the web. In addition, other important health-related domain names including .doctor, .healthcare, .hospital, and .medical are also pending award to exclusively private sector entities, the majority of which have no clear restrictions on use.

Summary/Conclusion: The lack of adequate representation by the global public health community in applying and management of new health-related gTLDs is worrisome and could compromise the future quality of health information online. Countries, medical associations, civil society, and consumer advocates have objected to these applications on grounds that they do not meet the public interest and may not adequately engage in consumer protection activities. We argue that there is a crucial need for quality and evidence-based sources of health information online and that proper governance by the international community is necessary. This could be accomplished by requesting ICANN to re-categorize .health as a sponsored gTLD and proactively appoint WHO its sponsor. By re-categorizing .health (similar to eligibility requirements in place since 2001 for .edu as a sponsored gTLD), WHO would develop policies to ensure accountability and transparency in gTLD operations that meet the best interests of the global health community and enforce eligibility rules regarding all future health registrants.

An expanded immunization program for US-bound refugees: Ethiopia, Kenya, Malaysia, Nepal, and Thailand, 2013

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Background: Up to 70,000 refugees, primarily from Asia, Africa, and the Middle East, will resettle to the United States in FY 2014. US-bound refugees are required to undergo a medical examination overseas to identify communicable diseases of public health significance, such as pulmonary tuberculosis. However, the required examination does not include vaccinations. Before resettlement, these refugees are at high risk for vaccine-preventable diseases due to difficult living conditions and lack of access to routine immunization services in both their countries of origin and host countries. Since 2005, US-bound refugees have experienced multiple outbreaks of vaccine-preventable diseases, including measles, rubella, and polio. Such outbreaks have led to morbidity, significant delays in resettlement, and substantial economic expenditure related to outbreak response and control. There is typically a 4- to 12-month period of processing between enrollment in the US resettlement program and US arrival. This time period presents a window of opportunity in which to deliver effective public health interventions to improve refugee health and prevent importation of diseases into the United States. We sought to develop and implement an expanded vaccination program for US-bound refugees.

Structure/Method/Design: The Centers for Disease Control and Prevention (CDC) Immigrant, Refugee, and Migrant Health Branch, in close consultation with CDC subject-matter experts, developed recommendations for provision of seven vaccines to US-bound refugees, protecting against 10 diseases. Implementation began in 2013. A toolkit covering vaccine schedules and administration, storage and handling, and adverse events monitoring was assembled. Checklists for program monitoring and evaluation were piloted.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): The International Organization for Migration, which conducts the overseas medical examination, is the implementing partner. The US Department of State co-funds the program with CDC.

Summary/Conclusion: A program for expanded immunization of US-bound refugees at the time of overseas medical examination is in the process of implementation, and may contribute to better health during and following resettlement as well as save costs. From January to September 2013, approximately 36,000 US-bound refugees in Ethiopia, Kenya, Malaysia, Nepal, and Thailand received immunizations as part of this program, with coverage rates of ~97% among those eligible for the first dose of MMR vaccine (used as a proxy since most age groups are eligible for this vaccine). Ongoing challenges have included vaccine procurement, cold chain maintenance, scheduling of next-due vaccine doses, proper review and documentation of previous immunization records, and modification of recommendations in outbreak settings. Future plans include expansion of this program to larger groups of US-bound refugees, and determination of its success in reducing the incidence and costs of vaccine-preventable diseases in recipients.

Global health influences internationalization priorities at Canadian universities

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Background: Canadian universities are at a turning point with federal funding reductions, national enrolment numbers declining, and private partnerships becoming a mandatory component to research and programming priorities. With these challenges, universities have turned to the international market focusing on enrollment and research funding as a potential answer to their financial challenges. The reality is that fee-paying international students will help budget constraints and provide an avenue for maintaining existing and enhancing additional resources of growth and diversification within institutions of higher education. The international market as only a "financial" resource is a narrow view of globalization.

Historically global health was viewed as a health issue germane to vulnerable communities like many countries in Africa, regions in conflict and humanitarian disasters. Now global health issues are recognized as a domestic issue (e.g., aboriginal child mortality) and global health solutions learned in other countries are now being established within the Canadian health care system (e.g., community based rehabilitation). It is of mutual benefit and interest to have a common global health strategy and network on which to learn together, share progress, and celebrate improvement in health status globally.

Resources, partnerships, and interest in global health continue to grow within the Canadian university environment. While the global health community is diverse, there is a common vision and set of principles based on social responsibility, ethical engagement, and collaboration.

Global health has typically sat in the background of the internationalization priorities within Canadian universities. However, several universities recognize the need to bring global health into the dialogue and planning of internationalization. This paper will explore the opportunities for global health to influence a socially and fiscally responsible Canadian university.

Structure/Method/Design: This review and analysis highlights a summary of Canada's International Education Strategy as well as approved internationalization strategies at Canadian universities.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Internationalization strategies exclude global health at most universities. Two Canadian universities have demonstrated their commitment to developing global health principles into their internationalization and socially responsible mandates. Parallel to this work are global health networks mobilizing to strengthen this

movement and ensure that global health principles are guiding university priorities.

Summary/Conclusion: Building a robust global health agenda for the training of talent, extension of relationships across multiple borders, and the mobilization of new ideas among higher education institutions and partners is what will unquestionably benefit our domestic community and foster global stability. Approaching internationalization of higher education where sector issues, like global health are core is a much richer, more relevant, and necessary approach to strategy development.

Health systems strengthening in the post-2015 global development agenda

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Background: The United Nations (UN) Millennium Development Goals (MDGs) were created in 2000 to address the world's most pressing development challenges. Though successful in some regards, all three health MDGs are not on track to meet their objectives by 2015. One possible explanation is the lack of emphasis on health systems strengthening (HSS) in global health (GH) efforts. In 2007, the World Health Organization (WHO) described an HSS framework, including six building blocks: service delivery; workforce; information; medical products, vaccines, and technologies; financing; and leadership/governance. Many GH organizations have subsequently advocated for HSS (Hafner and Jeremey, 2012). The UN post-2015 agenda provides an opportunity to prioritize HSS; the extent to which this is occurring in the post-2015 dialogue is unclear.

Citations:

World Health Organization. Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. 2007.

Hafner, Tamara and Shiffman, Jeremey. The Emergence of Global Attention to Health Systems Strengthening. Health Policy and Planning 2012;1–10.

Structure/Method/Design: Published post-2015 reports were reviewed from the following web pages (December, 2013):

UN: Beyond 2015 (http://www.un.org/millenniumgoals/beyond2015-overview.shtml)

UN: Sustainable development knowledge platform, health and population dynamics (http://sustainabledevelopment.un.org/index.php?page=view&type=9502&menu=1565&nr=6)

WHO: Health in the post-2015 UN development agenda (http://www.who.int/topics/millennium_development_goals/post2015/en/)

World We Want: Health Thematic Consultation (http://www.worldwewant2015.org/health)

Reports were examined if they discussed health goals for the post-2015 agenda.

These reports were searched for "health systems" and statements supporting the building blocks of HSS. Quotes were extracted and assessed for 1) the degree of support for HSS in the post-2015 agenda, 2) HSS metrics, and 3) the context arguing for HSS. Degree of support was categorized as absent (HSS not mentioned), weak (HSS mentioned but no building blocks included), or strong (HSS mentioned including at least one building block).

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): A total of 12 reports met the inclusion criteria. Four of the 12 reports were classified as "strong" in their support for HSS; 5 were weak and 3 made no mention of HSS. No reports suggested metrics for HSS. When HSS was mentioned, it was most often included in the context of calling for universal health coverage rather than other potential development goals, such as addressing noncommunicable diseases or accelerating the MDGs.

Summary/Conclusion: HSS appears to be mentioned in the majority of reports addressing health in the post-2015, although a robust roadmap for its incorporation is lacking. To insure that HSS is realized, subsequent steps in the post-2015 process should aim to 1) develop metrics to measure success and 2) broaden ways in which HSS can support all health-related development goals.

An NGO code of conduct for health systems strengthening: Maximizing the performance of nongovernmental organizations to support broad health system development

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Background: Health systems in the developing world are often characterized by severe shortages of human resources, inadequate infrastructure, and limited capacity. Despite a growing donor focus on "health systems strengthening," programs like PEPFAR and the Global Fund continue to preferentially seek out nongovernmental organization (NGO) partners. In addition, the growing global focus on the end of AIDS in a post-Millennium Development Goals (MDG) world often results in vertically funded programs that can have detrimental effects on public-sector human resources. The rise of NGO-driven service delivery has led to a proliferation of different projects and approaches, often with poor follow-up, limited oversight, and varied levels of success.

Structure/Method/Design: In May 2008, a group of health-focused organizations launched the "NGO Code of Conduct for Health Systems Strengthening." This voluntary strategy aims to ensure that NGOs "do no harm" and contribute maximally to building public health systems. We will present the process of developing the code, key elements and rationale, and concerns that have arisen during the adoption and implementation of Code policies.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Our own experience in implementing the Code, as well as the results of a 2010 evaluation among a sample of the 57 signatories, has shown that the current donor environment—which funnels financing toward international NGOs rather than long-term investments into the public sector—makes it extremely difficult for signatory NGOs to implement more equitable hiring processes. Barriers to implementation include recruiting qualified staff to implement NGO programs without damaging the public-sector workforce and providing comparable salaries to MOH staff.

Summary/Conclusion: In the areas of hiring practices, compensation schemes, training and support, reduction of management burden, and assistance in integrating communities into the formal health system, international NGOs have an opportunity to support public-sector health system strengthening through sustainable practices promoted in the NGO Code of Conduct. To effectively implement these practices, however, donors must be called on to also sign and make the implementation of the NGO Code of Conduct a requirement for recipient organizations as a condition of funding.

Generating political priority for urban health and nutrition: Application of a policy framework

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