Synergy for health equity: integrating health promotion and social determinants of health approaches in and beyond the Americas

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SYNOPSIS

Health promotion and social determinants of health approaches, when integrated, can better contribute to understanding and addressing health inequities. Yet, they have typically been pursued as two solitudes. This paper presents the key elements, principles, actions, and potential synergies of these complementary frameworks for addressing health equity. The value-added of integrating these two approaches is illustrated by three examples drawn from the authors' experiences in the Americas: at the community level, through a community-based coalition for reducing chronic disease disparities among minorities in an urban center in the United States; at the national level, through healthy-settings interventions in Canada; and at the Regional level, through health cooperation based on social justice values in Latin America. Challenges to integrating health promotion and social determinants of health approaches in the Americas are also discussed.

Key words: health promotion; health inequalities; health planning guidelines; health vulnerability; social policy; urban health; Americas.

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Recent efforts to generate an international consensus on addressing the social determinants of health (SDH) (1) present a timely opportunity to integrate—theoretically, politically, and practically—social determinants and health promotion (HP) frameworks for promoting health and health equity. Drawing on our work in the Americas, this paper aims to identify the potential synergies between these two approaches, as well as the challenges inherent to such an integration.

HP was launched in 1986, with a widely supported definition and framework for action, and has growing evidence of effectiveness (2, 3). The SDH framework builds on the legacy of HP, particularly HP's role in health care systems, and more recently, as articulated in the Health in All Policies (HiAP) approach (4–6). Yet, arguably, the SDH community has made inadequate use of HP concepts and methods; and, conversely, much of the HP community has not actively embraced SDH efforts. Advocates of HP, as originally conceptualized, have more than 25 years of experience working at multiple levels and in multiple sectors, using a variety of strategies to address inequalities in power and resources (7). Yet in many settings, social justice-oriented HP approaches have been overshadowed and distorted by individually-focused lifestyle and behavior change strategies. In addition, evaluation of collective action and social/political HP interventions has proven challenging (8, 9). SDH, by contrast, has a strong epidemiological rationale for understanding the impact of inequality on health and well-being and focuses on the role of policy in reducing inequality. At the same time, the HP's identification of *how* inequalities in power and resources are produced and reproduced, and notably *who* and *what entities* are implicated in these processes, have not been sufficiently taken up by mainstream SDH approaches (10–12).

Given the potential of each approach to improve health equity, we suggest that further integrating HP and SDH may prove synergistic. Activities in Latin America are especially illustrative of such synergies (13, 14). Here we draw on three examples of work in the Americas to bolster this argument. Table 1 outlines the background, principles, approaches, and challenges related to HP and to SDH, and the synergistic potential of integrating them, including implications for harmonized action. We conclude with some key messages about the future value of integrating these approaches, particularly for the World Health Organization and its Regional offices.

HEALTH PROMOTION

The health promotion approach emerged in the wake of the pivotal 1978 Alma-Ata Conference

TABLE 1. Comparison of principles and actions associated with Health Promotion (HP) and Social Determinants of Health (SDH)

Topic	HP	SDH	Potential for synergistic effects
World Health Organization (WHO) involvement & major source documents	• WHO-sponsored Ottawa Charter (1986) generated consistent definitions and concepts used around the world, and related World Health Assembly (WHA) resolutions • WHO Global HP Conference series resulting in a set of declarations and charters 1988, 1991, 1997, 2000, 2005, 2009, 2013	• The WHO Commission on SDH (CSDH) produced its final report, "Closing the gap in a generation: Health equity through action on SDH" (2008) • Rio Political Declaration on SDH (2011) at the WHO Conference on SDH in Rio de Janeiro and WHA resolutions related to both	• WHO and its Regional Offices could combine their support and initiatives for HP and SDH into a single unit/ effort and expand resources and reach of both. • Could develop a single summary document (and related tools) useful to grassroots and social movements so HP and SDH strategies can be used together to advance the equity agenda
Core recommendations	From the Bangkok Charter for HP in a Globalized World (2005)— Make promotion of health: (a) central to global development agenda (b) a core responsibility of all governments (c) a key focus of communities and civil society (d) a requirement of good corporate practices	From CSDH's, "Closing the Gap" final report (2008)— Improve daily living conditions by: (a) tackling the inequitable distribution of power, money, and resources (b) measuring and understanding the problem and assessing the impact of action	• Integrate core recommendations of both HP and SDH and show concrete evidence and examples of mutual interventions/actions, in particular settings at local, municipal, national and international levels
Principles/values	• Positive definition of health as more than just the absence of disease (WHO, 1948) • Broad set of prerequisites for health that include all SDH • Primary focus on participation and empowerment via engaging people in shaping the factors that affect their health, through: participatory planning and decisionmaking processes; and collaboration among community members, social movements, and nongovernmental organizations (NGOs) to influence governments and corporate sectors to change policies and sociopolitical structures	• Social justice: ensuring that all have what is needed for health and wellbeing • Participation: meaningful and equitable participation and control in decision making; including those oppressed and subject to social, economic and/or political exclusion. • Empowerment: process through which people act collectively to gain greater influence and control over the determinants of health and wellbeing in their community and society	• Be more explicit about who and what is driving inequality at all levels from local to international through use of political economy frameworks of analysis • Advocate for Health for All—and the conditions that ensure it—as a human right • Recognize and appreciate indigenous cultures and traditional ways based on human rights principles • Go beyond formulaic/legislated public consultation to ensure meaningful and equitable participation and control in decision making and agenda setting among all groups; including those oppressed and subject to social, economic, and/or political exclusion
Entry points for intervention	• Individual • Family/household • Community • Organizations/corporations/ workplaces • Health services • Settings such as schools, municipalities, islands • Society/populations • Global development entities	• Society/population level/ all levels of policymaking/ through the life course • Focus on specific vulnerable populations (socially-excluded, disadvantaged groups) • Global health, development, economic, and social policy agenda-setting fora	• Comprehensive interventions—in multiple settings and at all levels, from local to global—that reduce differential and unjust exposures, susceptibilities, and consequences for socially excluded / disadvantaged groups • Efforts across different sectors, levels of government, including the corporate sector. Taking into account their contribution to health and health (in) equity • Focus on environment/ climate change at multiple levels • Collaborate with social movements to advocate for change in policies at multiple levels and across sectors

(Continues)

TABLE 1. Continued

Topic	HP	SDH	Potential for synergistic effects
Strategies	• Building healthy public policy, intersectoralism, Health in All Policies, using whole of government approach • Creating supportive environments through changing social norms and public support for change • Strengthening community action and community participation in decisionmaking • Developing personal skills and capacity-building • Re-orienting health services to focus on primary health care (including health promotion and disease prevention)	• Health in All Policies • Mechanisms of social protection through the lifecourse (e.g., policies and programs that improve housing and reduce discrimination, economic insecurity, hazards, and harsh living conditions) • Redistributive policies (e.g., that ensure adequate financial resources for all children and families) • Universal access to education Strengthen occupational health safety and health protection and their oversight • Promote and strengthen universal access to health and social services • Build, strengthen and maintain public health capacity, including capacity for intersectoral action, on social determinants of health	• Health in All Policies • Enhance community control of health promotion/social determinants initiatives (e.g., listening to and starting with the voices and aspirations of the community in planning and action) • Ensure sustainable structures for people to work together across sectors, settings, and multiple levels • Establish sustainable financing mechanisms that ensure a coordinated, integrated and holistic response to community-determined goals • Enhance capacity among community members for implementing effective and appropriate equitable health promotion interventions in diverse contexts • Reverse current bias towards large-scale and unsustainable practices (e.g. subsidies/preferential legislation for extractive industries; outdated building codes)
State of evidence	• Some evidence of impact of policy change • Individual behavior change interventions require other strategies (e.g. policy, community engagement) for success • Weak evidence of impact of community action interventions. And multi-sector, multi-level collaborations need more research	• Strong evidence of associations between health inequities and SDH (i.e., socioeconomic position, social class, gender, race/ethnicity, education, occupation, income) • Limited evidence of what works (and under what conditions) in affecting social determinants and associated improvements in health equity	• Gather narrative stories and empirical evidence about how communities participate in creating conditions for improved health and health equity • Long-term, socially grounded analyses of what makes for healthy societies • Stronger emphasis on links between human and ecosystem health
Challenges	• Going beyond the national contexts to introduce health promoting policies at the global level	• Addressing contradictions of market capitalism and global financial and trade regimes	• Addressing large structural issues, e.g., resource depletion, climate change, extensive ecosystem degradation, social and economic inequality • Getting health concerns into international development, economic, and trade talks, treaties, regulations, and practices

on Primary Health Care, which sought to replace the existing top-down technical approach to disease control with a more explicitly political understanding of health to be achieved "in the spirit of social justice"(15). The Ottawa Charter for Health Promotion (16) aimed to operationalize the Alma-Ata principles with five main strategies for health promotion (see Table 1). The Ottawa Charter also listed a set of prerequisites for health, including peace, education, income, a stable ecosystem, social justice, and equity, which were expanded in the Bangkok Charter for Global Health Promotion in 2005 (17). Akin to SDH approaches, the Bangkok Charter recognized inequalities within and between countries related to environmental degradation, urbanization, and globalization. As reinforced in the Nairobi Declaration, HP also emphasized empowerment, collaboration, and public participation in decisionmaking (18, 19). Of the five Ottawa Charter strategies, three focus on creating broader changes in social, political, and economic environments through policy change, advocacy, and community action.

Over the past quarter century, a range of HP actions have been implemented across the world, including at the global level with the Framework Convention for Tobacco Control (20), using public policies, collaborative strategies, and community actions. Nonetheless, the bulk of interventions have focused on changing individual behavior (3), even as some have targeted social well-being, and political, environmental, and community-level efforts and outcomes (11, 21).

A key HP strategy is the settings approach (e.g., Healthy Schools, Healthy Cities/Communities, Healthy Workplaces), which involves multiple sectors and levels—from individual to collective and policy—in efforts to change the forces that produce and reproduce inequities in health and well-being (22). Central to the settings approach is collaboration and participatory work undertaken to address conditions for health within the setting, as well as coordination across settings (23, 24).

SOCIAL DETERMINANTS OF HEALTH

The conceptual framework for action on social determinants developed by the World Health Organization (WHO) Commission on SDH (25, 26) outlines three *levels* of determinants that interact to affect equity in health and well-being: (a) structural drivers (e.g., macroeconomic, social, labor, taxation, and environmental protections and policies; governance; societal norms and values); (b) social position and stratification determinants (i.e., social class, gender, race/ethnicity, education, occupation, and income); and (c) intermediary determinants (e.g., material circumstances, behaviors, and biological factors; psychosocial factors; health care system) (4). This framework also postulates three *mechanisms* by which health inequities are produced: (a) differential exposure to intermediary factors (e.g., poor material circumstances, such as inadequate housing, hazards, and harsh living conditions); (b) differential vulnerability to health-compromising conditions (e.g., ill health, disability); and (c) differential consequences (e.g., differential harm associated with having a health condition, such as that experienced by socially-excluded groups with limited access to quality health services).

However, none of these determinants and mechanisms explicitly names the marked increase in concentration of wealth and power by financial elites, or the accelerated ecological destruction caused by overemphasis on economic growth and consumerism—both of which have very real material consequences and could be seen as the "causes of the 'causes of the causes'" (12). It is especially in this context that Table 1 may prove useful. It begins by showing the many similarities between HP and SDH. For example, both pay attention to policies and socio-political structures that affect health. Both embrace participatory approaches to decisionmaking. And both are concerned with social justice and equity. HP is particularly concerned with focusing on many levels, from individual to policy, and offers much wisdom about working in settings, taking advantage of active social and public-interest civil society movements, and community action. SDH offers a strong epidemiological basis for equity, pays special attention to the most vulnerable populations, focuses on the life course, and emphasizes policy and social change as the key forms of action.

Synergies between HP and SDH could be achieved by deploying comprehensive approaches in multiple settings and sectors, at different levels, with the democratic participation of stakeholders, and using multiple entry points to address inequity. Unlike narrowly targeted programs that often stigmatize the most oppressed populations, a synergized HP-SDH strategy would embed particularistic efforts within universal policies to generate solidarity, rather than divisiveness. The following three examples drawn from our work at the community, national, and Regional levels illustrate the kinds of HP-SDH synergies already in practice in the Region of the Americas.

CASE STUDIES

Case 1. Community-level action: a community-based coalition to reduce chronic disease disparities affecting African-Americans

As in other parts of the Americas, widespread inequalities in chronic diseases particularly jeopardize the health of racial/ethnic minorities in the United States, a function of a long history of societal discrimination and oppression leading to increased exposure and susceptibility to unhealthy conditions, more severe consequences, and greater barriers to overcoming these unjust conditions (27). The Kansas City–Chronic Disease Coalition began in 2001 and worked for nearly a decade to modify exposures to health-promoting conditions and reduce vulnerability to diabetes and cardiovascular diseases (CVD) among African Americans in Kansas City, Missouri (28, 29). Funded by the United States Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH) 2010 initiative, the Coalition engaged community and scientific partners in changing contextual factors related to healthy nutrition and physical activity in low-income neighborhoods. The Coalition sought to address particular social determinants linked to health inequities, including enhanced exposure to health-promoting conditions (e.g., expanded walking groups) for low-income ethnic and minority groups and improving community-level abilities to respond (e.g., building the community's capacity to change policies and conditions at the local level).

The Coalition used a community-based participatory approach referred to as the Health for All model, that consisted of several components: (a) community-determined vision and mission that focused on reducing racial disparities in CVD and diabetes; (b) a locally-developed logic model to guide planning, implementation, and evaluation; (c) an action plan that specified particular changes (e.g., an expanded program or modified policy) to be sought in multiple sectors, with delegated responsibilities and timeline; (d) mini-grants to ensure community-led implementation of planned community/system changes; (e) community mobilization; (f) technical assistance to develop coalition capacities; and (g) documentation and systematic reflection on progress to guide ongoing improvement.

With the collaboration of over 20 partner organizations from multiple sectors, including faith organizations, health care providers, health departments, human services, media, neighborhood networks, the private sector, schools/education, and worksites during a 6-year period, the Coalition implemented 655 new programs, policies, and practices in the community that changed the local environment in which the residents lived. For example, access to healthy foods was modified and its changes were associated with a statistically significant increase in the percentage of African-American adults in the community reporting daily consumption of five or more servings of fruits and vegetables.

This case illustrates several important aspects of integrating HP and SDH, particularly the use of comprehensive interventions at multiple HP levels—individual, community, and organization—strategies of community action, policy development, and intersectoral collaboration to change conditions related to health and well-being among groups that have historically experienced health inequities. It also illustrates central SDH approaches, e.g., focusing on socially-oppressed groups as an entry point, and then employing community-determined strategies, such as addressing structural impediments, capacity-building, and policy change. Another element of synergy is the extent to which involvement in these activities enhances political interest and engagement that in turn influence the structural determinants of health.

Case 2. National-level action: Healthy settings approach in Canada

Creation of supportive environments for health is a basic action principle of health promotion, and equity is a core value. A settings approach offers an opportunity to bridge these two, with its focus on the interplay among individual, environmental, and SDH. The settings approach aims to influence health through action on "the places or social contexts in which people engage in daily activities, in which environmental, organizational, and personal factors interact to affect health and well-being" (30), as well as with people in those settings. Despite the challenges of evaluating this kind of work (31), evidence of the effectiveness of the settings approach is mounting, especially as a strategy to explicitly tackle health inequities (32–34).

In 2009, the Public Health Agency of Canada set up a Settings Approach Working Group comprised of members of the academic, government, and health sectors. The group conducted a scoping review of the literature to determine what evidence existed for a settings approach to reduce health inequities and what lessons had been learned from this work (35). Thirty-five articles concerning 20 different initiatives were critically analyzed regarding the following: objective(s); type(s) of settings targeted; what was acted on and how; who was involved; whether interventions had been evaluated, and if so, how and what the results were; and key issues raised by the authors. While many initiatives were evaluated, only eight included specific attention to the program's impact on reducing inequities.

Four elements emerged as central to an equity-focused settings approach: a) an explicit focus on SDH; b) addressing the needs of marginalized groups; c) effecting change in a setting's structure; and d) meaningfully involving stakeholders. Each came with related challenges. Drawing on complexity theory, critical realism, and community development theory and practice, the authors proposed a model for "settings praxis" that takes into account social context and the ways that inequities are produced and reproduced through interpersonal and institutional practices, as well as broader labor/taxation/environmental policies that build on local strengths/capacities and generate resilience (32, 35, 36).

This example illustrates the synergy of HP and SDH via attention to disadvantaged groups and structural change. When examining many cases, one can see the broader universal policy strategy (affecting social structures, such as labor law and taxation), and an emphasis on working with and addressing the needs of marginalized groups.

Case 3. Regional-level action: South-South cooperation based on social justice values

Another way to consider integrating HP and SDH is through country-to-country and Region-wide approaches to health. Amidst enormous diversity, the countries of Latin America share histories of colonialism, unstable governments, repressive and authoritarian regimes, and neoliberalism. Yet progressive solidarity has periodically and repeatedly materialized. Activists, advocates, and professionals have developed common health-enhancing policies, beginning in the 1890s with improving housing/sanitation and increasing access to education, and later, in the 1920s and 1930s, building social security systems (37)—all of which were facilitated by Americas-wide meetings and exchanges.

A case in point is the rights approach to child health developed in Uruguay and formalized by its Children's Code of Rights of 1934, which served as a reference point for the entire Region and beyond. After grappling with decades of stagnating infant mortality despite a variety of public health measures, Uruguay's passage of a Children's Code marked one of the world's most comprehensive mother and child social protection policies, delineating the judicial and administrative basis for the state's protection of children from the prenatal period to adulthood in the areas of health, education, legal tutelage (of 'delinquents' and abandoned children), nutrition, housing, social services, work (for adolescents), and other elements of well-being. Uruguay quickly shared its model with other Latin American countries, using the

Montevideo-based International American Institute for the Protection of Childhood, founded in 1927, as a vehicle for setting standards, advising on legislation and institutional development, and interchanging experiences across the Americas and beyond (38).

More recently in Latin America, a confluence of populist and left-wing parties has been elected in countries as diverse as Argentina and El Salvador. These parties have run on platforms that emphasize social redistribution, welfare-regime building, and social rights (39). Coupled with economic growth in certain large middle-income countries, such as Brazil and Venezuela, these political shifts have enabled development of solidarity-based forms of South-South cooperation, challenging the traditional, self-interested geopolitical-economic forces propelling this field. These alternative forms of health diplomacy do not dictate the terms of health and development cooperation, but rather respond to political demands for greater equity and draw from local participatory democracy, all building on HP and SDH approaches in areas such as universal comprehensive primary health care. Key players include the Union of South American Nations (UNASUR) and nation-nation efforts, such as Cuba's half-century of cooperative health solidarity in Latin America and beyond, and more recently, Brazilian cooperation in Latin America and Lusophone countries (40–42).

A further contemporary development from Latin America brings us back to HP's healthy settings strategy: locally-based movements, such as the indigenous "Buen Vivir" approach, questions and reframes conventional assumptions about "growth" and "development" and their links to well-being, instead calling for a new paradigm of "living well" within existing resources and in harmony with the natural environment. These efforts have circulated in the Region, moving from the local to the national, and are now enshrined in the Constitutions of Bolivia and Ecuador (43, 44).

This case study illustrates the value of SDH entry points into social policy agenda setting and using SDH strategies for social protection, redistributive policies, and universal access to health and social services (Table 1). How effectively these large-scale structural efforts meet the quotidian challenges of community and settings-level health promotion—including Buen Vivir—will be a central determinant of their long-term success.

SYNERGIES BETWEEN HP AND SDH

We have argued that to date, HP and SDH approaches have not made sufficient mutual use of each other's principles and strategies. Yet, all three case examples presented here show potential for or actual synergies. In terms of the principles and values shown in Table 1, HP and SDH share a belief in principles of social justice and empowerment. Both value public participation in policy formulation and promote bona fide engagement of public-interest civil society within government decisionmaking in order to reform, or even, revolutionize policies and practices that otherwise produce and reproduce social inequity. With respect to entry points (Table 1), SDH starts with engagement and solidarity with vulnerable populations, socioeconomic policies, and national/global fora for action. The main contribution of HP here is using settings as a point of entry. Both strive to work across all levels with multiple sectors. All three cases illustrated the integration of social structural policy change in settings as a route to health equity.

The challenges to this integrated approach arise principally from the political nature of these actions, especially for the large health promotion practitioner workforce. A combined HP-SDH approach would focus on policy and socioenvironmental change, politics of redistribution, actions around sustainability of the ecosystem, social justice approaches to societal development, and collaboration within civil society (4). However, a focus on individual lifestyle remains appealing to dominant political players because it does not "rock the boat" or focus on changing the underlying conditions and processes of unequal power and resources that generate differential exposures and susceptibilities to ill health. It fits with a medical model and has an established system of generating evidence.

By contrast, an integrated HP-SDH approach is a fundamentally political and social change-oriented endeavor that challenges the existing (and historical) distribution of power and resources. We believe it is essential that these efforts operate at multiple levels and sectors and engage communities in connecting local issues to global concerns; for example, by connecting local poverty and lack of livable wages with national and international trade policies. The synergies come particularly through intentional and multi-level collaborative efforts—at local, national, and international levels. Promising aspects of a synergistic agenda include investing in poverty alleviation (or wealth redistribution), financial reform to limit the concentration of wealth, community-oriented and publicly funded primary health care, legislation to reduce environmental degradation and promote food security, local community economic development, and fostering community participation and empowerment.

Decades of experience with HP approaches has much to teach us about methods for collaborative action to improve health equity, and there is a large workforce globally interested in advocating for this agenda. Both HP and SDH discourses have been subject to selective uptake and dismissal. In both cases, the crucial issue is willingness to name who/what is responsible for the production and reproduction of inequities over time, and recognizing the inherently political nature of, and long-term commitment to, social change required for equitable health promotion and protection. Latin America, far more than North America under the current political conditions, has become a leader in moving such an agenda forward.

Looking into the future, an ideal vehicle for integrating HP and SDH is the concept and emerging methods of "Health in All Policies" (5) with its focus on engaging stakeholders at individual, community, and policy levels to improve health and health equity. Integrating HP and SDH also affords the opportunity to underscore the importance of better grounding HiAP in human rights approaches (45). By integrating the strengths of the HP and SDH approaches, we can further the evidence base and the social justice underpinnings of ensuring conditions for health and health equity.

Conflicts of interest. None.

SINOPSIS

Sinergia para la equidad en salud: integración de los enfoques de la promoción de la salud y de los determinantes sociales de la salud dentro y fuera de la Región de las Américas

Los enfoques de la promoción de la salud y de los determinantes sociales de la salud, cuando se integran, pueden contribuir mejor a la comprensión y el abordaje de las inequidades en salud. No obstante, normalmente se han aplicado como dos cuestiones separadas. En este artículo se presentan los elementos clave, los principios, las acciones y las posibles sinergias de estos marcos complementarios para abordar la equidad en salud. El valor añadido de la integración de estos dos enfoques se ilustra mediante tres ejemplos extraídos de las experiencias de los autores en la Región de las Américas: a nivel de la comunidad, mediante una coalición comunitaria dirigida a reducir las disparidades en relación con las enfermedades crónicas entre las minorías de un centro urbano de los Estados Unidos; a escala nacional, mediante las intervenciones de promoción de entornos saludables en Canadá; y a nivel regional, mediante la cooperación en salud basada en los valores de la justicia social en América Latina. También se analizan las dificultades que entraña integrar los enfoques de la promoción de la salud y de los determinantes sociales de la salud en la Región de las Américas.

Palabras clave: promoción de la salud; desigualdades en la salud; directrices para la planificación en salud; vulnerabilidad en salud; política social; salud urbana; Américas.

REFERENCES

1. World Health Organization. Rio political declaration on the social determinants of health: proceedings of the World Conference on the Social Determinants of Health; 21 Oct 2011; Rio de Janeiro. Available from: http://www.who.int/sdhconference/declaration/en/ Accessed on 16 September 2013.
2. Jackson S, Perkins F, Khandor E, Cordwell L, Hamman S, Buasai S. Integrated health promotion strategies: a contribution to tackling current and future health challenges. Health Promot Int. 2007;1(suppl 1):75-83.
3. Yanful B, Jackson S. Effectiveness of health promotion strategies. In: Juvinya D, Arroyo H, eds. Health promotion, 25 years later. Catalonia (Spain): Documenta Universitaria; 2012:71-92.
4. Irwin A, Scali E. Action on the social determinants of health: learning from previous experiences. World Health Organization, 2010. Available from: http://www.who.int/iris/bitstream/10665/44488/1/9789241500876_eng.pdf Accessed on 16 September 2013.
5. Leppo K, Ollila E, Pena S, Wismar M, Cook S. Health in All Policies: Seizing opportunities, implementing policies. Finland: Ministry of Social Affairs and Health; 2013.
6. Kickbusch I. Health in All Policies: where to from here? Health Promot Int. 2010;25(3):261.
7. The Ottawa Charter for Health Promotion, 25 Years On. Health Promot Int. 2011; 26 (suppl 2).
8. Jackson N, Waters E. Criteria for the systematic review of health promotion and public health interventions. Health Promot Int. 2005;20(4):367–74.
9. Breton E, De Leeuw E. Theories of the policy process in health promotion research: a review. Health Promot Int. 2011;26(1):82–90.
10. Coburn D. Income inequality, social cohesion and the health status of populations: the role of neo-liberalism. Soc Sci Med. 2000;51(1):135–46.
11. Navarro V. What we mean by social determinants of health. Glob Health Promot. 2009;16(1):5–16.
12. Birn AE. Making it political: closing the gap in a generation: health equity through action on the social determinants of health. Soc Med. 2009;4(3):166–82.
13. Monteiro Andrade LO, deHolanda Cunha Barreto IC, Ferreira Gomes C, Chagas Canuto OM. Public health policies as guides for local public policies: the experience of Sobral-Ceara, Brazil. Promot Educ. 2005(suppl 3):28–31.
14. Wallerstein N, Mendez R, Minkler M, Akerman M. Reclaiming the social in community movements: perspectives from the USA and Brazil/South America. Health Promot Int. 2011;26(suppl 2):226–36.
15. World Health Organization. Declaration of Alma-Ata. Geneva: WHO; 1978. Available from: www.who.int/publications/almaata_declaration_en.pdf Accessed on 8 October 2013.
16. World Health Organization. Ottawa Charter for Health Promotion. Geneva: WHO; 1986. Available from: www.phac-aspc.gc.ca/ph-sp/docs/charter-chartre/pdf/charter.pdf Accessed on 16 September 2013.
17. World Health Organization. Bangkok Charter for Health Promotion in a Globalized World. Geneva: WHO; 2005. Available from www.who.int/health promotion/conferences/6gchp/bangkok_charter/en/ Accessed on 16 September 2013.
18. World Health Organization. Nairobi Call to Action for Closing the Implementation Gap in Health Promotion. Geneva: WHO; 2009. Available from: www.gesundheitsfoerderung.ch/pdf_doc_xls/e/GFPstaerken/Netzwerke/Nairobi-Call-to-Action-Nov09.pdf Accessed on 16 September 2013.
19. Fawcett S, Abeykoon P, Arora M, Dobe M, Galloway-Gilliam L, Liburd L, et al. Constructing an action agenda for community empowerment at the 7th Global Conference on Health Promotion in Nairobi. Glob Health Promot. 2010;17(4):52–6.
20. World Health Organization. Framework Convention on Tobacco Control. Geneva: WHO; 2003. Available from: www.who.int/fctc/about/en/ Accessed on 16 September 2013.
21. Andreense Silva EC, Pelicioni MCF. Participação social e promoção da saúde: estudo de caso na região de Pa-

ranapiacaba e Parque. Cien Saude Colet. 2013;18(2):563–72.
22. Scriven A, Hodgins M, eds. Health promotion settings: principles and practice. London: Sage; 2011.
23. Dooris M. Joining up settings for health: a valuable investment for strategic partnerships? Crit Public Health. 2004;14 (1):49–61.
24. Poland B, Green LW, Rootman I, eds. Settings for health promotion: linking theory and practice. Thousand Oaks, California: Sage Publications; 2000.
25. Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Geneva: World Health Organization; 2008.
26. Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social determinants of health discussion paper 2. Geneva: WHO; 2010. Available from: http://apps.who.int/iris/bitstream/10665/44489/1/9789241500852_eng.pdf Accessed on 16 September 2013.
27. Krieger N. Epidemiology and the people's health: theory and context. New York: Oxford University Press; 2011.
28. Collie-Akers VL, Schultz JA, Carson VL, Fawcett SB. Evaluating mobilization of neighborhood and faith organizations to reduce risk for health disparities within a REACH 2010 coalition in Kansas City, Missouri. Health Promot Pract. 2009; 10(2):118S–27S.
29. Schultz J, Collie-Akers V, Fernandez C, Fawcett S, Ronan M. Implementing community-based participatory research with two ethnic minority communities in Kansas City, Missouri. Int J Migrat Health Soc Care. 2009;5(1): 47–57.
30. Nutbeam D. Health promotion glossary. Health Promot Int. 1998;13(4):349–64
31. Dooris M, Poland B, Kolbe L, de Leeuw E, McCall D, Wharf-Higgins J. Healthy settings: Building evidence for the effectiveness of whole systems health promotion—challenges and future directions. In: McQueen DV Jones CM, eds. Global Perspectives on Health Promotion Effectiveness. New York, NY: Springer; 2007. Pp. 327–52.
32. Shareck M, Frohlich K, Poland B. Reducing social inequities in health through settings-related interventions: a conceptual framework. Glob Health Promot. 2013;20(2):39–52.
33. Poland B, Krupa E, McCall D. Settings for health promotion: an analytic framework to guide intervention design and implementation. Health Promot Pract. 2009;10(4):505–16.
34. Poland BD, Dooris M. A green and healthy future: the settings approach to building health, equity and sustainability. Crit Public Health. 2010;20(3): 281–98.
35. Shareck M, Frohlich K, Poland B. Reducing health inequalities through settings related interventions. Final report presented to the Public Health Agency of Canada. Ottawa (Canada): PHAC; 2011.
36. O'Dwyer L, Baum F, Kavanagh A, Macdougall C. Do area-based interventions to reduce health inequalities work? A systematic review of evidence. Crit Public Health. 2007;17(4):317–35.
37. Martínez J. Domesticar la incertidumbre en América Latina: mercado laboral, política social y familias [editorial]. San José: Universidad de Costa Rica; 2008.
38. Birn AE. Uruguay's child rights approach to health: What role for civil registration? In: Breckenridge K, Szreter S, eds. Registration and recognition: documenting the person in world history. Oxford: Oxford University Press; 2012. Pp. 415–47.
39. Fleury S. What kind of social protection for what kind of democracy? The dilemmas of social inclusion in Latin America. Soc Med. 2010;5:34–49.
40. Armada F, Muntaner C, Chung H, Williams-Brennan L, Benach J. Barrio adentro and the reduction of health inequalities in Venezuela: an appraisal of the first years. Int J Health Serv. 2009; 39(1):161–87.
41. Feinsilver J. Fifty years of Cuba's medical diplomacy: from idealism to pragmatism. Cuban Studies. 2010;41:85–104.
42. Almeida C, Pires de Campos R, Buss P, Ferreira JR, Fonseca LE. Brazil's conception of South-South 'structural cooperation' in health. R Eletr Com Inf Inov Saúde. 2010; 4(1):23–32.
43. Breilh J. La subversión del buen vivir (rebeldía esclarecida para el siglo XXI: una perspectiva crítica de la obra de Bolívar Echeverría). Salud Colect. 2011; 7(3):389–97.
44. Pachakuti TB. Indigenous perspectives, buen vivir, sumaq kawsay and degrowth. Development. 2011;54(4): 448–54.
45. Meier BM, Brodish PH, Koivusalo M. Human rights provide justification for the Health in All Policies approach. Health Hum Rights. Available from: www.hhrjournal.org/2013/06/10/human-rights-provide-justification-for-the-health-in-all-policies-approach/ Accessed on 28 October 2013.

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