Workshop Proceedings February 17-19, 2008 – Havana, CUBA

INTERSECTORALITY IN THE SOCIAL PRODUCTION OF HEALTH:

Sharing perspectives and experiences to orient a Cuba-Canada research program

BACKGROUND

In June 2003 an international interdisciplinary team linking Canadians at the University of British Columbia (UBC), Cuban colleagues from various institutions, and other international collaborators received support from the Canadian Institutes of Health Research (CIHR) to initiate a research program on the theme of Globalization, Social Organization and Health.

Recognizing Cuba's impressive health achievements despite decades of exclusion under the US embargo, our team decided to focus first on this "natural experiment", to examine the processes involved in producing excellent health results so that these could be better understood and shared - and opportunities for further improvement identified and applied.

Between 2005 and 2007, two pilot studies under this research program were also funded by CIHR and conducted in Cuba, primarily in the province of Villa Clara:

- Developing methodology to understanding Cuban health outcomes: a pilot study on the determinants of health in Cuba; and
- Impacts of tourism on health and gender in coastal communities: case of Caibarién and Cárdenas

As these studies were being undertaken, funding was secured (and is set to begin) for a 3 year national study on:

- Inter-Sectoral Collaboration in Securing Excellent Health Outcome: A multi-methods study of the approach to environmental health in Cuba's healthcare system

Our collaborative teams have also undertaken other successful collaborative research projects in Cuba (on the Cayo Hueso Intervention and the control of dengue in Central Havana). And team members have also accumulated extensive independent experience on how determinants of health have been managed in their respective country.

Our workshop, held February 17-19, 2008 in Havana, united Cuban and Canadian researchers and students (See Annex A for list of participants and Annex B for workshop agenda), which provided an opportunity to:

- Take stock of research findings from the two pilot studies;
- Allow reflection on related research and perspectives;
- Prepare specific plans for carrying out the new "Inter-Sectoral Collaboration" project;
- Identify other potential collaborations
- Mentor junior researchers from both countries, and involve trainees in producing outputs
- Define details of concrete outputs from work to date (peer-review publications, conference presentations, monograph, books or book chapters, other dissemination opportunities)

With the recently released interim Report of the WHO's Commission on Social Determinants of Health that highlights WHY it is imperative to take action on heath determinants, examining experiences in HOW health can be effectively addressed could not be more appropriate!

The remainder of this report provides an overview of the workshop proceedings. Day one was focused on the sharing of Canadian and Cuban perspectives on two key themes. First, the

knowledge base of health determinants and how we have used this body of knowledge to influence public policy in order to improve population health and increase health equity. The second theme focuses on the challenges of the intersectoral management of health determinants and how to develop effective collaborations between the health sector and other government sectors. During the second day, we examined specific Cuban research pilot projects that have been recently completed, followed by discussions of planning for an upcoming national project. Finally, the third day was oriented towards future directions, reflecting on the broader lessons in the social production of health including a potential collaboration with researchers from Kerala, India – an area that like Cuba has produced excellent health results despite having relatively low income. Outcomes, including key publications that will arise from the pilot projects and the workshop were also proposed.

DAY 1: SHARING CANADIAN AND CUBAN PERSPECTIVES AND EXPERIENCES

Health Determinants: what do we know and where are we going?

The Canadian perspective

Bob Evans illustrated the challenge of addressing the social determinants of health with a photo of a BC salmon jumping "upstream", a seemingly impossible yet – as the BC salmon population continues to demonstrate each year – ultimately achievable task. Evans reviewed what is known about the social gradient in health in high-income countries, which is related to processes that are much more complex than simply equating low incomes with bad health. And despite a significant body of evidence demonstrating the existence of social inequalities in health in these countries, little has been done in terms of action in addressing these disparities. The lack of action may be attributed to the difficulties associated with challenging the current status quo in the social hierarchy and the misguided approach of blaming social inequalities on the "lifestyles". In this context, the Cuba experience is illuminating. First, it reinforces the notion that the social gradient of health is not solely a matter of material deprivation as demonstrated by a healthy population despite a lack of economic wealth. Second, the role of health professionals assuming responsibility for the full range of their patients needs, including taking on roles viewed in Canada as health promotion and prevention activities that are generally outside the purview of physicians, illustrates a clear and effective strategy of how things may be done differently. The challenge remains for Canadians, however: knowing that inequalities exist and that there are successful experiences to learn from to address these inequalities does not necessarily translate into action.

The Cuban perspective

Adolfo Álvarez Pérez began by reviewing key frameworks of the social determinants of health, including the work of many Canadian researchers and policymakers (e.g. Laframboise and Lalonde, Mustard and CIAR, Evans and Stoddart, etc.) and key pieces of evidence documenting the relationship between income and other health determinants and health outcomes. The Cuban situation was then presented with a focus on two particular salient findings. First, during a period of time during the 1990s following the dissolution of the Soviet Union leading to a downturn in the Cuban economy, known as the special period, the deterioration of population health that one might expect during such economic turbulence did not occur and for certain health outcomes there was an improvement during this time. During this period five health intersectoral commissions were created and the national coverage by the family doctors was maintained at over 99%. Second, not only has Cuba managed to achieve and sustain good population health outcomes, these achievements are distributed with little geographical variation across the

country. The explanations for Cuba's achievements cannot be ascertained, however, simply by applying an understanding of the social determinants of health developed in Canada and elsewhere. A Cuba-specific framework was presented. One of the key differences of this framework was the central role given to political will (public health as a social responsibility), which in turn influences other health determinants. Another important difference was the emphasis on intersectoral action and decentralization of health decisions. Finally, the Cuban framework gives a much more central role to social cohesion.

Summary of group discussions:

Reflections on the presentations and a discussion of what the implications are for our respective communities was discussed in small mixed working groups of Cubans and Canadians. These discussions reinforced that Cubans have a different perspective and framing of the social determinants of health and how these determinants operate in the Cuban context. Not only may different frameworks need to be applied to understand health in the two different societies, but different approaches to assessing health needs and determinants may need to be used in informing public policy. Although in both societies, participants did emphasize the need to make a distinction between individual and collective determinants of health and any approach to understanding the health of populations must balance these two perspectives. Cuba does face important health threats that need to be addressed from both at a global (e.g. tourism) and national level (e.g. smoking).

Challenges of intersectoral management: Using evidence to manage determinants

Canadian perspective

John Millar presented an example of an existing initiative engaged in adopting an intersectoral approach to managing health determinants in the province of British Columbia (BC). In BC, there is a growing burden of avoidable chronic illness, marked by social inequalities in health, threatening to overburden the health care system and reduce economic productivity. To address this situation, the British Columbia Healthy Built Environment Alliance was created in order to "foster inter-sectoral networks and to provide a venue to coordinate knowledge exchange and key activities around health and the built environment in BC". The Alliance is involved in a number of activities, such as developing 'Healthy Built Environment Indicators' and their work has yielded a number of outputs, including a Centre for Excellence. At this time, the Alliance has generated considerable interest and awareness and ultimately seeks to coordinated action leading to healthier environments and a better population health.

Cuban perspective

Pastor Castell views intersectorality as both a 'philosophy' and a 'technology'. Whether or not an intersectoral approach is feasible depends on a number of factors, including determinants (e.g. demand for an intersectoral approach), conducive factors (e.g. policies), and appropriate investments (e.g. technologies). Timing and contextual factors are also critical. Castell's research, detailed in a book he has recently published entitled "Intersectorialidad en la practica social" (editorial Ciencias Medicas, Cuba), led to the identification of 9 conducive factors to implementing an intersectoral approach: (1) political will, (2) the role of the state, (3) appropriate reforms of the health sector, (4) strengthening of ministries and secretariats, (5) basic public health functions, (6) decentralization, (7) human resources, (8) technological investments, and (9) social organization. Six factors that contribute to investing in an intersectoral approach were also identified. There are: (1) solid health programs in place (2) an analysis of the health

situation, (3) actions that are organized on the basis of 'projects', (4) appropriate organization of personnel, managers and professionals, (5) integration of the concept of intersectorality into policy and practice, and (6) training of actors to work in the scope of an intersectoral approach. The uniqueness of the Cuban health system has led to particularly favorable environment for an intersectoral approach and therefore a particularly salient case to study for understanding how intersectorality can operate in practice.

Challenges of intersectoral management: Integration with primary care

Canadian perspective

Ryan Hoskins and Louise Nasmith identified expanding the role of primary care to include public health and the broader social determinants of health as a central challenge in the Canadian context. Despite numerous benefits towards a closer integration of population health practice into primary care, there exists a number of challenges to its implementation, including: (1) lack of resources and incentives, (2) the provider's ethical obligation to the 'individual', (3) existing status quo that primary care and public health are separate, (4) a lack of research, and (5) a need for curriculum changes. Community oriented primary care (COPC) is not a new concept, it can be traced back to the 1940s in South Africa in addition to other experiences in Latin America, the USA, and Canada. In Canada, there have been community health centres, most notably the CLSC model in Québec, and recent pilot projects throughout the country – but there has been limited success and uptake of these models and projects. There have been promising new models emerging, such as the Ontario Family Health Teams, but there will need to be systematic evaluation and research as well as policy to drive change.

Cuban perspective

After describing the Cuban healthcare system, Barbara Martinez focused on the relationship between primary care and health determinants. Primary care in Cuba has as a main goal to develop community participation (involvement) through the Municipalities and Communities for Health movement. As a healthcare policy Family Practice (Medicina Familiar) is viewed as a "new way of public health". The development of this type of primary care has the additional advantage of reducing (higher) hospital costs. To emphasize her point and show the political will on the issue, Dr. Martinez cited several articles from the Cuban legislative system. Finally, the intersectorality approach to health care was also introduced in Cuba in the early 1990's where the community actively participated through social organizations in health decisions on health determinants.

Summary of plenary discussions:

Clear differences emerged between the roles of health professionals in Canada where there is a clear distinction with health promoters and Cuba where health professionals are actively engaged in health promotion activities. This is related to a number of factors, including training (in Cuba doctors are trained in health promotion and education), organization (e.g. Cuba purely public health system), financing (e.g. in Canada physicians are paid on a fee per patient basis), and externals forces (e.g. in Canada the pharmaceutical industry offers "cure for everything). The question was raised whether or not 'primary health care' has the same meaning in Canada and Cuba. In Canada, PHC is more related to a 'level of care' whereas in Cuba it is a comprehensive 'strategy'.

DAY 2: REPORTING ON CUBAN RESEARCH PROJECTS & OTHER EXPERIENCES

Case study I: Reporting on Intersectoral Management – Two Municipalities in Villa Clara

"**Developing methodology to understanding Cuban health outcomes: a pilot study on the determinants of health in Cuba**". This pilot study seeks to develop a comprehensive qualitative and quantitative analytic approach to assessing the intersectoral management of health determinants in Cuba, with the goal of delineating "pathways" that affect the social construction of health. Structured focus groups were conducted in two municipalities in the province of Villa Clara, Cuba. This presentation reported preliminary results.

Adolfo Alvarez gave a short presentation about the conceptual framework that led to this pilot study. The framework includes good health outcomes together with a strong mandate (at the constitutional level) to guarantee health to all Cubans, as well as a healthcare structure that requires intersectoral collaboration.
Luis Fonticiella explained how the "Sala de Analisis" developed in the Municipality of Santa Clara contributes to the gathering, development and analysis of community indicators and information that can be used by decision-makers in a multi- and inter-sectoral environment.
Isa Alvarez introduced the pilot study in the municipalities of Santa Clara and Camajuaní in the province of Villa Clara, Cuba. Key informants were interviewed and five focus groups in each municipality were conducted. The focus groups included decision-makers at the government level, community organizations leaders and health workers. Questionnaires were also developed and used on participants to the focus groups. Areas that were covered were importance of health determinants, social cohesion and intersectoral collaboration. Copies of the questionnaires were shown. Preliminary results show that social cohesion is perceived to contribute in great proportion to individual health and well-being. Both municipalities also reported good social cohesion with community organizations (up to 78% of respondents) and official institutions (up to 53% of respondents), but low social cohesion with self-employed people (less than 43% of respondents).
Nino Pagliccia reported preliminary results on the reported level of intersectoriality using network analysis. Three main measures were calculated. 1 - density of intersectoral collaboration as the proportion of links among the different reporting organizations; 2 – intensity of internal engagement as a measure of the stage of involvement within the organization on each health determinant; and 3 – intensity of intersectoral collaboration as a reported level of 'closeness' of collaboration among organizations on health determinants. These measures show, for instance, different values for different determinants with high values of "intersectorality" for the determinant "healthy child development" and lower values for "employment and work conditions". Although no clear links could be established between the level of intersectoriality and health outcomes.*Case study II: Reporting on the impacts of tourism on health – The case of Caibarién*
"**Impacts of tourism on health and gender in coastal communities: case of Caibarién and Cárdenas**", would look into how impacts and corresponding mitigating factors are produced in communities. This study was approved in 2004 to be developed in collaboration with *Centro de Estudios Turísticos de la Facultad de Ciencias Empresariales de la Universidad Central "Martha Abreu" de Las Villas, Cuba* (UCLV) and *Centro de Estudios Demográficos* (CEDEM) of Universidad de La Habana, Cuba. We held a workshop in April 2004 to plan this work and identify key research themes, and the field work was ultimately conducted in 2005-2006. Recently a panel presentation on this study was given at the Latin American Studies Associations (LASA) Congress in Montreal (Sept 5-8, 2007).

Manuel Gonzalez first described the conceptual framework globalization-tourism-health that led to conceptualize this pilot study; next he highlighted the methodological process involving four focus groups in each of two coastal communities: Caibarién and Cárdenas, that included decision-makers, health professionals, tourism workers and a group of people from the

community and social organizations. Aside from the economic advantages of tourism development, all participants reported quite a few negative impacts at all levels (psycho-social, occupational, societal) including health and women in particular. Caibarién being a more recent tourism development seemed to have learned from the experience of Cárdenas (older development) and seemed to be more prepared for the negative impacts. But both communities had developed a variety of policies and programs to offset and prevent those impacts. Typical are the health promotion programs particularly for the prevention of STDs.
Javier Cabrera's focus was more on the intricate sustainability process of the tourism development that must include all sectors, the environment and universities as the promoters of the interdisciplinary knowledge-base necessary for sustainability. An environmental culture must be developed that sees the individual as object and subject of the environmental management. Community capacity needs to be developed in order to maintain healthy societies in the broadest sense or, equivalently, for a good social production of health. The development of mitigating programs with community participation uncovered in this pilot study shows this point.

Multi-year Intersectorialy Study

[JERRY, THIS IS MOSTLY YOUR PRESENTATION. MAYBE YOU CAN INSERT A COUPLE OF PARAGRAPHS HERE. I COULD COMPLEMENT LATER]

DAY 3: FUTURE DIRECTIONS

A broader perspective on social production of health: What can we learn (together) from Kerala?

Katia Mohindra provided and presented another society, similar to Cuba, where impressive health achievements were made despite modest economic growth – the Indian state of Kerala. In 1985, the Rockefeller Foundation published a seminal study in global health, entitled "Good Health at Low Cost". This study examined four societies which had achieved good health achievements despite a modest economy (Kerala, China, Sri Lanka, Costa Rica). There were, however, criticisms of this study, notably the exclusion of Cuba. The objective of the presentation was to explore the potential of developing a comparative study between Kerala and Cuba by first introducing the Kerala context to the Cuba research team. The health achievements (good health outcomes, equitably distributed health outcomes) and rationale for these achievements (e.g historical, public action) were presented. The proposed study aims to bring together researchers from Kerala and Cuba in order that they develop a project based on mutual interests and priorities (i.e. not donor driven), which would aim to yield policy relevant findings for Kerala and Cuba, but also for other poor countries who have poor health. The study is in its initial steps, beginning as a post doctoral project (funded by CIHR), but will seek additional funding (including a proposal that has been submitted to a CIHR competition in Fall 2007[1]) in order to expand the initiative.

Future Directions Plenary

Ideas for the future directions in the study of social production of health involved:

[1] This proposal has since been awarded funds to hold two international workshops and complementary scientific activities.

- A follow-up workshop in Vancouver around September 2008
- An international conference to be held in Havana in the spring of 2009
- Detailed work plan for the project "Intersectoral Collaboration in Securing Health Outcomes" involving three Cuban Provinces
- A possible collaboration between Kerala and Cuba with Canadian participation
- Publication of a book

The following were suggestions for papers/reports to be developed in the short term:

Title/content	Possible Contributors
1. Why we did the study – why some places are health and others are not	Jerry Spiegel, Annalee Yassi, Mariano Bonet,et al
2. Conceptual framework: determinants and political will	Adolfo Alvarez et al.
3. Write up focus groups	Luis Fonticiella, Isa Alvarez, M.A., Ana Maria Ibarra
4. Network analysis - Methodology	Nino Pagliccia, Anai Alvarez, Milagros Alegret
5. Case study	Barbara Martinez, Isa Alvarez, Milagros Alegret
6. Challenges of managing intersectoriality	Jerry Spiegel, Pastor Castell, John Millar, et al.

Small group discussions

Throughout the workshop small group discussions were organized to discuss issues presented and relate to personal work, research or training. The following are some relevant ideas that emerged:

Regardless of the society, there is a need to **balance the individual and social/collective** with regards to the determinants of health. For instance, to what extent obesity is both an individual and a social/community responsibility? People are aware of the link between smoking and disease, but continue to smoke. This issue is related to "lifestyle" as a health determinant.

People/communities need to be empowered in managing their own health. Decentralization helps in setting community priorities.

Health professionals need to be prepared/trained and be able to accept changes. Different perspectives influence how we analyze health determinants:

- technical dimensions
- political dimensions

The idea that **economic growth** will improve health care is problematic in Canada

- Why is this different in Cuba? Because the Cuban state controls resource distribution and prioritizes spending
- If Cuba is increasing funding to housing and transportation (two of the largest problems in Cuba) how does it maintain spending on health care? As the economy improves the Cuban government is able to invest in these areas in addition to maintaining the 3 key areas (education, health, food)

Mental health: Importance of incorporating the determinants of mental as well as physical health

Examples of mental health determinants:

- stigma
- war
- natural disasters
- fear is a common mental health determinant in North America: 'Culture of Fear'

Social cohesion can be defined as the integration of society that serves as a determinant of health Cuba has managed to draw people together breaking boundaries that are far more pronounced in other countries, and this concept has been critical for achieving the high health outcomes. There is little segregation of blacks; there is no ghettoization, there are small differences in income, there is a belief that healthcare workers should work amongst the population that they serve. Haitians and Jamaicans, and Santeria worshippers are tolerated and encouraged but there is an underlying commitment to be Cuban first; that allows these differences to contribute to culture without taking away from social cohesion

It is important to understand the **different ways we conceptualize health**. Cuba's situation is unique; it is important to understand the unique way of life in Cuba; it is important to understand the resilience in tough context, every Cuban is an expert in resilience or adapting to difficult situations

It's difficult to use indicators such as **income** in Cuba as it will be reported as less than it is Issues of income are important; some research (Ross, Jim Dunn) found strong correlations between income inequality and health in U.S. and U.K., but it did not find the same in Australia, Canada, Sweden. Question arises as to how income is related to health. It appears it is strongly related in U.S., however income per se is not crucial factor. What is crucial is to find good combination of indicators to design public health policy related to the reality of the country; it is important to find a proper set of SES indicators.

From a Cuban participant: "Next step in the **study of determinants must begin with developing our own** [Cuba's] determinants. It should take into account inequalities in health, community participation, and political will as a way to characterize our indicators. In Cuba, we have difference but not so strong, some difference is present between Eastern and Western regions, capital and middle, but not very much. Some gender differences and differences among different skin colours and spatial clusters of communities."

From a Cuban participant: "These are the points I believe we must consider:

1. **Resilience**
2. **Social cohesion**: a different term for Cubans than for Canadians. In Cuba the capacity of people to work together in social inclusion, not social cohesion.
3. Use of **information systems**, perhaps create social determinants information systems.
4. **Supranational determinants**: what are international dimensions of health and how do countries affect other countries."

It's important to take **supranational factors** into account in changing health situation, eg neoliberalism as an economic solution, some see it as a solution, Cuba does not. Most use U.S. model to explain health an issue of national security and how to improve national situation. In the 1990 to 1993 many factors were influencing Cuba, fall of the Soviet Union, the answer was not linear. We need to situate changing profile in relation to historical moments.

External forces must be considered

- On terrorism and bioterrorism: in 1981, Dengue 1 was introduced (1 among 4 types of Dengue). The CIA testified that they introduced Dengue in 1981. Many attacks were made on the Cuban tourism industry, including the introduction of Diseases in Tobacco and Sugar Cane.
- Attacks on ideology – there are important studies of effects of blockade on nutrition and pharmaceuticals, price of imported meds are 3 times as expensive.

We must reinforce **political will** and its influence on health services; even in crisis political will was an influence on population and income distribution.

The GDP increases have not been connected to health.

- [in Canada] at top level, no **political will** to improve health, strong popular will to improve health
- system in Canada held hostage by **medical profession**
- **Medical profession** has a role in Cuba, they are working to create solutions
- Judge in Canada (Virgi) commissioned to investigate plane crash. Reviewed crash of airplane in N. Ontario. Easy answer: pilot made mistake and took off in wrong conditions. Judge concluded there was no evidence that the pilot is suicidal. **Context is important**.

Comments on **methodology** of pilot study on intersectorality

- Questionnaires
  -too dense
  -focus group biased by the time they fill out questionnaire
  -need for different individuals in focus group and questionnaire group?
  -need to 'Cubanize' questionnaires
  -some terms, questions, culturally incompatible

- International community needs evidence of how intersectorality affects health outcomes in Cuba
- qualitative data valuable but also need for quantitative data

- How do we design this study?
  -case studies and comparative studies
  -compare populations in specific regions with different specific disease outcomes
  -determine whether outcomes are based on different levels of intersectorality

- Dispensarization (spelling?): Cuban classification of patients into four groups:
  1. apparently healthy
  2. at risk
  3. ill
  4. disabled

  -categorization would be useful tool for health indicators aspect of study

-**Intersectorality** comes about in relation to a problem: may be able to study the relation of intersectorality to a specific problem; what if intersectorality is not necessary when the problem is not there?

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Lessons learned:

- issue of **generalization** of focus group to wider community: generalization of pilot studies results: may or may not be able to take these results elsewhere

Methodology: to combine methods, focus group with other methods, eg. Ichikawi, Kawassaki (in-depth interviews) chose method that applied to particular situation selecting appropriate cases

- for **assessing impact**, it seems appropriate to focus on specific outcomes
- must clearly define object of research. Is it to improve health within Cuba? Is it to provide lessons for the rest of the world? Methods and approaches must stem from the purpose of the study.
- for tourism and health project, focus groups not as useful as **formative group**; can adapt methodology and educate people
- qualitative methodology taught by UNDP: **learning communities** – learning becomes collective rather than individual property

Policy:

- policy is an important area: not making a policy change is a policy decision
- require the use of levels of evidence and you come to a point where you must make a clear policy change with the evidence available

ANNEX A: LIST OF PARTICIPANTS

ANNEX B: BIOS

ANNEX C: PRESENTATIONS

ANNEX D: SUGGESTED IDEAS FOR PAPERS FROM DISCUSSION GROUPS

ANNEX B: WORKSHOP AGENDA

Day 1: Sunday, Feb 17*: Sharing Canadian and Cuban perspectives and experiences*

8:30 – 9:30 ***1a) Introduction: From research "projects" to a research "program"***

This session will consist of 3 parts:
- introducing the rationale, objectives, guiding framework, and expected outcomes of the workshop;
- having all participants introduce themselves (name, affiliation, interests, specific objectives)
- presentation of a framework for the analysis (subject to critique and revision based on discussions), linking this to the report of the WHO Commission on the Social Determinants of Health

Presenters: Jerry Spiegel and Mariano Bonet

9:30 – 9:45 BREAK

9:45 – 11:00 ***1b) Health determinants: what do we know and where we are going?***

This panel aims to provide a brief overview of our broad understanding of the determinants of health followed by more in-depth analysis of if and how Canada and Cuba have used this body of knowledge to orient their approach to health policy and improve population health and increase health equity. Based on their respective experiences, panellists will reflect on:
- What are the challenges in translating our knowledge on health determinants into policy action?
- How does the socio-political context (including regional, national, and global levels) influence how health determinants are addressed?

Presenters (20 minutes each): Bob Evans, Adolfo Álvarez Pérez
Discussant (10 minutes) Cándido Lopez
General Plenary Discussion (45 minutes)

11:00- 12:00 ***1c) What does this mean to each of us and our communities, countries?***

Small group discussion (5-6 groups - no more than 6-8 people each) to discuss morning session – how the issues discussed relate to each person's work, research or training.

12:00 –13:00 LUNCH BREAK

13:00 – 14:30 ***1d) Challenges of intersectoral management: Using evidence to manage determinant***

This panel aims to identify the key challenges of the intersectoral management of health determinants and how to develop effective collaborations between the health sector and other government sectors and society. Two specific issues will be addressed:
- How do different agencies work together to address health determinants?; what are the facilitators and barriers to this?
- How can information be used to promote evidence-based decision-making?

Presenters (20 minutes each) John Millar, Pastor Castell, Carlos Barceló
Discussant (10 minutes) Rolando García
General Plenary Discussion (20 minutes)

14:30 – 15:00 BREAK

15:00 – 16:20 ***1e) Challenges of intersectoral management: Integration with primary care***

This panel aims to identify strategies for how primary care networks and practitioners are involved in the management of health determinants – from gathering evidence to developing strategies to implementing actions to deal with them. Two specific issues will be addressed:
- How can primary health care services be integrated with sectors that address non-medical determinants of health?
- What are optimal ways for primary care providers to link to this effort?

Presenters (20 minutes each) Louise Nasmith / Ryan Hoskin, Barbara Martinez
Discussant (10 minutes) Manuel Romero
Questions and brief discussion (30 minutes)

16:20- 17:00 ***1f) What does this mean to each of us and our communities, countries?***

Small group discussion (5-6 groups - no more than 6-8 people each) to discuss afternoon session – how the issues discussed relate to each person's work, research or training.

17:00 – 17:15 Plenary – Comments on the day

18:30 DINNER

Day 2: Monday, Feb 18 *Reporting on Cuban research projects and other experiences*

8:30 – 8:45 ***2a) Introduction: Organization of the day***

Introduction to plan for taking stock and planning next steps for pilot studies
Presenters: Jerry Spiegel and Mariano Bonet

8:45 – 10:30 ***2b) Case study 1: Reporting on Intersectoral Management – Two Municipalities in Villa Clara***

This case study seeks to develop qualitative and quantitative tools to look at how intersectoral management of health determinants may improve population health. A special focus is given to the level of organizational network as a key factor, and the information system development linking needs, management and outcomes.
Presenters (60 min): Adolfo Alvarez, Milagros Alegret, Luís Fonticiella Padron, Nino Pagliccia
Discussants (10 min. each): Annalee Yassi, Anaí García
Questions 25 minutes

10:30 – 10:45 BREAK

10:45 – 12:30 ***2c) Case study 2: Reporting on the impacts of tourism on health – The case of Caibarién***

This case study looks at tourism as one sector under the pressure of globalization and explores how a structured methodology can be developed to build community capacity for sustainability and informed mitigating policies to build resistance.
Presenters (60 minutes): Manuel González, Javier Cabrera, Cheo (?)
Discussants (10 min each): Carolina Vidal, Sonia Catasús
Questions 25 minutes

12:30 – 13:30 LUNCH BREAK

13:30 – 15:00 ***2d) Opportunities and challenges from experiences***

Small group discussion (5-6 groups - no more than 6-8 people each) to discuss key opportunities and challenges from the experiences of studies that can relate to each person's work, research or training

15:00 – 15:15 BREAK

15:15 – 16:45 ***2e) Multi-year Intersectoriality Study***

Plans and methods for this study will be summarized, to stimulate ideas for refinements before initiating the work.
Presenters (45 min): Jerry Spiegel, Adolfo Alvarez, Milagros Alegret, Nino Pagliccia
Discussants (10 min each): Annalee Yassi, Mariano Bonet
Questions 25 minutes

16:45 – 17:00 ***2f) Perspective on Research "program" directions***

Perspective on how future research and knowledge translation activities can most effectively pursue narrower "project" and broader "program" objectives, to set context for final day.
Presenters: Jerry Spiegel and Mariano Bonet

Evening free

Day 3: Tuesday, Feb 19 *Future Directions*

8:30 – 8:45 ***3a) Introduction: Organization of the day***

Introduction to plan for taking stock and planning next steps for research program
Presenters: Jerry Spiegel and Mariano Bonet

8:45 – 10:15 ***3b) Perspectives on Research Program: Synthesis and future outlook***

a) Reflection on the themes introduced on the first day (led by 1st day presenters)
- •What do we know and where we are going;
- •Using evidence to manage determinants;
- •Integration with primary care

b) Consideration of new ideas based on exchanges
Focus on the key lessons learned with regard to the critical building blocks of the research program: resources (e.g. existing databases, survey tools, and publications), methodological approaches, thematic priority issues, partnership building, and knowledge transfer.
Facilitators: Jerry Spiegel and Mariano Bonet

10:15 – 10:30 BREAK

10:30 – 12:15 ***3c) What next: Developing plans***

Small group discussion (5-6 groups - no more than 6-8 people each). This session will pick up from yesterday's learning from the pilot studies and will develop ideas for areas of interest, collaboration plans and methods that can be pursued, and will make specific proposals related to each person's work, research or training.
Facilitators and Reporters:

12:15 – 13:15 LUNCH

13:15 – 15:00 ***3d) Future Directions Plenary – Where we go from here***

a) Groups report back on small group sessions and plans for each project area.
b) New ideas based on exchanges
- •Plans for dissemination / publications
- •Plans for a follow-up workshop in Vancouver (September) and in Havana (2009)
- •Plans for further work in the area

Facilitators: Jerry Spiegel and Mariano Bonet

15:00 – 15:30 BREAK

15:30 – 16:20 ***3e) A broader perspective on social production of health: What can we learn (together) from Kerala?***

This panel examines another society (outside of the Americas) that has produced impressive health achievements despite having a modest economy: the Indian state of Kerala. This society provides an interesting case study as the good population health outcomes were achieved *within* a nation. In addition to delivering an overview of the situation in Kerala, the panellists will explore potential commonalities between Cuba and Kerala.
Presenters (20 minutes): Katia Mohindra
Discussants (10 min each): Adolfo Alvarez and Armando Rodríguez
Questions 20 minutes

16:20 – 17:00 CONCLUDING REMARKS