International Forum
Vol. 13, No. 1
April 2010
pp. 53-65

FEATURE

Some Considerations in Promoting Healthy Lifestyles

Ayuka Oendo

Abstract. *This paper argues that the effectiveness of the approach used by the Seventh-day Adventist church to propagate its health message has been compromised by its failure to take full account of social determinants of health, and its apparent inability to recognize the role played by community both in lifestyle change decisions and in decisions related to food choices. A brief background provides an overview of the emergence of awareness of the role played by social factors as a determinant of health, and of the role that the World Health Organization has played in this process. The paper then discusses the important role played by social determinants of health and the place of the community in lifestyle choices. Finally, the paper highlights the bases of the Adventist health message and the suggests some considerations for adapting its approach in order to enhance its effectiveness in promoting behavior change that will lead to healthier lifestyles.*

Background

At its inception the World Health Organization (hereafter WHO) defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2006, p. 1). They then went further to point out that health is achieved by mobilizing "all systems and structures which govern social and economic conditions and the physical environment," including anything that has an "impact on individual and collective health and well-being" (WHO 1998, p. 1).

It is important to recognize from the outset the significance the WHO (1946) accorded to social well being as an integral part of health. This definition of health was predicated upon the understanding that health had, hitherto, been defined in a narrow sense, focusing on physical well being and freedom from physical illness. Still, it took a long time before this realization translated into policies and programs that gave priority to social determinants of health. Health

programs continued to be based on approaches that focused on dealing with disease and on restoring the human body to the state where it was free from physical malaise. With this focus on physical wellness, traditional health care associated health outcomes with the operation of the health care system. Thus, to meet the challenge of disease among the poor, it was assumed that access to health care facilities and health care professionals would be adequate to deal with the disease problem. The weaknesses of hospital-based curative services were recognized in the 1950s and 1960s, prompting a search for new ways to address the growing health challenges. The 1974 Lalonde Report was one of the first to directly point out the role of the social determinants of health (Lalonde, 1974).

In time, the inadequacy of hospital-based curative services was recognized, and there was a shift of emphasis toward lifestyle issues. This view considered health essentially as the responsibility of the individual, and that adherence to a healthy lifestyle would deal with the health problems experienced by sick people. Thus, efforts to reduce the incidence of disease and improve the health status of individuals began to focus on health promotion, with the aim of encouraging and promoting healthy lifestyles.

It was realized, however, that it took more than effective health care systems and improved personal lifestyle practices to bring about the desired health outcomes. Efforts in the 1950s were aimed at advancing medical technology and the eradication of infectious diseases. However, the principles espoused in the Universal Declaration of Human Rights (United Nations, 1948), and the community development movement (UNESCO, 1956) contributed to the trend in the 1960s and 1970s of increasing recognition of social factors in health, and community based approaches to health and development (Fairchild, Rosner, Colgrove, Bayer, & Fried, 2010).

The Adventist health message was developed at the time when health was thought of in terms of disease and physicians' efforts to bring about relief from physical suffering. While the emphasis that the Adventist health message placed on healthy lifestyle and on holistic health was ahead of its time, it is apparent that, in practice, it has achieved only limited success in transcending the hospital as the locus of its programs and curative services as the focus of its health ministry. It is also apparent that little recognition has been accorded to the role of social non-lifestyle factors in health and no effort has been made to address social risk factors. Among the most important risk factors are income and social status, education and literacy, social support networks, policy environments and discrimination (Raphael, 2006).

This paper focuses on the role played by social factors in decisions affecting health in general, and in practices relating to food choices and eating practices in particular. It will attempt to outline the general approaches used by

the Seventh-day Adventist Church in communicating its health message and contrast them with current thinking on effective strategies to meet global health challenges. It will also consider the potential and limitations of the approach of the Adventist health message in addressing causes of ill health, some of which reflect inequities associated with the effects of the social determinants of health.

Social Determinants of Health

The Alma Ata Declaration on Primary Health Care (WHO, 1978), drawn up by the International Conference on Primary Health Care was an important milestone towards the recognition of the critical role played by non-medical factors in health outcomes. It described primary health care as "essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford" (p. 16).

The declaration was founded on the principles of appropriate technology, a shift away from reliance on medical professionals and toward community health workers, and "an explicit linkage between health and social development, and social and environmental determinants of health" (WHO, 1978, p. 40). The declaration defined primary health care in terms of social and economic development, emphasizing concepts of participation and self determination, cultural acceptance and social appropriateness. It also defined primary health care in such a way as to incorporate such sectors as education, housing, public works, communications, and recognized the need for multisectoral coordination in order to realize the desired goals (WHO, 1978, p. 40). The principal contribution of the Primary Health Care declaration was that, for the first time, health professionals drew attention to the critical importance of non-medical factors in achieving health.

The Ottawa Charter for Health Promotion similarly adopted a more comprehensive view of health and considered the purpose of health promotion as being more than just a healthy lifestyle, but the attainment of well being (WHO, 1986). Equally important, the charter recognized the essential requirements and resources for health beyond individual choices and practices. The charter listed factors such as peace, social justice, and equity as prerequisites for attaining comprehensive health and well being. The role of these factors had not hitherto been explicitly acknowledged. The charter also emphasized the importance of creating supportive environments and argued for a socio-ecological approach that would recognize the complexity and interrelatedness of human societies. This approach emphasizes the necessity of exercising global responsibility by people caring for communities and the

natural environment. The health prerequisites defined by the Ottawa Charter represent the broad determinants of health (WHO, 2010).

Other studies following the Primary Health Care Declaration have explored in greater detail the role played by various factors in determining health status and outcomes. It has been suggested that these social determinants of health operate at different levels. Macro level factors are social, structural, and policy influences acting on the social, physical, economic and environmental factors. Micro level factors, on the other hand, operate at individual and household levels. There are also intermediate level factors, including psychosocial influences such as social support and health related behaviors (Krieger, 2008; Gehlert, et al., 2008; Marmot, 2005).

These social risk factors set the contexts in which health and disease are experienced and describe the limits of the effectiveness of health promotion interventions at individual and household levels. They also determine the potential and limitations of the health care system to improve the health of populations and the extent to which individual lifestyle changes can, on their own, lead to improved health and a better quality of life.

The recognition of the pivotal role played by social factors in health began in the 1960s. The establishment of the United Nations Commission on Social Determinants of Health was an effort to encourage the enactment of policies to address these factors at local, national and global levels (WHO, 2008).

Among the social determinants of health, macro level factors are especially important because of their overriding causal responsibility for disease and health disparities. These factors, which include income and social status, residence, gender, ethnicity, education and environment, influence the ability of people to achieve optimum health, while also limiting the effectiveness of any interventions to improve people's health (Raphael, 2006; Irwin et al., 2006).

It is now accepted that, as a strategy, addressing deficiencies in the health system and focusing on adoption of healthy lifestyles is not enough. Non-medical and non-lifestyle factors must be central to efforts to raise health standards and address the health care disparities (Navarro, 2009).

Culture, Community and Health

Culture may be defined as the shared, learned symbolic system of values, beliefs and attitudes that influence people's perceptions of their world, and the behavior that such perceptions engender. Culture can also be defined as people's means of adapting and relating to their environment in a way that ensures their survival and development. The environment, both physical and social, determines the resources that are available and describes the options that people

have for meeting their survival and developmental needs. Among the most important human needs are for food, health and safety.

Food procurement, preparation and consumption provide the settings in which cultural beliefs, attitudes and practices manifest themselves. On the one hand, for many cultures, the association between diet and health is so close that there is only a thin line separating what is merely 'nutritious' and what is 'medicinal.' Thus, practices associated with food preparation and eating represent the degree to which nutrition and health are integrated in a particular culture. But it is also important to note that there is great cultural variety in what is considered edible or inedible, suggesting that food consumption serves more than just physiological needs, whether these needs are nutritional or medicinal. This means that decisions as to whether or not and in what ways people are willing to change their dietary practices are constrained by the meanings they attach to what they eat. These meanings are largely social and cultural, and are created and sustained in the contexts of family and community (Pieroni & Price, 2006).

The link between culture and community is both direct and profound. Cultures define communities, while, at the same time, communities create, propagate and transmit cultures across generations. The community may be described as the social entity that is intermediate between the individual and society. It is the locus of social interaction, and the level at which most health determinants external to individuals come into play. The community, as a physical or conceptual entity, implies that its members display patterns of behavior in their daily lives that reflect the values of the group of which they are a part. Thus, community is the level at which important health and dietary decisions are made.

Studies have shown that social and community factors play an important role in lifestyle choices, including food choices. Decisions on what to eat are among the more important social choices people make, reflecting social and cultural considerations, and attaching relatively low significance to nutritional value (Mintz & Du Bois, 2002). Other studies have shown that culture plays an important role in the classification of foods, and in determining what constitutes a healthy diet. Because health and well being are a reflection of a people's worldview, food choices may disregard any medically appropriate diet prescribed by health professionals. What is equally significant is that both food choices and consumption are often regarded as social events, rendering difficult individual efforts to comply with medically prescribed dietary practices or dietary changes recommended by health promotion professionals. When food preparation and eating are cultural activities in social bonding, and in building and maintaining relationships, then the contribution of food to health goes far beyond its nutritional value (Scott, 1997).

Liburd (2003) found that, among the African American women in the Southern US, food choice and eating were rooted in history and culture, serving as a means of claiming or asserting social or cultural identity. Studies of immigrants to the US from Korea showed that eating practices correlated closely to their degree of acculturation into the dominant American society (Park & Barr, 2005). Probably more important is the role that religion and religious beliefs play in determining what is acceptable for food, including perceptions about the sources of the food. How the food is prepared, when, how and with whom it is eaten are important decisions, especially when food consumption has a ritual component to it. Thus, dietary choices may be a socially recognized way of acquiring and maintaining group identity, whether the group is ethnic or religious. (Heiman, Just, McWilliams, & Zilberman, n.d.) The important point here is that dietary choices are largely beyond the control of the individual, and when these choices are made, cultural beliefs play an important role.

The Adventist Health Message

The Seventh-day Adventist health principles, which are the basis of the Adventist Health Message, have their biblical foundations in the Levitical laws. The broad principles are drawn from Genesis 1:29, 3:18 and 9:4, where a non-flesh diet is enjoined. These laws are further elaborated in Leviticus 3:17 and in chapter 11 with instructions to avoid blood, fat and stipulating the animals that are permissible for food. The New Testament provides additional bases for recommending a different kind of lifestyle, emphasizing temperance and self control (1 Cor 3:16-17; 6:13-15; 9:25; 10:31). These are encouraged to maintain the body, mind and spirit in optimum condition as a means of keeping the body healthy and productive, and to honor the body as the temple of the Holy Spirit. The Levitical laws, on which Adventist health principles are based, prescribed what foods were admissible as diet for the Israelites and the environmental health practices that they were to observe.

The Adventist Health Message relies, in part, on divine revelations, Old Testament prescriptions and New Testament exhortations, but it also has carefully selected and judiciously incorporated scientific principles pertaining to healthy lifestyle practices. In practice, the Adventist Health Message is expressed in what is, essentially, a dual approach. One approach consists of its promotion of healthful living in churches. This approach has demonstrated the efficacy of the Adventist health principles in the developed world (Fraser, et al 1991; Phillips 1975). What is uncertain is the difference that the Adventist Health Message has made to the majority of Adventist believers in poor nations where lifestyle diseases are less of a problem than in the developed nations.

The other approach is through the work of Health Ministries Departments of the Adventist Church around the world. These departments ordinarily utilize

special occasions and programs to promote Bible-based health messages. They also maintain an active program of distribution of health literature, while some conferences also operate wellness and smoking cessation programs. The most regular occupation of these ministries, however, is the management of medical facilities that provide curative services. These include hospitals, health centers, clinics and dispensaries whose quality of care ranges from the state-of-the-art services in North America to 'no-frills' curative services in developing countries.

The common characteristic of Adventist health services is that they target the individual. The curative services utilize a medical missions approach, with the goal of physical healing as a worthy goal in itself, but also as a means of enabling the sick to achieve spiritual healing and restoration. The health promotional approach also targets the individual with messages designed to lead to a healthy lifestyle. There is no evidence of systematic programs designed to address social determinant of health, especially the macro level factors. It seems clear that programs to promote dietary changes, exercise and smoking cessation, for instance, do not recognize the cultural and social dimensions of decision making, nor do they consider the community a level at which health messages might be targeted.

Promoting Lifestyle Changes

To be effective, attempts to influence dietary practices must take into account social and cultural considerations that influence food choices and eating practices. They must devise approaches that recognize the social and cultural meaning of food choice and food consumption, and the role of family and community in the adoption of new lifestyle and, especially, changes in dietary practices.

Efforts to promote healthy dietary practices must also recognize that dietary change is, in a very significant way, cultural change, and they must adopt suitable approaches. A culturally sensitive approach will consider, as a strategy, efforts to identify acceptable food substitutes within the culture itself. It will also look within cultures and endeavor to accommodate food preparation and eating arrangements that meet non-nutritional needs for food consumption. A studied approach will make it possible to anticipate cultural or ethnic identity-based resistance or barriers and adopt appropriate accommodations.

An approach that recognizes the cultural significance of food choices and consumption patterns will consider creating or strengthening complementary 'communities' which will accommodate and legitimize new dietary practices. Ideally, this will enable people to adopt and practice the desired dietary practices without putting at risk their membership in a community that gives their lives purpose and meaning.

The models that have been proposed for use in health promotion program planning and behavior change already take into account such considerations as social and cultural factors, and community as the locus for health decision making. The Social Cognitive Theory and Theory of Reasoned Action both recognize the role played by social expectations, attitudes and beliefs in making lifestyle choices. The Theory of Planned Behavior, an extension of the latter, has proved effective in predicting food choices, by recognizing the contribution of social and cultural factors that are beyond the control of the individual (Shepherd, 1999;). Other models, including the Health Belief Model, a behavior change model, also recognize the role played by demographic, socio-psychological and structural variables as modifying factors in the change process. In the Trans-theoretical Model, social and environmental factors are considered to be important influences in the transition between stages in the behavior change process (Baranowski, Cullen, Nicklas, Thompson, & Baranowski, 2003; Fen & Hong, 2009; Fila & Smith, 2006).

According to Gruber and Haldeman (2009), most eating behavior is rooted not only in upbringing, but also in perceptions of close family as to what constitutes proper food intake. They suggest the need for a "Theory of Family Behavior Change," arguing that behavior change in relation to food intake must be family based in order to be successful. Gruber and Haldeman (2009) contend that eating behaviors are rooted and nurtured in family contexts and suggest that the family is the appropriate social unit to target in health promotion interventions. Delormier, Frohlich, and Potvin (2009) make a similar point by arguing that there is a difference between eating as individual behavior and eating as a social practice, and that food choice is best understood by examining social relations that are part of eating patterns as social processes. They suggest that recognizing eating as a social practice, rather than as an individual behavior, is necessary for understanding the way in which individual choices are constrained by social norms (Delormier et al., 2009).

Conclusion: Contextualizing the Adventist Health Message

Seeing the changes that have taken place in the way health needs are defined and the most effective means of addressing them, it is now clear that the approaches that the church employs are not consistent with insights that have been gained over the years (Fairchild et al., 2010). Programs implemented by the Adventist Church do not reflect the experience of practicing agencies, including churches, para-church and non-governmental organizations (Stephenson & Glover, 1998; Jaeger, 1999). One of the shortfalls is the continuing inability to design programs that take into account the role played by the community, and to adapt the health message to the needs of the poor and to peoples of other cultures. While the focus on the individual has demonstrated

some positive results, particularly in the developed world (Willett, 2003; Fraser and Shavlik, 2001), the approach has not demonstrated its capacity to address the health challenges of the developing world where traditions are stronger and lifestyle choices and decision making are much less individualistic.

Secondly, the Adventist health message still retains the individual as the target of its messages, although it is now clear that lifestyle and dietary choices are constrained by social norms. It is also a fact that illness and well being are defined at community, rather than at individual level. This recognition has led scientists and development practitioners to modify their approaches in the light of this reality.

Thirdly, recognition that lifestyle change *is* culture change is necessary in order to fully understand the complexity of the change process. Such an understanding will facilitate the development of strategies that will lead people to make the desired lifestyle and dietary changes.

Fourthly, it is now accepted that social determinants of health play a critical role in people's health status. While micro level social risk factors might be addressed at the individual or household level, macro level social determinants of health are not amenable to this approach. Issues at this level require interventions at national or even global level. Poverty, which plays a critical role in determining health status, requires policy interventions at the national level and advocacy for social justice at the global level. Failure to recognize and to devise appropriate strategies will diminish the relevance of the Adventist health message and confine its application to the relatively wealthy in developed countries.

Finally, it is clear from the reading of the Adventist health message that its principles were never intended to be applied in a rigid or dogmatic manner. Common sense and appreciation of local environmental limitations and economic constraints need to dictate what adjustment is needed to the message. While the health message has proven to be an effective evangelistic tool, it is necessary to avoid a doctrinaire approach to its application. To achieve this it may be necessary to consider whether or not, and to what extent, conscious and deliberate efforts to disengage the gospel message from the health message may contribute to restoring its authenticity and relevance. The Adventist health message has demonstrated its inherent value, and it has proved its effectiveness in facilitating the spread of the Christian gospel. However, it may require significant revision if it is to have real impact in achieving genuine and sustainable holistic health outcomes among the poor and non-western peoples.

To conclude, there is need for continuing research to identify the potential and limitations of the approach used by the Adventist church in propagating its health message in different social and environmental settings, and to maximize on local advantages to advance holistic health and well being. This will render

the Adventist health message more relevant and imbue it with new potency. It will move the Adventist church in the direction of harnessing knowledge and insights that have been developed over the years and using them to generate new and effective methods of communicating its life-changing message.

References

Baranowski, T., Cullen, K. W., Nicklas, T., Thompson, D., & Baranowski, J. (2003). Are current health behavioral change models helpful in guiding prevention of weight gain efforts? *Obesity Research, 11* (Supplement), 23S-43S. Retrieved from http://www.nature.com/oby/journal/v11/n10s/pdf/oby2003222a.pdf

Cueto, M. (2004). Origins of PHC and selective PHC. *American Journal of Public Health, 94*(11), 1864-1874. Retrieved from http://ajph.aphapublications.org/cgi/content/full/94/11/1864

Delormier, T., Frohlich, K. L., & Potvin, L. (2009). Food and eating as social practice –understanding eating patterns as social phenomena and implications for public health. *Sociology of Health & Illness, 31*(2), 215–228. doi:10.1111/j.1467-9566.2008.01128.x

Fairchild, A. L., Rosner, D., Colgrove, J., Bayer, R., & Fried, L. P. (2010). The exodus of public health. *American Journal of Public Health, 100*(1), 54-63.

Fee, E., Brown, T. M., (eds.). (2000). The past and future of public health practice. *American Journal of Public Health, 909*(5). Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446216/pdf/10800411.pdf

Fen, Y. S., & Hong, L. K. (2009). Exercise as a healthy lifestyle choice: A review and avenues for future research. *International Business Research, 2(1), 146-158. Retrieved from* http://www.ccsenet.org/journal/index.php/ibr/article/viewFile/153/150

Fila, S. A., & Smith, C. (2006). Applying the theory of planned behavior to healthy eating behaviors in urban Native American youth. *International Journal of Behavioral Nutrition and Physical Activity, 3*(11). Retrieved from http://www.ijbnpa.org/content/pdf/1479-5868-3-11.pdf

Fraser, G. E., & Shavlik, D. J. (2001). Ten years of life: Is it a matter of choice? *Archives of Internal Medicine, 161*, 1645-1652.

Gehlert, S., Sohmer, D., Sacks, T., Mininger, C., McClintock, M., & Olufunmilayo, O. (2008). Targeting health disparities: A model linking upstream determinants to downstream interventions. *Health Affairs, 27*(2), 339-349.

Gruber, K. J., & Haldeman, L. A. (2009). Using the family to combat childhood and adult obesity. *Preventing Chronic Disease: Public Health Research, Policy and Practice, 6*(3). Retrieved from http://www.cdc.gov/pcd/issues /2009/jul/pdf/08_0191.pdf

Heiman, A., Just, D., McWilliams, B., & Zilberman, D. (n.d.). *Religion, religiosity, lifestyles and food consumption.* Giannini Foundation of Agricultural Economics. Retrieved from http://www.agecon.ucdavis .edu/extension/update/articles/v8n2_4.pdf

Irwin, A., Valentine, N., Brown, C., Loewenson, R., Solar, O., Brown, H., Koller, T., . . . et al. (2006). The commission on social determinants of health: Tackling the social roots of health inequities. *PLoS Medicine, 3*(6), *p. E106.* doi:10.1371/journal.pmed.0030106

Jaeger, T. (1999). Community health development: Study pack for community development workers. *Tearfund Case Study Series.* Retrieved from http://tilz.tearfund.org/webdocs/Tilz/Roots/Community%20Health(1).pdf

Krieger, N. (2008). Proximal, distal and the politics of causation: What's level got to do with it? *American Journal of Public Health, 98* (2), 221-230.

Lalonde, M. (1974). *A new perspective on the health of Canadians: A working paper* (the Lalonde report). Government of Canada, Ministry of National Health and Welfare. Retrieved from http://www.hc-sc.gc.ca/hcs-sss /alt_formats/hpb-dgps/pdf/pubs/1974-lalonde/lalonde-eng.pdf

Liburd, L. C. (2003). Food, identity, and African-American women with type 2 diabetes: An anthropological perspective. *Diabetes Spectrum,16*(3), 160-165. Retrieved from http://spectrum.diabetesjournals.org/content/16/3 /160.full.pdf#page=1&view=FitH

Marmot, M. (2005). Social determinants of health inequalities. *Lancet, 365,* 1099–1104.

Mintz, S. W., & Du Bois, C. M. (2002). The anthropology of food and eating. *Annual Review of Anthropology, 31*, 99-119.

Navarro, V. (2009). What we mean by social determinants of health. *International Journal of Health Services, 39*(3), 423–441.

Park, Y.-S., & Barr, S. (2005). Food habits of Korean immigrants living at Pacific Coast areas by length of residence. *Journal of Community Nutrition, 7*(1), 36-41.

Phillips, R. L. (1975). Role of life-style and dietary habits in risk of cancer among Seventh-day Adventists. *Cancer Research 35*, 3513-3522.

Pieroni, A., Price, L. L. (eds.). (2006). *Eating and healing: Traditional food as medicine* (Introduction). New York, NY: The Haworth Press.

Raphael, D. (2006). Social determinants of health: Present status, unanswered questions, and future directions. *International Journal of Health Services, 36*(4), 651–677.

Scott, P.A. (1997). Culture, food, diet and diabetes: The West Indian perspective. *Practical Diabetes International, 14(7), 209-211.*

Seventh day Adventist Dietetic Association. (n.d.). *The Seventh-day Adventist health message.* Retrieved from http://www.sdada.org/sdahealth.htm

Shepherd, R. (1999). Social determinants of food choice. *Proceedings of the Nutrition Society, 58*, 807–812.

Stephenson, P., & Glover, S. (1998, July). *Child development policy*. Tearfund, UK. Retrieved from http://prevetteresearch.net/wp-content/uploads/image /car-country/TEARFUND%20-%20Child%20Development%20Policy.pdf

UNESCO. (1956). *The definition of community development.* UNESCO Working Paper for ACC Working Group on Community Development. Working Paper UNESCO/3 Paris 1956. Retrieved from http://unesdoc .unesco.org/images/0017/001797/179726eb.pdf

United Nations. (1948). *Universal declaration of human rights.* Retrieved from http://www.un.org/en/documents/udhr/index.shtml

Willett, W. (2003). Lessons from dietary studies in Adventists and questions for the future1–3. *American Journal of Clinical Nutrition,* 78 (Supplement), 539S–43S.

World Health Organization. (1946). *WHO constitution.* Retrieved from http://www.worldinbalance.net/pdf/1946-who-constitution.pdf

World Health Organization. (1978). *Primary health care*. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, September 6-12, 1978. Retrieved from http://whqlibdoc.who.int /publications/9241800011.pdf

World Health Organization. (1987). Ottawa charter for health promotion. *Health Promotion, 1*(4), iii-v. Retrieved from http://heapro.oxfordjournals.org /content/1/4/405.1.full.pdf

World Health Organization. (1998). *Health promotion glossary* (WHO/HPR/HEP/98.1). Geneva, Switzerland. Retrieved from http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf

World Health Organization. (2005). *Action on the social determinants of health: Learning from previous experiences.* A background paper prepared for the Commission on Social Determinants of Health. Retrieved from http://www.who.int/social_determinants/strategy/en/CSDH_socialdet_backgrounder.pdf

World Health Organization. (2006). Constitution of the World Health Organization. In *Basic Documents,* 45th edition (pp. 1-18). Supplement, October 2006. Retrieved from http://www.who.int/governance/eb/who_constitution_en.pdf

World Health Organization. Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health.* Commission on Social Determinants of Health, World Health Organization final report. Geneva, Switzerland: Author. Retrieved from http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

Ayuka Oendo, MPH, PhD
Public Health Department
Adventist International Institute of Advanced Studies
Silang, Cavite