ALZHEIMER'S ASSOCIATION INCLUSIVE LANGUAGE GUIDE

Guidance for Describing Social Identities and Characteristics of Individuals and Populations and Communicating about Health Disparities

The Alzheimer's Association Diversity and Disparities Lexicon Workgroup

Alzheimer's Association Inclusive Language Guide

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INTRODUCTION

About the Language Guide

The Alzheimer's Association Inclusive Language Guide was developed to provide guidance on inclusive language and communication practices for researchers and scientists working to address Alzheimer's disease and Alzheimer's disease-related dementias (AD/ADRD). The Language Guide prescribes minimum standards and offers more general guidance for communicating about social identities and characteristics of individuals and populations (i.e., race and ethnicity) as well as approaches to communicating about health disparities. While the language guide introduces some minimum standards, recommendations recognize the considerable variability in global, regional, and local contexts that necessitate flexibility in specific nomenclature and communication style. To that end, this language guide is designed to complement other resources and style guides that may be consulted for more specific guidance on stylistic issues such as capitalization and specific terminology used in a particular country or region (e.g., American Psychological Association Style Guide/Manual).

In the field of AD/ADRD, we observe differences in disease risk and outcomes among groups that are often referred to as underrepresented, marginalized and/or understudied. While these terms are not interchangeable, they are often used when referring to various sub-populations or groups of individuals or populations with shared identities and characteristics that systematically expose them to discrimination, marginalization, disadvantage and/or exclusion from social institutions including the research enterprise. Observed differences in disease risk and outcomes tied to socially linked inequities in fact represent **health disparities**, defined as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage".[1] Health disparities "adversely affect groups of people (with) characteristics historically linked to discrimination or exclusion."

Throughout the language guide, we refer to these characteristics as social identities and characteristics. We posit that these identities and characteristics represent a dynamic confluence of how we see ourselves and how others in our social world see us, as well as our perceptions of those labels.[2] Social identities and characteristics are nuanced and are not always visible. Examples include but are not limited to race, ethnicity, gender identity/expression, ability identity, nationality, and socioeconomic status identity. A broad range of social identities and characteristics may expose an individual or group to discrimination or marginalization, and these identities intersect in dynamic ways to shape our lived experience.

It is imperative that the AD/ADRD field both engender deep sensitivity towards these inequities and that these factors are treated with the same degree of rigor and care provided to any other research measure. Cultivating a culture of appreciation for inclusive language when referring to and communicating about individuals, populations, and health disparities—and the broader scientific constructs this terminology represents — is both an ethical and scientific imperative to advancing equitable AD/ADRD research, care, and treatments. To that end, the Language Guide is focused specifically on the language we use to communicate about these topics.

The Importance of language

Words carry meaning and create opportunities for shared understanding. A majority of ADRD scientists communicate with peers, trainees entering the field, and the general public as a crucial

part of their work. The language we use to refer to individuals and groups of people can convey respect, or it can reflect and perpetuate biases and stereotypes. Because the language we use is deeply engrained in social and cultural norms, we may not always recognize ways that biases or inaccuracies are intertwined with certain terminology or approaches to grouping and describing people and populations. Inclusive language acknowledges differences and conveys regard and respect. Defining and describing different groups, individual social factors, and population disparities measured in AD/ADRD research holds important implications for measurement precision, interpretation of findings, future research questions and approaches, policy recommendations, and inclusion.

Balancing Standardization and Flexibility

Diverse terminologies exist to communicate about an individual's or population's racial, ethnic, and/or cultural identities and the geographic contexts that shape their lived experiences. Variability in the terminology used to describe racial, ethnic, or cultural identities arises largely from geographic, socio-cultural, or communal differences in word usage or preferences and changes in those preferences over time. We understand that AD/ADRD is a *global* health priority and recognize that the meaning of certain terms and their usage varies considerably globally.

In recognition of the highly context-specific nature of specific terminology use, this guidance document emphasizes guiding principles for the AD/ADRD scientific community in communicating about social identities and characteristics and health disparities and minimum standards for communication practices. It is challenging but paramount that investigators carefully consider communication practices related to social identities and characteristics at all stages of design, conduct, and reporting of AD/ADRD research, while prioritizing flexibility and adaptability.

Language Guide Format and Recommendations

This Alzheimer's Association Inclusive Language Guide aims to provide guidance for communicating about social identities and health disparities. Current recommendations address: (1) Guiding Principles, (2) Race and Ethnicity, (3) Geographic, Social, and Economic Contextual Factors, (4) Sex and Gender Identity, and (5) Sexual Orientation Identity. While this is not an exhaustive set of dimensions that are relevant to AD/ADRD research, current guidance prioritizes domains that are commonly measured, demonstrated to be particularly relevant to the study of AD/ADRD health disparities and represent rapidly growing areas of focus in AD/ADRD research.

As noted, the Language Guide includes both broad recommendations and minimum standards. Recommendations serve to provide guidance to AD/ADRD researchers regarding: (a) principles for research to inform communication practices, (b) communication with research participants and communities, and (c) communication with the scientific community. Standards specify criteria that are considered to represent a mandatory communication practice, that may be further enforced by the *Association*, such as through author guideline requirements.

Developing and Revising the Language Guide

Recommendations were developed through a series of discussions with an interdisciplinary workgroup of experts in AD/ADRD health disparities research, which involved consultation of numerous existing standards and guidelines. Recommendations underwent peer review and will undergo further revision following a public Request for Information process soliciting input from stakeholders in the AD/ADRD research and care community. It is expected that the Language Guide will undergo ongoing revisions that are responsive to growth in our understanding of these constructs and best practices.

2. GUIDING PRINCIPLES

There is no universal standard terminology for describing individual and population-level social identities such as racial or ethnic identity or for communicating about health disparities. Here we highlight common guiding principles for reducing bias and stigmatizing language that should be prioritized in making decisions about terminology and communication approach.

Guiding Principles for Describing Individuals, Populations, and Health Disparities

1. Adopt terminology that does not exclude certain groups.
   - Use gender-inclusive language if not referring to a specific individual or group by avoiding the use of pronouns or using they or he/she/they.

2. Avoid language or communication that implies biological significance of race or ethnicity. Race and ethnicity are social constructs with no biological basis or meaning.

3. Health disparities are distinct from population differences and should be contextualized within frameworks of socially-linked inequities and related exposures such as the social determinants of health. Avoid framing questions or findings in a way that implies an individual, community, or population is responsible for health risks or outcomes.
   - A common example of poorly contextualized framing of health disparities is failing to recognize that some groups that are disproportionately affected by AD/ADRD may have systematically limited access to resources that enable them to follow certain health guidelines or recommendations.
   - Another common example of poorly contextualized framing of disparities is suggesting that addressing individual behavior can overcome challenges with structural determinants
   - Do not use language that posits a social identity as a risk factor. An example of this common problem is statements such as "Risk factors for poor sleep included older age, higher BMI, and Black race." Correlations of identity and outcome should be framed centering personhood, for example as "Black participants were at greater risk for poor sleep," and should be contextualized with empirically supported reasons that the identity factor exposes or confers heightened risk.

4. Carefully review language for use of blame, stigmatizing language, or stereotypes.
   - An example of language that may be stigmatizing is the use of the term "uneducated Black population" when referring to older adults who were unable to complete schooling due to segregation. Language that contextualizes the effects of social inequities and does not blame individuals is to state "Individuals who did not have access to education due to segregation."

5. Use language in a manner that acknowledges and respects different identities and groups.
   - Populations with shared social identities are not monolithic or homogenous in their lived experiences, preferences, or other characteristics and this should be explicitly acknowledged.
   - Be cautious about generalizing about a community

6. Use language that is preferred by the group that one is referring to. For example, some groups have published guidance regarding *their own* preferences for how they are referred to and not all groups prefer person-first language. Examples of these preferences include: people with disabilities, person living with dementia, autistic person, and Deaf people. *Word count concerns do not outweigh the need to use preferred language.*

7. Recognize that there is likely not universal consensus for terminology, that preferences likely vary by region and context, and that language is always evolving. Seek continual learning about the meaning of words, and how groups self-identify and would like to be identified by researchers.

8. Describe a person or group at the appropriate level of specificity. To avoid objectification, identify a group or an individual as a member of a group only when it is relevant to your message.

9. Avoid dehumanizing language. Use adjectival forms (e.g., *older adults*) or nouns with descriptive phrases (e.g., *individuals experiencing/affected by poverty, justice system involved persons, people experiencing homelessness*) rather than labels *(the elderly, the poor, the homeless, the Blacks).*

3. Communicating about Race and Ethnicity

Race and ethnicity are social constructs with no biological meaning or basis,[3] yet it shapes systemic and institutionalized differences in lived experiences across space and time.

An example of how race and ethnicity are social constructions is exemplified in the changes made to racial and ethnic classifications in the U.S. Census that are shaped by the political and social agendas of particular times. For example, the Mexican American population has been coded on the Census as different categories, including Mexican, White, and Hispanic or Latino – which is all related to the historical politics in this country.[4] These classifications influence law, policy, and allocation of resources that influence disease risk, diagnostics, and management (e.g., access to and quality of health care). In turn, these factors shape downstream biological processes and biological resilience, which are precursors to major diseases and health outcomes.[5] Moreover, these constructions of race and ethnicity need to be recognized as systems of structuring opportunity across domains and across the life course – such as through access to education, employment, housing, safe neighborhoods, and social connections. Thus, we need to consider explicitly that race and ethnicity are fundamental social causes of health since these constructions produce unequal outcomes;[6] and we must center race and racism with respect to racial and ethnic inequalities in ADRD research.

The approaches we use to group people and the terms we use to describe those groups can reinforce stereotypes, particularly those suggesting that social identities such as race emanate from biological differences. Because discrimination that results from the social construction of racial identities influences lived experience and biological processes in ways that modify disease risk, health access, and outcomes, grouping people according to social identities such as race ultimately supports the goal of being responsive to the effects of discrimination and health disparities. Cultural identities are often considered alongside but not interchangeable with race or ethnicity, and may include characteristics such as language, religion, nationality, or immigration status. Ancestry correlates with race and ethnicity to differing and often limited degrees; it should be operationalized and addressed separately if genetic risk factors are of primary scientific interest.

Understanding Uniform Classification Systems for Collecting Race and Ethnicity Data

Systems of racial and ethnic classification are used globally, and in many cases driven by efforts to count and categorize a region or nation's population. According to data from the United Nations derived from global census questionnaires, 65% of countries classify their population by identity-based factors such as nationality or ethnic group identity (United Nationals Statistical Division, 2003). The specific language used in these classification systems varies considerably and includes various terms, such as "race," "ethnic origin," "ancestry," "nationality," "indigenous," "tribal," and "aboriginal." The *meaning* of terms used in classification systems is often inconsistent or vague. For example, terms may be used interchangeably or a characteristic that is referred to as an "ethnic" identity in one country may be labeled as "nationality" or "race" in another. These classification systems may be derived from historical or socio-political understandings and motivations that may or may not be sufficiently specific, accurate, or inclusive for the purposes of a given research study. For these reasons, it is important for researchers to become familiar with policies or practices that have informed data collection practices relevant to their region and population(s), including the format of questions and response options about racial, ethnic, or other cultural identities.

> **Recommendation.** Identify nationally, regionally, and/or locally-specific uniform classification systems for collecting and reporting on race, ethnicity, and/or other cultural identity-based factors such as nationality. These classification systems may shape some requirements for data reporting and aggregation, but may not be sufficiently specific or diverse in question and format options for use in your research. Whenever possible, data collection and reporting should be informed by the characteristics and preferences of the communities involved in your study.

OMB Directive 15 in the United States. In the United States, a uniform and widely used classification for collecting and reporting data on race and ethnicity are derived from the Office of Management and Budget (OMB) Directive 15 established in 1997. The Directive defines minimum standards that remain in use by federal agencies including the National Institutes of Health and the US Census. The guidelines include 5 race categories and 2 ethnicity categories. It is important to acknowledge that administrative data can be limited due to requirements within these classification systems.

> **OMB Directive 15 Race and Ethnic Standards for Federal Statistics and Administrative Reporting**
> **Ethnic Categories**
> - Hispanic or Latino
> - Not Hispanic or Latino
>
> **Racial Categories**
> - Black or African American
> - American Indian or Alaska Native
> - Asian
> - Native Hawaiian or Other Pacific Islander
> - White
>
> *There is an alternative combined format that allows for the following categories: American Indian or Alaskan Native, Asian or Pacific Islander, Black, not of Hispanic origin, Hispanic and White, not of Hispanic origin.

Principles for Research to Inform Communication Practices

Because what is most appropriate varies considerably by context including national, regional and local differences in language preferences, our guidance for terminology on race and ethnicity focuses first on *how to approach communication and decision-making for specific terminology*. We subsequently provide specific guidance on non-inclusive or discriminatory terminology to avoid using and minimal standards for reporting.

1. **Know the community(ies) in your studies**: Where feasible, investigators should consider identifying terminology preferred and used by individuals in their studies. In some situations, investigators may decide to use multiple terms, such as African American/Black or Latina/Latino/Latinx/Latiné.

2. **Recognize that racial/ethnic identity is not dichotomous**. Individuals may identify with multiple racial, ethnic, and/or cultural identities. It is important to maximize flexibility in self-classification options for participants, meaning participants can be provided options to identify in more than one category. For example, a participant could select African American and Asian.

3. **Consider generational differences in terminology**. Examples of differences in preference might be the use of the term "Negro vs Black" or the term "Chicano/a." Note there may be generational differences in how some terminology that may be considered offensive contemporaneously is viewed; for example, some older African Americans may

embrace the term negro whereas younger generations may find the term offensive. In the event that terminology is preferred by participants from a specific generation of interest, as is often the case with AD/ADRD cohorts, investigators can describe that their terminology use is informed by the preferences of study participants.

4. **Prioritize flexibility and adaptability.** What is "right" or "preferred" often changes over time. Investigators from outside of the community they study will find that nuanced information about identity is likely to emerge as a function of continuing engagement with community members.

5. Participants should have the opportunity to self-identify their race and ethnicity with as much flexibility as possible. Researchers should acknowledge that self-identified race represents a confluence of how participants perceive themselves (racial identity) and the impacts of racialization by others. During dissemination, researchers are obligated to transparently describe and justify any aggregation that occurs for analytic purposes (i.e. sample size), and to note how pre-aggregation nuances might limit inference or shape future directions.

6. **Do not conflate self-reported race with ancestry.** Racial, ethnic, and/or cultural identities are not surrogates for genetic ancestry, a distinct construct that may also be relevant in ADRD studies. The reverse is also true: ancestry should never be used to "confirm" self-reported race or to assign individuals to racial categories.

Standards for Describing and Communicating about Race and Ethnicity

The following communication standards should be adhered to in all descriptors of and communication regarding race and ethnicity.

1. Collect and report self-identification of race and ethnicity.

2. Do not assign or label individuals to racial or ethnic identities based on researchers' perceptions.

3. Avoid adjectives as nouns to label people such as stating "Blacks" or "the poor." Instead, adopt adjectival forms, such as "Black older adults," "people living in poverty," and "people with limited literacy."

4. Avoid the use of terminology with roots in eugenics or racist philosophies, while recognizing that the meanings of these terms may vary by region and country. Examples of such terms from a Untied States context are Caucasian, Oriental, and Eskimo.

5. Do not conflate race and ethnicity with ancestry.

4. Communicating about Geographic, Social, and Economic Contextual Factors

<u>Background:</u>

Investigation into determinants of health disparities in AD/ADRD frequently emphasize individual-level experiences with social determinants of health, which include "the conditions in the environments where people are born, live, learn, work, play, worship, and age".[1] These include one's economic stability, experiences with health care access and quality, social and community settings, neighborhood and built environment, and education access and quality. However, the influence of these individual experiences with the social determinants of health is often dependent upon the geographic, social, and economic context in which individuals live. Geographically and environmentally situated contextual factors may include the rural vs urban settings or the built 'geography' where one lives, as well as other broader non-geographic features such as immigration policy, political environment, or historical and systemic discrimination against groups individuals belong to. Relevant constructs in AD/ADRD studies may vary across international contexts as well as linguistic diversity. Resources from the World Health Organization and World Bank can aid investigators in understanding country- and region-specific differences in salient contextual factors. For example, the implications and resource allocations within rural/urban or urban/suburban settings varies widely globally and regionally.

Geographically and environmentally situated contextual factors have been shown to exert independent, multifactorial impacts above and beyond individual-level factors a range of health-related outcomes, including ADRD. While these factors have been studied and measured for decades in other fields (e.g., Sociology, Demography, International Development, Economics, Epidemiology), their use in the ADRD field is relatively new. Given the breadth of disciplines that have studied -contextual socio-economic factors, terminology in this area is frequently inconsistent but often includes the following: geographic factors, socio-contextual factors, socio-contextual disadvantage, deprivation, and disadvantage (and variants therein including geographic, socio-contextual, neighborhood-level deprivation, disadvantage, and/or emergent group properties).

Individual-level social and economic factors, such as socio-economic status, are often associated with, yet are distinct from situational and contextual-level factors. Conflation and lack of specificity regarding attribution of contextual factors to the individual- is not uncommon and has important implications for the accuracy of inferences regarding social forces that operate at distinct levels, as well as for the inappropriate attribution of social context that surrounds individuals to persons within those populations. Understanding individual through macrosystems difference is paramount when contrasting/comparing study results regionally, nationally, and internationally. The following recommendations and guidance are offered to aid AD/ADRD researchers in addressing these constructs.

<u>Recommendations:</u>
- Consistently specify the geospatial region/level of contextual and geographic-based measures used. For example, do not substitute "neighborhood-level disadvantage" with use of a broader or vaguer term such as "area disadvantage." *Avoid use of shorthand descriptors such as "disadvantage" (without the contextual adjective) that risk conflation with individual-level factors.*
- Detail the dimensions measured or included in descriptions of applied contextual or geographic-based measures, to improve transparency and rigor. For example, a composite measure like a Multidimensional Poverty Index has multiple indicators (years of schooling, attendance) that are weighted to constitute a single dimension (education) out of the global composite.

- Specify consistently the geographic scale for contextual-level descriptors congruent with measurements/metrics applied. For example, if measurement of geographic disadvantage is operationalized at a neighborhood-level, this should be anchored to established discrete and validated geographic and/or social science constructs. Metrics should specified with consistent terminology accompanied by descriptors of how neighborhood—or any other geographic/social area of measure—was defined and operationalized in analyses.
- Use language that respects and is sensitive to unequal distribution of historically excluded and minoritized populations within regions characterized as having higher levels of deprivation or disadvantage. Such language attributes descriptors of geographic region to the context and not to individuals or communities. For example, "persons with exposure to neighborhood-level disadvantage" is preferred to stating "people from disadvantaged neighborhoods."
- Describe the methods for collecting, defining, and analyzing/coding geographic and contextual-based metrics of socio-economic status and any limitations associated with those methods.

6. Communicating about Sex, Gender, and Sexual Orientation

Background:

Sex, gender, and sexual orientation, though related, are conceptually distinct. They each demand attention in ADRD science. Sex is defined by differences in chromosomes, sex organs, endogenous hormones, and other characteristics encoded in DNA.[7,8] Historically, biologic sex has been thought of as a binary construct whereby sexually dimorphic qualities and reproductive roles have been used as phenotypes to discern men and women. However, biologic sex is not binary (e.g., male, female, intersex), but healthcare professionals most often assign a sex to an infant at birth based on their anatomical and biological characteristics. But emerging data show genetic and phenotypic variations (i.e., intersex) fall outside what's typically understood as the binary or male or female.[9] There is also growing recognition of "transgender" identities in which individuals are assigned a biologic sex at birth that differs from their later gender identity. Sex also is referred to as birth sex, natal sex, or biological sex; however, sex assigned at birth is the recommended term.[10]

Gender refers to "socially constructed and enacted roles and behaviors that occur in a historical and cultural context."[7] This means that the construct of gender varies over time and across cultures. Like biologic sex, the construct of gender comprises a range of attributes and qualities, such as gender roles, expression, ideology, occupations, and/or gendered relationships. Transgender refers to someone whose gender identity and sex assigned at birth do not correspond based on traditional cultural expectations. Transgender also may include individuals whose gender identities lay outside the historical binary structure (i.e., non-binary, genderqueer, and gender nonconforming).[10]

Sexual orientation refers to the characteristics of those to whom one is sexually and/or emotionally attracted as well as sexual behavior.[11] Research suggests that sexual orientation occurs on a continuum.[12-15] However, common categories of sexual orientation include attraction to members of one's own sex (gay, lesbian), attraction to members of the other sex (heterosexual), attraction to members of both sexes (bisexual), attraction that is not related to another's sex or gender (pansexual), as well as another sexual orientation. Sexual behavior reflects that individuals, who may not identify as gay, lesbian, bisexual, queer, or another identity, may engage in or have experienced sex with someone of the same sex or gender. Individuals may identify as heterosexual (straight), homosexual (gay or lesbian), queer, asexual, bisexual or another sexual orientation.[10]

Intersectional identities
        Sex, gender, and sexual orientation are identities. While gender and sexual orientation are often conceived of as being defined by an individual according to their self-concept, sex can both reflect society's expectations of an individual's social identity, such as "sex assigned at birth", and/or an individual's self-concept. The existence and operation of these identities are often actualized via conceptual models related to gendered behaviors, gender roles, sexual identity development, gender-as-performance, and others.
        Sex, gender, and sexual orientation identities are intersectional, meaning they can inform each other. Sexual orientation, for example, relies on sex to inform its categorization. These identities can also compound systematic oppression within social systems. A woman, for example, who is in a spousal relationship with another woman may experience effects of the systemic oppression of women directly and via her wife's experiences. In addition, aspects of identity related to sex, gender, and sexual orientation intersect with other identities. A Black transwoman, for example, can experience transphobia and homophobia in combination with systemic oppression of Black individuals. These identities and their social consequences are context dependent. The effects of these experiences on social, psychological, and biologic outcomes are not well understood.

Here, we offer considerations and recommendations for attending to these constructs in peer-reviewed, scientific publications.

Recommendations:

- Use language that respects that sex, gender, and sexual orientation may have biologic and social underpinnings and correlates.
- Use language that respects that self-reported sex, gender, and/or sexual orientation are 1) aspects of identity, 2) can be non-binary, and 3) appropriately measured by one's self-report of their identity.
- Describe the methods for collecting, defining, and analyzing/coding sex, gender, and sexual orientation variables and any limitations associated with those methods.
- Include the reasons justifying exclusion/inclusion of individuals based on sex, gender and/or sexual orientation.
- If results statistically adjusting for sex, gender, and/or sexual orientation are reported, results of stratified analyses also should be reported when statistically appropriate/sample size allows.
- Report on representation of sex, gender, and sexual orientation identities in research samples and/or state explicitly unrepresented (or unmeasured/uncounted) groups that may be relevant to study focus.
- When reporting on and/or interpreting the meaning of scientific results that are based on identity data related to sex and/or gender, particularly in instances such as secondary analysis of archival data where it may be unclear which construct was assessed, "sex/gender" may often be most appropriate term of art.
- Avoid making biologic inferences when reporting on and/or interpreting the meaning of scientific results that are based on identity data related to sex, gender, and/or sexual orientation. These groupings reflect sociocultural classifications. While they may have biologic correlates and most likely correspond to complex pathways between lived experience and biologic mechanisms, biologic inference in the absence of biologic data risks invoking ideas of biologic essentialism and social prejudices.
- As scientists report and interpret findings based on identity data, it is essential that variabilities in lived experience that are due to these groupings be considered, minimally, as potential confounders and, more productively, as active agents in investigative pathways
- Consult and apply the most current, existing guidelines:
    - NIH guidelines for consideration of sex as a biologic variable: https://orwh.od.nih.gov/sites/orwh/files/docs/NOT-OD-15-102_Guidance.pdf.
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- Consider the relevance of sex, gender, and/or sexual orientation to ADRD research, clinical outcomes, translation, and implementation:
    - How might findings related to sex, gender, and/or sexual orientation be indicative of ADRD disparities and diversity that warrant further investigation?
    - How might representation of sex, gender and/or sexual orientation of individuals help inform understanding or address a gap of the phenomenon under study, or
    - How might sex, gender, and/or sexual orientation be interacting with the mechanisms; or
    - How might sex, gender, and/or sexual orientation impact theory efficacy or effectiveness of interventions under study

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8. Glossary of Key Terms

Race: a socially constructed concept that refers to groups of people who are categorized by physical characteristics (e.g., skin color/complexion, facial features). Individuals may racially identify with a single race or as bi- or multiracial, and the meaning of race can vary across individuals within each racial group.

Ethnicity: characteristics such as country of origin, language, religion, history, or cultural traditions that are shared among a group of people.

Social identities: the self-concept derived from memberships in social groups or categories, representing a dynamic confluence between how we see ourselves and how others in our social world see us. Examples of social identities are race, ethnicity, gender, social class/socioeconomic status, sexual orientation, presence of (dis)abilities, or religion/religious beliefs.

Ancestry: several forms of ancestry can exist, such as a person's ethnic origin or descent, "roots," or heritage; the place of birth of the person or the person's parents or ancestors (geographic ancestry); or individuals from whom someone is biologically descended (genetic ancestry).

Health Disparity: a health difference that is closely linked with social, economic, and/or environmental disadvantage.

Health Equity: the absence of unfair, avoidable or remediable differences in health. Health equity allows all individuals to achieve their full potential for health.

Social Determinants of Health: the non-medical factors that influence health outcomes. They are the conditions in the environments where people are born, live, learn, work, play, worship, and age, and include aspects such as economic stability and working conditions, education access and quality, healthcare access and quality, neighborhood and build environment, and social context. Social determinants of health have an important influence on the presence of health disparities.

Discrimination: differential, unjust or prejudicial treatment of the members of a group based on characteristics such as race, ethnicity, gender, age, sexual orientation, gender identity or expression, religious identity, nationality, ability status, , national, or other factors.

Marginalization: a process through which an individual or group becomes identified as one that is not accepted fully into a larger or more "dominant" group which is treated as preferential.

Racialization: the social process of defining individuals as belonging to a certain racial group, on the basis of features such as skin color, hair texture, or facial features. These definitions are applied to individuals or groups of people by others, who typically are in a more powerful social position. Over time, groupings such as "race" can appear to be grounded in biological differences as the origins of racialization as a social process are forgotten.

Ethnicization: akin to racialization, it is the social process of defining individuals as belonging to a certain ethnic group, on the basis of features such as country of origin, language, religion, cultural traditions, food, or style of dress.

Diversity: wide range of variation among people and population groups, and can include such factors as age, gender, sexuality, race, ethnicity, nationality, and religion, as well as education, livelihood, and marital status.

Systemic and structural racism: A system in which public policies, institutional practices and normal, and cultural representations that often reinforce one another to perpetuate racial group inequity by limiting opportunities, resources, or justice in a standard and systematic manner.

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