



Glossary*

Rather than providing a mere list of the definitions or explanations of terms used in the main text of the course, the entries in this glossary help broaden perspectives, deepen discussion and encourage your interest in continuing your studies on this topic. Each entry is cast in relation to its significance to social epidemiology and not following alphabetical order; explication of salience to other disciplines is beyond the scope of this particular glossary.

Biological expressions of social inequality

Biological expressions of social inequality refers to how people literally embody and biologically express experiences of economic and social inequality, from in uterus to death, thereby producing social inequalities in health across a wide spectrum of outcomes. Examples include biological expressions of poverty and of diverse types of discrimination, for example, based on race/ethnicity, gender, sexuality, social class, disability, or age. The construct of “biological expressions of social inequality” thus stands in contrast with biologically deterministic formulations that cast biological processes and traits tautologically invoked to define membership in subordinate versus dominant groups (for example, skin color or biological sex) as explanations for social inequalities in health.

Discrimination

Discrimination refers to “the process by which a member, or members, of a socially defined group is, or are, treated differently (especially unfairly) because of his/her/their membership of that group.” This unfair treatment arises from “socially derived beliefs each [group] holds about the other” and “patterns of dominance and oppression, viewed as expressions of a struggle for power and privilege.” People and institutions that discriminate adversely accordingly restrict, by judgment and action, the lives of those against whom they discriminate. At issue are practices of dominant groups both institutionally and interpersonally to maintain privileges they accrue through subordinating the groups they oppress (intentionally and also by maintaining the status quo) and the ideologies they use to justify these practices, with these ideologies revolving around notions of innate superiority and inferiority, difference, or deviance. Predominant types of adverse discrimination are based on race/ethnicity, gender, sexuality, disability, age, nationality, and religion, and, although not always recognized as such, social class. By contrast, positive discrimination (for example, affirmative action) seeks to rectify inequities created by adverse discrimination.

Ecosocial theory of disease distribution

Ecosocial and other emerging multilevel epidemiological frameworks seek to integrate social and biological reasoning and a dynamic, historical and ecological perspective to develop new insights into determinants of population distributions of disease and social inequalities in health. The central question for ecosocial theory is: “who and what is responsible for population patterns of health, disease, and wellbeing, as manifested in present, past, and changing social inequalities in health?” Adequate epidemiological explanations accordingly must account for both persisting and changing distributions of disease, including social inequalities in health, across time and space. More than simply adding “biology” to “social” analyses, or “social factors” to “biological” analyses, the ecosocial framework begins to envision a more systematic integrated approach capable of generating new hypotheses, rather than simply reinterpreting factors identified by one approach (for example, biological) in terms of another (for example, social). Thus, ecosocial theory invites consideration of how population health is generated by social conditions necessarily engaging with biological processes at every spatiotemporal scale, whether from sub cellular to global, or nanoseconds to millenniums.

Cumulative interplay between exposure, susceptibility, and resistance, expressed in pathways of embodiment, with each factor and its distribution conceptualized at multiple levels (individual, neighborhood, regional or political jurisdiction, national, inter-national or supra-national) and in multiple domains (for example, home, work, school, other public settings), in relation to relevant ecological niches, and manifested in processes at multiple scales of time and space.

Accountability and agency, expressed in pathways of and knowledge about embodiment, in relation to institutions (government, business, and public sector), communities, households, and individuals, and also to accountability and agency of epidemiologists and other scientists for theories used and ignored to explain social inequalities in health; a corollary is that, given likely complementary causal explanations at different scales and levels, epidemiological studies should explicitly name and consider the benefits and limitations of their particular scale and level of analysis.

*Glossary adapted from Krieger Nancy. A Glossary for Social Epidemiology, Rev Panam Salud Pública [serial on the Internet]. 2002 June [cited 2008 Sep 03]; 11(5-6): 480-490. Available at http://www.paho.org/english/sha/be_v23n1-glossary.htm - Part 1
http://www.paho.org/english/sha/be_v23n2-glossary.htm - Part 2. Accessed in September 2008



Embodiment

A core concept for understanding relationships between the state of our bodies and the body politic. Embodiment, a concept referring to how we literally incorporate, biologically, the material and social world in which we live, from in uterus to death; a corollary is that no aspect of our biology can be understood absent knowledge of history and individual and societal ways of living. Pathways of embodiment, structured simultaneously by: a) Societal arrangements of power and property and contingent patterns of production, consumption, and reproduction, and (b) constraints and possibilities of our biology, as shaped by our species' evolutionary history, our ecological context, and individual histories, that is, trajectories of biological and social development.

Gender, sexism and sex

Gender refers to a social construct regarding culture-bound conventions, roles, and behaviors for, as well as relationships between and among, women and men and boys and girls. Sexism, in turn, involves inequitable gender relationships and refers to institutional and interpersonal practices whereby members of dominant gender groups (typically men) accrue privileges by subordinating other gender groups (typically women) and justify these practices via ideologies of innate superiority, difference, or deviance. Lastly, sex is a biological construct premised upon biological characteristics enabling sexual reproduction; sexual categories include: male, female, intersexual (persons born with both male and female sexual characteristics), and transsexual (persons who undergo surgical and/or hormonal interventions to reassign their sex).

Human rights and social justice

Human rights, as a concept, presumes that all people “are born free and equal in dignity and rights” and provides a universal frame of reference for deciding questions of equity and social justice. Operationally, translated to the realm of political and legal accountability, “international human rights law is about defining what governments can do to us, cannot do to us, and should do for us,” so as to respect, protect, and fulfill their human rights obligations. Human rights norms are premised, in the first instance, upon the 1948 Universal Declaration of Human Rights and its recognition of the indivisibility and interdependence of civil, political, economic, social, and cultural rights. A “health and human rights” framework thus not only spurs recognition of how realization of human rights promotes health but also helps translate concerns about how violation of human rights potentially harms health into concrete and actionable grievances that governments and the international community are legally and politically required to address. Understanding of what prompts violation of human rights and sustains their respect, protection and fulfillment is, in turn, aided by social justice frameworks, which explicitly analyze who benefits from and who is harmed by economic exploitation, oppression, discrimination, inequality, and degradation of “natural resources.” Together, both frameworks provide concepts relevant for analyzing social determinants of health and for guiding action to create just and sustainable societies.

Life course perspective

Life course perspective refers to how health status at any given age, for a given birth cohort, reflects not only contemporary conditions but embodiment of prior living circumstances, in uterus onwards. At issue are people's developmental trajectories (both biological and social) over time, as shaped by the historical period in which they live, in reference to their society's social, economic, political, technological, and ecological context.

Multilevel analysis

Multilevel analysis refers to statistical methodologies, first developed in the social sciences, which analyze outcomes simultaneously in relation to determinants measured at different levels (for example, individual, workplace, neighborhood, nation, or geographical region existing within or across geopolitical boundaries).

Poverty, deprivation (material and social) and social exclusion

To be impoverished is to lack or be denied adequate resources to participate meaningfully in society. A complex construct, poverty is inherently a normative concept that can be defined in both absolute and relative terms in relation to: “need,” “standard of living,” “limited resources,” “lack of basic security,” “lack of entitlement,” “multiple deprivation,” “exclusion,” “inequality,” “class,” “dependency,” and “unacceptable hardship;” see “socioeconomic position” below. Also relevant is whether the experience of poverty is transient or chronic. Deprivation can be conceptualized and measured, at both the individual and area level, in relation to: material deprivation, referring to “dietary, clothing, housing, home facilities, environment, location and work (paid and unpaid),” and social deprivation, referring to rights in relation to “employment,



family activities, integration into the community, formal participation in social institutions, recreation and education.” Poverty thresholds accordingly can be set at: (a) An income level (for example, poverty line) determined inadequate for meeting subsistence needs, or (b) “the point at which resources are so seriously below those commanded by the average individual or family that the poor are, in effect, excluded from ordinary living patterns, customs, and activities,” such that the poverty line equals “the point at which withdrawal escalates disproportionately to the falling resources.” Social exclusion, another term encompassing aspects of poverty, in turn focuses attention on not only the impact but also the process of marginalization. Avenues by which social groups and individuals can become excluded from full participation in social and community life include: a) legal exclusion (for example, de jure discrimination), b) economic exclusion (due to economic deprivation), c) exclusion due to lack of provision of social goods (for example, no translation services or lack of facilities for disabled persons), and d) exclusion due to stigmatization (for example, of persons with HIV/AIDS) and de facto discrimination.

Psychosocial epidemiology

A psychosocial framework directs attention to both behavioral and endogenous biological responses to human interactions. At issue is the “health-damaging potential of psychological stress,” as “generated by despairing circumstances, insurmountable tasks, or lack of social support;” see also “stress” below. Typically conceptualized in relation to individuals, its central hypothesis is that chronic and acute social stressors: (a) alter host susceptibility or become directly pathogenic by affecting neuroendocrine function, and/or b) induce health damaging behaviors (especially in relation to use of psychoactive substances, diet, and sexual behaviors). Social capital” and “social cohesion,” in turn, are proposed (and contested) as population level psychosocial assets that potentially can improve population health by influencing norms and strengthening bonds of “civil society,” with the caveat that membership in certain social formations can potentially harm either members of the group (for example, group norms encourage high risk behaviors) or non-group members (for example, harm caused to groups subjected to discrimination by groups supporting discrimination).

Race/ethnicity and racism

Race/ethnicity is a social, not biological, category, referring to social groups, often sharing cultural heritage and ancestry, that are forged by oppressive systems of race relations, justified by ideology, in which one group benefits from dominating other groups, and defines itself and others through this domination and the possession of selective and arbitrary physical characteristics, (for example, skin color). Racism refers to institutional and individual practices that create and reinforce oppressive systems of race relations (see “discrimination” above). Ethnicity, a construct originally intended to discriminate between “innately” different groups allegedly belonging to the same overall “race,” is now held by some to refer to groups allegedly distinguishable on the basis of “culture;” in practice, however, “ethnicity” cannot meaningfully be disentangled from “race” in societies with inequitable race relations, hence the construct “race/ethnicity.” Considering lived experiences of racism as real but the construct of biological “race” as spurious, social epidemiological research investigates health consequences of economic and non-economic expressions of racial discrimination.

Sexualities and heterosexism

Sexuality refers to culture bound conventions, roles, and behaviors involving expressions of sexual desire, power, and diverse emotions, mediated by gender and other aspects of social position (for example, class, race/ethnicity, etc.). Distinct components of sexuality include: sexual identity, sexual behavior, and sexual desire. Contemporary “Western” categories by which people self identify or can be labeled include: heterosexual, homosexual, lesbian, gay, bisexual, “queer,” transgendered, transsexual, and asexual. Heterosexism, the type of discrimination related to sexuality, constitutes one form of abrogation of sexual rights and refers to institutional and interpersonal practices whereby heterosexuals accrue privileges (for example, legal right to marry and to have sexual partners of the “other” sex) and discriminate against people who have or desire same sex sexual partners, and justify these practices via ideologies of innate superiority, difference, or deviance. Lived experiences of sexuality accordingly can affect health by pathways involving not only sexual contact (for example, spread of sexually transmitted disease) but also discrimination and material conditions of family and household life.

Society, social, societal and culture

Society, originally meaning “companionship or fellowship,” now stands as “our most general term for the body of institutions and relationships within which a relatively large group of people live and as our most abstract term for the condition in which such institutions and relationships are formed.” Social, as an adjective, likewise has complex meanings: “as a descriptive term



for society in its now predominant sense of the system of common life,” and also as “an emphatic and distinguishing term, explicitly contrasted with individual and especially individualist theories of society.” Societal, in turn, serves as a “more neutral reference to general social formations and institutions. By this logic, social epidemiology and its social theories of disease distribution stand in contrast to individualistic epidemiology, which relies on individualistic theories of disease causation (see “theories of disease distribution,” below”). Culture, originally a “noun of process” referring to “the tending of something, basically crops or animals,” presently has three distinct meanings: “1) the independent and abstract noun which describes a general process of intellectual, spiritual, and aesthetic development [...]; 2) the independent noun, whether used generally or specifically, which indicates a particular way of life, whether of a people, a period, a group, or humanity in general; and [...] 3) the independent and abstract noun which describes the work and practices of intellectual and especially artistic activity.”

Social class and socioeconomic position

Social class refers to social groups arising from interdependent economic relationships among people. These relationships are determined by a society's forms of property, ownership, and labor, and their connections through production, distribution, and consumption of goods, services, and information. Social class is thus premised upon people's structural location within the economy as employers, employees, self-employed, and unemployed (in both the formal and informal sector), and as owners, or not, of capital, land, or other forms of economic investments. Stated simply, classes like the working class, business owners, and their managerial classes exist in relationship to and co-define each other. One cannot, for example, be an employee if one does not have an employer and this distinction between employee and employer is not about whether one has more or less of a particular attribute, but concerns one's relationship to work and to others through a society's economic structure. Class, as such, is not an a priori property of individual human beings, but is a social relationship created by societies. As such, social class is logically and materially prior to its expression in distributions of occupations, income, wealth, education, and social status. One additional and central component of class relations entails an asymmetry of economic exploitation, whereby owners of resources (for example, capital) gain economically from the labor or effort of non-owners who work for them. Socioeconomic position, in turn, is an aggregate concept that includes both resource-based and prestige-based measures, as linked to both childhood and adult social class position. Resource-based measures refer to material and social resources and assets, including income, wealth, and educational credentials; terms used to describe inadequate resources include “poverty” and “deprivation” (see “poverty,” above). Prestige-based measures refer to individuals' rank or status in a social hierarchy, typically evaluated with reference to people's access to and consumption of goods, services, and knowledge, as linked to their occupational prestige, income, and educational level. Given distinctions between resource-based and prestige-based aspects of socioeconomic position and the diverse pathways by which they affect health, epidemiological studies should state clearly how measures of socioeconomic position are conceptualized. The term socioeconomic status” should be eschewed because it arbitrarily (if not intentionally) privileges “status” over material resources as the key determinant of socioeconomic position.

Social determinants of health

Social determinants of health refer to both specific features of and pathways by which societal conditions affect health and that potentially can be altered by informed action. As determinants, these social processes and conditions are conceptualized as “essential factors” that “set certain limits or exert pressures,” albeit without necessarily being “deterministic” in the sense of “fatalistic determinism.”

Social inequality or inequity in health and social equity in health

Social inequalities (or inequities) in health refer to health disparities, within and between countries, that are judged to be unfair, unjust, avoidable, and unnecessary (meaning: are neither inevitable nor irremediable) and that systematically burden populations rendered vulnerable by underlying social structures and political, economic, and legal institutions. As such, social inequalities (or inequities) in health are not synonymous with “health inequalities,” as this latter term can be interpreted to refer to any difference and not specifically to unjust disparities. For example, recently proposed measures of “health inequalities” deliberately quantify distributions of health in populations without reference to either social groups and or social inequalities in health. Social equity in health, in turn, refers to an absence of unjust health disparities between social groups, within and between countries. Promoting equity and diminishing inequity requires not only a “process of continual equalization” but also a “process of abolishing or diminishing privileges.” Thus, pursuing social equity in health entails reducing excess burden of ill health among groups most harmed by social inequities in health, thereby minimizing social inequalities in health and improving average levels of health overall.



Social production of disease/political economy of health

Social production of disease/political economy of health refers to related (if not identical) theoretical frameworks that explicitly address economic and political determinants of health and distributions of disease within and across societies, including structural barriers to people living healthy lives. These theories accordingly focus on economic and political institutions and decisions that create, enforce, and perpetuate economic and social privilege and inequality, which they conceptualize as root or “fundamental” causes of social inequalities in health. Although compatible with the ecosocial theory of disease distribution, they differ in that they do not systematically seek to integrate biological constructs into explanations of social patterning of health.

Social production of scientific knowledge

Social production of scientific knowledge refers to ways in which social institutions and beliefs affect recruitment, training, practice, and funding of scientists, thereby shaping what questions we, as scientists, do and do not ask, the studies we do and do not conduct, and the ways in which we analyze and interpret data, consider their likely flaws, and disseminate results. That scientists' ideas are shaped, in part, by dominant social beliefs of their times are well documented. Relevant to social epidemiology, a substantial body of literature demonstrates how scientific knowledge and, more importantly, real people, have been harmed by scientific racism, sexism and other related ideologies, including eugenics, which justify discrimination and discount the importance of understanding and ameliorating social inequalities in health. Tellingly, as of the year 2000, only 0.05% of the approximately 34,000 articles indexed in Medline by the keyword “race” had explicitly investigated racial discrimination as a determinant of population health.

Stress

Stress, a term widely used in the biological, physical, and social sciences, is a construct whose meaning in health research is variously defined in relationship to “stressful events, responses, and individual appraisals of situations.” Common to these definitions is “an interest in the process in which environmental demands tax or exceed the adaptive capacity of an organism, resulting in psychological or biological changes that may place persons at risk for disease.”

Theories of disease distribution

Theories of disease distribution seek to explain current and changing population patterns of disease across time and space and, in the case of social epidemiology, across social groups (within and across countries, over time). Using like any theory interrelated sets of ideas whose plausibility can be tested by human action and thought, theories of disease distribution presume but cannot be reduced to mechanism oriented theories of disease causation. Explicit attention to etiological theory is essential, because shared observations of social disparities in health do not necessarily translate to common understandings of causes. Excess risk of HIV/AIDS among poor women of color, for example, is attributed to social inequity by ecosocial and social production of disease theories of disease distribution, but is attributed to “bad behaviors” by biomedical lifestyle theories of disease causation.