THRIVE Overview and Background

Tool for Health and Resilience in Vulnerable Environments

What is THRIVE?

THRIVE (Tool for Health and Resilience in Vulnerable Environments) was created to answer the question, what can communities do to improve health and safety and promote health equity? THRIVE is:

- *A framework* for understanding how structural drivers[i] play out at the community level to impact community determinants,[ii] and consequently, health and safety outcomes, and inequities in outcomes; and,
- *A tool* for engaging community members and practitioners in assessing the status of community determinants, prioritizing them, and taking action to change them to improve health, safety, and health equity.

THRIVE identifies 12 community determinants of health and safety, grouped in 3 interrelated clusters: 1) the social-cultural environment (people), 2) the physical/built environment (place), and 3) the economic/educational environment (equitable opportunity). THRIVE is a framework and tool to support communities in improving daily living conditions related to these 12 factors in order to enhance health and safety and promote health equity.

Our collective knowledge of how a variety of factors influence health and safety outcomes, and levels of equity or inequity in those outcomes among different populations, has deepened significantly over the past decade. In analyzing the social determinants of health and health inequities, the World Health Organization (WHO) has identified the structural drivers—the inequitable distribution of power, money, and resources—that determine health and safety outcomes, in part by shaping the circumstances in which people are born, grow, live, work, and age.[1] THRIVE provides the *framework* for understanding how these structural drivers play out at the community level, impacting daily living conditions and, consequently, neighborhood outcomes for health, safety, and health equity. THRIVE also helps communities understand how creating change at the community level can influence and push back against structural drivers.

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[i] Structural drivers are the inequitable distribution of power, money, and resources that determine health and safety outcomes, in part by shaping the circumstances in which people are born, grow, live, work, and age. (World Health Organization Commission on Social Determinants of Health, 2008.)

[ii] Community determinants are daily living conditions – where people live, work, learn, play, and age – including education, employment, housing, food, and transportation. (World Health Organization Commission on Social Determinants of Health, 2008.)

As a tool, THRIVE helps communities identify strengths and assets, prioritize concerns, and develop an action plan for making effective investments that increase resilience, improve community conditions, and expand opportunities, thereby enhancing health and safety outcomes for all. THRIVE has supporting resources, including a Community Assessment Worksheet to assign effectiveness scores and priority ratings for each of the 3 overarching clusters, and each of the 12 factors. THRIVE also includes additional resources to support planning and action, including background research, examples of actions that can be taken across the Spectrum of Prevention to change community determinants, and examples of metrics to measure progress.

What's the relationship between THRIVE and the social determinants of health?

In 2008, the World Health Organization's (WHO) Commission on Social Determinants of Health issued a seminal document: *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*.[2] Providing a common language and framework to advance health equity, the report includes overarching recommendations and three principles of action:

1) Improve the conditions of daily life—the circumstances in which people are born, grow, live, work, and age.
2) Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally.
3) Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

All three principles of action are critical. THRIVE dovetails with the WHO framework, providing communities with a blueprint for taking effective local action to help close the health equity gap.

THRIVE is a framework for understanding how structural drivers play out at the community level, shaping daily living conditions, which impact health, safety, and health equity. As a tool, THRIVE helps communities improve the conditions of daily life equitably, thereby enhancing health and safety for all. Finally, the THRIVE process emphasizes measurement and understanding, the importance of which are underscored by the third principle.
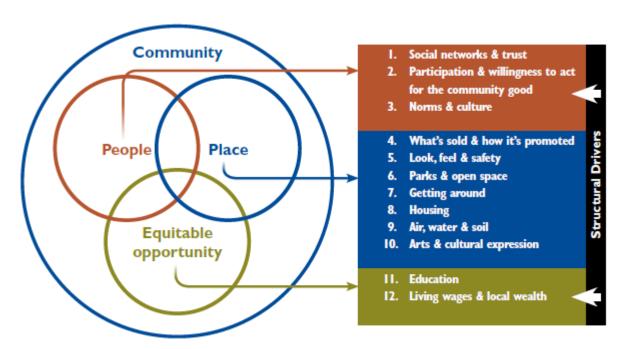
THRIVE was developed in 2002 based on extensive research linking medical conditions to community-resilience factors that can be strengthened for better health and safety outcomes. As part of updating THRIVE in 2011, Prevention Institute reviewed 22 social determinants of health frameworks and mapped the determinants identified in each framework onto the THRIVE clusters and factors. Prevention Institute found that there is strong alignment and consistency between and among THRIVE and the frameworks that were examined.[3] THRIVE in particular, affirms that the social-cultural, physical/built, and economic/ educational environments at the community level – i.e., the community determinants of health – have a significant impact on health and safety outcomes and their inequitable or equitable distribution. THRIVE's focus on community determinants through a health equity lens places communities at the center of analysis and action.

Why does THRIVE focus on community determinants?[iii]

Structural drivers—the inequitable distribution of power, money, and resources—play out at the community level, influencing daily living conditions, which shape health and safety outcomes. Due to the impact of structural drivers, research has shown that after adjusting for individual risk factors, there are neighborhood differences in health and safety outcomes.[4] In fact, on the whole, a person's zip code is a better predictor of his/her health status and life expectancy than his/her genetic code. THRIVE helps communities focus on altering the ways that structural drivers are playing out at the community level to create inequities in daily living conditions. By addressing community determinants through a health equity lens, THRIVE places communities at the center of analysis and action to develop and implement community-informed, actionable strategies for measurable change.

What is the THRIVE framework?

The THRIVE framework is organized into 3 interrelated clusters: 1) people (the social-cultural environment); 2) place (the physical/built environment); and, 3) equitable opportunity (the economic/educational environment). Each cluster includes factors that research has shown relate to health and safety outcomes. The THRIVE framework shows that structural drivers shape the 12 factors at the community level, and consequently, influence health and safety outcomes, and inequities in outcomes.

The THRIVE framework helps communities focus their analysis of the factors that contribute to illness, injury, and inequity at the community level, and helps them think comprehensively to understand, and focus their attention on, the impact of a range of interacting and reinforcing factors in the socio-cultural (people cluster), physical/built (place cluster), and educational/economic (equitable opportunity cluster) environments.

[iii] From: Prevention Institute. *A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety.* Commissioned by the Institute of Medicine's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

What is the THRIVE tool?

THRIVE is not just a framework for analysis. THRIVE and related PI tools and resources support communities in moving through five steps to improve health, safety, and health equity through a comprehensive, multi-sector approach to improving the community determinants of health. The process begins with building shared understanding of how structural drivers play out at the community level to impact community conditions, and consequently, health and safety outcomes, and inequities in outcomes. Then, communities assess the status of community determinants, prioritize them, and take action to change them. These steps are not linear, but rather are iterative and mutually reinforcing:

1) *Engage and partner:* **identify and engage the support of key participants and decision-makers, including diverse members of the community.** Tools such as Prevention Institute's [Developing Effective Coalitions: An 8 Step Guide](#), and case examples such as [The Community-Driven Eden Area Livability Initiative Phase II Summary Report](#) support communities in this step.

2) *Foster shared understanding and commitment:* **cultivate a shared understanding of the determinants of health and foster buy-in for addressing them as an effective, equitable approach to improving health and safety outcomes.** Tools such as Prevention Institute's [Taking Two Steps to Prevention](#), resources such as the THRIVE Clusters and Factors Background Research, papers such as [Moving from Understanding to Action on Health Equity: THRIVE and Social Determinants of Health Frameworks](#), and case examples such as [THRIVE Advances a Shared Understanding of Social Determinants of Health: A Louisiana Case Example](#) support communities in this step.

3) *Assess:* **use the [Community Assessment Worksheet](#) to identify the assets and needs of the community or neighborhood and its particular health and safety concerns and inequities.** The worksheet includes an effectiveness score (A–F) and a priority rating (low-medium-high) for each of the 12 factors. The worksheet is flexible and adaptable, and allows communities to add in factors that they deem applicable and important within each of the clusters, or as an overarching factor that cuts across the clusters. The worksheet supports participants in selecting top priorities for action among all the factors. Case examples such as [The Community-Driven Eden Area Livability Initiative Phase II Summary Report](#) can also support communities in this step.

4) *Plan and act:* **clarify vision, goals, and directives; establish decision-making processes and criteria; and implement multifaceted activities to achieve desired outcomes.** Tools such as Prevention Institute's [Spectrum of Prevention](#), [Developing Effective Coalitions: An 8 Step Guide](#), and [Collaboration Multiplier](#) are useful in planning and action. Resources such as [Examples of Action on THRIVE Factors Across the Spectrum of Prevention](#), [Examples of Action on THRIVE Factors in Communities](#), and case examples such as [THRIVE Empowers Youth to Improve Community Safety: A California Case Example](#) can also support communities in this step.

5) *Measure progress:* **ensure that communities use resources in the most effective, efficient manner and that efforts accomplish the desired outcomes.** Resources such as [Sample Indicators for Measuring Progress on THRIVE Factors](#), and papers such as [Measuring What Works to Achieve Health Equity](#), and [Good Health Counts A 21st Century Approach to Health and Community for California](#) can support communities in this step.

How were THRIVE's clusters and factors developed?[iv]

THRIVE was developed through an iterative process conducted from July 2002 to March 2003. The development team scanned peer-reviewed literature and relevant reports and interviews with practitioners and academics. The team also performed an internal analysis, which included brainstorming, clustering of concepts and information, and searching for supportive evidence as the analysis progressed. The literature scan began with *Healthy People 2010 Leading Health Indicators* (a forecast of indicators that Surgeon General Satcher identified as having a role in eliminating health disparities[5]) and with the "actual causes" of death identified by McGinnis and Foege.[6] Reviewers then gathered and evaluated subsequent information linking the *Leading Health Indicators* with social, behavioral, and environmental elements.[7]

The resulting set of 12 factors fell into three interrelated clusters, reflecting the socio-cultural, physical/built, and economic/educational environments. THRIVE's national expert panel reviewed and ratified the clusters and factors, incorporating them into a tool that was then pilot tested. The THRIVE research was updated in 2011–2012, including a review of literature on social determinants of health.

What are health disparities? What are health inequities? How do they differ?[v]

Health disparities are "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."[8] *Health inequities* are "differences in health, which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust."[9]

Thus, the terms *equity* and *inequity* are based on core values of fairness and justice, whereas *disparity* is a narrow descriptive term that refers to measurable differences, without determining whether or not these differences arise from an unjust root cause.[10] *Inequity* pertains to differences in health and safety outcomes produced by historic and systemic social injustices or by the unintended or indirect consequences of social policies.

Why do health inequities occur?[vi]

Health inequity is related to a legacy of overt discriminatory actions on the part of government, businesses, and the larger society. In addition, many present-day practices and policies of public and private institutions continue to perpetuate a system of diminished opportunity for certain populations. These systemic adversities and exclusions negatively impact health and safety outcomes. For example:

- Poverty, racism, and lack of educational and economic opportunities are among the fundamental determinants of poor health, lack of safety, and health inequities. They contribute to chronic stress and build upon one another to create a weathering effect,

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[iv] Adapted from Davis R, Cook D, Cohen L. A community resilience approach to reducing ethnic and racial disparities in health. *Am J Public Health*. 2005;95:2168-73

[v] From: Prevention Institute. *A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety*. Commissioned by the Institute of Medicine's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

[vi] From: Prevention Institute. *A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety*. Commissioned by the Institute of Medicine's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

whereby health greatly reflects cumulative experience rather than chronological or developmental age.[11]

- Inequities in the distribution of a core set of health-protective resources continue to create and maintain clear patterns of poor health and safety throughout the U.S. [12]
- Social isolation and a collective sense of hopelessness pervade many low-income and racially segregated places, where health disparities abound. This individual- and community-level despair fuels chronic stress and can foster short-term decision-making.
- Continued exposure to racism and discrimination may in and of itself exert a great toll on both physical and mental health.[13]

In many low-income communities and communities of color, whole populations are consigned to shortened, sicker lives with limited economic opportunities, a lack of healthy options for food and physical activity, increased presence of environmental hazards, substandard housing, lower performing schools, higher rates of crime and incarceration, and higher costs for common goods and services (the so-called poverty tax).[14]

What does health equity mean?

Health equity means that every person, regardless of who they are—the color of their skin, their level of education, their gender or sexual identity, whether or not they have a disability, the job they have, or the neighborhood they live in—has an equal opportunity to achieve optimal health and safety.[15]

How does THRIVE promote health equity?

THRIVE promotes health equity by: 1) identifying ways that structural drivers, including poverty, racism, and other forms of oppression, play out to alter community conditions; 2) delineating the specific community determinants that shape health and safety; and, 3) providing a community-informed, path to action. The THRIVE process helps identify policies and institutional practices that are the key levers for systemic change. Institutional practices along with public and private policies helped produce and continue to perpetuate the inequitable living conditions and poor health and safety outcomes confronting too many communities today.[16] Reversing these practices and policies and implementing equity-oriented policies and practices can help produce equitable neighborhood conditions and improve health and safety outcomes.

THRIVE promotes health equity by:

1) Changing the way people think about health and safety:[17] THRIVE guides communities in understanding and critically evaluating community elements and structures, community determinants of health and safety, and the value of community-resilience approaches.

2) Providing an evidence-informed, practice-based framework for change:[18] THRIVE is a framework that can be customized to embrace and reflect local nuances and culture. THRIVE supports communities in finding solutions that reflect the values and cultures of people who live there.

3) Developing community capacity while building on community strengths:[19] THRIVE encourages communities to reflect on their own strengths and capacities. It helps local leadership understand

how to address important community and health issues, and it fosters community ownership of proactive solutions.

4) Facilitating links to decision-makers and other resources:[20] THRIVE helps build bridges connecting under-resourced neighborhoods to those with access to resources and influence in local decision-making. It helps cultivate trust and accountability with regard to local decision-makers and policy-makers. THRIVE also helps develop equal partnerships between communities and universities concerned about health equity, by providing a framework for communities to prioritize and take action and for universities to provide credible assessments and evaluations, based on community participation.

How is THRIVE a tool for community resilience?

One of THRIVE's unique contributions includes its emphasis on fostering resilience, leveraging community strengths, and encouraging community leadership to enact positive change. The THRIVE approach acknowledges that communities have strengths and assets. When cultivated, these provide valuable opportunities to promote health, safety, and well-being. THRIVE recognizes that some communities are exposed to greater health and safety risks. Therefore, it is critical to define the positive elements that will enable people to withstand these risks and flourish in spite of them. THRIVE defines community resilience as the ability of a community to recover from and/or thrive despite the prevalence of risk factors. THRIVE's 12 factors are those resilience elements within a community that can be shaped and leveraged to increase health, safety, and health equity and to diminish the detrimental impact of risk factors.

Does THRIVE work?[vii]

THRIVE has been successfully piloted in rural, suburban, and urban sites. The pilot events confirmed that THRIVE broadens the understanding of what constitutes and determines community health and safety; demonstrates the value of upstream, resilience-based approaches; challenges the traditional assumption that health education is the sole means of promoting health; organizes difficult concepts; enables systematic planning; applies to rural, suburban and urban settings; is useful for both practitioners and community members; and maximizes strategic planning at community and organizational levels.

Changes that communities implemented after the THRIVE pilot process include:
- Launching farmers' markets to increase access to healthy food.
- Incorporating health and public safety considerations into its work of a Redevelopment Advisory Commission.
- Utilizing a medical facility's shuttle bus system to transport people to supermarkets and farmers' markets.
- Enhancing opportunities and supports for young people, including initiating a Big Brothers/Big Sisters program; launching a teen center with a youth-inspired service-learning component; and using the THRIVE tool to train young people on in its community-resilience approach.
- Solidifying partnerships between community-serving agencies, such as housing, health care, transportation, and public health.

[vii] Adapted from Davis R, Cook D, Cohen L. A community resilience approach to reducing ethnic and racial disparities in health. *Am J Public Health*. 2005;95:2168-73

From 2012-2015, twelve public health institutes were trained to use THRIVE. The twelve public health institutes in turn conducted THRIVE trainings in their communities, and integrated THRIVE into ongoing organizational processes and programmatic efforts. Since 2012, THRIVE trainings and processes have been conducted in urban, suburban and rural communities, with participation from community partners and residents from low-income communities of color, including youth, and residents who are immigrants and refugees with limited English proficiency. These trainings and processes have contributed to a wide range of outcomes, including the formation of multi-sector coalitions, the development of long-term action plans, and local and state policy and practice change initiatives.

What kind of things should be taken into account in promoting health equity?[viii]

The following *principles* provide guidance in addressing health inequities:

- Understand and account for the *historical forces* that have left a legacy of racism and segregation, as well as structural and institutional factors. This is key to enacting positive structural changes.
- Acknowledge the *cumulative impact of stressful experiences and environments*. For some families, poverty lasts a lifetime and even crosses generations, leaving its family members with few opportunities to make healthful decisions. Further, continued exposure to racism and discrimination may in and of itself exert a great toll on both physical and mental health.[21]
- Recognize the *role of privilege* in contributing to inequity in health outcomes and acknowledge that policies have afforded privilege to some groups at the expense of others.
- *Encourage meaningful public participation* with attention to outreach, follow-through, language, inclusion, and cultural understanding. Government and private funding agencies should actively foster civic engagement and support efforts to build resident capacity to engage.
- Adopt an overall approach that recognizes the cumulative impact of multiple stressors and focuses on *changing community determinants,* not blaming individuals or groups for their disadvantaged status.
- Strengthen the *social fabric of neighborhoods*. Residents need to be connected and supported and to feel empowered to improve the safety and well-being of their families. All residents need a sense of belonging, dignity, and hope.
- Promote equity solutions that address urgent survival issues for low-income people and people of color, while simultaneously responding to *national and international concerns*, such as the global economy, climate change, U.S. foreign policy, and immigration reform.
- Address the developmental needs and transitions of *all age groups*. While infants, children, youth, adults, and elderly require age-appropriate strategies, the largest investments should be in early childhood, which establishes the foundation for adult health.
- *Work across multiple sectors* of government and society in order to make the necessary structural changes. Such work should be in partnership with community advocacy groups that continue to pursue a more equitable society.

[viii] Adapted from Alameda County Public Health Department*'s Life and Death From Unnatural Causes: Health and Social Inequity in Alameda County* (2008) and featured in Prevention Institute's *A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety* (2009), commissioned by the Institute of Medicine's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

- *Measure and monitor the impact of social policy* on health and safety to ensure equity goals are being accomplished. Institute systems to track governmental spending by neighborhood. Monitor changes in health equity over time and place to help identify the impact of adverse policies and practices.
- *Enable groups heavily impacted by inequities to have a voice* in identifying helpful policies and in holding government accountable for implementing them.
- Recognize that eliminating inequities provides a huge *opportunity to invest in community.* Inequity among us is not acceptable, and we all stand to gain by eliminating it.
- Efforts should build on the *strengths and assets* of communities, recognizing that communities are resilient and have a strong history of making change.

What is the role of health care in reducing health inequities?

Access to quality healthcare services is also an important determinant of health. People want and need high-quality medical care, including good medical, mental health, and dental services, and access to quality, culturally and linguistically appropriate medical and dental care, and emergency medical responses. The factors within health care that have significant impact on maximizing quality of life and lifespan, and improving health equity include: preventive services, access to timely screening, appropriate diagnosis, culturally competent disease management, in-patient services, alternative medicine, and emergency response.[22] However, low-income people and people of color consistently have less access to health care and receive worse quality care, and health inequities are often exacerbated by health care practices. For example, patients with limited English proficiency are less likely to have a usual source of care, receive fewer preventative services, and have an increased risk of nonadherence to medication.[23] Even without language barriers, discrimination and cultural miscommunications impact patient care, leading to disparities in service provision. When controlling for socioeconomic status and other factors, researchers have found that people of color seeking necessary medical services are less likely than whites to be treated adequately, including clinically necessary procedures. Disparities exist in a range of disease treatments—from HIV/AIDS and diabetes to cardiovascular disease, cancer, and mental illness.[24]

Addressing inequities in access and treatment can help to reduce health inequities. At the same time, there are at least 3 reasons why addressing health care alone is insufficient for reducing health inequities:[ix]

1) *Health care is not the primary determinant of health.* Of the 30-year increase in life expectancy since the turn of the 20th century, only about 5 are attributed to medical-care interventions.[25] Even in countries with universal access to care, people with lower socio-economic status have poorer health outcomes.[26]

2) *Health care treats one person at a time.* By focusing on the individual and on specific illnesses as they arise, medical treatment does not reduce the incidence or severity of disease among groups of people, because new people become afflicted even as others are cured.[27]

3) *Health intervention often comes late.* Many of today's most common chronic health conditions, such as heart disease, diabetes, asthma, and HIV/AIDS, are never cured. It is

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extremely important to prevent them from occurring *in the first place.* When they do occur, their ongoing prognosis will depend on a number of factors in addition to medical care.

While health care alone is insufficient for reducing health inequities, health care providers can play significant roles in advancing health equity by engaging in efforts to assess and improve the community determinants of health in the communities in which they operate. Prevention Institute has developed the [Community-Centered Health Homes (CCHH) model](#) to help bridge community prevention and health service delivery. This model guides health care providers in systematically and comprehensively incorporating community prevention and advocacy activities into their everyday practices. For example, in their data collection and analysis efforts, health care clinics can collect relevant socioeconomic and demographic data that identifies community determinants negatively affecting health, uncovers inequities, and provides more information about community perceptions of pertinent health, social, and environmental issues. Additionally, clinics can leverage their standing in communities to play a leadership role in advocating for change that addresses these issues.[28]

The U.S. healthcare system has broadly adopted the Triple Aim as a framework for successful reform. The Triple Aim – improved care, reduced costs, and improved population health – is supported through community-based prevention efforts with a focus on equity. Improved population health depends on supporting health before a patient ever reaches the doctor's office. Additionally, as half the nation's healthcare expenditures can be attributed to the care of just 5 percent of Americans (individuals more likely to be people of color), improving the community conditions that impact these most vulnerable patients will significantly decrease the financial strain placed on healthcare systems. Finally, improving the underlying community conditions responsible for injury and illness supports the critical contributions providers have on health by creating environments where wellness can be restored and sustained. A patient suffering from diabetes, for example, is more likely to be compliant with medical advice and less likely to be readmitted if she lives in a community where healthy, culturally-appropriate food is available and places to exercise are both safe and accessible.

Who funded THRIVE?

From 2010-2015, the U.S. Office of Minority Health provided funding to the National Network of Public Health Institutes (NNPHI) and Prevention Institute to update THRIVE and expand its reach through training for NNPHI's member public health institutes and dissemination through NNPHI's membership and networks. The U.S. Office of Minority Health also funded the initial development and piloting of an earlier version of the tool in 3 U.S. locales (2002–2004). The California Endowment provided resources for the initial research and conceptualization of the THRIVE factors. ZeroDivide (formerly the California Community Technology Foundation) provided resources for subsequent modifications to reflect language that is more community friendly.

Where can I get more information?

For more information about THRIVE and how to use it, including the supporting research, and the Community Assessment Worksheet, visit: www.preventioninstitute.org/THRIVE. More information about the development of THRIVE, the pilot sites, and the partnership with the National Network of Public Health Institutes can be found at www.preventioninstitute.org. To inquire about THRIVE, or to request training, technical assistance, or consultation on the use of THRIVE, contact Prevention Institute at consult@preventioninstitute.org or (510) 444-7738.

References

[1] 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.

[2] 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.

[3] Prevention Institute. Moving from Understanding to Action on Health Equity: Social Determinants of Health Frameworks and THRIVE. 2015. Oakland, Ca.

[4] House, J.S. and D.R. Williams. 2000. "Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health." In *Promoting Health: Intervention Strategies from Social and Behavioral Research*, edited by B.D. Smedley and S.L. Syme. Washington DC: Institute of Medicine/National Academy Press.

[5] Satcher D. Eliminating racial and ethnic disparities in health: the role of the ten leading health indicators. *Journal of the National Medical Association.* 2000;92(6):315-318.

[6] McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA*. 1993:270:2207-2213.

[7] Davis R, Cook D, Cohen L. A community resilience approach to reducing ethnic and racial disparities in health. *Am J Public Health*. 2005;95:2168-73

[8] National Institutes of health. (2002). NIH's strategic research plan and budget to reduce and ultimately eliminate health disparities (Vol. I). Available at: Http://ncmhd.nih.gov/our_programs/strategic/pubs/VolumeI_031003Edrev.pdf. Accessed on June 26, 2008.

[9] Whitehead, M. The Concepts and Principles of Equity and health. Copenhagen: WHO Regional Office for Europe. 1990. Available at: http://whqlibdoc.who.int/euro/-1993/EUR_ICP_RPd_414.pdf. Accessed on May 1, 2009.

[10] Cohen L, Iton A, Davis RA, Rodriguez S. A time of opportunity: local solutions to reduce inequities in health and safety. In State and Local Policy Initiatives To Reduce Health Disparities - Workshop Summary, September 13, 2011. Board on Population Health and Public Health Practice, Institute of Medicine, Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

[11] Geronimus AT. Understanding and eliminating racial inequalities in women's health in the United States: the role of the weathering conceptual framework. J Am Med Womens Assoc. 2001;56:133-6, 149-50.

[12] Cohen L, Iton A, Davis RA, Rodriguez S. A time of opportunity: local solutions to reduce inequities in health and safety. In State and Local Policy Initiatives To Reduce Health Disparities - Workshop Summary, September 13, 2011. Board on Population Health and Public Health Practice, Institute of Medicine, Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

[13] U.S. Department of Health and Human Services. (1999). *Mental Health: A report of the Surgeon General.* Rockville, MD. Supplement: Mental Health: Culture, Race, And Ethnicity

[14] Smedley B, Jeffries M, Adelman L, Cheng J. Race, Racial Inequity and Health Inequities: Separating Myth from Fact. 2008. Available at: http://www.unnaturalcauses.org/assets/uploads/file/Race_Racial_Inequality_Health.pdf

[15] Braveman PA, Kumanyika S, Fielding J, LaVeist T, Borrell LN, Manderscheid R, et al. Health disparities and health equity: The issue is justice. American journal of public health 2011;101(S1):S149.

[16] Cohen L, Iton A, Davis RA, Rodriguez S. A time of opportunity: local solutions to reduce inequities in health and safety. In State and Local Policy Initiatives To Reduce Health Disparities - Workshop Summary, September 13, 2011. Board on Population Health and Public Health Practice, Institute of Medicine, Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

[17] Prevention Institute. September 2004. THRIVE – Toolkit for Health and resilience in Vulnerable Environments: Final Project Report Executive Summary. Available at http://thrive.preventioninstitute.org/pdf/THRIVE_execusumm_web_020105.pdf . Accessed 9/25/2012.

[18] Prevention Institute. September 2004. THRIVE – Toolkit for Health and resilience in Vulnerable Environments: Final Project Report Executive Summary. Available at
http://thrive.preventioninstitute.org/pdf/THRIVE_execusumm_web_020105.pdf .

[19] Prevention Institute. September 2004. THRIVE – Toolkit for Health and resilience in Vulnerable Environments: Final Project Report Executive Summary. Available at
http://thrive.preventioninstitute.org/pdf/THRIVE_execusumm_web_020105.pdf .

[20] Prevention Institute. September 2004. THRIVE – Toolkit for Health and resilience in Vulnerable Environments: Final Project Report Executive Summary. Available at
http://thrive.preventioninstitute.org/pdf/THRIVE_execusumm_web_020105.pdf .

[21] U.S. Department of Health and Human Services. (1999). *Mental Health: A report of the Surgeon General.* Rockville, MD. Supplement: Mental Health: Culture, Race, And Ethnicity

[22] California Campaign California Campaign to Eliminate Racial and Ethnic Disparities in Health. Health for All: California's Strategic Approach to Eliminating Racial and Ethnic Disparities in Health. November 2003.

[23] (Flores, G 2005 NEJM).

[24] (IOM, Unequal Treatment, p. 5)

[25] Pincus T, Esther R, Dewalt DA, Callahan LF. Social Conditions and Self Management are More Powerful Determinants of Health than Access to Care. *Annals of Internal Medicine*. 1998; 129:406-411.

[26] Institute of Medicine (2000). A social environmental approach to health and health interventions. In: Smedley BD, Syme SL, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research.* Washington, DC: National Academy of sciences.

[27] Smedley B, Stith A, Nelson A eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington D.C.: The National Academies Press; 2003: 5

[28] Prevention Institute. 2011. Community-Centered Health Homes: Bridging the gap between health services and community prevention. Available at: http://www.preventioninstitute.org/component/jlibrary/article/id-298/127.html.