child and Youth Mental Health." <www.mentalhealthcommission.ca/English/Pages/evergreen.aspx> (March 2010).
Mental Health Commission of Canada (undated-b). "Mental Health Strategy for Canada." <www.mentalhealthcommission.ca/English/Pages/Strategy.aspx> (March 2010).
Labonté, Ronald, and Michelle Gagnon (2010). "What Is the Case for a Canadian Global Health Strategy?" Paper commissioned by the Strategic Policy Branch of the International Affairs Directorate of Health Canada. Draft of March 15.
Orbinski, James (2007). "Global Health, Social Movements, and Governance." In Andrew F. Cooper, John Kirton and Ted Schrecker, eds., *Governing Global Health: Challenge, Response, Innovation*. Aldershot: Ashgate.
Organisation for Economic Co-operation and Development (2009a). "Measuring Aid to Health." November. <www.oecd.org/dataoecd/44/35/44070071.pdf> (March 2010).

Organisation for Economic Co-operation and Development (2009b). "OECD Health at a Glance 2009: Key findings for Canada." <www.oecd.org/documentprint/0,3455,en_2649_33929_44220787_1_1_1_1,00.html> (March 2010).
Phillips, Anne (2001). "Canada Leads the Way in Diabetes Research." *GSK News* (November) <www.gsk.ca/english/docs-pdf/PPNov01ENG.pdf> (March 2010).
Price-Smith (2009). *Contagion and Chaos: Disease, Ecology, and National Security in the Era of Globalization*. Cambridge: MIT Press.
Public Health Agency of Canada (2005). "The Integrated Pan-Canadian Healthy Living Strategy." <www.phac-aspc.gc.ca/hl-vs-strat/pdf/hls_e.pdf> (March 2010).
Public Health Agency of Canada (2006a). "Canada's New Government to Develop a New Heart Healthy Strategy." Press release, October 23. <www.phac-aspc.gc.ca/media/nr-rp/2006/2006_09-eng.php> (March 2010).
Public Health Agency of Canada (2006b). "Diabetes Facts and Figures." <www.phac-aspc.gc.ca/ccdpc-cpcmc/ndss-snsd/english/facts_figures-eng.php> (March 2010).
Public Health Agency of Canada (2007). "Centre for Chronic Disease Prevention and Control." <www.phac-aspc.gc.ca/ccdpc-cpcmc/cancer/cpac-accc_e.html> (March 2010).
Public Health Agency of Canada (2008a). "Canadian Diabetes Strategy." <www.phac-aspc.gc.ca/cd-mc/diabetes-diabete/diabetes_strategy-diabete_strategie-eng.php> (March 2010).
Public Health Agency of Canada (2008b). "Diabetes in Canada: Highlights from the National Diabetes Surveillance System, 2004–2005." <www.phac-aspc.gc.ca/publicat/2008/dicndss-dacsnsd-04-05/pdf/dicndss-04-05-eng.pdf> (March 2010).
Public Health Agency of Canada (2008c). "Report from the National Diabetes Surveillance System, Diabetes in Canada 2008." <www.phac-aspc.gc.ca/publicat/2008/ndssdic-snsddac-08/index-eng.php> (March 2010).
Public Health Agency of Canada (2008d). "Vaccine-Preventable Diseases Measles." <www.phac-aspc.gc.ca/im/vpd-mev/measles-eng.php> (March 2010).
Public Health Agency of Canada (2009a). "HIV and AIDS in Canada: Surveillance Report to December 31, 2008." <www.phac-aspc.gc.ca/aids-sida/publication/survreport/2008/dec/pdf/survrepdec08.pdf> (March 2010).
Public Health Agency of Canada (2009b). "Obesity in Canada: Snapshot." <www.phac-aspc.gc.ca/publicat/2009/oc/pdf/oc-eng.pdf> (March 2010).
Public Health Agency of Canada (2009c). "Report from the National Diabetes Surveillance System, Diabetes in Canada 2008." <www.phac-aspc.gc.ca/publicat/2008/ndssdic-snsddac-08/index-eng.php> (March 2010).
Public Health Agency of Canada (2009d). "West Nile Virus Monitor." <www.phac-aspc.gc.ca/wnv-vwn/index-eng.php> (March 2010).

Public Health Agency of Canada (2009e). "West Nile Virus Monitor: Human Surveillance." <www.phac-aspc.gc.ca/wnv-vwn/mon-hmnsurv-archive-eng.php> (March 2010).
Public Health Agency of Canada (2010a). "The Canadian Pandemic Influenza Plan for the Health Sector." <www.phac-aspc.gc.ca/cpip-pclcpi> (March 2010).
Public Health Agency of Canada (2010b). "Government of Canada Announces Significant Contribution to WHO Global Pandemic Relief Efforts." News release, January 28. <www.phac-aspc.gc.ca/media/nr-rp/2010/2010_0128-eng.php> (March 2010).
Public Health Agency of Canada (2010c). "Tuberculosis Prevention and Control." <www.phac-aspc.gc.ca/tbpc-latb/surv-eng.php> (March 2010).
Public Works and Government Services Canada (2008). "Annual Report 2003–2004." <www.tpsgc-pwgsc.gc.ca/rop-por/rapports-reports/2003-2004/page-13-eng.html> (March 2010).
Ray, Monali, Abdallah Daar, Peter A. Singer and Halla Thorsteinsdóttir (2009). "Globetrotting Firms: Canada's Health Biotechnology Collaborations with Developing Countries." *Nature Biotechnology* 27: 806–814. <www.nature.com/nbt/journal/v27/n9/abs/nbt0909-806.html> (March 2010).
Robbins SCE Research (2004). "Gay Rights Not Important to Canadians — Canadians Want Lower EI Premiums, Proper Military Funding and Health Care Resolved." December 16. <www.robbinssceresearch.com/polls/poll_155.html> (March 2010).
Sharp, Walter R. (1947). "The New World Health Organization." *American Journal of International Law* 41(3): 509–530.
Silberschmidt, Gaudenz (2009). "The European Approach to Global Health: Identifying Common Ground for a U.S.-EU Agenda." Center for Strategic and International Studies. <csis.org/files/publication/091112_Silberschmidt_EuroApproach_Web.pdf> (March 2010).
Singer, Peter (2009). "Canada's Strategic Role in Global Health." Meeting Summary of the Canadian Academy of Health Sciences Global Health Symposium. <www.cahs-acss.ca/e/pdfs/CAHS_Global_Health.summary.pdf> (March 2010).
Singer, Peter (2010). "Innovation and Global Health: Canada's G8 Opportunity." Speaking notes for a conference on "Accountability, Innovation and Coherence in G8 Health Governance: Seizing Canada's G8 Opportunity," Toronto, January 25. <www.mrcglobal.org/files/PSinger-InnovationandGlobalHealthCanadasG8OpportunityJanuary252010.pdf> (March 2010).
Smylie, Janet (2004). "Why Canada Should Support an Independent International Indigenous Global Health Strategy." <www.csih.org/en/advocacy/IndigenousGlobalHealth.pdf> (March 2010).
Sridhar, Devi (2009). "Foreign Policy and Global Health: Country Strategies." Introduction to Health and Foreign Policy. Global Health Governance Project, University College, Oxford University. <www.globaleconomicgovernance.org/

wp-content/uploads/Health-and-Foreign-Policy-Introduction-28-May-2009.pdf> (March 2010).
Starky, Sheena (2005). "The Obesity Epidemic in Canada." Ottawa: Library of Parliament. <www2.parl.gc.ca/Content/LOP/ResearchPublications/prb0511-e.pdf> (March 2010).
Switzerland. Federal Department of Home Affairs and Federal Department of Foreign Affairs (2006). *Swiss Health Foreign Policy: Agreement on Health Foreign Policy Objectives.* Geneva. <www.bag.admin.ch/themen/internationales/index.html?lang=en> (March 2010).
United Kingdom. HM Government (2008). "Health Is Global: A UK Government Strategy 2008–13." <www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702> (March 2010).
United Nations (2010). "Millennium Development Goals." <www.un.org/millenniumgoals> (March 2009).
World Health Organization (2004). "Summary of Probable SARS Cases with Onset of Illness from 1 November 2002 to 31 July 2003." 21 April. Geneva. <www.who.int/csr/sars/country/table2004_04_21/en> (March 2010).
World Health Organization (2006). "Obesity and Overweight." Fact Sheet No. 311, September. <www.who.int/mediacentre/factsheets/fs311/en> (March 2010).
World Health Organization (2007). "New Initiative Seeks Practical Solutions to Tackle Health Worker Migration." May 15. <www.who.int/mediacentre/news/notes/2007/np23/en> (March 2010).
World Health Organization (2009). "10 Facts on HIV/AIDS." November. <www.who.int/features/factfiles/hiv/en> (March 2010).
World Vision International (2009). "Global Health and Nutrition Strategy." <www.wvi.org/wvi/wviweb.nsf/11FBDA878493AC7A882574CD0074E7FD/$file/Quick_Guide_for_Global_Health_and_Nutrition.pdf> (March 2010).

Appendix A:
Canada's Global Health Contributions

Selected Projects

Global Polio Eradication Initiative	CA$267 million (1985–2010)
Global Fund to Fight AIDS, Tuberculosis and Malaria	US$100 million (2002–10)
Global Alliance Vaccine Initiative (core funding)	US149 million (2002–06)
Global Alliance Vaccine Initiative (AMC)	US$200 million (2007–10)
Catalytic Initiative to Save a Million Lives	CA$105 million (2007–12)
Avian and/or pandemic influenza	CA$1 billion (2006–11)
Bilateral aid to India for the health sector	US$1 million (2006–07)
Bilateral aid to Nigeria for the health sector	US$9 million (2006–07)
Bilateral aid to Kenya for the health sector	US$3 million (2006–07)
Bilateral aid to South Africa for the health sector	US$6 million (2006–07)
Bilateral aid to Mozambique for the health sector	US$8 million (2006–07)
Bilateral aid to Ethiopia for the health sector	US$37 million (2006–07)
Bilateral aid to Zambia for the health sector	US$15 million (2006–07)
Bilateral aid to Tanzania for the health sector	US$11 million (2006–07)
Bilateral aid to Uganda for the health sector	US$1 million (2006–07)
Bilateral aid to Pakistan for the health sector	US$7 million (2006–07)
Bilateral aid to unspecified recipients for the health sector	US$358 million (2006–07)

Funding Recipients

- Afghanistan
- Bangladesh
- Bolivia
- Ethiopia
- Haiti
- Honduras
- Indonesia
- Mali
- Mozambique
- Pakistan
- Peru
- Sudan
- Tanzania
- Ukraine
- West Bank and Gaza

Additional recent and current initiatives include support for:

- Responding to cholera outbreaks in Angola
- Community-based treatment of malaria and pneumonia in all African countries
- UNICEF's Recovery of Vital Social Sector program in Iraq
- Support for the Global Fund to Fight AIDS, Tuberculosis and Malaria, which includes funding to the Middle East and Eastern Europe
- Support for the Pan American Health Organization, which includes the Americas
- The CARE Canada program, which focuses on HIV/AIDS and assists Cambodia and Nepal, and others
- Asia-Pacific Strategy for Emerging Diseases, a component of the Canada-Asia Regional Emerging Infectious Disease Project (CAREID) in South East Asia and China
- Strengthening Health Systems, a World Health Organization project in Boznia-Herzegovina
- HIV/AIDS Harm Reduction, an Open Society Institute project in Russia, Ukraine and Georgia
- The World Bank's Montenegro Health System Improvement Project
- Canadian Society for International Health's Primary Health Care Policy Reform in the Balkans

Note: Canada announced in 2009 that it would focus 80% of bilateral resources in 20 countries of focus chosen according to real needs, capacity to benefit from aid and alignment with Canadian foreign policy priorities.

Sources: Global Polio Eradication Initiative (2010); Global Fund to Fight AIDS, Tuberculosis and Malaria (2010); GAVI Alliance (2010); Canada International Development Agency (2009b, 2009c, 2010); Organisation for Economic Co-operation and Development (2009a); Canada, Department of Finance (2006).

Appendix B:
Global Health Actors in Canada

- Canadian Food Inspection Agency (CFIA)
- Canadian Institutes for Health Research (CIHR)
- Canadian International Development Agency (CIDA)
- Department of Agriculture and Agri-Food Canada
- Department of Foreign Affairs and International Trade (DFAIT) (formerly Department of External Affairs)
- Department of National Defence (DND)
- Environment Canada
- Health Canada
- Health Council of Canada
- Indian and Northern Affairs (INAC)
- Industry Canada
- International Development Research Council (IDRC)
- Prime Minister's Office (PMO)
- Privy Council Office (PCO)
- Public Health Agency of Canada (PHAC)
- Public Safety Canada

Appendix C:
Canada's Role in Regional and International Health-Related Organizations

International – Multilateral
- Food and Agriculture Organization (FAO)
- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- United Nations General Assembly (UNGA)
- United Nations High Commission for Refugees (UNHCR)
- World Health Organization (WHO) and the World Health Assembly (WHA)
- World Intellectual Property Organization (WIPO)
- World Trade Organization (WTO)

International – Plurilateral
- Asia Pacific Economic Cooperation (APEC)
- Commonwealth
- Global Health Security Initiative (GHSI)
- Global Public Health Intelligence Network (GPHIN)
- Group of Eight (G8)
- La Francophonie
- Organisation for Economic Co-operation and Development (OECD)

Regional
- Arctic Council
- Commission for Environmental Cooperation of North America (CEC)
- North American Leaders' Summit
- Pan American Health Organization (PAHO)

Appendix D:
Canadians Affected by Diseases

Year	West Nile Virus		Tuberculosis[a]		HIV[b]	AIDS[c]		SARS		H1N1		Seasonal Influenza	Measles	Diabetes	Obesity[e]
	Cases	Deaths	Cases	Deaths	Cases	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Cases	Cases	% of Population
1979						1									
1980						3	2								
1981						8	5								
1982						26	13								
1983						64	28								
1984						162	80								
1985						402	175								
1986						688	341								
1987						1,012	528								
1988						1,180	622								
1989						1,408	820								
1990			1,997			1,466	912								
1991			2,018			1,515	1,105								
1992			2,109			1,755	1,292								
1993			2,012			1,829	1,412								
1994			2,074		32,878[f]	1,789	1,470								
1995			1,931		2,948	1,651	1,501								
1996			1,849	117	2,737	1,189	1,063								
1997			1,975	120	2,471	725	473								
1998			1,810	122	2,293	647	282								
1999			1,821	129	2,191	558	272					7,027		1,200,000	
2000			1,724	111	2,105	500	265					4,154	~200		14.9
2001			1,773	126	2,217	426	202					6,771	~10		
2002	414	14	1,666	115	2,469	410	144					3,517	~10		
2003	1481	14	1,613	112	2,482	382	153	251	44			11,435	~10		15.4
2004	25	0	1,613	105	2,530	324	83					12,879	~10	1,800,000	23.4
2005	225	10	1,641	98	2,496	354	66					7,422	~10	1,900,000	24
2006	151	2	1,654	111	2,550	311	56					8,133	~10	2,000,000	
2007	2215	12	1,577	143	2,452	260	48					12,256	101		25
2008	36	0	1,600	NA	2,623	255	45			12,262	77	23,376			
2009	8	0								33,477	348	39,044			

Notes:

SARS = severe acute respiratory syndrome.

a. Incidence rate is per 100,000. Numbers for 2008 are provisional.

b. The number of positive HIV test reports by year up to February 13, 2009. Annual data are unavailable for positive HIV test reports prior to 1995. Positive HIV test reports vary for cases under two years of age.

c. The number of reported AIDS cases by year of diagnosis goes to February 12, 2009, except for Quebec, for which no data are available after June 30, 2003.

d. In 2008–10 there has been an increase in cases due to pandemic (H1N1) 2009 influenza virus. The 2009–10 influenza season began on August 30, 2009. Cases include influenza A and B up to February 6, 2010.

e. Data for 2000–04 include adults ages 20–64. Data for 2005 and 2007 include adults over age 18.

f. Number of cases reported between 1985 and 1994.

Sources: Community and Hospital Infection Control Association – Canada (2009, 2010a, 2010b); Public Health Agency of Canada (2006b, 2008b, 2008c, 2008d, 2009a, 2009b, 2009c, 2009e, 2010c); Starky (2005); World Health Organization 2004.

Appendix E:
Canadian Public Opinion on Health Issues

Date	%	Rank	Statement	Poll
Dec 2004	35	1[a]	Canadians believe their member of Parliament should be spending time on discussions of the Canada Health Act and its practical evolution in maintaining high standards of health care for all Canadians	RSR
2006	67		Canadians approve the overall quality of healthcare services available	IR
Sep 2006	*54*		*Harper was wrong not to attend the International AIDS conference*	*IR*
Apr 2006	63		Canadians are not confident that Canada will have enough healthcare professionals in 10 years	IR
Apr 2006	60		Canadians believe that health services are best improved with increased numbers of health professionals	IR
Aug 2007	27		Canadians have been affected by an environmental health concern	IR
Aug 2007	65		Canadians have taken action to protect their health from the environment	IR
Aug 2007	36		Canadians think the federal government is doing enough to address environmental and health concerns	IR
Aug 2007	87		Canadians are concerned about environmental standards in other countries and impact on imported food	IR
Aug 2007	82		Canadians are concerned about climate change and its impact on health	IR
Aug 2007	82		Canadians are concerned about the potential for climate change to encourage spread of disease	IR
Aug 2007	79		Canadians are concerned about air pollution	IR
Aug 2007	76		Canadians are concerned about heat and sun exposure	IR
Aug 2007	75		Canadians are concerned with the use of herbicides and pesticides	IR
Aug 2007	74		Canadians are concerned with the effects of soil contamination on local fruits and vegetables	IR
Aug 2007	70		Canadians are concerned with water quality	IR
Aug 2007	62		Canadian approved of the overall quality of healthcare services available	IR
Aug 2007	*91*		*Canadians believe it is important for government to help increase access to treatment for people with HIV/AIDS in developing countries*	*IR*
Aug 2007	*48*		*Canadians believe government's foreign spending on HIV/AIDS is not enough*	*IR*
Nov 2007	*77*		*Canadians are concerned about HIV/AIDS when they think about global issues*	*IR*
Nov 2007	*90*		*Canadians believe if they can prevent people from getting infected with HIV they have a moral obligation to try*	*IR*
Nov 2007	*80*		*Canadians think government should do more to ensure people get HIV/AIDS treatment*	*IR*
May 2008	86		Canadians think there is a shortage of doctors	IR

Date	%	Rank	Statement	Poll
May 2008	96		Canadians think the government should address the shortage of doctors	IR
Aug 2009	86		Canadians strengthening public health care rather than expanding for-profit services	NR
Aug 2009	85		Canadians aged 15 and over reported being "very satisfied" or "somewhat satisfied" with the way overall healthcare services were provided	NR
Nov 2009	*88*		*Canadians believe Canada should use its influence in hosting the G8 and G20 to reduce global child mortality*	*IR*
Jan 2010	*89*		*Canadians believe that Canada should be a global leader in global health and medical research*	*RC*
Jan 2010	84		Canadians think health and medical research makes an important contribution to the economy	RC
Jan 2010	90		Canadians believe basic research should be supported by the government even if it brings no immediate benefit	RC
Jan 2010	12	3[b]	Canadians think health care is the most important issue facing Canada today	RC
Mar 2010	23	2[c]	Canadians think health care should be the top priority for Canadian leaders	IR

Notes:

IR=Ipsos Reid; NR = Nanos Research; RC = Research Canada; RSR=Robbins SCE Research.

Italics indicates polls related to international issues.

a. Canadian were asked to choose between discussions of the Canada Health Act and its practical evolution in maintaining high standards of health care for all Canadians (35%), the role of Canada's Armed Forces in negotiations related to Canadian sovereignty and strategic missile defence with U.S. president George W. Bush (32%), the issue of Charter rights and specifically the rights of gay men and women to marry (3%), and the use of the employment insurance surplus of $50 billion to reduce negative impact of high employment insurance rates on employees and employers (34%).

b. Of 14 issue areas, health care was ranked third most important after the economy (32%) and the environment (13%).

c. The economy was ranked first (36%), followed by health care (23%), the environment (17%), and jobs and unemployment (16%).

Sources: CNW Group (2009b); Ipsos Reid (2006, 2007, 2008, 2009); Association of Faculties of Medicine of Canada et al. (2010); Robbins SCE Research (2004).

Appendix F:
Benefits, Costs and Risks of a Global Health Strategy for Canada

Benefits

A global health strategy for Canada would:

- lead to better health in Canada and globally
- provide added value for each ministry involved
- improve the understanding of what is being done among Canadian actors and stakeholders
- improve effectiveness and efficiency, in terms of both financial and human resources
- provide a clear framework, aim and focus
- support Canada in meeting its domestic and international heath objectives
- be an example of cooperation that could be followed in other areas, such as agriculture
- provide articulated and identifiable goals
- provide greater transparency on Canada's global health goals and on actions taken to achieve them
- determine topics, subjects and research that might be explored
- address any competing objectives that exist within different departments or agencies
- coordinate and streamline the health-related departments and agencies
- ensure that Canada can respond to unexpected health-related crises
- ensure that Canada's interests and values are reflected in its global health initiatives
- support Canada's foreign policy and international economic and development goals
- strengthen national security through better partnerships at home and abroad
- respond to the desires of Canadians and stakeholders who want Canada to play a larger role in global health
- mobilize more resources by providing a centralized forum where all actors can identify opportunities for cooperation
- identify activities to be enhanced, eliminated or reformed during resource-constrained times
- help Canada coordinate best practices
- support Canada's collaboration with partner countries that already have a global health strategy

Costs

Costs involved in a global health strategy include:

- financial and human resources to developing a strategy (staffing, consultations, etc.)
- diversion of resources and attention from other challenges
- possible adjustment or modification of missions among actors
- possible difficulty in agreeing on a comprehensive approach
- possible factions or divisions among actors involved
- delays in developing the strategy
- time-consuming analysis of existing commitments and component strategies
- potential requirement or modification of legislation to authorize the involvement of some actors or resources
- possible complications that arise from Canada's complex federal system

Risks

Risks to Canada in having a global health strategy include:

- dissatisfaction among actors due to conflicting priorities
- alienation among actors
- overcrowding of actors
- possible unintended consequences, such as resources diverted from issues that need more attention
- negative consequences for other countries (such as seeking health providers from other countries)
- unwanted debates
- a strategy that is too rigid to be able to adapt to changing situations and needs
- a strategy that is under- or over-ambitious
- a strategy that does not include all the relevant actors
- a strategy that is too general or insufficiently focused
- limits to coherence in investments
- satisficing
- log rolling
- failure to achieve declared goals
- failure to fulfil expectations and satisfy demands for accountability
- disregard for existing commitments in favour of new priorities or pledges
- reduced competition among health actors

Note: This is a compilation of points identified through research of published materials, key interviews and brainstorming exercises.

Appendix G:
Canada's Free Trade Agreements

Canada has free trade agreements with the following:
- Chile
- Colombia
- Costa Rica
- Iceland (Canada-European Free Trade Association)
- Israel
- Jordan
- Liechtenstein (Canada-European Free Trade Association)
- Mexico (North American Free Trade Agreement)
- Norway (Canada-European Free Trade Association)
- Panama
- Peru
- Switzerland (Canada-European Free Trade Association)
- United States (North American Free Trade Agreement and previously the Canada-U.S. Free Trade Agreement)

Canada is negotiating free trade agreements with the following:
- Americas
- Andean Community
- Caribbean Community
- Centre American Four — El Salvador, Guatemala, Honduras and Nicaragua
- Dominican Republic
- European Union
- India
- Korea
- Morocco
- Singapore
- Ukraine

Source: Canada, Department of Foreign Affairs and International Trade (2010b).

Appendix H:
Effects of Climate Change on Human Health Identified by the Intergovernmental Panel on Climate Change

Very High Confidence	High Confidence	Medium Confidence	Low Confidence
Climate change contributes to global burden of disease and premature deaths	Emerging evidence shows that climate change has altered seasonal distribution of some allergenic pollen species	Emerging evidence shows climate change has altered distribution of some infectious disease vectors	Projected trends will increase number of people at risk of dengue
Projected trends will affect malaria: contract in some areas and expand in others; transmission season may change	Projected trends will increase malnutrition and consequent disorders, including those relating to child growth and development	Emerging evidence shows that climate change has increased deaths related to heat waves	
Economic development is component of adaptation but cannot insulate population from disease and injury due to climate change	Projected trends will increase the number of people suffering from death, disease and injury from heat waves, floods, storms, fires and droughts	Projected trends will increase burden of diarrheal diseases	
	Projected trends will change range of some infectious disease vectors		
	Projected trends will increase cardiorespiratory morbidity and mortality associated with ground-level ozone		
	Projected trends will bring some benefits to health, fewer deaths from cold, but likely outweighed by negative effects of rising temperatures, especially in developing countries		
	Adaptive capacity needs to be improved; impacts of recent hurricanes and heat waves show that even high-income countries not well prepared for extreme weather events		
	Adverse health impacts will be greatest in low-income countries and, in all countries, on urban poor, elderly, children, traditional societies, subsistence farmers and coastal populations		

Source: Intergovernmental Panel on Climate Change (2007b).

Appendix I:
Comparison of National Global Health Strategies

Britain	Switzerland	European Union	United States
Principles			
• Do no harm; evaluate impact of domestic and foreign policies on global health to ensure intentions are fulfilled • Base global health policies and practice on evidence; develop evidence where it does not exist • Use health as agent for good, recognizing it can promote a low-carbon, high-growth global economy • Promote global health outcomes that support the MDGs • Promote health equity through foreign and domestic policies • Ensure effects of foreign and domestic policies on global health are explicit; ensure transparency on conflicts between the policy objectives • Work for leadership through reformed, strengthened institutions • Learn from other countries' policies and experience to improve population health and healthcare delivery • Protect health by tackling health challenges that begin abroad • Work with other governments, multilateral agencies, civil society and business		• Based on shared health values • Consider health the greatest wealth • Consider Health in All Policies (HIAP) • Strengthen the EU's voice in global health	• Match ambitions with long-term commitments at the highest levels of US leadership • "Trust but verify" • Build on existing successes • Prioritize prevention • Be targeted • Embed global health investments within larger development enterprise

Britain	Switzerland	European Union	United States
Goals			
• Better global health security • Stronger, fairer and safer systems to deliver health • More effective international health organizations • Stronger, freer and fairer trade for better health • Strengthening of the way evidence is developed and used to improve policy and practice	• Protect health interests of the Swiss population • Harmonize national and international health policies • Improve effectiveness of international collaboration in health • Improve global health situation • Safeguard role as host to international organizations and base for companies in health sector	• Fostering good health in an aging Europe • Protecting citizens from health threats • Supporting dynamic health systems and new technologies	• Maintain commitment to fight against HIV/AIDS, malaria and tuberculosis • Prioritize women and children in US global health efforts • Strengthen prevention and capabilities to manage health emergencies • Ensure the United States has capacity to match global health ambitions • Invest in multilateral institutions
Measures			
		• Establish coordinating office for health foreign policy • Create information platform for health foreign policy • Produce policy papers on health foreign policy and strengthen academic competence • Harmonize with general foreign policy and other policies • Create Interdepartmental Conference on Health Foreign Policy	
Resources			
• 07% of GNI on international development by 2013 • £6 billion on health systems and services (2008–15) • £1 billion for the Global Fund • £400 million for global health research (2008–13)	• No additional resources planned for implementation	• Actions supported by existing financial instruments until end of 2010 financial framework (2013), without additional budgetary consequences	• $63 billion for Global Health Initiative (2009–14) • $25 billion annually (adjusted for inflation) (2010–15) • increase multilateral funding from 15% to 20%

Notes:
Bold indicates actions where Canadian priorities and interests overlap.

Global Fund = Global Fund to Fight AIDS, Tuberculosis and Malaria; GNI = gross national income; MDGs = Millennium Development Goals.

Sources: Switzerland, Federal Department of Home Affairs and Federal Department of Foreign Affairs (2006); United Kingdom, HM Government (2008); Commission of the European Communities (2007); Sridhar (2009); Fallon and Gayle (2010).

Appendix J:
Steps for Creating a Canadian Global Health Strategy

The next steps to consider when developing a Canadian global health strategy should include the following:

1. Choose a task team that will be responsible for overseeing and reviewing the process, reporting on implementation and suggesting next steps. An independent, third-party could make up this team or it could comprise key officials from Health Canada, Public Health Agency of Canada (PHAC), the Canadian International Development Agency (CIDA) and the Department of Foreign Affairs and International Trade (DFAIT). The team would be responsible for overseeing the Canadian global health strategy and coordinating the additional departments and actors involved.
2. Engage in two phases of consultations with all key actors, both within Health Canada and PHAC as well as interdepartmentally at the federal level, to include the Prime Minister's Office, DFAIT, Agriculture and Agri-Food Canada, Environment Canada, Indian and Northern Affairs, Public Safety Canada, Department of National Defence, Industry Canada, CIDA and the Canadian Food Inspection Agency. Consultations should also include the Health Council of Canada, the Canadian Institutes of Health Research, the International Development Research Centre, and provincial and territorial governments. They should also draw on expertise that exists in the private sector and in civil society, including philanthropic entities, non-governmental organizations and academia.
   - Phase One: Identify the objectives of the Canadian global health strategy and their underlying principles of those objectives. The task team should compile a list of all the objectives and principles. Any contradictions that cannot be resolved internally should be addressed with the involvement of relevant outside actors. Provincial, international and public objectives and principles should be next considered and compared with those identified for a national global health strategy.
   - Phase Two: Determine the priorities of the Canadian global health strategy. The specific targets should be weighted according to those with the most support among stakeholders and then placed within a broader framework. The lead and supporting actors for each action should then be identified.
5. The task team should choose an appropriate time line that fits with the established priorities. A five-year term is consistent with the other countries' global health strategies and fits well within the Millennium Development Goals. However, the priorities chosen should dictate the time frame. The schedule for conducting reviews should also be decided so that the strategy can remain relevant and effective.
6. The task team should identify partners within Canada from outside government, including academia, the private sector and civil society, as well as other national governments and international organizations.
7. The task team should identify necessary resources to develop the global health strategy, including financial commitments, human resources and programming costs to implement the global health strategy.

Appendix K:
Research Methodology

A team of researchers from the University of Toronto's Global Health Diplomacy Program and G8 Research Group compile the appendices from published and public material. The analysis used to identify the Canadian principles relevant to global health was based on a systematic analysis of all health-related passages in the Speeches from the Throne and major foreign policy statements since 1947, including statements by Canadian prime ministers at the United Nations General Assembly and statements made by Cabinet ministers. Materials are available upon request.

Interviews were conducted with key stakeholders and experts in the fields related to Canada and global health.

Deliberations held at the Global Health Diplomacy Program's conference on "Accountability, Innovation and Coherence in G8 Health Governance: Seizing Canada's G8 Opportunity" in January 2010 at the Munk Centre for International Studies in Trinity College at the University of Toronto were considered.

The authors' field experiences and past research were drawn on.