



National Collaborating Centres
for Public Health

Centres nationaux de collaboration
en santé publique

Collaborative Models for Improving Public Health Knowledge

The Experience of the National Collaborating Centres for Public Health, Canada

Lars K. Hallstrom, PhD. (Acting Director, NCCDH)

Denise Kouri (Lead, NCCHPP)

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The Canadian National Collaborating Centres



Background

- Initiated in 2004 as part of the Pan-Canadian Public Health Strategy
 - Identified need for supporting evidence-based or informed public health
 - 6 different centres created
 - To be hosted in 6 different regions and institutions
 - Both reactionary and visionary
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Structure

- Decentralized approach – reflects federal structure and political reality of Canada
 - Centres in 5 different provinces (2 in BC)
 - 1 Centre in each “region” except Northern Canada
 - 1 Centre is explicitly situated in a region: NCCDH
 - 1 Centre is explicitly population-specific: NCCAH
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Structure

- Each centre is largely self-directed
 - Secretariat support at the centre (PHAC)
 - No central hub or node
 - Each NCC is structured differently and operates accordingly re: staffing, budgets and location
 - Some commonalities:
 - International Advisory Council to PHAC
 - 6 Advisory Councils/Committees
 - Drawing from national and international expertise
 - 2 – 4 meetings per year
 - Scientific Leads/Leads/Directors
 - Different structures and policies of host institutions (3 universities of different size, 3 health bodies)
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Strengths

- Still early to assess complete range of strengths
 - One key strength: capacity to link networks and identify gaps in both knowledge, network connectivity and KSTE activities
 - Indicated by extensive collaboration across Canada and internationally with actors from multiple levels
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Theories of collaboration...

- No formal theory or method articulated – still emerging
 - Different interpretations of the nature, purpose and functions of collaboration across the NCCs
 - Eg. for NCC Aboriginal Health, collaboration is explicitly “bi-cultural” and seeks to recognize and work within the intersection between indigenous knowledges and “dominant culture” knowledge
 - NCCDH and Atlantic Canadian institutions collaborate to capitalize on economies of scale and to share often scarce resources
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Operational Collaboration

- One key collaboration is between researchers (knowledge generation) and public health practitioners (knowledge users)
 - Universities are primary knowledge generators – model was initially uni-directional
 - Increasing awareness of multiple sources/location of public health knowledge, as well as relationships between different locations
 - Inter-NCC and with the public health “system”
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Collaboration and improving (Canadian) public health

- Collaboration is a tool intended to:
 - Support evidence-informed decisionmaking as method and practice
 - Increase capacity of public health practitioners to make evidence-informed decisions
 - Implicit strengths of collaboration:
 - the underlying ethical principles of collaboration, namely cooperation, mutual benefit, economies of scale and even cost-sharing;
 - building connections across multiple networks of researchers, practitioners, policy makers and policy analysts (these networks can be social, institutional, issue-based, etc);
 - recognizing that there are multiple contexts within which public health interventions, policies and programs can be implemented and evaluated, thus requiring a certain degree of flexibility and adaptability
 - What is meant by “improving”?
 - Different measures and conceptions
 - National vs. regional forces and foci
 - What about the international ?
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Collaborating Actors and Organizations

- Knowledge generators:
 - Universities across Canada
 - Consultants
 - NGOs
 - Content experts
 - Policy analysts
 - Government (F/P/T)
 - Knowledge synthesis:
 - Universities across Canada
 - PH Practitioners at local, regional and national levels
 - PH Organizations (regional and national)
 - National Collaborating Centres
 - Consultants
 - National and International bodies and associations (eg. WHO CSDOH, PAHO, CPHA)
 - Knowledge users:
 - Public policy officials
 - Public health officials
 - Public health practitioners
 - Universities
 - NGOs
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Conclusions

- All 6 NCCs collaborate via monthly and quarterly meetings, collaborative projects, consultations, joint and overlapping committees and Leads meetings
 - Joint NCC presence on Advisory Committees
 - National Advisory Council presence on NCC Advisory Committees
 - Overlap in “client base” and target audience
 - Requires some degree of commonality and coordination
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- There is a significant number of “embedded” actors and organizations seeking to provide input to NCCs (9 for NCCDH alone)
 - Multiple areas of overlap and complexity require complex form of collaboration and both vertical and horizontal integration
 - This leads to:
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Concerns

- Multiple directions and pressures for collaboration
 - Temporal issues – good collaboration takes time
 - Generates uncertainty
 - Competing agendas and incentives, particularly in terms of knowledge generation vs. knowledge use
 - KSTE itself is unproven as a method for creating change
 - Other methods can and should be used
 - Raises concerns over how public policy processes are framed and understood
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Opportunities

NCCs can inspire/create reflection on

1. Public health policy
2. Health and other public policy processes
3. The role of knowledge(s) in public policy
4. The “Policy Paradox” - a common mission of rescuing public policy from the irrationalities and indignities of politics, hoping to make policy instead with rational, analytical, and scientific methods (Stone 1997)

NCCs can expand the knowledge base in public health, improve exchange and use of knowledge, and increase understanding about knowledge, practice and policy.
